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Institutional Cooperation and the Ethical and Religious Directives

by

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The topic of institutional cooperation has generated a considerable discussion among ethicists, bishops and administrators of American Catholic health care facilities. In order to advance that discussion, I wish to develop several issues related to the topic:

- the inevitable disagreement that cooperation produces
- foundational insights for approaching the principle of cooperation
- a brief explanation of the principle
- a consideration of the cooperating agent and therein an appreciation of the breadth of the principle's utility
- a reflection on why cooperation is important
- a discussion of the particularly difficult issues of duress, immediate material cooperation, and episcopal judgement

- a case of immediate material cooperation

I. The Inevitable Disagreement that Cooperation Produces

It has always been the case that anyone who engages the principle of cooperation is bound to meet with disagreement. The disagreement is due to difficulty that arises from differences in prudential judgement: inasmuch as the principle concerns how much good people ought to be involved in wrong activity, each person has a different opinion on the matter. Thus, in asking how to apply the principle of cooperation, the English Jesuit moral theologian Henry Davis remarked in 1958 there is "no more difficult question than this in the whole range of Moral Theology."[1] Earlier, in 1923, the famous moralist Jerome Noldin noted that the disagreement was not simply among those who were unfamiliar with it; on the contrary, Noldin noted that it has routinely been granted that this disagreement happens among the most competent moral theologians.[2] Thus, we find earlier on these pages the Reverend Russell E. Smith in disagreement on the topic of institutional cooperation with both Professor Germain Grisez and the Reverend Richard McCormick.[3]

Certainly, the reason for the renewed interest in the principle of cooperation arises from the important role that it plays in assisting those responsible for Catholic health care ministry to navigate the complex moral, religious and economic issues that emerge in today's highly interdependent network of American health care. Anticipating the emergence of these issues, the National Conference of Catholic Bishops offered its own "clarification of the terms relative" to the principle of cooperation in the Appendix of the *Ethical and Religious Directives* (hereinafter, ERD).[4]

That clarification, like the entire ERD itself, did not occur overnight. Rather, only after six years and eleven drafts of ERD was the NCCB's Committee on Doctrine ready to offer it to the full assembly of bishops. Only then did the Committee members win from the assembly of their brother bishops a unanimous vote approving ERD's promulgation. To appreciate, then, the fact that complexity and disagreement are part and parcel of the principle, a brief review of the

bishops' attempts to incorporate the principle into ERD proves itself useful.

Examining those eleven drafts, we find within one of the earliest versions a section on cooperation. That version was a modest description of each of the principle's conditions. When this draft was circulated among a variety of Catholic ethicists, disagreement broke out immediately. Progressives assailed it for narrowing the tradition; conservatives for expanding it.

The next draft attempted an even more modest description: a virtually skeletal outline. No condition was described: it was simply stated. The draft left to individual health care facilities, their ethical review boards and diocesan offices the responsibility to apply and therefore to interpret the principle. But to this rendition, the bishops and health care administrators objected: it was not user friendly. Both suggested presenting cases to explain the text.

To meet this request, the theologians working for the bishops contacted colleagues around the world who, like themselves, had written on cooperation. Several cases of both personal and institutional cooperation were presented. But when faced with these cases, the bishops fell into disagreement with one another. Bishops offered their differing solutions to each of the cases (It should be noted that one case prompted great concern: this described an internist consulted about the asthmatic condition of a woman seeking an abortion. Many bishops did not want any description of cooperation in abortion, even if the cooperation was licit and remote. Ironically, *Evangelium Vitae* specifically referred to an abortion case in describing licit cooperation, #73.). After all this disagreement, the Committee eliminated the cases from ERD's drafts.

Finally the bishops decided to go back to the original version and together labored in the last drafts over the actual wording of the text. They were joined by six theologians. Then, after it was complete, they submitted it to their brother bishops and to the Vatican's Congregation for the Doctrine of the Faith. After receiving comments from both fora, the Committee finally submitted the last draft to the November 1995 NCCB assembly and received its unanimous approval.

Thus it took the bishops six years to articulate the principle, and then only after broad consultation and considerable disagreement. But, consensus was eventually achieved in an atmosphere of mutual trust

and respect. That atmosphere must be promoted today among negotiating boards, ethicists, and chanceries, if Catholic health care is to survive into the next century, for the principle of cooperation is a major guide in the present negotiations of joint ventures, mergers and partnerships.[5]

II. Foundational Insights for Approaching the Principle of Cooperation

There are preliminary insights that we must acknowledge before applying the principle. The first is that cooperation is NOT a permitting principle, but rather a guiding principle. It provides guidelines for determining to what degree one should cooperate. It is not a "may I" cooperate principle, rather it is a guide as to "whether" and "how much" one should cooperate.

We need to get away from the notion that principles permit activity. We look to principles as permitting all sorts of things. This is especially evident in our pathetic dependency on double effect. We ask, can we advise about condoms and AIDS? Yes, we answer, by the principle of double effect. Can we bomb military installations within civilian populations? Yes, by the principle of double effect. Can we apply dangerous levels of pain medication to a person dying in unremitting pain? Yes, double effect. Just as we have been rightly warned away from this knee-jerk dependency on double effect,[6] we need to avoid a similar tendency as we become reacquainted with the principle of cooperation.

