The recent decision of Catholic Healthcare West to divest itself of its Catholic identity will undoubtedly provide the media with yet another opportunity to present the Church as rent by internal division. These media presentations typically take the same form: brave progressives who are battling for truth, justice, and the American way against hidebound bishops whose principal goal is to force people to do what they do not want to do and what no sensible person would want to do.

There is no question that traditional Catholic health care ethics is under fire, especially in the media. From nightly crime and medical dramas to the standard news stories of the day, Catholic ethics is routinely portrayed as cruelly rigid, inscrutable, or even outright dangerous to public health. A case in point is the December 4, 2011, lead story for the CBS Sunday Morning show. The story, titled “The Catholic Church: A House Divided?,” focused on the 2010 decision of Bishop Thomas Olmsted of Phoenix, Arizona, to remove the Catholic status of St. Joseph’s Hospital and Medical Center in Phoenix, because of an abortion performed there on an eleven-week-old unborn child whose mother was ill with life-threatening pulmonary hypertension. The chief medical officer at St. Joseph’s Hospital stated in an interview that the abortion was medically necessary to save the mother’s life. Adding fuel to the media fire, the CBS show reported that Bishop Olmsted excommunicated Sister Margaret Mary McBride, RSM, administrator and member of the ethics committee at St. Joseph’s Hospital for approving the abortion.

The story portrayed the issue as one where abortion was the only medical solution. But was this true? CBS suggested that Sr. McBride, and American women religious in general, were being punished by a dogmatic and out-of-touch Catholic hierarchy. Again, was this true? And what exactly were the details surrounding the excommunication of Sr. McBride? Was it, as the CBS show implied, an arbitrary exercise of power?

The Untold Story

The real story behind the St. Joseph’s Hospital abortion tragedy and its consequences is much more complicated than that depicted by the CBS show. Unfortunately, the average Catholic is unlikely to encounter clear and thoughtful explanations of the Church’s governing principles in cases such as this, especially if he or she depends primarily on the media for information. Thus it is not surprising that Catholic patients and families who are suddenly faced with ethical dilemmas find themselves confused and troubled by differing opinions about what is the best course of action, even at Catholic hospitals. This is a grave problem that I have seen often during my forty-two years as a nurse.

In the case of the abortion at St. Joseph’s Hospital, not surprisingly, given media hostility toward the Catholic Church, quite a lot of information was left out of the CBS Sunday Morning report, that is, facts that would have been helpful to future patients and families who will face similar decisions. Too often, Catholics find themselves on the defensive because they do not know the actual teaching of their own moral tradition. The Church’s prohibition against direct abortion makes both moral and practical sense because it is rooted in natural moral law and in scientific fact.

In the case of the abortion at St. Joseph’s Hospital, the Church’s prohibition against direct abortion was not a hard-hearted dogma designed to force the death of a mother, but rather it was a commitment to both lives involved. There is an enormous difference between terminating the life of an unborn child (a direct abortion) and treating a serious or even life-threatening condition of the mother that may lead to the unfortunate but foreseeable death of the unborn. The classic example of a pregnant woman with uterine cancer, where the diseased organ must be removed along with the unborn child, is justifiable under the principle of double effect. The object of the act is the removal of an unhealthy organ. The death of the child is foreseen but not intended.

In the case of St. Joseph’s Hospital, there was no diseased organ to be removed, and the child, of course, was healthy. Although women with pulmonary hypertension are advised to avoid pregnancy because the risk of
pregnancy-related death is substantial (reported to be 30 to 50 percent), tremendous advances have been made in treating pulmonary hypertension in pregnant and nonpregnant patients. In addition, although the media rarely report it, abortion poses physical and emotional risks to even a healthy mother in the first trimester of pregnancy. Bishop Olmsted determined that the hospital’s medical staff and ethics committee had decided to perform an abortion rather than treat the woman’s disease.1

The CBS program ignored these facts. The other major controversy presented in the report was whether Bishop Olmsted had overstepped his bounds by revoking the Catholic status of the hospital and by excommunicating Sr. McBride. Were these actions a sudden and rash decision of an authoritarian monarch, as most secular media and even some Catholic critics claimed? Hardly. There was a long and complex history behind these events, a history that continues to show itself in Catholic Healthcare West’s recent decision to abandon its Catholic identity.

