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In This Issue

Feature Articles
PAGE 1
Francis the Ecological Physician:
Assessing the Symptoms, Diagnosing the Illness
and Prescribing a Cure
Dan DiLeo, M.T.S.

PAGE 8
Catholic Identity and the Reshaping of Health Care
in the United States
Michael R. Panicola, Ph.D.
Ron Hamel, Ph.D.

From the Field
PAGE 18
Reflections on the Encyclical
- Sr. Rose Dowling, FSM
- Birgitta N. Sujdak Mackiewicz, Ph.D.
- Elizabeth Keene & Kirsten Walter
- Michael Cox & Sr. Mary Ellen Leciejewski, OP
- Cristina Richie

Ethical Currents
PAGE 33

Of Note
PAGE 36

Resources
Bibliography
PAGE 39
Francis the Ecological Physician: Assessing the Symptoms, Diagnosing the Illness and Prescribing a Cure

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Since the publication of Laudato Si’ (LS’), Pope Francis has been called many names: prophet, Marxist, eco-pope, radical, rock-star and Christian. One name that does not seem to have been used, however, is physician. Perhaps it is because I write for health care professionals, but it seems to me that – save for Christian and prophet – physician is a term that describes the author of LS’ better than most others. This is due to the fact that in LS’, Francis utilizes the best available science to assess the symptoms of ecological degradation, diagnoses the illnesses that produce these symptoms, and prescribes a cure to heal our current ecological disorders. Understood as such, the Catholic health care ministry has a unique vocation to serve as ecological nurse, partnering with the physician to help the world implement the doctor’s orders prescribed in LS’.

ASSESSING THE SYMPTOMS

Francis the physician begins his ecological exam in LS’ by utilizing cutting-edge science to evaluate the physiological symptoms of illness that non-human creation is presenting. In particular, he notes that “a very solid scientific consensus indicates that we are presently witnessing a disturbing warming of the climatic system” (23). Additionally, the pope also observes the physical realities of increasing water scarcity and the widespread “loss of biodiversity” (38).

While Francis thus assesses the biological symptoms that creation is experiencing, he also evaluates the symptoms of illness that humanity is concurrently suffering. These include climate change-induced loss of resources and population displacement among the poor, “social exclusion, an inequitable distribution and consumption of energy and other services, social breakdown, increased violence and a rise in new forms of social aggression, drug trafficking, growing drug use by young people, and the loss of identity” (24, 46).

At first glance, it may seem odd for the pope to attend to social ills in an ecological examination. Here, however, Francis pioneers the term “integral ecology” to name the precedent of Catholic awareness that human flourishing is inexorably connected to the rest of creation. He insists that “it cannot be emphasized enough how everything is interconnected” in the world, and says this is especially true of human and non-human creation (138). As such, Francis says, “we are faced not with two separate crises, one environmental and the other social, but rather with one complex crisis which is both social..."
and environmental” (Ibid.). As one example, Francis highlights how the physiological consequences of anthropogenic climate change are already forcing the migration of poor persons who are unjustly least responsible for historical greenhouse gas emissions (25) – a particular reality which highlights the general fact that the poor are often disproportionately harmed by ecological degradation.

DIAGNOSING THE ILLNESS(ES)
Following his assessment of the symptoms presented by human and non-human creation, Francis, the ecological physician, diagnoses the underlying illness that is their cause. Guided by the concept of integral ecology, Francis recognizes that the combination of cataloged biological and humanitarian symptoms is due to comorbid illnesses in the body of society. As he says, awareness of widespread ecological degradation means that “it is no longer possible to find a specific, discrete answer for each part of the problem” (139). In particular, Francis diagnoses several structural, anthropological and theological illnesses in which contemporary ecological harm is rooted.

Structural Diagnoses: Technocracy, Economics and Politics
Francis’ most over-arching structural diagnosis is that humanity suffers from the illness of what he calls a “technocratic paradigm.” By this, he means:

An undifferentiated and one-dimensional paradigm … [which] exalts the concept of a subject who, using logical and rational procedures, progressively approaches and gains control over an external object. This subject makes every effort to establish the scientific and experimental method, which in itself is already a technique of possession, mastery and transformation. It is as if the subject were to find itself in the presence of something formless, completely open to manipulation (106, emphasis in original).

Plagued by this technocratic paradigm, Francis observes how humans have moved from a symbiotic relationship with creation – including with other persons – to one of domination and exploitation. In particular, Francis observes that “the technocratic paradigm … tends to dominate economic and political life” (109). With respect to economics, Francis critiques neoliberal capitalism in particular for its “accept[ance of] every advance in technology with a view to profit, without concern for its potentially negative impact on human beings (Ibid.). Relatedly, and with special focus on human-forced climate change, Francis highlights the failure of civil society to enact policies that mitigate ecological harm:

It is remarkable how weak international political responses have been … There are too many special interests, and economic interests easily end up trumping the common good and manipulating information so that their own plans will not be affected (54).

Anthropological and Theological Diagnoses: Anthropocentrism, Selfishness and Sin
Although Francis offers perceptive diagnoses of the structural ills that plague the physical, material and enlivened inhabitants of our common home, the pope also identifies deeper anthropological and theological
maladies that gave rise to and perpetuate ecologically deleterious systems. First, Francis identifies “modern anthropocentrism” which overemphasizes humanity’s distinct place in creation and is partly rooted in skewed Christian theology which overstates humanity’s autonomy in creation (116). Interestingly, this insight tacitly embodies the robust controversy around Lynn White, Jr.’s classic essay, “The Historical Roots of our Ecological Crisis.”

In 1967, White alleged that contemporary ecological degradation is largely due to resource exploitation justified by Christians’ appeal to Genesis 1:28, wherein God says to humanity, “Be fertile and multiply; fill the earth and subdue it. Have dominion over the fish of the sea, the birds of the air, and all the living things that crawl on the earth.” In response, commentators point out that the Hebrew words for “dominion” and “subdue” — rādâ and kābaš, respectively — do not call for heedless exploitation. The former is a term that signifies the governance of a benevolent ruler whose surrogates are called to exercise the same caring supervision over that which has been entrusted to them. Within the context of ecology, its use in Genesis 1:28 indicates that humans are called to steward creation with the ethic of our loving Creator. Additionally, the Hebrew term for “subdue,” kābaš, is used in reference to an adversary and is thus employed in Genesis 1:28 to convey the difficulty of domesticating creation – not as exploitative license. As such, Francis’ comments provide the latest rebuttal to White’s controversial thesis in particular and to the larger problem of anthropocentrism in general.

In addition to anthropocentrism, Francis also diagnoses human selfishness – both individual and collective – as one of the ills in which contemporary ecological degradation is rooted. For example, he observes that “the cost of the damage caused by such selfish lack of concern [for creation] is much greater than the economic benefits to be obtained” (36). Moreover, he describes how “international [climate change treaty] negotiations cannot make significant progress due to positions taken by countries which place their national interests above the global common good” (169). Finally, the pope notes that “the current global situation engenders a feeling of instability and uncertainty, which in turn becomes ‘a seedbed for collective selfishness’” antithetical to integral ecology (204). This is especially so due to the fact that “when people become self-centered and self-enclosed, their greed increases” and they consume resources at an insatiable rate (Ibid.).

Ultimately, Pope Francis points out that the human illness at the core of ecological harm is sin. He describes sin as the “rupture” of the “three fundamental and closely intertwined relationships” that constitute the human condition: “with God, with our neighbour and with the earth itself” (66). Animated by this understanding, Francis quotes Patriarch Bartholomew who says that “a crime against the natural world is a sin against ourselves and a sin against God” (8). Additionally, the pope laments “our situation today, where sin is manifest in … attacks on nature” (66) and “indifference” to the suffering of other creatures, both human and non (25, 52, 93, 115, 232, 246).
FEATURE ARTICLE

PRESCRIBING A CURE

Given his diagnosis of the human illnesses in which the symptoms of ecological degradation are rooted, Francis the physician prescribes theological, anthropological and systemic remedies by which humanity can heal the ecological wounds of creation. He recognizes that the scope of the contemporary ecological crisis means that “no branch of the sciences and no form of wisdom can be left out” of conversations about solutions (63). In particular, Francis asserts that its “syntheses between faith and reason” enables the Catholic Church to make several distinct contributions to conversations about solutions to ecological harm (63). As such, he prescribes to humanity “the Gospel of Creation” (62), an embrace of “integral human ecology” with special attention to particular tenants of Catholic social thought (137), political and economic policy interventions, and “ecological education” (202).

“The Gospel of Creation”

Pope Francis’ regimen for ecological healing begins with consideration of “the Gospel of Creation” understood as the church’s creation theology constituted by two key parts: “the wisdom of the Biblical accounts” (66-68) and “the mystery of the universe” articulated in non-biblical sources (76-83). The former, he says, can help humanity recognize the sinful roots of ecological harm and the need for reconciled relationships, and to recover an appreciation for the intrinsic goodness and dignity of all creation (66, 68). The latter, Francis insists, can destabilize anthropocentrism and foster a deeper “universal communion” between persons and with all other creatures characterized by “the common destination of goods,” a preferential option for the poor and vulnerable, and “the subordination of private property” to the universal destination of goods (89-95).