Ethics is about right reasoning and right living. Only to the extent that a principle resonates with right reason is it right. Likewise, a principle can only be applied to the extent that it is rightly applied. Cleverly applying a principle to a situation does not make a wrong solution right. If we have learned anything with our recent studies on casuistry, [7] it is that we cannot look to moral principles to legitimate morally questionable conduct. The rightness of one's conduct must be demonstrable in itself by human reason; it cannot be legitimated by appeal to some external general principle. Thus, the principle's function is rather modest: it helps to highlight the general direction which we ought to pursue in trying to find a morally right solution.

The second insight into cooperation is that it is a principle which we avoid as much as possible. To cooperate in the wrong-doing of another is something every morally good person regrets. While there may be morally legitimate reasons for cooperation, we must remember that the controlling insight in applying the principle is to cooperate as little as is necessary.

Third, one of the basic reasons for cooperation is to contain evil. A person or an institution engages in cooperation often to minimize the presence of evil. *Evangelium Vitae* caught this intent in talking about the case

> where a legislative vote would be decisive for the passage of a more restrictive law, aimed a limiting the number of authorized abortions, in place of a more permissive law already passed or ready to be voted on...when it is not possible to overturn or completely abrogate a pro-abortion law, an elected official whose absolute personal opposition to procured abortion was well known could licitly support proposals aimed at limiting the harm done by such a law and at lessening its negative consequences at the level of general opinion and public morality. This does not in fact represent illicit cooperation with an unjust law but rather a legitimate and proper attempt to limit its evil aspects. (*Evangelium Vitae* 73)

A concrete example of this insight was actually taken by the NCCB when Archbishop John R. Roach and Cardinal Terence Cooke testified at the United States Senate in support of the Hatch amendment, which did not eliminate abortion, but restricted it.[8] The NCCB became involved in legislation on abortion precisely to contain this evil.

Fourth, we cannot apply the principle mechanistically; we have to apply it with human reasoning. We have to deal with the specific, real, concrete situations which we face. It was, after all, those situations that gave rise to those principles. Here we can learn much from John Gallagher's fine essay in which he recommends that Catholic health care facilities get into the habit of moral discernment, that is, that a facility's board members become reflective agents leading the institution forward by profound deliberations.[9] In the context of those deliberations, a turn to the principle of cooperation might occur. For people who discern well know how to use the principle.

III. What is the Principle of Cooperation?

In institutional cooperation it is important to distinguish individual beliefs from those that the institution holds. While an individual might personally believe that not all forms of birth control are wrong, as an employee of a Catholic health care facility, she is responsible for upholding the Church's teaching regarding birth control. Thus, personal beliefs are not the issue of institutional cooperation. Rather, the issues are those actions which the Church judges to be themselves wrongful. These include: assisted suicide, certain reproductive technologies that separate the unitive from the procreative, sterilization, direct abortion, and birth control. No Catholic health care institution can freely elect to perform any of these wrong actions. Nonetheless, under certain conditions an institution might consider to partner, merge, or enter into a joint venture with another institution that does perform these wrong actions. For that reason, we must consider the basic conditions of the principle itself.

In an act of cooperation we must distinguish five conditions, the first being between formal and material cooperation.[10] The former is always wrong. It describes the stance of the cooperator as approving, wanting or intending the wrongdoer's action. Material cooperation, however, is the assistance in an act of wrongdoing without that approval. Thus, if a Catholic institution were ever to cooperate with another institution it could never formally cooperate, that is, it could never endorse the wrongful activity that the other agent provides.

Under material cooperation, we must distinguish between immediate and mediate cooperation. Whereas the previous distinction was about our intention with regard to the cooperation, this distinction concerns the action itself. If the cooperation is mediated it means that the institution is not directly involved in the wrongful activity. Immediate cooperation means that the activity of the wrongdoer is identical with the activity of the cooperator. While the tradition has been generally willing to consider mediated cooperation, it has considered some instances of immediate cooperation as legitimate, but only under duress.

Under mediated cooperation we are advised to be as far away from the activity as is possible. That is, we are to be more remote and less proximate. Next, the reason for the cooperation must be serious.

This is extraordinarily important. Since the nineteenth century, the tradition has used the phrase "proportionate reason" to describe this condition. In the case of cooperation, the term means that one only cooperates to the extent that something valuable is threatened and then the degree of cooperation depends upon how urgently that value needs to be protected. Unlike other contexts for the concept "proportionate reason", it functions in cooperation solely to protect a value, like life or property, that is being threatened: it is not invoked to simply promote something, but rather to protect something that is endangered. Thus, in the majority of cases of legitimate cooperation, either the source of one's livelihood and/or a particular dimension of the common good is jeopardized. Determining the value of the threatened good as well as determining the actual feasibility of the threat constitute the factors of this fourth condition, "proportionate reason".

Finally, scandal arises often when we cooperate and do not demonstrate reasonably to our communities that our conduct is actually in keeping with traditionally accepted forms of behavior. The possibility that our communities might misconstrue what we are doing imposes on us the duty to help them to understand that our cooperation is not an approval of another's wrong activity. Moreover, we have a responsibility to help our "weaker brothers and sisters" to understand that we are not undermining our tradtion, but rather protecting it. Especially in light of health care reform, educational efforts must precede the entering of new partnerships, particularly when scandal is likely. Our efforts must make clear that our entering into a partnership is to protect threatened Catholic values in health care and to contain wrong-doing.