As Bishop Olmsted made clear in his December 2010 statement, he spent months discussing with officials of the hospital and Catholic Healthcare West not just this abortion but what the bishop determined to be a pattern of behavior that violated the Ethical and Religious Directives for Catholic Health Care Services, the governing document for Catholic health care institutions. According to Bishop Olmsted’s, this behavior included administering contraceptives, contraceptive counseling, voluntary sterilizations, and abortions in cases of rape, incest, and even for the benefit of the mental health of the mother—a dubious medical claim. Bishop Olmsted expressed his reluctance to remove the Catholic status of the hospital and stated that “the Catholic faithful are free to seek care or to offer care at St. Joseph’s Hospital, but I cannot guarantee that the care provided will be in full accord with the teachings of the Church.”3

Bishop Olmsted said that he had had discussions for years with Catholic Healthcare West, the parent company of St. Joseph’s Hospital, about resolving violations of the Ethical and Religious Directives but that CHW had refused to comply. Those directives recognize a bishop’s essential responsibility over Catholic health care institutions: “As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese.”4

The CBS Sunday Morning show criticized Bishop Olmsted for excommunicating Sr. McBride, but in fact he privately informed her that she had incurred an excommunication latae sententiae, that is, that it happened automatically at the procurement of the completed abortion. Canon 1398 states, “a person who procures a completed abortion incurs a latae sententiae excommunication.” Of course, there are extenuating circumstances, such as intention or coercion, that could mitigate the penalty of excommunication, but this is far from the liberal feminist cause célèbre that the CBS Sunday Morning show would have its viewers believe.

A Deeper Problem

As troubling as is the media criticism and lack of depth, it is the confusion spread by Catholic sources that is arguably the most damaging, for Catholics and non-Catholics alike. The United States Conference of Catholic Bishops issued a thoughtful statement on the case, ignored, of course, by the media.5 But it was also ignored by prominent Catholic organizations and theologians.

The Catholic Health Association, claiming to include more than six hundred hospitals and 1,400 long-term care and other health facilities in all fifty states, issued a strong statement in support of the abortion and of the hospital.6 Marquette University professor and theologian M. Therese Lyseught, hired by St. Joseph’s Hospital to provide an “independent” analysis, denied that the termination was a direct abortion.7 Such events lead many devout Catholics to scratch their heads. They wonder whom they can trust when it comes to making health care decisions in the light of Catholic teaching.

The real-world consequences of such division within the Church are frightening. The American Civil Liberties Union, citing the abortion case at St. Joseph’s Hospital, already complained to federal health officials that “no hospital—religious or otherwise—should be prohibited from saving women’s lives and from following federal law.”8 The Obama administration’s February 2011 revision of a federal protection of conscience rights regulation has left both health care professionals and institutions vulnerable to litigation and coercion.

A consistent ethical standard of care is crucial for protecting patients as well as Catholic health care itself. Reliability builds trust, an indispensable component of good health care that appeals to both Catholics and non-Catholics alike in this uncertain health care environment. At a time when hospitals are competing for patients, Catholic hospitals can stand out by offering both the best technology and the best standard of ethics.

Bishop Olmsted’s difficult decision to revoke the Catholic status of St. Joseph’s Hospital exposed the problem of Catholic institutions and ethicists who ignore or reinterpret many of the clear and definitive principles of the Ethical and Religious Directives to justify certain practices. Generations have gratefully entrusted their confidence, respect, and donations to Catholic health care institutions in order to build up the wonderful system of care that we have. Catholic institutions must now prove themselves worthy of that trust.

Nancy Valko, RN

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DEVELOPING A POLICY ON FETAL REMAINS

This is the story of one Catholic hospital’s efforts to find a way to respectfully lay to rest the remains of babies miscarried at less than twenty weeks’ gestation. I tell our story in the hope that it might in some way ease the way for other hospitals and health care professionals who want to do what is right.

Our journey began in Spring 2010 when a grandmother called the director of the maternity unit to ask where her grandchild was buried. Her grandchild died at eighteen weeks’ gestation when the mother was injured in a car accident. Although this had happened ten years before, the pain of the loss of the child was still felt in the family.

Developing a Policy

As the manager of the pastoral care department, I was asked about the hospital’s policy regarding disposition of fetal remains. At the time, the policy did not provide for burial. The grandmother’s question launched our efforts to develop a policy that would ensure burial of a baby’s remains following miscarriage.