Integral Ecology

In addition to the “Gospel of Creation,” Francis prescribes that humanity embrace the aforementioned notion of integral ecology in order to recover from the illnesses that cause ecological harm. In the words of Pope John Paul II, this will entail awareness of and response to the fact that “we cannot interfere in one area of the ecosystem without paying due attention both to the consequences of such interference in other areas and to the well-being of future generations” (emphasis in original).5 This, Francis, says, requires candid “reflection and debate about the conditions required for the life and survival of society, and the honesty needed to question certain models of development, production and consumption” (138). It also calls for particular commitment to three other pillars of Catholic social thought: the common good which requires peace and is understood as “the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfilment” (156-158); the preferential option for the poor and vulnerable (158); and “intergenerational solidarity,” i.e., commitment to the common good of future generations (159-162).7

Political and Economic Policy Interventions

Given the scale of ecological degradation – especially human-forced climate change – and historical lack of solutions, Pope Francis goes on to prescribe political and economic policy interventions essential to ecological healing. First, he insists that “technology based on the use of highly polluting fossil fuels – especially coal, but also oil and, to a lesser degree, gas –
needs to be progressively replaced without delay” (165). Towards this end, he asserts that “enforceable international agreements are urgently needed” and must be guided by “common and differentiated responsibilities” which account for the “ecological debt” owed by the historically fossil fuel-intensive Global North to the exploited Global South (51-52, 170, 173). Additionally, Francis emphasizes the need for just local and national environmental policies (176-181). In all cases, the pope insists that “politics and economics [must] enter into a frank dialogue in the service of life, especially human life” (Ibid.). Furthermore, he also holds that such interventions should always be guided by the principle of subsidiarity which addresses problems at the lowest possible but highest necessary level of society (157, 196).8

Ecological Education
A final prescription that Francis offers in response to the ecological illnesses of creation is ecological education (209-215). In particular, the pope teaches that successful ecological education can highlight:

- the gravity of today’s cultural and ecological crisis … critique of the ‘myths’ of a modernity grounded in a utilitarian mindset (individualism, unlimited progress, competition, consumerism, the unregulated market) … restore the various levels of ecological equilibrium, establishing harmony within ourselves, with others, with nature and other living creatures, and with God … facilitate making the leap towards the transcendent which gives ecological ethics its deepest meaning [and] instill good habits (209-211).

Such education, he says, “can take place in a variety of settings: at school, in families, in the media, in catechesis and elsewhere,” and requires “educators capable of developing an ethics of ecology, and helping people, through effective pedagogy, to grow in solidarity, responsibility and compassionate care” (210, 213).

CATHOLIC HEALTH CARE AS ECOLOGICAL NURSE
Given the assessments, diagnoses and prescriptions of Pope Francis the ecological physician, the Catholic health care ministry is now called to respond as an ecological nurse that helps persons and society implement and follow the script of LS’. This distinct vocation is rooted in the ministry’s Catholic mission, experience of how ecological degradation harms human health (20, 21, 28, 44) and capacity to effect change through operations and advocacy. As such, there are several things that Catholic health care can do.

First, the Catholic health care ministry can implement Francis’ prescription of “the Gospel of Creation” by creating and sharing resources that help persons reflect on Catholic teaching about creation. For example, systems can follow the advice of the Catholic Health Association (CHA) to utilize encyclical prayer cards in meetings or shared spaces.9 Additionally, hospitals might display pictures that combine images of creation and ecological Scripture passages in hallways and patient rooms.

Next, the ministry could embrace integral human ecology by recognizing ecological harm as a cost to be considered in economic calculations. For example, a system could utilize renewable energy that is more expensive in the short term based on the understanding that
climate change compromises the life, health and dignity of the world’s poorest and most vulnerable persons. Moreover, a hospital could decide to pay a premium for more ecologically responsible health care products, office supplies and cafeteria foodstuff.

Third, Catholic health care might implement Francis’ prescription of political and economic policy interventions by advocating for domestic and international climate change policies. In the U.S., it is especially important that the ministry urge Congress to support the CHA-backed national carbon pollution standard (Clean Power Plan) and contribute to the United Nations’ Green Climate Fund for adaptation. This is due to the fact that both are considered critical to the adoption of an international climate change agreement.

Finally, the ministry could employ the pope’s prescription of ecological education by pushing for greater attention to integral ecology in all types of health care education. This would include, for example, working to further incorporate integral ecology into medical school curricula, undergraduate and graduate programs in bioethics and health care ethics, and continuing education programs for all health care professionals.

CONCLUSION
At the end of *LS*, Francis the ecological physician finishes his work with “a Christian prayer in union with creation” (246). There, he offers a poetic synthesis of his script and provides a starting point from which the Catholic health care ministry might partner with the pope to nurse creation back to health following the publication of *LS*. He writes:

Father, we praise you with all your creatures. They came forth from your all-powerful hand; they are yours, filled with your presence and your tender love. Praise be to you!

Son of God, Jesus, through you all things were made. You were formed in the womb of Mary our Mother, you became part of this earth, and you gazed upon this world with human eyes. Today you are alive in every creature in your risen glory. Praise be to you!

Holy Spirit, by your light you guide this world towards the Father’s love and accompany creation as it groans in travail. You also dwell in our hearts and you inspire us to do what is good. Praise be to you!

Triune Lord, wondrous community of infinite love, teach us to contemplate you in the beauty of the universe, for all things speak of you. Awaken our praise and thankfulness for every being that you have made. Give us the grace to feel profoundly joined to everything that is.

God of love, show us our place in this world as channels of your love for all the creatures of this earth, for not one of them is forgotten in your sight. Enlighten those who possess power and money that they may avoid the sin of indifference, that they may love the common good, advance the weak, and care for this world in which we live. The poor and the earth are crying out. O Lord, seize us with your power and light, help us to protect all life, to prepare for a better future, for the coming of your Kingdom of justice,
peace, love and beauty.
Praise be to you!
Amen.

2 For an extended analysis of this term, see:
   http://teilharddechardin.org/mm_uploads/TP_Spring_Summer_2015.pdf

Catholic Identity and the Reshaping of Health Care in the United States

Editor’s Note: The process and tools accompanying this article were developed primarily by Michael Panicola. Given the number of mergers and affiliations occurring in Catholic health care, these materials might be of help to others in the ministry. The explanation of the process refers to 4 Appendices. Only two are included here—the 1st and 3rd. A summary of this article, the narrative explanation of the process and all four Appendices will appear in the September-October issue of Health Progress. The third Appendix consists of a grid illustrating an application of the Principle of Cooperation. Because principles involve judgments in a particular set of circumstances, it is quite possible that others might come to different conclusions than those illustrated in the grid. Furthermore, a revision of Part Six of the Ethical and Religious Directives that is currently in development could also affect the application of the Principle of Cooperation to new mergers and affiliations.

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Health care in the United States is in the midst of a major transformation, the likes of which perhaps we have never seen, not even in the oft-mentioned reform era of the 1990s when managed care rose to prominence. As stated in a white paper by the health care consultancy, Oliver Wyman, “We are at the beginning of the largest industry transformation in the past century…” Traditional providers and new entrants – spurred by government, employers, and individuals – “are igniting a volume-to-value revolution” that will result in a radically different health care system than the one we know today (Tom Main and Adrian Slywotzky, “The Volume to Value Revolution,” Oliver Wyman, 2013). The wheels are already in motion as payers are beginning to adopt value-based reimbursement models; employers are demanding more return on their considerable investment in employee health; providers are consolidating and forming strategic partnerships with an eye toward greater integration; consumers are becoming more cost-conscious as their share of the health care bill increases; start-ups and deep-pocket technology companies are challenging the status quo; and price transparency advocates are exposing the irrationality of a wide variation in health costs.
Encouraging Trends
Much of what we are seeing is encouraging, especially:

- The shift to population health with a focus on wellness, prevention, care coordination and chronic disease management;

- The development of new delivery structures and the proper alignment of financial incentives toward value and away from volume;

- The significant drop in the number of uninsured Americans as a result of the improving economy, Medicaid expansion and health care marketplaces offering individual and family plans made affordable through premium subsidies that were fortunately spared in the recent U.S. Supreme Court’s decision in King v. Burwell.

These are not only encouraging trends for U.S. health care in general but also for Catholic health care in particular as they hold the promise of creating a more just, sustainable health care system in line with a Catholic-Christian vision of health care. In fact, “the shift to population health and the development of delivery structures to enact this shift actually begin to embody some of the fundamental commitments of Catholic health care. Therefore, they have the potential for strengthening and realizing Catholic identity” (“Catholic Identity, Ethics Need Focus in New Era,” Health Progress, May-June 2013).

Concerning Trends
However, there are concerning trends as well. At the same time the percentage of uninsured is declining, the number of underinsured is increasing as close to 40 percent of individuals under 65 years of age now have a high-deductible health plan, defined as plans with deductibles of at least $1,250 for single coverage and $2,500 for family coverage. While these individuals may have health coverage, many cannot afford to meet their deductible and as a result delay necessary care or go without needed medications. According to a recent survey by the Commonwealth Fund, approximately three out of five non-elderly insured individuals with low incomes and two out of five with moderate incomes reported that their deductibles are difficult to afford (Sara R. Collins et al., “Too High a Price: Out-of-Pocket Health Care Costs in the United States,” The Commonwealth Fund, November 2014). This problem is stretching beyond low- and moderate-income individuals as the average annual out-of-pocket health care expenses all non-elderly insured individuals incur annually has reached its highest point at $5,000 and, correspondingly, the percentage of household income that goes to pay health care has been on the rise and for many is over 10 percent.

The concerns do not stop here as health care providers, too, are experiencing challenges of their own. The three major credit rating agencies maintained their negative outlook for the health care
sector in 2015 and singled out not-for-profit health systems, particularly, because of rising expenses and weaker reimbursements that will continue to put downward pressure on operating margins (see, for instance, Robin Respaut, “Grim Outlook for Healthcare, Hospital Sector in 2015: Rating Agencies,” Reuters, December 16, 2014). This has led, in part, to a rash of mergers and acquisitions with highly capitalized, larger health systems getting stronger, while less-capitalized, smaller health systems and free-standing hospitals get weaker, especially rural and critical access hospitals. There are many examples of this merger mania in health care, including: Community Health Systems’ purchase of Health Management Associates for $7.6 billion making it the largest system by number of hospitals with more than 200 in 29 states and over $18 billion in net patient revenue; and Tenet Healthcare’s $4.3 billion acquisition of Vanguard Health Systems creating a system with over $16 billion in net patient revenue (Modern Healthcare’s 2015 Hospital Systems Survey). Catholic health care has its own examples as we have seen the rise of mega-Catholic systems with revenues close to or surpassing those of the systems noted above and the proliferation of Catholic and non-Catholic partnerships.

The rapid consolidation in health care is hardly unique in the business world. Other industries that have undergone transformations of their own have experienced this same phenomenon – think banks, airlines, cell phone carriers, and car manufacturers. And, as many financial analysts and the rating agencies tell us, it may indeed be necessary as size and scale will be critical for future success. Still, when it comes to Catholic health care, we have never been in this for the money or merely to survive. It has always been or at least should be about our ability to further the healing ministry of Jesus by living out our fundamental value commitments, which are the true measure of our identity and are at stake in every merger, acquisition, and partnership. But are we considering the impact on identity at this time when Catholic health care is being reshaped in unprecedented ways? Or, in our desire to ensure long-term sustainability, are we “chasing the market,” blindly accepting the practices and strategies the market dictates and unwittingly failing to consider what impact this has on identity? Are we asking how growth opportunities further our ability to live out our fundamental value commitments? Or, are we largely bypassing these concerns and only focusing on the narrower cooperation issues that could derail the transaction?