On the topic of scandal St. Paul's discernment is helpful. In I Corinthians 8, he raises the responsibility that stronger members have for their weaker members over the question of eating meat offered to idols. Here they are to help the brothers and sisters to see what they are *not* doing: they have an obligation to help their siblings understand that by eating this meat they are *not* acknowledging idols. If they cannot help these members to understand this, then they should abstain from the eating of idol meat altogether. But elsewhere, Paul considers another topic, circumcision. Here he is not at all concerned about the scandal of his position regarding those who insist on circumcision. Rather, he sees them as placing a stumbling block on the way to others

and rather than trying to soothe their alarm, he wishes that they would "mutilate themselves!" (Galatians 5:2-12). Thus, scandal cannot be used as a concept to hold hostage a particularly right way of proceeding. Rather it requires us to explain our actions as congruent with the tradition.

IV. Who Cooperates? Getting a Sense of the Breadth of the Principle

Two ethicists, Germain Grisez and Russell Smith, have suggested that the applicability of the principle is fairly restrictive. Grisez wrote "Classical moral treatments of cooperation were almost entirely about the problems of individuals - especially servants, employees, and other subordinates - called upon to help superiors.[11] But this is an oversimplification. Certainly there are cases concerning subordinates, e.g., a messenger bearing letters between people in illicit relations,[12] a servant continually assisting his master's attempts to engage in illicit relations,[13] an assistant chemist working in a drug store which sells abortifacients,[14] etc. But there are two other very different classes of cases of cooperation regarding participants who are not subordinates. The first class concerns when one has a right to perform a particular act, but others who perform the same act have wrong intentions. For instance, one considering cremation had to ask to what degree he was participating in the same action as the Masons.[15] Another example concerns the wife who asks for her marriage dues from her husband who habitually withdraws.[16]

The other more important class of cases are those in which someone cooperates precisely to diminish the physically evil effects of another's illicit or morally wrong actions. Here, rather than being a question of options or rights, cooperation is a means of determining whether potential catastrophes can somehow be averted. A classic example is the belt-offering wife of the husband intent on beating his children with a baseball bat. Not participating in the moral evil, she cooperates to diminish the physical effects of his illicit action. Similar instances of material cooperation for the sake of diminishing the physical effects of moral evil are found in the cases of priests giving communion to unworthy recipients,[17] judges presiding over divorce cases,[18] doctors working in clinics that provide birth control instruction,

[19] nurses assisting in illicit operations,[20] etc. Effectively, in each case the agent asks at some point in her deliberations whether more harm than good could occur by her failure to cooperate materially. Clearly this class of actions includes the case offered by *Evangelium Vitae* and practiced by Cardinal Cooke on behalf of the NCCB. It also includes the case from the "Many Faces of AIDS" in which a worker in a Catholic health care facility tells a person who tests HIV positive that he should be sexually abstinent, but the patient responds that he has no such intention. Then, in the name of the common good, the worker urges the patient to use a condom.[21]

Two conclusions result from this examination. First, in light of these cases one is hard pressed to argue that the principle of cooperation refers "almost entirely" to matters between subordinates and superiors. Second, cases regarding professionals differ considerably from those concerning subordinates. The cases differ because the former consider the question of the common good. In the case of subordinates, the concern is whether someone can be *excused* from any moral blame in cooperating with another because of that person's threats. In the cases of the judge, the priest, the doctor, the health care worker, the politician, or the archbishop, cooperation is invoked to contain harmful effects on the common good which result from another agent's actions.

As Germain Grisez attempts to delimit cooperation to only "subordinates", Russell Smith attempts the exact opposite move by describing the cooperator as a singularly free agent. He does this by a clever triptych of the roles of an accomplice, a taxpayer and a hostage.[22] He describes the accomplice as formally cooperating in the wrongdoing. Being as culpable as the wrongdoer, the accomplice is never an example of licit cooperation. The hostage on the other hand, without any freedom, can hardly be described as "cooperating" in the activity. Only the mean between these two extremes, that is, the taxpayer, is the quintessential cooperator: taxpaying is something no one wants to do, yet one is supporting a government's activity which is inevitably somewhere wrong. On the face of it, Smith's distinctions are deceptively attractive. Only the taxpayer is the paradigm cooperator; the other two are not. The first because he formally cooperates, the latter because he lacks freedom. But like Grisez, Smith has oversimplified the tradition, for not all cooperators are completely free

agents. For instance, in the case of the accomplice, certainly a free accomplice is always acting wrongly, but not all accomplices are free. To appreciate this, we should see that "accomplice" can have two meanings. An accomplice in intention would be one who formally cooperates. An accomplice in action is then an instance of immediate cooperation. Thus, contrary to Smith's claim, the moral theologians of the last three centuries have discussed immediately cooperating accomplices. Davis,[23] with other moralists,[24] judged as licit, for example, the case of a man under threat of death who must destroy another person's property. This was clearly an accomplice, but the accomplice was not sharing the same intention, though he was sharing the same action. What distinguished the accomplice from the wrong-doer was the duress. (Clearly, anyone familiar with the case of Patricia Hearst and the SLA remembers similar discussions.) Such exceptions are noteworthy insofar as they help illustrate that the tradition did not make the black and white distinctions that Smith suggests; rather it often examined a lot of the gray areas of moral ambiguity.

