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Adventist-Catholic Healthcare

Extending the Healing Ministry of Christ

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Introduction

An extraordinary interfaith collaboration quietly developed over the past twenty-plus years between Seventh-day Adventists and Roman Catholics in our healthcare ministry to local communities. This article attempts to introduce the collaborative business arrangements (CBA) presently (or soon to be) operating in three regions across the United States. Of note in this article is the manner with which these CBAs are considered and contracted. What sort of analysis is conducted ahead of time and how are the issues identified managed? There are business matters to attend to, of course, but equally important are the religious, theological, and ethical issues within each tradition.

On the Catholic side, there are several documents, institutions, and structural methods of management that help set standards. These may be unfamiliar to many of us on the Adventist side of things. Of central concern is the document *The Ethical and Religious Directives for Catholic Health Care Services* (ERD).[1] This is a document managed by the United States Conference of Catholic Bishops (USCCB).[2] The ERDs are occasionally edited based upon the felt need of the USCCB. In June 2018, the sixth edition of the ERDs was published with changes explicitly addressing the cooperative arrangements between Catholic and non-Catholic healthcare corporations and facilities. Section Six is now titled "Collaborative Arrangements with Other Health Care Organizations and Providers." In addition to a brief introduction identifying the long-standing principles of "material" and/or "formal" "cooperation," there are ten specific, brief assertions against which all cooperative arrangements must be evaluated.

In this article, I hope to offer the unique perspective of my past experience and present position. I am an ordained Seventh-day Adventist minister with a PhD in religious ethics. I presently work for a Catholic healthcare system (Providence St. Joseph Health) as the Regional Director of Ethics in Alaska. In my previous roles at Loma Linda University's School of Religion, I was a professor of ethics and Theological Co-Director of the Center for Christian Bioethics. In that role, I served as a consultant for Centura Health, the first of the CBAs between Adventists and Catholics.

My thesis is that these cooperative arrangements between our two faiths are both feasible and necessary in the current American healthcare industry. Indeed, they are to be celebrated. The success of Centura Health is an indicator of the high likelihood of success for present and future arrangements, even considering the recent ERD revision, which some have thought to be more rigorous than past editions. Nonetheless, it is also important for us to question our conceptions of "success" as these healing ministries of Christ continually morph and respond to the present-day American healthcare industry. Could American healthcare ever change so much that we should seriously consider backing away from some or all of our present involvement in it?

The Ethical and Religious Directives, Part Six, 2018

Almost 100 years old, within about sixty pages, the ERDs serve as the formal guidance document for ministries of the Catholic Church in the United States that serve in the healthcare context. The new edition only modifies the last section, Part Six. The impetus for these changes came from a document published in 2014 by The Vatican Congregation for the Doctrine of the Faith (CDF),[3] entitled *Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services*.[4] In an analysis of the CDF document, Peter Cataldo notes "there is much that is new" in this document, in that it offers "for the first time a delineated set of specific principles pertaining to the institutional application of the traditional Principle of Cooperation."[5] How does this delineation "pertaining to the institution" get expressed by the CDF? Cataldo notes "the institution has a specific identity and moral character itself as a result" of moral decisions made. The institution thus "possesses this identity and character not as a natural person, but analogously as a corporate person."[6]

> Given this moral dimension of institutions that the CDF and Catholic teaching in general recognizes, it is appropriate to assess cooperation in evil on the part of both "administrators" within an institution and the institutions themselves.[7]

With attention to Catholic and "other-than-Catholic" healthcare cooperative arrangements, however, "its content is more confirmatory than new."[8]

In an online webinar,[9] sponsored by the Catholic Health Association of the United States, both Father Charles Bouchard and Dan O'Brien noted that there is nothing particularly new or challenging about the revisions to Part Six, itself. "These revisions are mainly a question of clarification," states Father Bouchard. In his conversations with representatives from the United States Conference of Catholic Bishops, they said they hope readers will understand this new Part Six as "a clarification that would help address new and more complicated situations that we are facing. So, if there is any single take away, that might be it." O'Brien comments, with regard to the introductory content on the Principle of Cooperation, "they are pretty high-level descriptions…they are not saying everything that can be said."[10]

In his analysis of the revised Part Six, John A. Gallagher points out a shift toward the church's "prophetic witness" or "witness to Christ" in our present-day world. In "Theology and Ethics: Reflections on the Revisions to Part Six of the ERDs,"[11] Gallagher writes:

> These Directives are not primarily about the principle of cooperation nor are they principally about the discernment of moral evils, although these remain elements of an appropriate discernment of the church/world, faith/culture tension. The revisions to Part Six of the ERDs are primarily concerned to ensure that prophetic witness, the church's witness to Christ, the new evangelization are vitally engaged in the world and culture through the health care ministry.[12]

Gallagher notes that in this revision, "there is something new coming forward." In juxtaposition to more particular interpretations of the threat of scandal or even the principles of cooperation or double effect, he notes that "What the church is and what the church does frames its engagement with the world and culture." Indeed, Gallagher asserts that, in light of this emphasis, "the principle of cooperation has become secondary."[13] If it is the case that the primary concern for CBAs revolves around the church's prophetic witness to Christ, how would an analysis of a potential CBA with a Seventh-day Adventist healthcare corporation appear to us? Would the discernment of such a deal take a broad, sweeping look at commonalities of commitments to being Christ's witness to world and culture? Or, would the discernment be more concerned for the details of specific ERDs dealing with abortion, end-of-life care, or contraception? Perhaps both analyses are essential.

How Do We Go About Forming a Collaborative Arrangement?

What exactly does a discernment process look like for both sides of such CBAs? For the purposes of this article, I reached out to over twenty individuals who were party to the discussions that formed three CBAs:

- Centura Health of Colorado[14]
- AMITA Health of the Chicago area[15]
- Sacred Trust of the Northern California area: This CBA is still under review by the Federal Trade

Commission and the California State Attorney General. It remains to be seen whether they will approve it.[16]

For Seventh-day Adventist healthcare corporations, the analysis of a possible CBA revolves around two central questions: is it beneficial to the long-term financial health of the corporation and can it maintain its identity and mission in the process?

In personal interviews with several involved parties of the Centura and Sacred Trust CBAs, those two themes capture their concerns. At first blush, it seems that the analysis (I won't use the term "discernment" since it is not the term Adventists would use) is somewhat ad hoc, but the reader should realize that Adventism is very young (at 155 years) in comparison with Catholicism (almost 2,000 years). It is important to highlight the fact that, as a denomination, Adventism is in a stage of development quite unlike that of Catholicism. One important commonality I have found, however, regards the tension between the clerical branch and the healthcare branch for each tradition. I'll say more about this later.

In 1995, in the Denver, CO market, a deal was struck between PorterCare (Adventist) and the Sisters of Charity Health Services, Colorado to form Centura Health. Stephen King (Adventist) and Sister Nancy Hoffman (RCC) were present at the outset. Sister Nancy noted in a 1999 article, "It seemed a most unlikely partnership."[17] But market forces compelled these unlikely partners into considering the unusual:

> They were, indeed, extraordinary times. By the early 1990's, the for-profit hospital giant Columbia/HCA had rolled into Denver, purchased several hospitals, forced closures and buyouts, and captured 35 percent of the market share[18]

King highlights the second of the two concerns, namely maintaining Adventist identity and culture (an issue similarly important to the Catholic side of the Centura deal): "We stayed totally faithful to what needed to be different—our own theologies—yet there was so much good work to be done together that it did not violate our identities."[19] What appeared at first to Sister Nancy as an "unlikely partnership," years later had become a "wonderful journey," for which she comments, "When you

come down to the true Christian message, you see how similar we are."[20]

Yet, there were and remain significant differences. In a *Spectrum*[21] article, Linda Andrews writes:

> there have been some tensions. King explains that the Catholic system is more hierarchical than the Adventist system, so cultural differences began to surface. "There was never a struggle over mission or names," King says, "but our ways of doing business were different. The Adventists have a less centralized system. The Catholic side is more hierarchical."[22]

Pointing to the overall mission and identity concerns of both sides, what Gallagher identified as aiming toward the prophetic witness to Christ in our world and culture, Sister Nancy and Stephen King authored an article of their experience together at Centura. They comment: "Those of us whose mission and values support the health and well-being of all members of the community have struggled to find innovative ways to continue to provide quality service and patient care to our fellow human beings." Even though "we lived out our faithfulness to our sponsors in different ways," they attest to a "reverence" for each other and their traditions as well as a "confidence" in the future.[23]

In the first iteration of the Mission leadership within Centura, King and Hoffman were the two Senior Vice Presidents in the corporate headquarters, working with Vice Presidents in three operating groups in their respective territories. In 2014, Centura restructured, reducing from three to two operating groups, as well as from two Senior VPs to one Senior VP.[24] This reduction of Mission leadership at the corporate office may be a more manageable model as budgets force a reduction of staff. One wonders, nonetheless, if mission identity and leadership formation will suffer as a result.