**Fundamental Value Commitments**

The business nature of health care today may make it easy to overlook the fact that Catholic health care is motivated, first and foremost, out of its faith in the redemptive act of Jesus Christ, which, as Henry Sigerist describes, causes us to see things in a different light:

> In Jesus “the Christian faith introduced the most revolutionary and decisive change in the attitude of society toward the sick. Christianity came into the world as the religion of healing, as the joyful Gospel of the redeemer and of redemption. It addressed itself to the disinherited, to the sick and the afflicted, and promised them healing, a restoration both spiritual and physical” (Civilization & Disease, 1943, pp. 69-70).

Viewed through this lens, Catholic health care’s mission is and will always be to reveal God’s healing and reconciling presence to the sick and suffering of the community. This mission commits us to certain values and corresponding behaviors, namely: respecting the dignity and sanctity of human life;
providing compassionate, holistic care to those in need; promoting the health and well-being of the community; caring for those living in poverty and at the margins of society; exercising responsible stewardship of natural, human, and financial resources; advocating for and acting on behalf of justice; and contributing to the common good. These fundamental value commitments, which are rooted in the Gospel, are known throughout Catholic health care. Indeed, they are encompassed in the organizational documents of Catholic health ministries and make up the substance of the Catholic Health Association’s Shared Statement of Identity. Yet despite this, the urgency placed on consolidation today may be muting our sensitivity to these fundamental value commitments as we strive to keep pace in the increasingly competitive health care marketplace.

As we pursue new business arrangements, we have to ensure we are really and truly advancing the mission of Catholic health care. This requires that we remain vigilant and deliberate about our fundamental value commitments and about who we are as ministry. An added reason to do this is the call of Pope Francis, who has challenged the entire Catholic-Christian community to a deepened living out of the Gospel values. Although he may not be explicitly addressing Catholic health care, the pope has taken up certain themes that reorient us to core aspects of our fundamental value commitments, aspects that must be taken into account when considering a merger, acquisition, or partnership if we are to advance the mission. In what follows, we will outline three such themes and highlight some of the implications for us within Catholic health care as we navigate our way through these uncertain times.

The Challenge of Pope Francis

**What We Must Be – A Sign of Mercy and Hope**

The first theme is that of mercy and hope. From the beginning of his papacy, Pope Francis has preached that the church mediates God’s love of humanity by being a sign of mercy and hope, especially to people who are suffering, lost, and in need of help. As the pope explains:

“[B]eing the Church, to be the People of God, in accordance with the Father’s great design of love, means to be the leaven of God in this humanity of ours. It means to proclaim and to bring God’s salvation to this world of ours, so often led astray, in need of answers that give courage, hope and new vigor for the journey. May the Church be a place of God’s mercy and hope, where all feel welcomed, loved, forgiven and encouraged to live according to the good life of the Gospel. And to make others feel welcomed, loved, forgiven and encouraged, the Church must be with doors wide open so that all may enter. And we must go out through these doors and proclaim the Gospel” (Pope Francis, “General Audience,” St. Peter’s Square, June 2, 2013).

While Pope Francis is speaking of the church as a whole, his words have special relevance for Catholic health care and remind us of the memorable pastoral letter on health care by the late Cardinal Joseph Bernardin in which he stated quite similarly that: “As Christians, we are called, indeed empowered, to comfort others in the midst of their suffering by giving them a reason to hope. We are called to help them experience God’s enduring love for them” (Cardinal Joseph Bernardin, “A Sign of Hope: A Pastoral Letter on Healthcare,” October 18, 1995).

To do this – be a sign of mercy and hope – Catholic health care needs to be where the suffering is and ministering to those who are suffering. Pope Francis describes this well:
“I see clearly that the thing the church needs most today is the ability to heal wounds and to warm the hearts of the faithful; it needs nearness, proximity. I see the church as a field hospital after battle. It is useless to ask a seriously injured person if he has high cholesterol and about the level of his blood sugars! You have to heal his wounds. Then we can talk about everything else” (“A Big Heart Open to God: The Exclusive Interview with Pope Francis, America 209, September 30, 2013).

Is this what we are weighing when considering a new business arrangement – whether the merger, acquisition, or partnership gets us closer to the suffering so we can be a sign of mercy and hope? Are we looking at whether the reconstituted health system or health services will further our ability to reveal God’s healing and reconciling presence to the sick and suffering of the community?

**Who We Must Care For – The Poor**

The second theme is that of care for the poor. Perhaps more than any other pope in recent history, Pope Francis is intimately familiar with and committed to the plight of the poor. Indeed, he has stated that he wants a “Church which is poor and for the poor,” and has emphasized that all Christians are “called to find Christ in them, to lend our voice to their causes, but also to be their friends, to listen to them, to speak for them and to embrace the mysterious wisdom which God wishes to share with us through them” (*The Joy of the Gospel*, n. 198).

Not only has Pope Francis made the poor a central focus of his ministry, but also he repeatedly insists on and witnesses to a preferential option for the poor that is an essential component of living the Gospel values. As he explains:

“For the Church, the option for the poor is primarily a theological category rather than a cultural, sociological, political or philosophical one. God shows the poor ‘his first mercy.’ This divine preference has consequences for the faith life of all Christians, since we are called to have ‘this mind… which was in Jesus Christ’ (*Phil* 2:5). Inspired by this, the Church has made an option for the poor which is understood as a ‘special form of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness.’ This option ‘is implicit in our Christian faith in a God who became poor for us, so as to enrich us with his poverty’” (*The Joy of the Gospel*, n. 198).

The significance of the pope’s words and deeds for Catholic health care cannot be mistaken. The poor needs to be a primary focus of our ministry if we are to be true to our mission and this goes beyond merely charity care. Furthermore, any organizational decisions we make - whether related to services offered to a community, consolidation of jobs, or new business arrangements – have to take into consideration and be influenced by how they will impact the poor. At times, it could be that the best business decision is the wrong ministerial decision and we have to look for another way. Yet, are we considering the poor when we seek to merge with, acquire, or partner with another organization? Are we asking how the new business arrangement will further our ability to care for the poor? Are we looking to go into medically underserved communities, especially rural and inner-city areas, or are we only considering growth opportunities with prospective partners that have significant revenues, positive margins, and good payer-mixes?
What We Must Also Focus On – Social Justice

The third theme is that of social justice. While continuing to address traditional moral issues, Pope Francis has raised our awareness of the profound social justice issues that we must also concern ourselves with and focus on in the moral life. Issues such as poverty, racial inequality, income disparity, climate change, trafficking, and migrants/refugees have all been subject to the pope’s analysis and advocacy. In so doing, Pope Francis is broadening our moral scope and bringing into better focus issues that have long been pushed aside or overlooked. For the pope this is necessary so we can bring the Gospel to bear on the whole range of moral issues:

“The dogmatic and moral teachings of the church are not all equivalent. The church’s pastoral ministry cannot be obsessed with the transmission of a disjointed multitude of doctrines to be imposed insistently… We have to find a new balance; … The message of the Gospel, therefore, is not to be reduced to some aspects that, although relevant, on their own do not show the heart of the message of Jesus Christ” (A Big Heart Open to God: The Exclusive Interview with Pope Francis, America 209, September 30, 2013).

Some have taken comments such as this one to indicate Pope Francis is less concerned with issues of abortion, contraception or other sexual ethical issues. On the contrary, what the pope is attempting to do is awaken us to the profound social justice issues of our day and spur us to action by getting involved with the messiness in the world. As he describes:

“I prefer a Church which is bruised, hurting and dirty because it has been out on the streets, rather than a Church which is unhealthy from being confined and from clinging to its own security… More than by fear of going astray, my hope is that we will be moved by the fear of remaining shut up within structures which give us a false sense of security, within rules which make us harsh judges, within habits which make us feel safe, while at our door people are starving” (The Joy of the Gospel, n. 49).

The emphasis placed on social justice by Pope Francis is important for Catholic health care in three ways. First, we need to be models of justice within our own organizations in terms of how we treat our employees, care for our patients, and act as corporate citizens, especially as this relates to how we invest our substantial resources and care for the environment. Second, we need to be a force for good in our communities by advocating for justice and working with others to undue and correct injustices. Finally, and most relevant for this essay, we need to be aware of the broader social justice issues engendered by new business arrangements and attend to these as much as we attend to issues related to cooperation. But do we think about such things? Are we looking at how employees will be affected by a merger, acquisition, or partnership in terms of job stability, wages, and benefits? Are we considering the impact on the communities we serve and the increase in our environmental footprint when we expand the size of our systems? Are we evaluating the prospective partner from a moral perspective beyond simply their involvement in abortion, contraception, and/or sterilization?

Mission/Ethics Discernment and Integration in New Business Arrangements

We have spent some time outlining these themes promoted by Pope Francis because they deepen our
understanding and awareness of the fundamental value commitments of Catholic health care. As we continue to reshape our ministry, as we should to meet the signs of the times, we must never let the need for size and sustainability blind us to the importance of these commitments. Living out these commitments is a necessary condition for realizing our mission of revealing God's healing and reconciling presence to the sick and suffering of the community. Consequently, every new business arrangement undertaken by a Catholic health care organization (CHCO) must be evaluated on the basis of whether it allows us to live out our fundamental value commitments.

Ensuring this will be the case in new business arrangements is no easy task. It will take senior leaders who are cognizant of, sensitive to, and willing to stand up for the fundamental value commitments at times when it might be easier to set them aside in the interest of getting the deal done. It is also going to take a better, more systematic approach or process to discernment on the front-end and integration on the back-end. With regard to discernment, we have to ask broader and deeper mission- and ethics-related questions about the transaction itself and about the prospective partner. Discussion around such questions should precede any other serious discussions, including those related to financial valuation and legal issues. The questions asked at this initial stage should center on whether we are advancing the mission and on justice concerns viewed with a preferential option for the poor. With regard to integration, we have to focus on ensuring our fundamental value commitments are embedded into the organizational structure and permeate throughout the culture, even as we incorporate and assimilate the best attributes of the other organization. We cannot simply be content that these commitments are being lived when a newly merged or acquired organization or one with whom we are partnering is abiding by our prohibitions. As we have made clear, these are not the only issues with which Catholic health care is or should be concerned.

