

May 2001

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### Recommended Citation

McMahon, Kevin T. (2001) "Revising the ERDS'94: Goals, Opposition and Resolution," *The Linacre Quarterly*: Vol. 68: No. 2, Article 3.

Available at: <http://epublications.marquette.edu/lnq/vol68/iss2/3>

# Revising the ERDS'94: Goals, Opposition and Resolution

by

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## Introduction

The Catholic bishops of the United States are currently revising the *Ethical and Religious Directives for Catholic Health Care Services* which they last issued seven years ago.<sup>1</sup> Their specific goal is to refine the treatment of the Principle of Cooperation given in directives 69 and 70, and in the Appendix. They need to give a presentation of this Principle that is precise and unambiguous enough to ensure its proper interpretation and application. In so doing, they will help to prevent those misinterpretations and misapplications of the Principle that would permit unjustifiable cooperation in moral evil. Although the bishops wish to exclude cooperation with all intrinsically evil acts, the central issue for the past thirty years has been direct sterilization.

In this article we will examine the steps taken by the Magisterium over the past thirty years to ensure a unity of Catholic belief and practice in Catholic health care, especially as it relates to the question of direct sterilization. We will also examine the debate that has surrounded these efforts and the arguments presented by the Holy See, the National

Conference of Catholic Bishops, representatives of Catholic health care and theologians in the many exchanges that have occurred. Because the debate centered on various magisterial teachings, our examination is divided into four major sections corresponding to specific interventions made either by the Holy See or the United States bishops. The four divisions are: Section I: *The Ethical and Religious Directives for Catholic Health Facilities*, 1971;<sup>2</sup> Section II: *Quaecumque Sterilizatio*, 1975<sup>3</sup> and the NCCB Commentary on this document, 1977;<sup>4</sup> Section III: *The Ethical and Religious Directives for Catholic Health Care Services*, 1994;<sup>5</sup> Section IV: The proposed revisions to the 1994 directives.

## **SECTION I: THE ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH FACILITIES, 1971**

In 1971 the United States Catholic Conference issued *Ethical and Religious Directives for Catholic Health Facilities* (ERDs'71). This document met an important pastoral need inasmuch as it updated the previous version and presented the United States bishops' own application of Catholic moral teaching to many specific medical moral questions regularly encountered in Catholic health facilities.<sup>6</sup> The bishops highlighted the connection between Catholic identity and adherence to Catholic moral teaching, and they located the directives within this context.

Any facility identified as Catholic assumes with this the responsibility to reflect in its policies and practices the moral teachings of the Church, under the guidance of the local bishop....

The Catholic-sponsored health facility and its board of trustees, acting through its chief executive officer, further, carry an overriding responsibility in conscience to prohibit those procedures which are morally and spiritually harmful. The basic norms delineating this moral responsibility are listed in these *Ethical and Religious Directives for Catholic Health Facilities*.<sup>7</sup>

Because Catholic medical institutions and personnel were following the guidelines set out in 1954, they were already in general compliance with those portions of the ERDs'71 that addressed the same issues. To the extent that this was true there was no contradiction between their Catholic identity and practice. The one glaring exception concerned contraception and direct sterilization. Negative reaction to the ERDs'71 left little doubt that some Catholic physicians were prescribing contraceptives, at least in private practice, and performing direct sterilizations even in Catholic facilities.<sup>8</sup> Efforts on the part of ecclesiastical authorities to implement the directives revealed that hospital administrators and the religious communities that

operated Catholic facilities were countenancing direct sterilizations.<sup>9</sup>

### ***Direct Sterilization and Theological Dissent***

In some instances direct sterilizations may have been permitted through a misapplication of the Principle of Double Effect by which they were incorrectly considered to be indirect.<sup>10</sup> In others, they may have been permitted because those responsible somehow believed that the 1954 guidelines, and the Church teaching which they articulated, were no longer relevant. This claim became implausible with the restatement of that teaching in *Gaudium et Spes* and *Humanae Vitae*.<sup>11</sup> However, the record shows that the primary reason that some physicians and hospital administrators performed or permitted direct sterilizations was that they simply did not accept the Church's teaching which forbids them.<sup>12</sup>