More importantly, Smith's exclusion of the other category, "the hostage", leads us to believe that only free agents and no subordinates were subjects of cooperation. Though Grisez is wrong to say that cooperation "almost entirely" concerned subordinates, Smith is wrong to exclude them entirely. The actions of subordinates, who were much more like hostages than they were like taxpayers, were regularly evaluated. In considering these subordinates, the degree of constraint or duress was a routine factor in weighing the legitimacy of their cooperation.

In light of the fact that so few read the tradition as it was espoused by ethicists over the last few centuries, it is important that we realize that the tradition was not as narrow as others would have us believe. Traditional ethicists were willing to review a great breadth of activity by people in diverse positions of power and authority. In reviewing that grand array, the ethicists recognized that reasons for cooperating differed. The slave, servant, or teenage employee were generally cooperating not because they were interested in protecting the common good; rather, they were cooperating to keep their jobs. The judge, priest and others were cooperating to protect the common good. But some who protected the common good also cooperated because they wanted to keep their jobs. That is, people cooperated not simply

for one reason, but for several. The nurse may have stayed in the hospital not only for her job but also because she felt that a moral vacuum would arise with her departure; the judge may have stayed in family court and still ruled on divorce cases in part to keep an authoritative Catholic voice in the family court, but also to keep her job as well.

Both Grisez and Smith have also questioned the validity of applying cooperation to institutional agency, precisely because so many cases were originally of individuals cooperating. But history teaches us that just as individuals cooperate with others, similarly for centuries institutions have cooperated in others' wrong-doing. In fact, Roman Catholicism with its appreciation for institutional governance probably has a longer tradition of institutional cooperation than other religions have had. This can be seen by considering the Vatican's institutional engagement of other institutions. One clear instance includes the concordats which certainly bind the Vatican into cooperative endeavors, some of which entail evil. The Vatican has always astutely and prudently negotiated its involvement in evil, trying to use its own authority to contain it. But the Vatican uses its authority not only with concordats but in every instance where it sends a delegate, an emissary or an ambassador to recognize another government. The recognition of another regime's legitimacy, the participation in its inaugural receptions, and any other instances of support for another government is quite clearly a political act of involvement by the Vatican. Likewise, its involvement in international agencies is always an act of institutional cooperation. For instance, its important voice at the United Nations is not a voice of detachment, but involvement. Certainly in all these ways that the Vatican is involved in international organizations, it recognizes that there is wrong-doing to some extent within the practices of these organizations. Clearly, sometimes the wrong-doing is so unacceptable that the Vatican must withdraw its involvement with a particular government or with some international organization at the United Nations. But, for the most part, the Vatican remains involved, sometimes with governments and agencies that are clearly not promoting work that the Vatican would describe as morally right. For this reason one could say that the Vatican's institutional engagements are the proper paradigm for institutional cooperation.

Moreover, it is not simply the Vatican, but the NCCB that also

engages in institutional cooperation in evil. This happens again almost every time that the Conference supports some particular legislation, for often legislation is laden with a variety of programs, not all of which the NCCB would call right. And, yet, it testifies in support of the laws, as they did for the Hatch amendment. In sum, our leaders in the hierarchy are probably more familiar with institutional cooperation than others are. They do this because they recognize the power and authority they have on the one hand to restrict evil and on the other, to protect threatened values.

V. Why Cooperate?

Institutional cooperation arises from those leaders of institutions who recognize the power and authority that they have to both restrict existing evil while protecting their own concerns. We have just seen how this applies to our bishops' activities. But I think it would be helpful to apply this to a more recent medical case of in vitro fertilization.

In 1987 the Vatican issued the encyclical dealing with reproductive technology entitled *Donum Vitae*, which determined among other issues the moral unacceptability of in vitro fertilization because the unitive and procreative dimensions of the reproductive act were separated. Some moral theologians believed that the moral boundaries of in vitro should be drawn not with the procreative act but with the procreative partners.[25] That is, they believed that only husband and wife should become father and mother and that the moral liceity of in vitro fertilization depended on who the partners were. Despite this disagreement, moral theologians were as concerned as the Vatican with the procedure of oocyte retrieval. This procedure is problematic because, due to pain, difficulty, and cost, several eggs or gametes of the mother must be retrieved at once. To save them, these eggs must be fertilized. One is implanted in the mother, while the others are frozen and these are commonly referred to as "spares". "Spares" are available for later implantation in the likely event that the first implant fails.

On the eve of *Donum Vitae* there were five internationally known Catholic health care facilities involved in in vitro fertilization. They were interested in facing two concerns: restricting parenthood to spouses and reducing the dependency on the spares. When *Donum*

Vitae was published, the Vatican expected the five Catholic Universities to close their in vitro facilities because of the separation of the unitive and procreative functions of the procedure. However, of the five, only the one American facility closed. The other four, all northern European, remained open.

As a result, in the United States there was no longer a facility able to address the ethical status of spares or the pre-implanted embryo. Since that time the situation has worsened radically. At an in vitro conference that I attended three years ago, a researcher from a major American university explained its present procedures for in vitro. Now, multiple spares are implanted and, should the expectant mother not spontaneously abort several of the developing embryos, then the physicians selectively abort those extra fetuses! The process is called "embryo reduction".