For Charles Sandefur, at the time the President of the Rocky Mountain Conference of Seventh-day Adventists, the Centura Health deal was a "pivotal moment" for the entirety of Adventist healthcare in the United States. As the General Conference of Seventh-day Adventists backed away from legal ownership of Adventist healthcare corporations in the late 1980's, those corporations began to coalesce into five, roughly regional entities. PorterCare in the Denver area didn't naturally fit into any of the five areas. Realizing they needed help to stay in the healthcare ministry, they came to the difficult conclusion that they would be better off partnering with the Sisters of Charity.

Many of the Adventist constituents, however, felt it was better to be purchased and get out of the business than to partner with Catholics. But Sandefur and others, enough others, felt that in order to maintain the mission of Adventist healthcare ministry it needed to be dragged into the twenty-first century, regardless of the existential angst associated with forming such a collaborative association. Those who opposed the collaborative association held to an intense Adventist, anti-Catholic sub-culture. They were not able to imagine upholding commonalities with a Catholic healthcare ministry. Thankfully, more thoughtful people prevailed and Centura was launched.

Aside from this socio-political reality, from a broad-based emphasis on mission and identity, Sandefur noted two specific concerns regarding the connection with the Sisters of Charity. First, emerging from the Adventist mission ethos were concerns for advancing healthy-living principles and maintaining the specialness of Sabbath in Adventist facilities. Second, emerging from identity issues were ownership and branding/naming elements of the deal.

What at first felt more like a "survival mechanism" in a tough market situation has evolved. Now, says Sandefur, such CBAs are seen as "positive expressions of Adventist healthcare mission." The core mission and identity prior to such CBAs were occasionally casual and assumptive within Adventist healthcare, but as we've moved into and through the cooperative ventures, we've had to fine tune our understanding of ourselves, and this is good.

In the process of negotiating with interested parties, Sandefur went to Chicago to visit with a select group of bishops from the United States Conference of Catholic Bishops. He felt they were impressed by the Adventist ability to insist upon and find qualified persons of the Adventist faith to place in executive leadership in the healthcare corporations. For his part, Sandefur left these meetings with a new appreciation for Catholic concern for social justice and for providing health care to the poor and vulnerable of our communities.[25]

For Catholic healthcare corporations, there were similar market force considerations. As American healthcare industry watchdogs noted at the time, affiliation and

collaborative business arrangements dramatically swept through the American healthcare industry. Reaching back further, in 1984, Paul Starr explored the development of the American healthcare corporation in his volume, *The Social Transformation of American Medicine*. Of note for our concern here is how American corporations grew to control how health care was offered. His final chapter, "The Coming of the Corporation," should be standard reading for anyone today who wants to fully understand where we are as faith-based "corporations."[26] Catholic entities, aware of the corporatization and affiliation, understood the inherent difficulties of maintaining identity that reaches back for two millennia.

In a 1997 *Health Progress*, "Special Section" article entitled "Catholic Healthcare's Future," Alan M. Zuckerman and Russell C. Coile wrote:

> Even with 550 hospitals, the U.S. Catholic healthcare system is too small and spread too thinly to succeed without partners. Under the demands of competition and capitation, only tightly organized regional and statewide networks have the bargaining strength to deal with HMOs and employer purchasing coalitions…. Catholic sponsors must find mission-compatible business allies, including managed care plans. Catholic health facilities will announce many transactions and linkages, because the alternative of "going-it-alone" isolation is not sustainable. Catholic healthcare providers must pursue strategies of integration, or they may fail to carry out their mission in the twenty-first century.[27]

With appreciation to Dan O'Brien, senior vice president for ethics, discernment, and church relations at Ascension,[28] we have a bit of a window into the moral analysis that went into the development of AMITA Health[29] in the Chicago, IL area. AMITA Health is a joint operating company originally formed by Adventist Health Midwest, part of AdventHealth based in Altamonte Springs, Florida, and Alexian Brothers Health System, a subsidiary of St. Louis-based Ascension.