To address the concern around mission/ethics discernment and integration in new business arrangements, below we outline a process for consideration. We do so with the caveat that it should be taken as a first attempt or starting point of sorts that we hope others within Catholic health care will refine, expand upon, and adapt to address the unique circumstances and cultures of their organizations. Engaging the process will not guarantee every merger, acquisition, or partnership we enter into will advance the mission of Catholic health care. However, it will ensure we ask necessary questions for understanding our motivations and that we keep our fundamental value commitments at the center of our decisions.

**Three-Phase Process**

When a CHCO is considering entering into a formal business arrangement, especially with a non-Catholic party (either organization, physician(s) or other individual), senior leaders must ensure:

- The business arrangement furthers CHCO’s Vision and Mission (this applies also to arrangements with Catholic parties);
- The prospective partner is compatible with CHCO from a Values perspective or, at a minimum, refrain from activities that are notably inconsistent with CHCO’s Value Commitments;
- CHCO’s Value Commitments are adopted at a level proportionate to the facts and circumstances of the particular business arrangement;
- The business arrangement meets cooperation guidelines and any medical interventions with restrictions are acceptably structured or “carved-out”; and
• A mission and ethics integration plan is developed prior to the close of the transaction and implemented effectively thereafter.

The process and timing for ensuring these critical features are met should be sequenced in three phases as depicted in Appendix 1 and described below.

Phase 1: Assess Ability to Further CHCO's Vision and Mission, Compatibility with CHCO's Values, and Level of Adoption of CHCO's Value Commitments

This phase, which has three parts, is the most important in any discernment about a new business arrangement and should be the first order of business, preceding even financial and legal discussions. The focal point in this phase is: (a) whether and to what extent the business arrangement will further CHCO's Vision and Mission; (b) whether the prospective partner is compatible with CHCO from a Values perspective; and (c) at what level should CHCO's Value Commitments be adopted in the business arrangement.

A. Further CHCO's Vision and Mission (note: applies to all arrangements):
For this part of phase 1, several questions for discernment should be asked and reflected upon by senior leaders to reach a conclusion. These include but are not limited to the following:

A. Will this business arrangement enable CHCO to increase access to care, especially for the uninsured and those in economically, physically, and socially marginalized communities?
B. Will this business arrangement enable CHCO to improve community health as defined by key metrics related to mind, body, spirit and environment?
C. Will this business arrangement enhance CHCO's ability to manage the health of populations, and lower the total cost of care?
D. Will this business arrangement improve CHCO's financial position and its ability to reinvest in the communities it serves?

If the answers to these questions are “yes,” senior leaders may proceed to the second part of this phase.

If the answers are “no,” generally the business arrangement should not be pursued. However, circumstances may arise, in limited situations, whereby CHCO’s senior leaders may choose to discern further whether the business arrangement is worth pursuing if they believe it may be necessary for the overall good of the ministry or, alternatively, proceed cautiously to determine if the arrangement can be restructured.

B. Compatibility with CHCO’s Values
Senior leaders need only ask one question in this part of Phase 1 and it is a critical question requiring an honest answer not clouded by the desire to move forward with the business arrangement.

i. Does the prospective partner exhibit evidence of living core aspects of CHCO’s Values or, at a minimum, refrain from activities that are notably inconsistent with CHCO’s Value Commitments as outlined in Appendix 2 (NOT INCLUDED HERE)?

Ideally, the answer to this question should be “yes” and, if so, senior leaders may proceed to the third part of this phase. If, however, the answer is “no,” meaning the prospective partner does not exhibit evidence of living core aspects of CHCO’s Values, the arrangement may still be pursued if one of the following conditions is met: (a) the prospective partner refrains from activities that are notably inconsistent with CHCO’s Value Commitments or...
(b) CHCO will have majority control of the new company and can ensure adoption of its Value Commitments. If neither of these conditions is met, the business arrangement cannot be pursued any further. CHCOs must forgo entering into a formal business arrangement with a prospective partner when they do not have majority control and the prospective partner acts in ways that are notably inconsistent with CHCO’s Value Commitments.

C. Adoption of CHCO’s Value Commitments
Discernment in this part of phase 1 can be rather complicated because the extent to which CHCO’s Value Commitments should be adopted will vary depending on the facts and circumstances surrounding a particular business arrangement. For instance, a merger with a hospital or medical group whereby CHCO will have majority control calls for a high level of adoption, whereas a minority investment in a technology company or health plan calls for a much lower level of adoption because many of CHCO’s Value Commitments may not apply. As a general rule, the greater the control CHCO has in the new business arrangement and the more the prospective partner will be integrated into and/or associated with CHCO, the higher the level of adoption of CHCO’s Value Commitments. At a minimum, CHCO should seek to incorporate the following Value Commitments into a new business arrangement whenever applicable:

i. Creating a safe, just and diverse work environment and providing fair wages and benefits to all employees.

ii. Protecting the sanctity of human life from conception to natural death and refraining from actions such as direct abortion, assisted suicide, euthanasia, and embryonic stem cell research.

iii. Serving uninsured, underinsured, Medicaid, and other vulnerable populations. For non-health care providers, this value commitment may be addressed through community outreach and charitable programs that seek to promote the health and well-being of the local community, with special emphasis on those living in poverty and at the margins of society. As an example, the technology company may establish a charitable donation program of equipment or software to schools in economically distressed neighborhoods or the health plan may coordinate a program to help uninsured individuals enroll in eligible insurance programs.

If the prospective partner is unwilling to adopt these minimal Value Commitments, when applicable, the business arrangement cannot be pursued, as they are central to the meaning and mission of Catholic health care. Of note, it is important that the level of adoption of CHCO’s Value Commitments be discussed early in the proceedings with the prospective partner. Whatever level of adoption is deemed necessary based on the discernment must be tentatively agreed to in advance and be demonstrated in the contractual documents, which should also include a clause stating that CHCO has the right to mandate compliance with the Value Commitments if necessary and remove itself from the relationship for lack of compliance after an agreed upon time of non-compliance.

Phase 2: Identify Cooperation Issues Related to ERD-Restricted Interventions
At some point in the negotiations prior to a definitive agreement being signed, CHCO needs to identify if any cooperation issues will arise in the new business arrangement with a non-Catholic party that is engaged in medical interventions with restrictions as defined in the Ethical and Religious Directives for Catholic Health Care Services (ERD). Beyond issues related to the direct taking of life, which are addressed in Phase 1, ERD-restricted interventions typically
include services related to contraception, sterilization, and in vitro fertilization. Which ERD restrictions apply and what cooperation guidelines should be followed often varies depending on the nature and terms of the business arrangement. **APPENDIX 3** provides ethical guidance on the major types of business arrangements that senior leaders from strategy and other areas should use for discussion purposes with a prospective partner. However, a formal analysis addressing cooperation issues needs to be completed by a qualified and experienced ethicist before a definitive agreement is signed. In many business arrangements involving non-Catholic parties, ERD-restricted medical interventions can be acceptably structured, thereby allowing negotiations to proceed. In some cases, however, they cannot or the prospect of the new business arrangement causing scandal is too great that it should not be pursued.

**Phase 3: Establish Mission/Ethics Integration Plan**

After the definitive agreement is signed but before the closing, System Mission and Ethics should conduct an on-site assessment (if applicable) and document review to determine key integration opportunities based on the list of items detailed in **APPENDIX 4 (NOT INCLUDED HERE)**. The outcome of this phase should be a well-developed integration plan that clearly outlines the key mission and ethics components that will need to be developed under the new business arrangement as well as a timeline, communication plan, and a list of responsible parties that corresponds to each action item of the plan.
Appendix 1
Three Phases of Mission/Ethics Discernment and Integration in New Business Arrangements

PHASE 1: Assess Ability to Further CHCO’s Vision and Mission, Compatibility with CHCO’s Values, and Level of Adoption of CHCO’s Value Commitments

A. Further CHCO’s Vision & Mission (note: applies to all arrangements):
   i. Will this business arrangement enable CHCO to increase access to care, especially for the uninsured and those in economically, physically, and socially marginalized communities?
   ii. Will this business arrangement enable CHCO to improve community health as defined by key health indicators related to community health needs assessment?
   iii. Will this business arrangement enhance CHCO’s ability to improve the patient experience, manage the health of populations, and lower the total cost of care?
   iv. Will this business arrangement improve CHCO’s financial position and its ability to reinvest in the communities it serves?

B. Compatibility with CHCO’s Values:
   i. Does the prospective partner exhibit evidence of living core aspects of CHCO’s values or, at a minimum, is not engaged in activities that are notably inconsistent with CHCO’s Value Commitments as outlined in Appendix 2?

C. Adoption of CHCO’s Value Commitments
   i. To what extent should the Value Commitments of CHCO be adopted by the prospective partner? As a general rule, the greater the control CHCO has in the new business arrangement and the more the prospective partner will be integrated into and/or associated with CHCO, the higher the level of adoption of CHCO’s Value Commitments. At a minimum, CHCO should seek to incorporate the following Value Commitments into a new business arrangement whenever applicable:
      • Creating a safe, just and diverse work environment and providing fair wages and benefits to all employees.
      • Protecting the sanctity of human life from conception to natural death and refraining from actions such as direct abortion, assisted suicide, euthanasia, and embryonic stem cell research.
      • Serving uninsured, underinsured, Medicaid, and other vulnerable populations. For non-health care providers, this value commitment may be addressed through community outreach and charitable programs that seek to promote the health and well-being of the local community, with special emphasis on those living in poverty and at the margins of society.

Discussions Begin — Negotiations —> Definitive Agreement — Closing — Integration

PHASE 2: Identify Cooperation Issues Related to ERD-Restricted Interventions

A. Determine the type and extent of cooperation issues related to the provision of ERD-restricted medical interventions by the prospective partner.

B. Assess willingness and ability of prospective partner to effect carve-outs for the specified business arrangement as outlined in Appendix 3.