The absence of a major research facility working in reproductive technology committed to the values of embryonic and fetal life are strikingly apparent. The absence of a Catholic university facility involved in in vitro fertilization has meant the absence of an alternative in which "embryonic wastage" is not taken for granted. Could not this American Catholic facility have found some way of cooperating with another facility so as to maintain its interests in promoting human life? Could it not have found through cooperation a way to limit embryonic wastage and to provide an alternative to multiple implants and selective abortion? The withdrawal of Catholic health care from such research meant also the withdrawal of a Catholic voice that could protect the values that the Church teaches are for aall people of good will. It could have championed an alternative. This is precisely why the European Catholic university health care facilities remained with their work. But, in the United States, a concern for purity helped to let the many problems attending in vitro to run unchecked. As a result, today in the United States, unlike several years ago, an embryo is more likely to be discarded or aborted *routinely* in a process that is actually pursuing childbirth.

While many regret our absence, others would say, "Amen." Germain Grisez, for instance, maps out the complexities of cooperation for a Catholic institution and doubts that religious women will be able to avoid substantially wrongful cooperation. In a breath-takingly blunt article, he writes, "So, since you must avoid wrongful cooperation, you

should prepare to give up at least some of your hospitals and eventually, perhaps, all of them." He adds, "However, very likely your institute has experienced a decline in new members, and by now you are probably able to staff only a few positions in your hospitals and fill only a few others with Catholics who regard their work as an apostolate." He concludes, "I suggest that reflection of this sort will...point toward giving up the hospitals and adopting more suitable means of serving those most in need and least served by that system."[26]

Grisez is concerned singularly with avoiding wrong-doing. For that reason, he advises a withdrawal from those large health care facilities where we cannot avoid cooperation. Better that we not do the wrong. But those in ministry are not singularly involved in avoiding the wrong; we are as interested in containing wrong-doing. We are not satisfied with a self-knowledge that exculpates us from getting our hands dirty. That does not mean that we irresponsibly cooperate. On the contrary, because we believe that we should cooperate in order to protect threatened values, we seek to do it as rightly as possible.

Moreover, religious women are not simply faced with the moral choice between divesting from their hospitals or doing evil. Rather, they have initiated and sustained an enormous expansion of their ministry: religious have brought the laity into their mission. But this incorporation of the laity into health care ministry is not as recent as we may think. True, the laity may be more recently involved in the administration of a facility. But religious women have brought the laity into their mission since the first day they hired a lay physician or nurse. These lay persons have found in Catholic facilities a way of pursuing their own ministry without finding themselves compromised elsewhere. Many Catholic nurses, for instance, have long believed that only at a Catholic hospital could they pursue ethically their work. If a religious order gives up its health care facility where do the hundreds of employees go? Where are they provided the institutional support to continue their helpful ministry? If other health care facilities are so morally problematic that we should not cooperate with them (as Grisez contends), how could a good Catholic become an employee in one? While the sisters give up their ministry in administration, should the nurses and physicians give up their ministry in health care?

Grisez argues prophetically that we should not compromise. Consider, for instance, a large emerging IDN where a Catholic partner

is in the position to be the manager but a prophetic voice says that we should not manage because one partner provides sterilizations. The money will be dirty, the sterilizations will be inevitably identified with the Catholic provider, and scandal will ensue.[27]

But where is the scandal? In the case of the university above, is the scandal in the presence of a Catholic facility in in vitro research or in its withdrawal from that research? Is the scandal in its attempting to diminish the need for spares and in offering an option to women that does not include as a standard operating procedure selective abortion? Or is the scandal in not offering any alternative at all? In the face of moral complexity, the question of scandal is not necessarily faced by withdrawing one's involvement.

VI. Duress, Immediate Material Cooperation and Episcopal Judgment in ERD

In the Appendix of ERD, we find "Immediate material cooperation is wrong, except in some instances of duress. The matter of duress distinguishes immediate material cooperation from implicit formal cooperation." About duress and immediate material cooperation, Russell Smith has rightly remarked that both I and the Reverend Thomas Kopfensteiner have argued "that duress should not be exaggerated to justify cooperation in wrongdoing."[28] But in that same essay which originally was delivered to the annual Bishop's Workshop in Dallas, he claims that in the dossier entitled *Catholic Health Ministry in Transition* it is "repeatedly asserted that immediate material cooperation is permissible for proportionate reason."[29] He calls this assertion "gratuitous". But Smith exaggerates here. In reviewing that dossier, I found only one of the fourteen essays making the assertion. Moreover, in that essay, we find "Immediate material cooperation is acceptable *only* in some circumstances of duress when there is a proportionately grave reason, e.g., avoiding the abandonment of an indigent or poor population of persons whose access to other health services is limited or averting loss of Catholic presence."[30] Later in a diagram, explaining the text, that statement is truncated: immediate material cooperation "may be acceptable for proportionate reason." But

that comment is prefaced by "cooperation is acceptable only in circumstances of duress..."[31] Thus, only someone misreading the diagram could claim the assertion that immediate material cooperation was acceptable by any proportionate reason. Instead, in that carefully worded text, words like "only" and "duress" as well as the examples proposed make perfectly clear the rather rare grounds on which immediate material cooperation is determined to be licit. Those grounds are the same that can be found in the manuals. No one on those dossier pages was routinely advancing immediate material cooperation.