At a general level, the history of Adventism's view toward Roman Catholicism was a concern. Despite the fact that the Adventist Church's official statement makes the effort to "stress the conviction that many Roman Catholics are brothers and sisters in Christ,"[30] Dr. O'Brien's analysis rightly points out that "present day statements are far more palatable" than history would suggest.[31] All told, the Catholic analysis of the potential AMITA deal examined nine areas of concern: 1) Commitment to Health and Healing, 2) Adventist views toward the Catholic Church, 3) Adventist Statement on Values, 4) Sexually Transmitted Diseases, 5) Contraception in Marriage, 6) Abortion, 7) Assisted Reproduction, 8) Care of the Dying, and 9) Employer-Employee Relationships and Unions.

Two areas of concern for Ascension, identified under the principle of cooperation with Adventist facilities, included their policies that allowed a small number of pregnancy interruptions, as well as routine sterilizations. Because the principles of cooperation do not permit the Catholic party to condone or to have oversight for procedures evaluated as intrinsically immoral under Catholic teaching, the proposed Joint Operating Agreement (JOA) explicitly rejected inclusion of the Adventist OB/GYN service lines into the Joint Operating Company (JOC), enabling the moral analysis to conclude that there would be "only remote mediate material cooperation" in the arrangement. The analysis offered by Ascension anticipated the judgment of the Archbishop of Chicago (then Cardinal George) that "nothing stands in the way" (*nihil obstat*) of the affiliation moving forward "from the perspective of Catholic faith and morals." Indeed, "during exchanges with the Diocese of Joliet" (some facilities fell within this jurisdiction), the Bishop of Joliet indicated that,

> Catholic moral theologians or ethicists who direct the development and provision of the various educational and formation programs for the Catholic hospitals within the JOC will need the approval of the Archbishop of Chicago or his delegate.[32]

On balance and given the explicit separations demanded by the JOC, the arrangement was found to be:

> justified by the great goods that will be achieved by the affiliation….The transaction is clearly intended to strengthen both the Alexian Brothers and Adventist health systems…and strengthen

the healing ministry of Jesus Christ in metropolitan Chicago.[33]

How Do the CBAs Protect the Denominational Concerns of Both Sides?

Centura Health was important in the early stages of Catholic-Adventist CBAs. In a 1997 article in *Health System Leader*, entitled "Centura Health—Two Faiths in Alliance,"[34] Elaine Zablocki quotes Dean Coddington, the managing director of BBC Research and Consulting, "a national healthcare consulting firm," saying that:

> Centura is promising. They've done something most people didn't think could be accomplished: They've gotten the Catholics and the Adventists to work together, and that's actually a pretty amazing combination if you stop to think about it.[35]

At the time of the formation of Centura, Terry White, the first Centura executive vice president, said of the arrangement, "We were inventing the wheel. Now hospitals in other parts of the country are using our documents as models."[36]

Quoting Leland Kaiser (then president of the consulting firm Kaiser and Associates) in her summation, Zablocki writes:

> Across the country you find hospitals with religious backgrounds—Adventist, Catholic, Lutheran, Baptist, Methodist—but all with a built-in desire to serve and a spiritual orientation. What really brought these two hospitals together was, first, that it made good business sense, but second, that their shared spirituality was more important than their religious differences. What's happening in Denver is very important, because I think you're going to see it across the United States.[37]

Kaiser's words could not have been more prescient. Twenty years later, we read in the news on almost a weekly basis about major healthcare corporate deals. One wonders how many corporations will populate the sector ten years hence. Indeed, if CBA deals are good for some of our corporations why would we not pursue such arrangements to the logical end—one massive, faith-based, not-for-profit corporation with branded branches all over the country. If our denominational concerns are well managed what would be the argument against such conglomeration? Perhaps there are legal ramifications I am unaware of, but if focus remains on market strength with mission protections what would stop us from joining forces?

For both sides, maintaining focus on Christ's healing ministry in our local communities is paramount. O'Brien's analysis for Ascension from the Catholic perspective is revealing. In addition to the nine points of his Moral Analysis noted above, Ascension, for whom O'Brien works, upholds "System Policy #1." Meant to establish a baseline from which all other matters emerge, Policy #1 makes clear what is important to their work.