We formed an interdisciplinary team to look into the matter. The team consisted of representatives from virtually all hospital departments: maternity, nursing, pastoral care, ethics, surgery, emergency care, laboratory, administration, social work, risk management, and security (who are in charge of the morgue). We also consulted with our Catholic cemetery association and a local funeral director.

Of great help was an article written by Marie Hilliard of The National Catholic Bioethics Center, titled “Care of Fetal Remains: A Pastoral Matter.” The article discussed respectfully disposing of fetal remains in a way consistent with the Ethical and Religious Directives for Catholic Health Care Services and with canon law. I spoke to Dr. Hilliard on the phone, and she was an immense help and support.

What we were facing was the challenge of changing the old protocol and creating new consent forms. First, we contacted several other Catholic hospitals in our area and requested copies of their policies and consent forms. Then the interdisciplinary team met and drafted an updated policy that established a process for burial of babies miscarried at less than twenty weeks’ gestation. The hospital would arrange for common burial; parents would also be given the option for private burial. If there were a need for burial in a non-Catholic cemetery, the hospital would work with the family and the funeral home to accommodate this need as well.

Creating a Consent Form

We then moved to the consent form, which provoked much discussion. We changed it many times because of the many disciplines involved, and we had input from the medical records committee to consider as well. The Catholic cemetery association staff clarified what the consent form needed to say. They pointed out that both the doctor and the parents needed to sign the form. It was also important to obtain the information needed by the municipality for the burial permits and by the office of vital statistics. After months of back and forth and four drafts, we finally settled on a workable form with which everyone felt comfortable.

We also met with the staff in the laboratory to work out a procedure for storing the remains until burial. And with the help of the funeral director, we made sure that the burial containers would serve their proper function. We also arranged for the lab staff to keep the central log of the fetal remains, with medical record number, mother’s name, and other important information.

The Catholic cemetery association found a space in one of their cemeteries for the common burial site. The hospital's pastoral care department donated the headstone, which is pink granite and inscribed with an angel and the words “In loving memory of our littlest angels.”

We printed a card that is given to each mother who has a miscarriage, offering our condolences. In the card is information about our burial and interfaith memorial services, which will be held twice a year, with the name and address of the cemetery where their baby will be buried. The phone number for the pastoral care department is included, as is bereavement counseling information.

We then instructed physicians and hospital staff on the updated policy. Although some initially objected to additional paperwork, all are now committed to following the new protocol.

Laying to Rest

Finally, on a chilly November afternoon almost two years after we began this journey, twelve people gathered
in a circle around a small casket that held thirty-eight tiny babies. We cried, and prayed, and blessed the little ones. We sang to them. They would finally be laid to rest, as will those who follow.

It was a long and difficult journey through politics, practicality, personalities, and pressures, but we finally did the right thing for our youngest and most vulnerable patients and their grieving parents. If another parent or grandparent were to call, we would now be able to tell them where their baby is buried.

Geralyn Abbott

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Sample Policy for the Disposition of Fetal Remains

The purpose of this policy is to establish a process for burial of a fetus or fetal remains resulting from a loss of pregnancy at less than twenty weeks’ gestation. This policy adheres to the Ethical and Religious Directives for Catholic Health Care Services.

1. An informed consent for authorization for disposition of fetal remains will be completed. A copy will be sent to the pastoral care department for burial purposes.
2. A death certificate (if issuable in the state of the fetal death) will be completed for private burial purposes only.
3. Catholic parents who intended to have their baby baptized will be informed to contact the diocesan chancery if they wish to have a funeral Mass.
4. A fetus or fetal remains for private burial will be sent to the morgue by Women, Infants, and Children or by the lab.
5. A fetus or fetal remains for common burial shall be placed in a specimen container labeled with the name and medical record number. A pathology slip will also be completed. The remains shall be sent to the laboratory.

Laboratory Protocol:
1. The pathologist will examine the specimen to determine if there is fetal tissue.
2. If fetal tissue is present, the laboratory will place the tissue in a separate container for disposition.
3. If fetal tissue is not present the specimen will be disposed of per laboratory protocol.
4. Remains for common burial will be kept in the laboratory until the burial occurs.
5. The laboratory will be responsible for recording all pertinent information per laboratory policy.

Pastoral Care Protocol:
1. A representative from the pastoral care department will be available to offer a blessing at the time of fetal death and to offer family support throughout the hospitalization and time of burial.
2. At least once yearly, there will be a common burial consistent with diocesan and liturgical guidelines.
3. Burial records will be maintained at the hospital.