PHASE 3: Establish Mission/Ethics Integration Plan

A. Conduct on-site assessment (if applicable) and document review prior to closing to determine key mission and ethics integration opportunities based on integration components detailed in Appendix 4.
### Appendix 3
Ethical Guidelines for New Business Arrangements with Non-Catholic Parties

Prior to a definitive agreement being signed in any new business arrangement involving a non-Catholic party, CHCO needs to identify if any cooperation issues will arise as a result of the prospective partner engaging in certain medical interventions with ERD restrictions. The restrictions that may materialize are outlined below for the major type of business arrangements and are segmented into three sub-categories, namely: (1) “prohibited” services, which are not allowed under the arrangement and are not subject to carve-out; (2) “tolerable” services, which may be provided but are done so without the approval or support of CHCO; and (3) “carve-out” services, which may be provided if established by the non-Catholic party and the cooperation guidelines are met. Senior leaders from strategy and other areas should use the information below for discussion purposes when considering a new business arrangement. However, a formal analysis addressing cooperation issues should be completed by a qualified and experienced ethicist before a definitive agreement is signed.

<table>
<thead>
<tr>
<th>Business Arrangement</th>
<th>Medical Interventions with ERD Restrictions</th>
<th>Cooperation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prohibited</td>
<td>Tolerable</td>
</tr>
<tr>
<td><strong>Health System or Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sole or Majority Control</td>
<td>Direct abortion</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Euthanasia and assisted suicide</td>
<td></td>
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<tr>
<td></td>
<td>IVF</td>
<td></td>
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<tr>
<td></td>
<td>ESCR</td>
<td></td>
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<tr>
<td><strong>Minority Control</strong></td>
<td>Direct abortion</td>
<td>NA</td>
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<tr>
<td></td>
<td>Euthanasia and assisted suicide</td>
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<td></td>
<td>IVF</td>
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<tr>
<td></td>
<td>ESCR</td>
<td></td>
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<tr>
<td><strong>Management</strong></td>
<td>Direct abortion</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Euthanasia and assisted suicide</td>
<td></td>
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<tr>
<td></td>
<td>IVF</td>
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</tr>
<tr>
<td></td>
<td>ESCR</td>
<td></td>
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<tr>
<td><strong>Affiliation</strong></td>
<td>Direct abortion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Euthanasia and assisted suicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IVF</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Physician Practice</th>
<th>Health Plan</th>
<th>ESCR</th>
<th>Direct abortion</th>
<th>Euthanasia and assisted suicide</th>
<th>Direct contraception</th>
<th>Direct sterilization</th>
<th>Direct abortion</th>
<th>IVF</th>
<th>NA</th>
</tr>
</thead>
</table>

**Physician Practice**

- encompasses all types of employment agreements with physicians, including professional service agreements, at any CHCO outpatient care site.

**Health Plan**

- Euthanasia and assisted suicide
- Direct contraception
- Direct sterilization
- Direct abortion
- IVF

**ESCR**

- Direct abortion
- Euthanasia and assisted suicide
- IVF
- ESCR

- Direct contraception
- Direct sterilization

| NA | Though CHCO neither condones, approves of, nor supports counseling and medical interventions related to contraception and sterilization, these interventions, provided by CHCO physicians in [outpatient settings](#), may be tolerated under the concept of professional moral agency and non-interference in the patient-physician relationship when deemed necessary by the physician due to medical indications and in consultation with the patient. As with other medical interventions, CHCO physicians are required to document in the patient’s chart that services or procedures related to contraception or sterilization are medically indicated. Of note, CHCO physicians are prohibited from marketing or advertising medical interventions related to contraception and sterilization. Additionally, print and other educational materials related to contraception and sterilization should not be displayed publicly.

Employment agreements with CHCO physicians who, in order to provide the standard of care to their patients, deem it necessary to continue to provide medical interventions that are prohibited in CHCO hospital [inpatient settings](#) (e.g., direct sterilization), excluding those that involve the direct taking of life, should be structured as follows:

**Less than 100% employment** (e.g., 97.5% CHCO employment with 2.5% limited private practice capacity) with right of limited private practice capacity to provide inpatient prohibited medical interventions (excluding those that involve the direct taking of life) **only at non-CHCO facilities.** Insurance coverage provided by CHCO to such physicians may remain in effect and support services (e.g., scheduling, billing) may continue to be provided. Payments for medical interventions covered under these terms should be directed to the individual physician and not to the CHCO.

**Member benefits related to contraception and sterilization** may be covered by a CHCO-owned Health Plan or within a CHCO risk-based contract. Though CHCO neither condones, approves of, nor supports these benefits, the coverage of such benefits may be tolerated for two reasons, namely: (1) they are benefits for which coverage is required under federal law as part of the Patient Protection and Affordable Care Act; and (2) medical interventions related to contraception and sterilization are ethically permissible in limited circumstances within Catholic teaching making it unreasonable for health plans to absolutely exclude them as covered benefits and impossible for health plans to relegate coverage to only permissible circumstances without inappropriately intruding into the patient-physician relationship and usurping clinical decision-making authority. To avoid the possibility of scandal, however, CHCO should consider inserting a disclaimer into its health plan contracts and Summary Plan Descriptions that reads similarly to the following:

"Any benefits covered by this plan that are related to contraception and sterilization are provided solely and exclusively by reason of legal requirement. Contraception and sterilization are contrary to Catholic moral teaching. CHCO does not approve, condone, or promote contraception or sterilization."

If benefits for direct abortion and/or IVF are required to be covered under federal and/or state law, they should be carved-out and structured as follows to create maximum moral distance for CHCO:

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1. A separate insurer with its own license is enlisted to make decisions related to, accept payment for, assume risk for, contract with providers, and oversee the administration of the carve-out benefits. 
2. A separate policy is established from that of the CHCO-owned Health Plan for the legally required carve-out benefits. 
3. A note indicating the carve-out benefits are excluded within the CHCO-owned Health Plan product is added to informational materials, including Summary Plan Description, and the separate insurer develops its own informational materials and sends them directly to the members without CHCO involvement.

<table>
<thead>
<tr>
<th>Pharmacy Benefit Management (PBM)</th>
<th>Services Prohibited for All Providers</th>
<th>Other Services Prohibited for CHCO Providers</th>
<th>Other Services Prohibited for Non-CHCO Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abortifacient medications (i.e., RU486)</td>
<td>• Contraceptive medications</td>
<td>NA</td>
<td>Member benefits related to contraceptive medications may be managed by a CHCO-owned PBM. Though CHCO neither condones, approves of, nor supports these benefits, the management of such benefits may be tolerated for two reasons, namely: (1) they are benefits for which coverage is required under federal law as part of the Patient Protection and Affordable Care Act; and (2) contraceptive medications are ethically permissible in limited circumstances within Catholic teaching making it unreasonable for PBMs to absolutely exclude them as managed covered benefits and impossible for PBMs to relegate management to only permissible circumstances without inappropriately intruding into the patient-physician relationship and usurping clinical decision-making authority. To avoid the possibility of scandal, however, CHCO should consider inserting a disclaimer into its PBM contracts and Summary Plan Descriptions that reads similarly to the following: &quot;Any benefits managed under this plan that are related to contraception are provided solely and exclusively by reason of legal requirement. Contraception is contrary to Catholic moral teaching. CHCO does not approve, condone, or promote contraception or contraceptive practices.&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Integrated Organization (CIO) or Accountable Care Organization (ACO)</th>
<th>Services Prohibited for All Providers</th>
<th>Other Services Prohibited for CHCO Providers</th>
<th>Other Services Prohibited for Non-CHCO Providers</th>
</tr>
</thead>
</table>
| • Direct abortion  
• Euthanasia and assisted suicide 
• ESCR | Inpatient  
• Direct contraception  
• Direct sterilization  
• IVF  
Outpatient  
• IVF | NA | CHCO may arrange for, structure, and be the sole owner of CIO and ACO arrangements that involve non-CHCO providers who provide medical interventions that are prohibited for CHCO providers, excluding those that involve the direct taking of life, if the following conditions are met:  

**Governance:** Non-CHCO providers must have at least a minority of board seats and CHCO board members must recuse themselves from decisions pertaining to medical interventions prohibited for CHCO providers.  
**Finance:** CHCO must not derive any direct revenue/profit from or provide direct funding for the provision of medical interventions prohibited for CHCO providers.  
**Management:** CHCO must not oversee the management of medical interventions prohibited for CHCO providers. Such medical interventions should be managed by non-CHCO providers who report to a subset of the board that does not include CHCO members.  
**Performance:** CHCO providers must not participate in or provide essential support to non-CHCO providers for the provision of medical interventions prohibited for CHCO providers; and the medical interventions prohibited for CHCO providers must not be provided in CHCO majority-controlled and/or identified spaces/buildings. |
Impact Investing: Investments That Promote the Common Good

Editor’s Note: As a complement to the feature article by Dan DiLeo on Pope Francis’ recent encyclical, we invited several individuals from within or associated with the ministry to reflect on the encyclical and some of its implications for Catholic health care, along with examples of what the contributors’ organizations are doing by way of ecological initiatives. Their reflections follow.

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“Interdependence obliges us to think of one world with a common plan.”
(Pope Francis, *Laudato Si’,* 164)

Pope Francis’s encyclical *Laudato Si’* gives welcome support for many of us who see the earth in crisis “because of the harm we have inflicted on her by our irresponsible use and abuse of the goods with which God has endowed her” (2). In 2011 the Franciscan Sisters of Mary (FSM) assumed a focus of compassionate care of creation in collaboration with others—though, like many others, our congregation had been involved with ecological and justice issues long before.

For many years the FSM, like most religious congregations, have engaged in socially responsible investing—avoiding investment in companies or organizations that fail to conform to our Catholic and Franciscan values.

We have also been involved in shareholder advocacy—using our investments to effect changes in corporations by our shareholder vote. Through our presence on boards, filing shareholder resolutions and voting proxies, we have raised concern about clean water rights, recycling, genetically modified foods, and the cleanup of regional landfills, among other issues.

But we wondered whether we could find more direct and effective ways to actually *further* our mission and focus. We began exploring new strategies for investment.

What we discovered was a cutting-edge approach to investing called impact investing or mission-related investing, defined as investments “designed to generate a positive social or environmental impact in addition to providing a financial return.” Like Pope Francis, these investors, entrepreneurs, and social impact
leaders believe we need an inclusive and socially responsible economy to deal with the difficult challenges our world is facing—to bring about social and environmental change.