> It is the policy of Ascension to function as and to fully express its identity as a ministry of the Catholic Church consistent with Church teaching—including the Ethical and Religious Directives for Catholic Health Care Services…and our Mission, Vision, and Values, in accord with the guidance of the Ascension Sponsor, which is the Ministerial Public Juridic Person accountable to the institutional Church (Holy See).[38]

The seven principles that form the core of the expression of Policy #1 are 1) Solidarity with Those Who Live in Poverty, 2) Holistic Care, 3) Respect for Human Life, 4) Stewardship, 5) Participatory Community of Work and Mutual Respect, 6) Act as a Ministry of the Church, and 7) Fidelity.

Although, a cursory look at Catholic healthcare in the US might give the impression that abortion, contraception, and serving the poor and vulnerable would summarize their concerns, this is not the whole story. We run a similar risk when looking at the key elements within Adventist healthcare mission and identity.

Similar to Ascension's "System Policy #1," AdventHealth outlined what matters most to them as they engage others within the American healthcare industry. AdventHealth is the parent company of the Adventist side of both AMITA and Centura Health.[39] The document, "Mission and the Management of an AdventHealth Facility,"[40] has three main sections: "Where We Came From, Who We Are, and How We Manage." The purpose of the document is to "identify, describe and

provide rationale for essential principles regarding the mission and culture of AdventHealth." It is explicitly designed to be used "in the process of negotiating mergers, acquisitions and joint operating agreements with external partners." There are six substantive sections meant to express "historic, ecclesiastic, moral, and ethical foundations for health care delivered by AdventHealth:" 1) Social Responsibility, 2) Pastoral/ Spiritual Care, 3) Seventh-day Adventist Church and Beliefs, 4) Clinical Care, and 5) Business Relationships.

Meredith Jobe, JD, serves as General Counsel for Adventist Health, the Adventist side of Sacred Trust (should it receive necessary governmental approvals). In general, he noted that, "We are more alike than otherwise, in our mission of providing healthcare to our communities." He expressed appreciation for the intense concern for society's poor and vulnerable from the Providence St. Joseph side of the CBA. Additionally, he says Adventist Health would like to learn more about the efforts PSJH puts into mission education and leadership development. Jobe also noted Catholic concerns for end-of-life care (particularly as it relates to legislation for physician-assisted suicide), abortion, and the role bishops play in providing oversight on these issues.

Of special concern for Adventist Health in the maintenance of its mission is the ability to protect positions of leadership in the new venture. Preference for Adventist persons in senior management and executive leadership is a clear concern and it is not limited to positions of mission leadership. Jobe echoed what Charles Sandefur said in my interview with him, namely, the protection of Sabbath observance and healthy-living principles must be maintained in the CBA deals.

The one official document, published by the General Conference of Seventh-day Adventists, that best summarizes Adventist concerns for its healthcare mission is entitled, "Operating Principles for Healthcare Institutions."[41] Approved in 1988, these principles are best summarized as follows:

- Whole person care, to include preventative medicine and health education to the community.
- Concern for the "unique Christian witness of Seventh-day Adventists," namely, the seventh-day Sabbath, vegetarian diet free of stimulants, and no alcohol or tobacco.
- Human life, dignity, and relationships.
- Functioning as a part of the local community.
- Competent staff who seek to uplift Christ to those served.
- Financial responsibility in concert with the *Working Policy of the General Conference of Seventh-day Adventists*.

While this document does not approximate the ERDs, it does help establish a broad sense of agreement and collegial involvement from the General Conference of Seventh-day Adventists to Adventist healthcare corporations. Like Catholicism, the Adventist Church does not legally own "Adventist" healthcare corporations, but there remains a very strong bond between the Church administration and the healthcare corporations.

Regarding this bond, it helps to recognize the difference between Catholic and Adventist ethos. For Catholicism, the local bishop has authoritative oversight of all Church ministries operating within his diocesan jurisdiction. The diocesan bishop, for example, has the power to withdraw his recognition of the Catholic identity of a hospital located within his diocese if he determines its administrators are seriously failing in their accountabilities to operate the hospital in accord with church teaching. Such a scenario is unlikely to occur within Adventism.

The Protestant ethos is strong within Adventism (at least in North America) and as such there is a rather wide latitude offered in the relationship between Adventist healthcare systems and the General Conference of Seventh-day Adventists (which provides worldwide leadership). If the General Conference were to consider and reject a healthcare corporation's Adventist identity, it would likely be vigorously defended by Church leadership at the national and regional levels and likely be intensely argued in an American court rather than simply accepted by the system.