As the case at the end of this essay hopefully conveys, immediate material cooperation can only be legitimately considered in extraordinary instances of duress. Duress means that one's options have been constrained, but to preserve something that is threatened, one may cooperate to protect that value.

In an earlier essay, Smith's position on immediate material cooperation was unclear,[32] but now he claims that teaching on duress has ben misunderstood and that the misunderstood notion of duress compromises the tradition's position on immediate material cooperation. Thus he first states that the tradition of immediate material cooperation is impermissible. But a review of the tradition shows exceptions like those noted above.[133] Moreover, common sense tells us that in the history of the Church we should be able to find instances wherein under duress good Catholics participated both licitly and immediately in wrong doing. For instance, Peter Holmes describes some interesting cases of ethicists who wrote during the English Reformation of people under duress licitly participating immediately in outlawed religious services.[34]

Then Smith reflects on duress. Rightly, he turns to two documents from the mid-1970s to understand its meaning in ERD. Both the "Reply of the Sacred Congregation for the doctrine of the Faith on Sterilizations in Catholic Hospitals"[35] and the USCC commentary on it[36] discuss the possibility of Catholic hospitals being involved in sterilizations. The first thing that the two documents state is that the Catholic health care facility cannot "approve" the sterilizations; that is, the cooperation can never be formal For this reason the USCC writes,

"In judging the morality of cooperation a clear distinction should be made between the reason for the sterilization and the reason for the cooperation...If the cooperation is to remain material, the reason for the cooperation must be something over and above the reason for the sterilization itself." The second thing that it does is to stipulate the condition for cooperation in sterilization: "Material cooperation will be justified only where the hospital because of duress or pressure cannot reasonably exercise the autonomy that it has."

Duress appears repeatedly in these documents and Smith uses these as a key for interpreting ERD. From these documents he claims that legitimate duress is episodic and not systematic. I find this distinction curious, because Smith, by again introducing a conceptual distinction, restricts the original meaning of the concept. The distinction that he introduces is between something temporal and something that is not. But duress is always temporal: it is always "episodic". The question, of course, is how long is the episode.

In the tradition, duress, constraint, or pressure could be for a brief moment, like when one has a gun held to her head by another, or something more long-standing, like a person's servitude to another or a nation enslaved during an oppressive regime. In either case, the grounds for cooperation shift when the duress is lifted. Inasmuch as duress is only in effect as long as it lasts, any cooperation that is grounded in duress lasts as long as the duress does. Duress conditions the cooperation.

Duress may be a concept that functioned for those living under communist rule. Once the rule ended, then the grounds for cooperation ended. But certainly the cooperation that is engaged is engaged because of the duress. In the same way, when any hospital by duress is pressured into sterilizations, its cooperation is not for a flashing moment, but rather as long as the duress exists. Likewise, just as those living under a regime differentiated some actions that they could participate in from those that they could not, similarly ERD distinguished the possibility of cooperatively providing sterilizations from the prohibition from providing abortion services (ERD, 45).

Smith sees much in an important sentence from the 1977 commentary to support his distinction: "In making judgments about the morality of cooperation each case must be decided on its own merits. Since hospital situations, and even individual cases, differ so much, it

would not be prudent to apply automatically a decision made in one hospital, or even in one case, to another."[37] But whereas he sees this as highlighting a normative "episodic" condition for cooperation, I see it as simply explaining the sentence that preceded it" "In making judgments about the morality of cooperation each case must be decided upon its own merits." The administrative board of USCC recognized then the complexity of such cooperation in sterilization; they did not suggest that each instance of sterilization must be judged as licit or not, but rather each health care facility's particular policy of duress and sterilization must be judged separately. The administrative board, then, was stating then that they ought not to resolve the question of sterilization by a simple nation or trans-diocesan policy. Rather, bishops were recognizing that each instance of duress and cooperation in sterilization ought to be prudently and locally resolved.

The Vatican and the bishops themselves have given the individual bishops then the latitude to work with duress, cooperation, and sterilizations. Prudence requires that each bishop take a hard look at this. For this reason, I agree with many who say that we need to consider what constitutes duress in the concrete. But I think that the Bishops have been wise not to try to treat this issue of duress as soluble by some sort of general definition. On the one hand, no one wants to see duress used to release the floodgates by "legitimating" all forms of immediate cooperation for any sort of reason; on the other hand, no one wants to take from the bishop the authority of making a determination about a particular hospital and a particular policy on sterilization in his diocese. That's what the bishops did with their vote for ERD: they, with the Vatican, allowed the individual bishop the prudential discretion in determining duress and legitimate cooperation.

Significantly, while the NCCB left to individual bishops the discretion to resolve questions concerning sterilizations, that discretion was not extended to questions concerning abortion. On the contrary, ERD explicitly stated, "Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation." By this directive, the bishops insured that the possibility of providing sterilizations under duress would not become grounds for the possibility of providing abortion under duress.