In 2012 the Franciscan Sisters of Mary began integrating mission-driven (impact) investment into our investment program. To date, the FSM have allocated $10 million to funds, enterprises and projects that have environmental and social impact as well as bring in financial returns. So far, we have invested $6.54 million in enterprises focused on clean and renewable energy, energy efficiency, greenhouse gas reduction, sustainable forestry, livelihoods and job quality, waste-to value efforts, water recycling, and sustainable agriculture.

An example: We are investing in M-KOPA Solar, a Kenya-based company that provides low-cost solar energy systems for East African families with no access to the electrical grid. Besides cooking and heating, the system allows families to charge cell phones and to generate light to read and study at night. They no longer depend on kerosene and other fossil fuels, making homes safer and reducing air pollution. The company is also expanding. Since October 2012, they have provided more than 200,000 customers with the product and created jobs for more than 650 people and 1,000 sales agents. M-KOPA is having a terrific environmental and social impact.

One need not go across the world to find impact investment opportunities—many entrepreneurs throughout the U. S. are involved in sustainability, renewable energy, recycling, etc. Impact investing can be a great way to invest in the communities one serves, both at home and abroad.

Furthermore, one doesn’t have to try to scope out impact investing on one’s own. Impact investing is complicated, and hiring expert advisors to help chart a course makes good business sense. After some research on the part of our chief financial officer, the FSM engaged Imprint Capital of San Francisco to guide our venture into impact investing. Imprint helps us develop an investment strategy, construct a portfolio, and monitor the financial and mission performance of those investments. One can find other investment advisory firms that specialize in impact investing.

Once one finds a solid impact investment firm to guide one’s portfolio, one needs to determine how much of total investment capital is to be devoted to impact investing.

The FSM actually went one step further. By the end of 2014, we had fully divested from fossil fuel producers, especially the “Filthy Fifteen,” joining a growing number of mission-driven institutions turning away from fossil fuels and investing in climate change solutions. This action freed up capital to use for impact investing.

Throughout *Laudato Si’*, Pope Francis urgently calls us to concern for the common good and the need to take responsibility for our environment and for
those in our society who are powerless and marginalized.

Impact investing provides an excellent, cutting-edge way for faith-based organizations and institutions—like Catholic health care organizations—to focus their investments in ways that actually further the values and goals they hold dear.
Laudato Si’, Relationships, and a Role for Ethics Committees

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Pope Francis’ encyclical, Laudato Si’: On Care for Our Common Home, speaks of our responsibilities towards our Sister, the Earth. Reflecting on the conservation of natural resources and the often negative impact that technicalization and progress have had on our environment, the pope implores us to see creation as that with which we are in relation. But Laudato Si’ is not limited to concern for the environment in the traditional sense. This concern must also be “joined to a sincere love for our fellow human beings and an unwavering commitment to resolving the problems of society” (91). Like Rerum Novarum and Laborem Exercens the encyclical has a particular focus on the dignity of the human person, in connection with the environment. Francis’ understanding of environment is holistic, encompassing the physical, social and human aspects of being. “[E]very ecological approach needs to incorporate a social perspective which takes into account the fundamental rights of the poor and underprivileged” (93).

Laudato Si’ is fundamentally about relationship, the integral relationship that exists between God, the earth and human persons (224). The word “relationship” or some form of it appears 71 times in the encyclical. “System” appears 58 times and “integrated” or “integral” appears 42 times. Care for the earth necessitates care for the human person. Francis posits that a “true ecological approach always becomes a social approach” allowing us to “hear both the cry of the earth and the cry of the poor” (49). These two areas of concern are inseparable: “Social love moves us to devise larger strategies to halt environmental degradation and to encourage a ‘culture of care’ which permeates all of society” (231). In health care we often speak of the patient-physician relationship or the patient-professional relationship, but rarely of the relationship of Catholic health care to creation, to the environment, or to the larger world.

Early in the encyclical, Francis introduces the notion of systems thinking in relation to “authentic human development” which must, according to John Paul II, “take into account…[our] mutual connection in an ordered system” (5). Our “relationships with nature [are] inseparable from fraternity, justice and faithfulness to others” (70). There is not a singular way of relationship or means of participation, but “countless forms” (79). “Our relationship with the environment can never be isolated from our relationship with others and with God” (119). We must always remember that we are in relationship “with” persons as subjects and not see ourselves in
relationship “to” objects. We must see the poor and the vulnerable as subject, not object (81). Relationship is mutual and requires participation of all.

Practically speaking, what impact does this encyclical have on Catholic health care? More specifically, what might Laudato Si’ imply for the work of ethics committees and ethics professionals in Catholic health care? The work of ethics committees is centered around the promotion of the dignity of the human person. The advent of next generation ethics committees calls for ethics committees in Catholic health care to be integrated into the entire organization and to utilize systems thinking. Committees should be equipped to examine organizational and clinical ethics issues, and engage in proactive preventative ethics. It does not take much imagination to see that organizational ethics in Catholic health care should support environmental stewardship via minimization of medical waste, recycling, and forming business relationships with companies who seek to do the same (21). Yet it is rare that ethics committees or ethics professionals are engaged in such decision making.

As ethics committees strive to become more integrated within their organizations in areas such as quality and safety which are heavily data driven, they have a particular duty to keep human persons at the forefront of health care. Francis cautions against the negative impact that data and media overload can have and the resulting depersonalization (47). A focus on objective data points may also constitute an institutional blind spot: “fragmentation of knowledge and the isolation of bits of information can actually become a form of ignorance, unless they are integrated into a broader vision of reality” (138) and “it often leads to a loss of appreciation for the whole…which then becomes irrelevant. This very fact makes it hard to find adequate ways of solving the more complex problems of today’s world, particularly those regarding the environment and the poor; these problems cannot be dealt with from a single perspective or from a single set of interests” (110).

Ethics committees also have an opportunity to engage in population health efforts keeping the human person at the forefront where in fact the individual may become lost in a sea of quantitative measures. Catholic health care organizations are engaging the challenge of population health and wellness via Accountable Care Organizations (ACO), Patient-Centered Medical Homes (PCMH) and Clinically Integrated Networks (CIN) or similar approaches. The promotion of the health of the population rather than an exclusive focus on the individual is consonant with the commitment to the common good. It is no longer enough to care only for the individual poor and vulnerable patient in the acute care setting. “Social problems must be addressed by community networks and not simply by the sum of individual good deeds” (219).

Laudato Si’ presents a challenge to look beyond the organization and even beyond the care continuum. Though Catholic health care has always provided various levels of care in various locations, the intentional focus on the systems in which Catholic health care exists and serves is imperative. A focus on population health and participation in ACOs and similar modes of health care delivery force us to examine the relationship between our care of the individual patient and the health of...
the population. We can see what impact Catholic health care is actually having on the community at large. Ethics committees have opportunities to engage with organizations in developing measures in conjunction with the local community that can discern whether the care being provided is contributing to the common good.

Ethics committees must discern what integration and systems thinking looks like when examining the relationship of the Catholic organization with other health care or social organizations in the community. The ethics committee must ask what it means to be in relationship with an ethics committee of a non-Catholic organization. For example, should ethics committees work together with one another and with the community to form policies regarding withholding of non-therapeutic CPR as the Harvard community ethics committee did? (http://bioethics.hms.harvard.edu/sites/g/files/mcu336/f/CEC-Report-on-Withholding-Non-therapeutic-CPR-022009.pdf) Similarly, ethics committees in Catholic health care should be in relationship with community health initiatives, particularly those focused on public health. These initiatives may currently have representation from Catholic health care organizations but how many of them have ethics committee representation? The participation of Catholic ethics committees in these sorts of groups provide additional opportunities for promoting respect for the dignity of the human person, particularly the poor and the vulnerable, that otherwise may be overlooked.

In the spirit of *Laudato Si’*, ethics committees and ethics professionals in Catholic health care should engage in reflection about how their work contributes to the care of our common home and thus of the common good, recognizing the need for integration within and outside of the organizations in which they serve, for participation with “politics and economics” in “a frank dialogue in the service of life, especially human life” (189).
Authentic Development: Encouraging a Culture of Care

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Pope Francis’ encyclical letter, *Laudato Si’*, is a profound example of the prophetic voice of the Church, calling us to convert our hearts and our behaviors in order to establish a culture of care. In a recent article in *The New Yorker*, activist Naomi Klein wrote that at the recent Vatican gathering entitled, “People and Planet First: The Imperative to Change Course,” Cardinal Peter Turkson of Ghana noted that the word “stewardship” appears in the papal encyclical twice but the word “care” appears many times. He interprets that to mean that stewardship correlates to a relationship based on duty, but “when one cares for something it is something one does with passion and love.”

For the Catholic health ministry, the bridge from stewardship as a duty to that of a relationship of care is ingrained in our history. Stewardship is a constitutive element of the *Shared Statement of Catholic Identity* and one of the core values at St. Mary’s Health System in Lewiston, Maine. For us, stewardship involves “taking good care” of our resources (including human, material, financial and environmental resources.) A culture of care includes our mandate to provide holistic care—care attuned to physical, spiritual, social and emotional well-being, care that moves beyond duty.

In Section III, Pope Francis stresses this holistic approach while reflecting on the ecology of daily life. Author Kevin Clarke distinguishes that for Catholics: Authentic development extends a “holistic understanding of the interaction of economies and rights and dignities of people. Authentic development includes attending to the spiritual and material fulfillment of the primary focus of economic systems, the human person and his or her dignity and full self-expression.” This mirrors the philosophy that St. Mary’s incorporates into our commitment to the community and our approach to population health.
Just as the poor are disproportionately affected by climate change, so they also experience health disparities. As noted in the encyclical [147], the setting in which people live their lives influences the way they think, feel and act. It also affects their health. It is documented that clinical care accounts for only about 20% of the factors that contribute to health outcomes; the physical environment accounts for 10%, health behaviors (such as tobacco use, diet/exercise and alcohol use) account for 30% and socio-economic factors (employment status, education level, income level, social support, etc.) account for 40%. In our urban community of 60,000 people, the downtown urban core has poverty rates as high as 60%. Recognizing the impact of socio-economic factors, along with the identified health needs of the area we serve (chronic diseases, obesity, mental health, and substance abuse), St. Mary’s has established a Nutrition Center that aims to strengthen community by improving access to good food. Located in the heart of downtown Lewiston, The Nutrition Center includes an emergency food pantry, a demonstration kitchen for cooking classes, community gardens and farmers’ markets.