On a local level, even if a Conference President (the rough equivalent of an Archbishop) proclaimed a hospital as no longer Adventist, it would have no practical impact because the denomination's governance structure gives Adventist systems more autonomy from

the local Conference. Indeed, it is hard to imagine such a scenario unfolding because the trust and relationships developed between church administrators and healthcare administrators is important and presently robust. Perhaps this is a strength of the Adventist system that allows for a more trustful relationship with local clergy. The fear of oversight and control that occasionally presents in the Catholic context is almost completely absent in the Adventist context.

Nevertheless, there is an ongoing tension in the relationship between Church officials and health care administrators in both traditions. While this topic deserves a full-length address, suffice to say for this article that the Part Six revisions of the 2018 edition of the ERDs is an indicator of the felt need for high-level involvement and assertive oversight by Catholic Church Bishops, particularly as it relates to Church teaching on morality and on the administration of sacraments. Similarly, within Adventism, the General Conference ethos is to protect the fundamental beliefs of the Church.

On the other hand, healthcare ministry, whether Adventist or Catholic, faces a public in need. Serving those in need inclines us toward compassion and empathy, even if we occasionally do not fully understand or support the morality behind the requests they make. For instance, caring for transgender persons is a challenge to both faith groups. Catholicism and Adventism both are challenged by philosophical and theological accounts of human nature that are not binary (male or female or no gender at all). Yet, our healthcare systems must (and do) care for persons who walk through our doors. Science and culture are pushing us, once again, and challenging our historical theological understandings. The tension that this places between healthcare administrators and caregivers and Church administration is obvious to those of us who work on the inside.

A Few Final Questions to Ponder

Let me leave the reader with two lingering questions. First, what will be the ongoing attention to theology and ethics in these CBA structures? A good bit of analysis goes into the formation of the entity up front, but what of the day-to-day work of leadership and spiritual formation, theology and ethics, in the structures that follow? Are there elements of the deal that demand a structure for attending to the faith and moral concerns of both sides? How will each CBA, each facility, allocate staffing and finances for these concerns? Will there be dedicated, informed theologians and/or ethicists on site? Will such persons be on staff in each facility or regional offices?

The Joint Commission[42], the accrediting entity for US Hospitals, only requires a mechanism of some sort to deal with ethical issues in a hospital. Will Catholic and Adventist healthcare corporations go above and beyond this simple requirement? In a world where billable services rule the day, mission leaders, theologians and ethicists usually do not bring in any income for these CBAs. Both chaplain services and clinical ethics consult services are expenses for the facilities we operate. When budgets get tight, which service gets funded? A common scenario presently places ethics consult services within spiritual-care departments. Will chaplains with a modicum of ethics training bear the burden of having to take ethics consult calls? I could highlight this question with detailed knowledge of both Catholic and Adventist corporations and hospitals who do not pay for trained clinical ethicists, depending instead on placing the burden of hospital case consult services on chaplains or spiritual-care personnel. It begs the question of authenticity when we make such effort to offer theological, ethical, and legal analysis of these deals at the outset but fail to pay for persons who will give ongoing attention to the day-to-day reality of clinical ethics education and consultation needs.

Second, what does "success" mean for our faith-based systems? Both Catholic and Adventist Church administrative bodies understand and account for financial deliberations as part of the moral discernment necessary to operate in today's American healthcare industry. Both sides note in their analysis the harsh reality of market forces in the evolution of our healthcare corporations. So, how do we measure success? If we do not meet a certain percentage EBIDA (earnings before interest, depreciation, and amortization) are we failing? Do we fail in our prophetic witness to Christ if one or more of our facilities or full corporations must close their doors? What if we have to file for bankruptcy or sell out to a larger system because our finances simply will not allow us to keep our doors open? Have we failed, in such a scenario, to offer our community the healing ministry of Christ?

Putting the question another way, what are we willing to do in terms of corporate deals and arrangements to stay in the healthcare business in present-day America in order to continue the healing ministry of Christ? Is there

a scenario of how healthcare evolves in a purposefully secular America that compels Catholics or Adventists to back away from the industry? As American for-profit healthcare corporations do battle with not-for-profit, faith-based healthcare corporations, what are we willing to concede? As we often ask in PSJH, "What would the Sisters do" in such a scenario? Would they, would we, ever shut down or sell our ministries in the face of overwhelming obstacles? And on the Adventist side, did the "Heath Message"[43] vision of our Adventist pioneers entertain such a radical reality in light of responding to the signs of the times?