Standing on the theological dissent from *Humanae Vitae*, some physicians made it clear that they would continue to prescribe contraceptives and perform contraceptive sterilizations where they and/or their patients believed them to be necessary for physical or psychological reasons. A task force of the Catholic Theological Society of America and various theologians who dissented from *Humanae Vitae*, presented arguments supporting the physicians' intentions and challenged the relevance of the ERDs'71 to Catholic health care as it existed in a pluralistic society.<sup>13</sup> They also argued that Catholic hospitals whose professional staffs and patients often included many non-Catholics who do not agree with Catholic moral teaching on such matters, ought to respect the consciences of these individuals and permit direct sterilizations in Catholic facilities. It was said then, as it continues to be said, that the Catholic Church should not impose her morality on others. Nothing was said about respecting the conscience of the Catholic institution whose programs and policies ought to reflect the teaching of the Church.

### ***Correction and Compromise***

Given this context, the following two directives were particularly problematical to some:

- 18 Sterilization, whether permanent or temporary, for men or for women, may not be used as a means of contraception.
- 20 Procedures that induce sterility, whether permanent or temporary, are permitted when: (a) they are immediately directed to the cure, diminution, or prevention of a serious pathological condition and are not directly contraceptive (that is, contraception is not the purpose);

and (b) a simpler treatment is not reasonably available. Hence, for example, oophorectomy or irradiation of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom; and orchidectomy is permitted in the treatment of carcinoma of the prostate.<sup>14</sup>

The steps necessary to ensure compliance with these directives were straightforward in theory. First, administrators needed to determine whether any direct sterilizations were being performed in their facilities; second, if so, they needed to stop them. The first task confirmed that indirect sterilizations of women, in which they included "uterine isolation," were taking place whenever necessary, and that direct sterilizations, although less frequent, were also being performed. However, given the dissent from the teaching, the second step of stopping these immoral procedures was not an easy one to take.

Another route would be to find some moral justification for allowing direct sterilizations to continue. Could they be justified, as various authors had suggested, by the need to comply with the mandate of a public authority, by the Principle of Totality, by theological dissent from the Church's teaching on contraception and contraceptive sterilization, or by the Principle of Cooperation? Facing the mounting evidence that direct sterilizations were continuing to take place in Catholic facilities despite the ERDs'71, in 1974 the bishops of the United States raised such questions about their possible justification with the Sacred Congregation for the Doctrine of the Faith.

## **SECTION II: *QUAECUMQUE STERILIZATIO*, 1975 AND THE NCCB COMMENTARY ON THIS DOCUMENT, 1977**

The Congregation responded with the document *Quaecumque Sterilizatio* issued in March, 1975.<sup>15</sup> The Congregation made these points: 1.) since direct sterilizations are intrinsically evil, there could be no moral basis for a mandate by any public authority; 2.) they could not be justified by the Principle of Totality since it did not apply; 3.) theological dissent did not constitute a "theological source" which could be followed in opposition to the teaching of the authentic Magisterium; 4.) that any cooperation which involved consent or approval was absolutely forbidden, but material cooperation, with all proper distinctions observed, could apply.<sup>16</sup>

Even if rejected by some, the first three points were clear to all. None of these reasons could any longer be given to justify immoral practices in a Catholic facility. However, those who wanted to continue allowing direct sterilizations in Catholic facilities found some hope in the CDF's

response to the fourth question about cooperation. What sort of situation did the Congregation envision when it stated that "The traditional doctrine regarding material cooperation, with the proper distinctions between necessary and free, proximate and remote, remains valid, to be applied with the utmost prudence, if the case warrants"?<sup>7</sup>