VII. A Case

We need to remind ourselves that most instances of institutional material cooperation are solved without any appeal to immediate material cooperation. But, there are some instances where it may need to be invoked under duress. This does not give a particular health care facility a blank check to provide sterilizations. Rather, the situation needs to be resolved prudently and specifically by the ethicists. lawyers, administrators and diocesan officials. To highlight the *limitedness* of the issue of duress, immediate cooperation and episcopal judgement, I present a case that is fairly representative of the type of immediate material cooperation at stake.

In an American city of 100,000 inhabitants there are two hospitals, one community and the other Catholic. In the field of obstetrics, the former provides a full selection of services which the latter for ethical reason does not. The latter, instead, tries to protect and promote the values of its tradition. In renegotiating their contract with the Catholic administration, the obstetrics team demands a new proviso: they want permission to do tubal ligations on those women who want ligations *while* having their infant delivered through cesarian section. The team estimates that the number of direct sterilizations would be very limited. Their reasons for the proviso are simply that they believe it is unethical and medically ccontraindicative to "open" the patient twice. This team is well respected by the administration and is well established in the community. They are prosperous enough that they could move out of the facility, if they were not to receive the proviso. In all other matters they have acceded to the hospital and have regularly observed ERD. If they were to leave the Catholic health care facility, the facility believes it would not be able to deliver any obstetric services and thus would provide no alternative to the community facility.

This is a case of material and not formal cooperation. Clearly the administration does not want any sterilizations. But the material cooperation is, I think, evidently immediate. Not everyone agrees; Gary Atkinson and Albert Moraczewski call a similar case mediate cooperation (but without explanation).[38] Some others have claimed that the cooperation is mediate because the Catholic health care facility is

only authorizing the cesarian section; the obstetricians are insisting on the tubal ligations. While I think that this point could be probable, I am more inclined to describe the activity as immediate: I cannot imagine the facility claiming not to be authorizing both procedures.

We ought to note that we are not suggesting that any kind of direct sterilization is being authorized here. Rather, the obstetricians here seem to be respecting the Catholic tradition inasmuch as they raise *only* the case of women who are already having surgery: in conscience, they argue, that they cannot follow ERD on this one point.

Against this limited case of immediate material cooperation is the issue of duress: that is, the threatened loss of all obstetrics from the Catholic health care facility to this large urban area. Here then are two considerations. First, what would be the impact of a loss of this service for women? Would women find a set of values like those of the Catholic health care facility at the community hospital or wherever the obstetrics team eventually offered their services? Second, how realistic is the threat? Were they to carry it out, what possibility is there for the health care facility to rebuild a new team? Could they find a team as faithful to ERD as this team was and be as medically and ethically qualified as this team was? In sum, if the threat is real and the possibility of offering a real alternative is minimal, many seem to believe that prudence guides both the facility's administrators and the bishop to approve the contract.

Scandal could be avoided by explaining the duress and the limited number of exceptions that are being provided. On the one hand, there is no blanket policy of admitting sterilizations here, rather there are few exceptions and these are based upon the physicians' insistence that it is medically contraindicative to not do a requested sterilization on a woman undergoing a cesarian section. On the other hand, if the health care facility or the bishop were to reject out of hand the contract, the scandal of abandoning pregnant women would be strikingly apparent, especially in the prevailing ethos of abortion.

By the cooperation, the health care facility is still able to offer its services while promoting its Catholic values. It is not opening up the possibility of losing an otherwise reputable obstetric team. In fact, it is keeping the team faithful to ERD and the Catholic tradition notwithstanding the exceptional case of tubal ligations on women undergoing cesarian sections. Certainly the facility is not approving the

exceptions; rather under the duress of losing their services and therefore being unable to offer any comparable services to their patients, the Catholic facility acknowledges that it has no other alternative.

Conclusion

Through institutional cooperation, a Catholic health care facility attempts to negotiate where and to what degree it should be involved in the work of another facility. Catholic leaders, both in chanceries and in the facilities, must work in trust with one another, willing to recognize the fact that the tradition has not placed a stranglehold on their future. Rather the tradition provides for the facility a guiding principle that ought to help the facility maintain the integrity of its own Catholic identity, mission, and values. That guiding principle does not jeopardize the facility's integrity; on the contrary, it guides it into locating as specifically as possible the degree of involvement that thfacility should pursue, while maintaining its authority, power, and influence by providing its services, protecting threatened values and containing the evil near it.

References

1. Henry Davis, *Moral and Pastoral Theology* (London, Sheed and Ward, 1958), p. 342.

2. See Hieronymus Noldin, *Summa Theologia Moralis* (Innsbruck: F. Rauch, 1923), II.119, 121, PP. 134, 137.

3. Russell Smith, "Ethical Quandary Forming Hospital Partnerships", *The Linacre Quarterly* 63 (May 1996) 87-96.

4. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington: USCC, 1995).

5. With M. Cathleen Kaveny, I discuss cases and the roles of the board and lawyers in negotiations concerning cooperation in "Ethical Issues in Health Care Restructuring", *Theological Studies* 56 (1995) 45-59.

6. See my "The Function of the Principle of Double Effect", *Theological Studies* 54 (1993) 294-315; Bruno Schueller, "The Double Effect in Catholic Thought: A Reevaluation", *Doing Evil to Achieve Good*, ed. Richard McCormick and Paul Ramsey (Chicago: Loyola University Press, 1978) 165-191.