Indeed, in nomenclature precious to Adventism, the "signs of the time" were central to the Sisters of Providence's expression of their mission as they transitioned to a Public Juridic Person.[44]

> We have no fixed blueprint for how to express the role and responsibilities of Providence Ministries other than by reading the signs of the time, trusting in Providence, and embracing our Baptismal call to follow Christ.[45]

What would success and responding to the signs of the time look like for our ministries in a time of environmental crisis that points to healthcare as a significant source of pollution?[46] When the Pope himself is calling for all his believers to adjust their economic and institutional imbalance out of concern for our planet and the poor,[47] what is an appropriate way for our healthcare systems to adjust our views of corporate growth? One international economist, Kate Raworth,[48] rightly notes that we in the West are "structurally addicted to growth."[49] What is whole-person care in a system that pays surgeons obscene amounts of money for quick fixes to unsustainable lifestyles? Does keeping our doors open, responding to the times, mean that we slavishly demand of ourselves a certain percentage EBIDA?

In America's capitalistic healthcare industry, where built-in injustices necessarily marginalize so many of our societal members, what does it mean to offer *preferential option for the poor*,[50] to minister for the poor and vulnerable? Ironically, Catholic and Adventist healthcare are two of the more successful players in the American healthcare industry. How do we rationalize being part of an unjust system while stating that we serve the poor and vulnerable? Darlene Fozard Weaver summarizes my point well:

> In short, once we understand human dignity not only as a stipulation of inherent moral worth but as a practice of inclusive regard, health care ethics, health care practices, and health care systems appear as both culprits in sinful dynamics of misrecognition of dignity and as vehicles for restoring dignity to its full expression.

Conclusion

These questions may be uneasy for us; they should be. But we can and should celebrate our work together in the ever-changing scene of American health care. Expanding the reach and methods of health care beyond the walls of our hospitals is something we can and should do together, for the good of the communities we serve. Let our past differences quietly slip away and let us focus on our commonalities. Life in American healthcare will not get any easier for faith-based corporations. But we know we can work together and thus far, at least, we can celebrate an unlikely reverence for each other as we together advance the prophetic witness and healing ministry of Christ.

Endnotes

1. Available at: www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

2. www.usccb.org/about/.

3. For a full description of the CDF, see: www.vatican.va/roman_curia/congregations/cfaith/index.htm.

4. Available at: www.ncbcenter.org/files/4914/4916/4379/Q14.2_Verbatim_CDF_Principles.pdf.

5. Peter Cataldo, "CDF Principles for Collaboration with Non-Catholic Health Care Entities: Ministry Perspectives," *Health Care Ethics USA* (2014): 24-29; 24. Available at: www.chausa.org/docs/default-source/hceusa/cdf-principles-for-collaboration.pdf.

6. Peter Cataldo, "A Commentary on Collaboration with Non-Catholic Entities in Health Care Services," *Origins*, 26:44 (Nov. 2014): 431-439.

7. Ibid., 433.

8. Cataldo, "CDF Principles," 24.

9. The webinar, "Understanding the Revision to Part Six of the ERDs," is available to CHA members at: www.chausa.org/online-learning/viewer/understanding-the-revision-to-part-six-of-the-erds.

10. These comments begin at approximately 1:27:00 minutes.

11. John A. Gallagher, "Theology and Ethics: Reflections on the Revisions to Part Six of the ERDs," *Health Care Ethics USA*, (Fall, 2018): 28-34. Available at: www.chausa.org/docs/default-source/hceusa/fall-2018-hceusa_final_update_102618.

pdf?sfvrsn=2. See also "U.S. Bishops Revise Part Six of the Ethical and Religious Directives," *Health Care Ethics USA*, (Summer, 2018): 12-15. Available at: www.chausa.org/docs/default-source/hceusa/2018-summer-issue-v2.pdf?sfvrsn=2.

12. Ibid., 33.

13. Ibid., 31.

14. www.centura.org/.