Since 1999, the Nutrition Center’s Lots to Gardens program has transformed over a dozen vacant neighborhood lots into thriving community gardens where more than 500 people of limited income build self-reliance and grow food to meet their nutritional needs. The gardens are located primarily in low-income neighborhoods, contributing to vibrant city neighborhoods and removing barriers for underserved people in accessing healthy foods. On the surface, one of the primary objectives of the gardens was to create access to healthy food in the midst of an impoverished community. But in addition to vegetables, other things have also flourished: a communal gathering place for native Mainers and new Mainers, opportunities for shared learning, and the creation of a sense of pride and accomplishment—all elements of well-being. Hands-on garden activities create opportunities for participants to connect with the natural world in meaningful ways as part of their regular life, cultivating an environmental ethic and a more active and engaged population.

Just as Pope Francis cites in paragraph 213 of the encyclical, “Good education plants seeds when we are young, and these continue to bear fruit throughout life,” we believe that fostering a sense of stewardship (based on a relationship of caring) at an early age will lead to a greater appreciation of the environment later in life. Through exploration of their food systems, youth learn about how energy use affects the environment and food production; how inequitable access to food leads to malnutrition and hunger; and how institutionalized structures of oppression relate to the mistreatment of farm workers as well as the existence of food deserts. This allows youth to have a better understanding of the connection between what they eat and the environment and encourages them to think critically about how to explain these connections to others.
In addition to participating in workshops, youth work in urban gardens located throughout Lewiston, visit local farms, and participate in cooking and nutrition classes. By being outside, connecting with local farmers and learning healthy, tasty recipes, youth develop a broader understanding of how the environment affects the food system and form deeper connections to the land and cultivate a sense of place. One of our youth gardeners reports, “I came to the United States from Congo. I moved from place to place and had a hard time meeting people. But I loved to cook for my family. It made me happy. Then I moved to Lewiston. It was hard to make friends at first. When I started working at Lots to Gardens, my experience changed. I have closer friends now for the first time since I was in Congo; I am digging in the dirt, growing food, eating it and working. That makes me really happy.”

These words and this approach exemplify what Pope Francis refers to “bonds of belonging and togetherness” that enable an “experience of community in which the walls of the ego are torn down and the barriers of selfishness overcome” [149].

St. Mary’s is part of Covenant Health in Tewksbury, Mass. It is fitting that the name of our system refers to the “covenant” between human beings and nature that God established. Our goal as a health system is to be a visible sign of hope and the promise of God’s care in a broken world, whether we are protecting vulnerable people or this fragile planet.

Embracing a New Anawim – Reflections on
*Laudato Si’*

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Understanding Earth as God’s sacred gift to humanity, Pope Francis’ recent encyclical, *Laudato Si’*, invites the entire world into an inspiring and challenging dialogue that recognizes the environment’s centrality as a partner in human flourishing. In fact, both our environment and the human family must flourish together. Pope Francis facilitates this dialogue by acknowledging humanity’s double-edged power: to exploit in destructive ways that impose suffering upon the Earth and to heal our environment in transformative ways that enable human flourishing. Furthermore, Pope Francis calls for recognizing the ways in which healing both Earth and humanity brings about the Kingdom of God, a cause the Catholic health ministry has been about since its earliest days. Thus, this encyclical offers the Catholic health ministry numerous opportunities for reflection and integration. We will focus on two.

At the encyclical’s outset, Pope Francis invites Earth to be known as “barren and laid to waste, among the most abandoned and maltreated of our poor” (2). Pope Francis reminds us that this ecological poverty is felt most acutely in some of the most economically vulnerable and disadvantaged areas of the world and demands a response. Our Earth is fast becoming the ecological anawim within and surrounding our human communities. In Hebrew, the anawim are the poorest of the poor, the outcast, those without any recourse for salvation other than the mercy and grace of God. The encyclical points out that humanity’s apathetic inaction and abusive action has created our ecological anawim. The notion of the anawim is familiar to us because the healing ministry was founded in response to humanity’s anawim. Pope Francis invites us to reframe our healing mission suggesting that healing our human anawim cannot occur unless we also heal our ecological anawim. In fact, they are inseparable.

The Catholic health ministry may also find value in that Pope Francis wrote this encyclical in the tradition of Saint John XXIII’s *Pacem in Terris*, intent on all people
hearing its message. Its purposeful release on Pentecost demonstrates trust and hopefulness in the Spirit’s presence to transform the diverse peoples of the world into a single human community. This community should be disposed towards advocacy and justice for God’s creation, recognizing that the environment and humanity are perennially intertwined as two of God’s most precious gifts. *Laudato Si*’s prophetic message also invites collaborative healing action, recognizing that the Catholic Church cannot address the problems of Earth unilaterally yet emphasizing the Church’s capacity to be an excellent collaborative partner with others equally intent on innovatively healing the wounds that humanity has caused.

The Catholic health ministry knows well the value of collaborative innovation. Its leadership in passing the Affordable Care Act is one of the ministry’s most powerful recent accomplishments. Furthermore, numerous efforts in our local and regional communities to address population health, mental health, human trafficking, and physician-assisted suicide (to name only a few) are epitomes of the Catholic health ministry’s leadership in communities of concern seeking innovative healing solutions for God’s human anawim.

Responding to Earth’s isolation, abandonment, suffering, and pain demands reimagining the day to day lived integration of our mission statements that operationalize healing for both humanity and the environment. Our internal and external efforts to apply a healing balm to our ecological anawim should be characterized by collaborative innovation with community partners with integrated strategies addressing population health, human trafficking, and mental health. Collaborative efforts to respond to these vulnerable populations should explicitly address the environmental factors contributing to their suffering. Gratefully, Dignity Health’s healing ministry has a tremendously positive track record for healing through collaborative innovation. For example,

- With millions of people world-wide lacking access to adequate medical care, we are ensuring that our excess medical supplies and equipment are distributed to health care facilities in the developing world and safety net clinics in the U.S. and abroad.
- Recognizing that access to high quality potable water is necessary for the flourishing of all life, that water scarcity affects public health and the economic sustainability of the region where Dignity operates, we are conserving water by retrofitting existing plumbing fixtures, improving landscaping choices, and implementing water saving technology throughout our facilities.
- Chemical use, another critical area for our industry, impacts human health, water quality, and marine life. Simultaneously with our work to purchase products containing chemicals and/or materials that are the least toxic throughout their lifecycles, we continue to advocate at the local, state, and federal levels for safer chemicals.
- How we dispose of our waste impacts not only the communities we serve, near and far, but our very life support systems. We dispose of our trash
FROM THE FIELD

responsibly and work to reduce the amount of materials we use in the first place.

We are aware that the issues of water, chemicals, food, energy, waste, and so many more that we in the health care industry deal with everyday are inextricably linked to each other, to public health, and to climate change, which is one of the defining challenges facing the world today. We seek to address them in order to meet the needs of a growing population in a resource-constrained world.

May Pope Francis’ message further inspire us to embrace our ecological and human anawim as one single community and apply our passion, perseverance, and inspired love of all that is vulnerable towards a new and invigorated harmonious relationship between our human and environmental family. Surely, doing so will lead our environment and us into achieving God’s hope for human flourishing for millennia to come.
Laudato Si’, Catholic Health Care, and Climate Change

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In Laudato Si’: On Care for Our Common Home, Pope Francis acknowledged that “numerous scientists, philosophers, theologians and civic groups have enriched the Church’s thinking” on sustainability. Hospitals and health care organizations may not be an obvious resource for ecological inspiration, but they have been responsible for shaping the contours of sustainability as well. While some Catholic health care organizations have already established measures to mitigate climate change, Laudato Si’ challenges all of Catholic health care to reflect the dual concerns for “God’s creation and the poor and outcast.” Concretely, two ways this can be achieved are by cutting carbon emissions and reducing water footprints.

Cutting Carbon Emissions

Francis writes, “there is an urgent need to develop policies so that, in the next few years, the emission of carbon dioxide and other highly polluting gases can be drastically reduced” (26). The medical industry is taking stock of their carbon emissions in an effort to curb climate change. In 2009, the Journal of the American Medical Association estimated the carbon output of the health care sector in the United States at 546 million metric tons of carbon dioxide in 2007 alone. Hospitals and health care facilities are major contributors to carbon emissions due to electricity, air conditioning, and single-use instruments. Realizing their impact, Catholic organizations have made strides to reduce carbon emissions.

Dignity Health, for example, lays claim to being the first hospital system to join the California Climate Action Registry and voluntarily measures and reports all emissions of greenhouse gases. Carbon-saving initiatives of Dignity Health include mercury free hospitals, water saving devices in their facilities, being PVC/DEHP-free since 2005, and utilizing sustainable design energy retrofits. Health care facilities often work from a position of resource abundance, which translates to a large carbon output. But Catholic hospitals and health care facilities are investing in a sustainable future through curbing CO₂.

Pope Francis writes, “Reducing greenhouse gases requires honesty, courage and responsibility, above all on the part of those countries which are more powerful and pollute the most.” Laudato Si’ verifies the urgency of cutting carbon emissions in
the health care sector. The carbon emissions of the medical industry—from services offered to prescription drugs—must be quantified as systematic policies make strides towards sustainability. A further issue for human health and the environment is water scarcity and use.

Reducing Water Footprints

Almost one fifth of the world’s population, about 1.2 billion people, lives in areas where water is physically scarce. Pope Francis calls us to recognize that “every day, unsafe water results in many deaths and the spread of water-related diseases.” Countless people take the availability of water for granted, but growing recognition of water as a limited commodity is a concern of health care ethics and theological ethics.9 *Laudato Si’* also recognized “in some places there is a growing tendency, despite its scarcity, to privatize [water], turning it into a commodity subject to the laws of the market.” The privatization of water comes in many forms like land-ownership rights and corporate buy-outs. Yet, in the developed world, we most often encounter the privatization of water in the form of a plastic, “disposable” bottle, with a significant environmental impact. Again, we see Catholic health care organizations leading the way in ethical reflection on the water crisis, water purchase, and consumption.