7. James F. Keenan and Thomas Shannon, eds., *The Context of Casuistry* (Washington, D.C.: Georgetown University Press, 1995); Albert Johnson and Stephen Toulmin, *The Abuse of Casuistry* (Berkeley: University of California Press, 1988).

8. Archbishop John R. Roach and Cardinal Terence Cooke, "Testimony in Support of the Hatch Amendment", *Abortion and Catholicism*, ed. Patricia Beattie Jung and Thomas A. Shannon (New York: Crossroad, 1988) 10-43.

9. John Gallagher, "The Ecclesiology of the U.S. Bishops' 1994 Health Care Directives", *Review for Religious* 55 (1996) 230-248.

10. The principle is presented in the appendix of ERD. CHA has provided a wonderful model for understanding the principle in "Catholic Health Ministry in a Changing Environment: Maintaining Ethical Integrity", *Catholic Health Ministry in Transition* (Silver Spring, MD: National Coalition on Catholic Health Care Ministry, 1995) 1-10. See also Joseph Boyle, "Radical Moral Disagreement", John Finnis, Joseph Boyle, and Germain Grisez, eds., *Nuclear Deterrence, Morality and Realism* (Oxford: Oxford UP, 1987) 343-357; Anthony Fisher, "Cooperation in Evil", *Catholic Medical Quarterly* 44 (1994) 15-22; my "The Principle of Material Cooperation", with Thomas Kopfensteiner, *Health Progress* 76.3 (April 1995) 23-27; Judith Lee Kissell, "Cooperation with Evil: Its Contemporary Relevance", *The Linacre Quarterly* 62 (1995) 33-45; Russell Smith, "The Principles of Cooperation in Catholic Thought", Peter Cataldo and Albert Moraczewski, eds., *The Fetal Tissue Issue* (Braintree, MA: Pope John XXIII Center, 1994).

11. Germain Grisez, "The Public Funding of Abortion: A Reply to Richard McCormick", *Homelitic and Pastoral Review* 185.9 (1985) 50.

12. Davis, *Moral and Pastoral Theology* 343.

13. Henricus Denzinger, *Enchiridion Symbolorum,* 37 edition (Rome: Herder, 1976) 2151.

14. Davis provides a summary on this case in footnote 1, p. 347.

15. Denzinger, 3278, cf. 3195.

16. Ibid. 2715, 2758, 3634, 3917a. Davis, 348. Jean Pierre Gury, *Compendium Theologiae Moralis,* (Lungduni: J.B. Pelagaud, 1858) II. 921-26, pp.631-35. Benedictus Merkelbach, *Summa Theologiae Moralis*, (Paris: Desclee de Brouwer,

1932) III. 929-933, pp. 922-931.

17. Code of Canon Law, (1917) 855, 2. Davis 343.

18. Denzinger 3190-93. Davis 349-350.

19. Davis 351-2.

20. Edwin Healy, *Moral Guidance* (Chicago: Loyola University Press, 1942) 320; Gerald Kelly, *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1958) 332-335.

21. USCC Administrative Board, "The Many Faces of AIDS: A Gospel Response", *Origins* 17.28 (1987). See my "Prophylactics, Toleration and Cooperation: Contemporary Problems and Traditional Principles", *International Philosophical Quarterly*, 29 (1989) 205-220.

22. Russell Smith, "The Principles of Cooperation and their application to the Present State of Health Care Evolution", *Catholic Health Ministry in Transition* (Silver Spring, MD: National Coalition on Catholic Health Care Ministry, 1995) 1-6.

23. Davis 342-3.

24. Noldin, II. 118, pp. 133-4. Merkelbach, I. 489, p. 396.

25. See for instance, Lisa Sowle Cahill and Richard McCormick, "The Vatican Document on Bioethics: Two Responses", *America* 156 (1987) 246-8.

26. Germain Grisez, "Difficult Moral Questions, How Far May Catholic Hospitals Cooperate with Non-Catholic Providers", *Linacre Quarterly* 62 (1995) 67-76, at 71-72.

27. Smith provides an interesting solution to the management of the IDN in "The Principles of Cooperation and Their application to the Present State of Health Care Evolution".

28. Smith, "Ethical Quandary", at 93.

29. Ibid, 92.

30. No author, "Catholic Health Ministry in a Changing Environment", *Catholic Health Ministry in Transition,* 4.

31. Ibid., 5.

32. Russell Smith (from note 25) contends that implicit formal cooperation was rarely used in the manuals and then proceeds to cite McHugh's use of it. Then he argues that implicit formal cooperation is the same as immediate material cooperation, and refers the reader to texts by Zalba but the texts do not support Smith's claim. Then he admits that it is "unresolved" whether the situations analogous to the one I am addressing are "immediate".

33. See 23 and 24 above.

34. Peter Holmes, *Resistance and Compromise: The Political Thought of the Elizabethan Catholics* (New York: Cambridge UP, 1982) 105 and 115.

35. "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilizations in Catholic Hospitals", *Origins* 6 (June 10, 1976) 33, 35.

36. USCC, "Sterilization Policy for Catholic Hospitals", *Origins* 7 (December 8, 1977) 399-400.

37. Smith, "Ethical Quandary", 94, *Origins*, 34.

38. Gary Atkinson and Albert Moraczewski, *A Moral Evaluation of Contraception and Sterilization* (St. Louis: Pope John XXIII, 1979) 86-87.