15. www.AMITAhealth.org/. My interaction with personnel at AMITA was limited for this article. In kind correspondence, Deborah S. Fullerton, vice president and chief marketing officer, let me know that they had recently experienced the arrival of two new mission officers. On the Catholic side, Mary Paul, a VP for Mission Integration at Ascension is serving on an interim basis and on the Adventist side, Ismael Gama is now caring for mission services.

16. For further information go to: oag.ca.gov/charities/nonprofithosp#notice2.

17. Linda Andrews, "Centura Health: Two Faiths, One Mission," *Spectrum* 27:3: 53-57.

18. Ibid., 53.

19. Ibid., 57.

20. Ibid.

21. "*Spectrum* is an independent publication of Adventist Forum:" www.spectrummagazine.org/about

22. Andrews, "Centura Health," 55.

23. Stephen B. King and Sr. Nancy Hoffman, "An Unlikely Reverence: The Story of Centura Health A Partnership Between Seventh-day Adventists and Roman Catholics," *UPDATE* 16:3 (November 2000). A publication of the Loma Linda University Center for Christian Bioethics.

24. Personal correspondence.

25. I appreciate Charles Sandefur's willingness to discuss his memories and analysis of the establishment of Centura Health.

26. P. Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982).

27. Allan M. Zuckerman and Russell C. Coile, "Catholic Healthcare's Future," *Health Progress* (Nov-Dec. 1997): 23–35.

28. www.ascension.org.

29. www.AMITAhealth.org.

30. www.adventist.org/en/information/official-statements/statements/article/go/-/how-seventh-day-adventists-view-roman-catholicism/.

31. "Moral Analysis: Proposed Joint Operating Agreement Between Ascension Health and Adventist Health System." Dan O'Brien, principal author.

32. O'Brien, "Moral Analysis," 29.

33. Ibid.

34. Elaine Zablocki, "Centura Health—Two Faiths in Alliance," *Health System Leader* (Jan. 1997): 17–26.

35. Ibid., 25.

36. Ibid.

37. Ibid., 26.

38. Provided in personal correspondence with Dan O'Brien. For a description of a "Public Juridic Person" see: www.vatican.va/archive/ENG1104/_PD.HTM.

39. I'm appreciative of Ted Hamilton's help understanding AdventHealth's approach to these CBAs. Mr. Hamilton is the Chief Mission Integration Officer for AdventHealth.

40. Provided to me via personal correspondence. Interested persons may call 407.357.2458 for more information.

41. Available at: www.adventist.org/en/information/official-statements/statements/article/go/-/operating-principles-for-health-care-institutions/.

42. www.jointcommission.org/.

43. Two articles may be helpful to the reader to understand the "health message" in Adventism: www.ministrymagazine.org/archive/2017/03/healthmessage. And another one from the official Adventist website: www.adventist.org/en/vitality/health/.

44. www.vatican.va/archive/ENG1104/_PD.HTM.

45. in.providence.org/or/departments/missionintegration/Documents/OR%20Region%20Hopes%20and%20Aspirations%20for%20Providence%20Ministries.pdf.

46. M. J. Eckelman and Jodi Sherman, Shama Agmad, ed., "Environmental Impacts of the U.S. Health Care System and Effects on Public Health." *PLoS One* 11(6) (2016): e0157014. See also a book by Jessica Pierce and Andrew Jameton who raised concern for this issue over 17 years ago in *The Ethics of Environmentally Responsible Health Care* (Oxford University Press: New York, 2004).

47. Pope Francis, *Laudito Si—On Care for our Common Home*. United States Conference of Catholic Bishops, 2015.

48. Kate Raworth is a professor at Oxford and Cambridge Universities. www.cisl.cam.ac.uk/directory/kate-raworth.

49. See the transcript of a recent TED talk from Dr. Raworth: www.npr.org/2018/12/07/674117856/kate-raworth-how-can-we-create-a-thriving-economy-for-ourselves-and-the-planet.

50. See the following article by Thomas A. Nairn, OFM for a good description of the "preferential option for the poor" in healthcare in particular: journalofethics.ama-assn.org/article/roman-catholic-ethics-and-preferential-option-poor/2007-05.

51. Darlene Fozard Weaver, "Christian Anthropology and Health Care," *Health Care Ethics USA* (Fall 2018). Available online: www.chausa.org/publications/health-care-ethics-usa/archives/issues/fall-2018/christian-anthropology-and-health-care.

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