Catholic Health Initiatives [CHI], based outside of Denver, Colorado, notes “of the estimated 2.7 million tons of plastic used each year to make water bottles, only about 20% of these bottles are recycled.” Therefore, CHI decided to eliminate purchasing bottled water at its national offices as a show of solidarity for those without water, and as an environmental action. Hospitals are being asked to address both the health effects of unclean water and the environmental effects of bottled water, even as *Laudato Si’* indicates water as a global health care issue and an environmental concern. The Holy Father’s encyclical may call us to go one step further and eliminate bottled water from all hospitals and health care facilities.

Conclusion

In the 1970s, environmental bioethics made connections between pollution, carbon emissions, and human health. By 1976, James Gustafson linked ecology, the common good, theology, and health care. Catholic health care has been attentive to the theological imperative to conserve resources through numerous avenues. With the promulgation of *Laudato Si’*, Catholic health care facilities have one more tool in support of their mission to care for people and planet, whether by cutting carbon emissions, reducing water footprints, or the innumerable ways people of good will aspire to care for our common home.

2 Francis, *Laudato Si’,* 10.
4 Dignity Health, “What’s Good for the Patient is Good for the Planet: Other Environmental
Partnerships and Initiatives,” (n.d.) at http://www.dignityhealth.org/cm/content/pages/Environmental-Focus.asp
5 See Catholic Health Association of the United States and Practice Greenhealth, Environmental Suitability: Getting Started Guide (St. Louis: The Catholic Health Association of the United States, 2010.)
6 Francis, Laudato Si’, 169.
8 Francis, Laudato Si’, 29.
10 Francis, Laudato Si’, 30.
11 Approximately 17 million barrels of oil equivalent were needed to produce the plastic water bottles consumed by Americans in 2006 alone. Pacific Institute, “Fact Sheet: Bottled Water and Energy: Getting to 17 Million Barrels,” (December 2007), 1-2 at 1, at http://pacinst.org/wp-content/uploads/sites/21/2013/04/bottled_water_factsheet.pdf
On June 18, 2015 Pope Francis revealed to the world his vision regarding the relationship between humanity and creation. In *Laudato Si’*, Francis challenges what he calls the “technocratic paradigm” and its damage to the environment and to the poor. Needless to say, the world media responded to such a heartfelt and, at times, difficult call.

*The National Catholic Reporter* dove into the science Francis relies upon when he confirms the human effect towards global warming. *NCR* quotes Michael E. Mann, Distinguished Professor of Meteorology at Penn State University, who writes in an email that Francis “accurately reflects what the science has to say.” He continues stating that the consensus of scientists is that Francis "got the science right."


Beyond meteorology and climatology, Francis argues that there exists a technocratic paradigm which blinds us to the negative consequences of unbridled advancements in science, technology, and free market capitalism. *The New York Times* explains, “His most stinging rebuke is a broad economic and political critique of profit-seeking and the undue influence of technology on society. He praised the progress achieved by economic growth and technology, singling out achievements in medicine, science and engineering. But, he added, ‘Our immense technological development has not been accompanied by a development in human responsibility, values and conscience.’”


*America Magazine* continues on this theme writing, “He challenges the mentality of technocratic domination that leads to the destruction of nature and the exploitation of people and the most vulnerable populations, and the technocratic paradigm ‘that tends to dominate politics and economic life’. He notes that ‘humanity has entered a new era in which our technical prowess has brought us to a crossroads’ because never before ‘has humanity had such power over itself, yet nothing ensures that it will be used wisely, particularly when we consider how it is currently being used.’” Francis’s reflection seems particularly challenging to the health care community where we praise the newest imaging technology or high end pharmaceutical, where the hospital with the most expensive surgical or diagnostic equipment becomes the jewel in a network’s crown. His highlight of this paradigm drives the rest of the encyclical’s call for a radical change in society. *America Magazine*: [http://americamagazine.org/content/dispa](http://americamagazine.org/content/dispa)
How does this relate to the environment and the person? The pope frames his response to the needs of creation through the idea of integral ecology. Jim Yardley and Laurie Goodstein take up this idea for The New York Times, “‘integral ecology,’ links care for the environment with a notion already well developed in Catholic teaching — that economic development, to be morally good and just, must take into account the need of human beings for things such as freedom, education and meaningful work. ‘The basic idea is, in order to love God, you have to love your fellow human beings, and you have to love and care for the rest of creation,’ said Vincent Miller, who holds a chair in Catholic theology and culture at the University of Dayton, a Catholic college in Ohio. ‘It gives Francis a very traditional basis to argue for the inclusion of environmental concern at the center of Christian faith.’”

The connection between ecology and human ecology goes further to encompass the moral necessitude to protect the least among us. The Catholic News Agency quotes a section of the encyclical which will appease the more conservative wing of the church. Francis writes, “When we fail to acknowledge as part of reality the worth of a poor person, a human embryo, a person with disabilities – to offer just a few examples – it becomes difficult to hear the cry of nature itself; everything is connected.” Catholic News Agency.

Meanwhile, some Catholic bloggers have noticed areas in need of expansion and unanswered questions. On the fairly new, but extremely popular blog Daily Theology, Assistant Professor Kevin Ahern of Manhattan College highlights three things missing from this text. He posts, “First, there is no mention of social or structural sin. This surprised me given his analysis of the root causes. Second, there is little mentioned about the effect of war on the environment and the poor. There are rumors that the next encyclical will be on disarmament, but this is a big hole in the text. Finally, it lacks a strong call to action on the part of parishes, schools and other church institutions. I can see a pastor, university president or hospital administrator looking at this and saying ‘so what?’. The challenge is to find a way to articulate, with some moral weight, how the church and church institutions can and should live up to our vocation to be ‘instruments of God our Father, so that our planet might be what he desired when he created it and correspond with his plan for peace, beauty and fullness.’ (53)” Daily Theology.

Finally, we might wonder what impact the pope's words can and should have on Catholic health care. Adam Rubenfire poses this question for Modern Healthcare in his post titled, “Catholic Healthcare Providers Echo Pope Francis on Sustainability Efforts.” Rubenfire quotes Sister Carol Keehan, CEO of Catholic Health Association. Sister Keehan “praises the pope’s initiative, noting that Catholic health ministries have learned firsthand the harmful effects climate change can have on public health.” Rubenfire quotes Sister Keehan as saying, “I think that this is an incredible gift, not only to the Catholics of the world but to all the people of the world. There is no question that there are horrible consequences for the way we're treating the planet, and the Holy Father points these out.”

The article by Dan DiLeo in this issue, along with the reflections in “From the Field,” further explore implications of Francis’ Laudato Si’ for Catholic health care and provide examples of what some organizations are currently doing. But there is much more to be done to mine the richness of the encyclical and to embrace the challenges it poses. Catholic health care organizations would do well to devote time over the next six to twelve months to study Laudato Si’ and to explore how its insights can be translated into action.

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Of Note

**Withholding Results From Clinical Trials Is Unethical, Says WHO**

This April the World Health Organization (WHO) released a statement calling for the results of all clinical studies to be made available to the public. (http://www.who.int/ictrp/results/reporting/en/) Marie-Paule Kieny, an assistant director at WHO, said in a press statement, “failure to publicly disclose trial results engenders misinformation, leading to skewed priorities for both R&D and public health interventions.” WHO recognizes the many reasons for study results to go unpublished: unwanted results, difficulty in obtaining a publisher, and the amount of time it takes to write up a report. However, WHO and others, argue that these challenges can be overcome through more readily available resources. They have created a checklist of what needs to be in a paper in their CONSORT statement found at www.consort-statement.org. They also champion clinical trial registries such as https://www.clinicaltrials.gov which, even though it does not contain as much detail, provides a database from which a broader picture can emerge. The United States and Europe already have made important steps towards trial registration and public reporting. Vasee Moorthy, an author of a paper about the new statement published in *PLOS Medicine*, “hopes the WHO’s statement will stimulate countries elsewhere to do the same.” Martin Enserink, *Science Magazine*, April 14, 2015.

**New Group Pushes to Overhaul Organ Donations**

A new group launched in May seeks to reform the process of liver transplants by reducing geographical differences. The group, called the Coalition for Organ Distribution Equity (CODE), consists of hospitals and organ donation organizations. The current system divides the nation into 11 regions based on geography. This creates a disparity in wait times such that California and the Northeast have higher wait times than more rural regions. CODE argues that by reducing the number of regions, “discrepancies in wait times can be reduced and lives can be saved.” Leaders in Congress from those overcrowded regions are joining the cause. “Because of disparities in the existing system, patients in our states in need of transplants have disproportionately longer wait times and waitlist mortality rates,” according to correspondence from a bipartisan group of senators from those states to the Health Resources and Services Administration. Peter Sullivan, *The Hill*, May 20, 2015.

**Genetic Testing is Not Flawless, Study Finds**

A new report “from a big private-public project to improve genetic testing reveals it is not as rock solid as many people believe, with flaws that result in some people wrongly advised to worry about a disease risk and others wrongly told they can relax.” Study leader, Heidi Rehm,
OF NOTE

Dr. Eric Topol, director of the Scripps Translational Science Institute, believes that with more sharing, the mystery gene variant problem “will largely go away, but that’s going to take a few years at least.” Marilynn Marchione, AP, May 27, 2015.

Industry Growth Leads to Leftover Embryos, and Painful Choices

With the rise of reproductive technologies in the United States, a major ethical dilemma continues to grow regarding the fate of leftover embryos. In 2011 a survey estimated the existence of 612,000 embryos remain in storage. Today, that number could be closer to a million. Unfortunately, there are no statistics on what happens to these embryos. Many sit in storage costing clinics, facilities, or the donor couple $300 - $1,200 a year. A new movement has occurred calling for the donation of these embryos to non-related individuals. Donation has risen from 596 in 2009 to 1,084 in 2013. This has caused the creation of specialty clinics meeting the needs of both donors and infertile couples. Tennessee has The National Embryo Donation Center and Florida has Embryo Donation International. These organizations share a mission to bring leftover embryos and infertile couples together.

One clinic in California, California Conceptions, goes beyond embryo donation to embryo creation. This business seeks out donor gametes whose profiles are most likely to have “broad appeal.” They believe that this process along with a money back guarantee will open the field of reproductive technologies to those in lower financial situations. This practice raises legal and ethical questions. States such as New York ban the creation of embryos for reproduction and the American Society for Reproductive Medicine is looking into the ethics of this practice. Tamar Lewin, The New York Times, June 17, 2015.

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