### ***Contradictory Applications of the Principle of Cooperation***

Although the Congregation gave no example of justifiable material cooperation in direct sterilizations, theologians advising Catholic facilities and diocesan bishops on such matters employed the Principle of Cooperation to justify not only mediate material cooperation, but also immediate material cooperation and what many would call implicit formal cooperation. The theological arguments supporting these ethical judgements seemed to gain official approbation in the United States bishops' *Commentary on Quaecumque Sterilizatio*.<sup>18</sup> The bishops write: "Material cooperation will be justified only in situations where the hospital because of some kind of duress or pressure cannot reasonably exercise the autonomy it has (i.e., when it will do more harm than good)."<sup>19</sup> The bishops continue: "Since...the hospital has authority over its own decisions, this should not happen with any frequency."<sup>20</sup> As an example of duress, the bishops present the closing of a hospital which they state could, under some circumstances, be a more serious evil than the grave evil of direct sterilization.<sup>21</sup>

The theological tradition recognized duress as a factor to be considered in justifying the immediate material cooperation of an individual person with the immoral acts of another. Many, therefore, interpreted the discussion of material cooperation in the *Commentary* to allow for immediate material cooperation on the part of a Catholic institution. But, how could this conclusion be reconciled with the Congregation's statement that "...the official approbation of direct sterilization and, *a fortiori*, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil. The hospital cannot cooperate with this *for any reason*"?<sup>22</sup> Is it possible that direct sterilizations could take place in a Catholic facility without that institution's consent or approval at least being implied? Or, to ask this question another way, is it possible to claim that a direct sterilization taking place in a Catholic facility or in one administratively linked to such a facility, might only involve that facility in the kind of material cooperation allowed by *Quaecumque Sterilizatio*?

Between 1971 and 1994 many factors made cases of such cooperation increasingly frequent. The basic reason given to justify them was the duress caused by the threat of hospital closure. The specific threats to institutional survival involved financial ruin for either of two reasons.



First, the loss of OB/GYN services because doctors who did not accept the Catholic teaching on direct sterilization would go elsewhere. Second, the inability to compete in the market place without entering into some sort of cooperative arrangement with non-Catholic entities where some immoral practices, excluded by the directives, would take place. The particular cases that gained media attention did so largely because of interventions made by the Holy See judging that the cooperation involved in these arrangements was unjustifiable. In these cases, the Principle of Cooperation was understood and applied in different ways by the institutions and dioceses involved on the one hand, and by the Holy See on the other. As differing theological opinions and ecclesiastical judgements were presented on more cases, confusion about the definition and application of the Principle of Cooperation increased.

### **SECTION III: THE ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES, 1994**

#### ***The Principle of Cooperation Clarified***

A clarification of the Principle of Cooperation was attempted in the ERDs'94. The Principle, not treated in the ERDs'71, was explained in the ERDs'94 Appendix and addressed by directives 69 and 70. However, notwithstanding the overall value of the ERDs'94, its treatment of the Principle of Cooperation proved to be inadequate. That fact was only exacerbated when the Appendix and specific directives were read in the light of the NCCB's *Commentary on Quaecumque Sterilizatio*.<sup>23</sup> The ERDs'94 restatement of the proscription against contraception in directive #52 and against direct sterilization in #53 encountered some of the same opposition presented twenty-three years earlier. However, the *Commentary* and the treatment of the Principle of Cooperation in the ERDs'94 blunted its intensity. For the most part the ERDs'94 were not viewed as a threat to continuing with the *status quo*. Nor, as it turns out, were they. Again, the need to respect the consciences of physicians and patients who did not share the Catholic view on these matters, and the need to cooperate because of duress were put forth as factors justifying cooperation in direct sterilizations.

#### ***Uterine Isolation***

While the discussion about the application of the Principle of Cooperation continued, another procedure taking place in Catholic facilities was being questioned. Was the practice of "uterine isolation" an example of indirect sterilization and, therefore, in conformity with the ERDs'71, or was it an instance of direct sterilization that also needed to be discontinued?

This question, raised by the United States bishops, was answered by the CDF in July, 1993.<sup>24</sup> The CDF judged that uterine isolation was really tubal ligation for contraceptive purposes and so was an example of direct sterilization. This practice was not to continue in Catholic facilities.

### ***The Teaching Opposed***

Writing five months after the CDF's statement on uterine isolation and while the ERDs'94 were being drafted, one author, who is today a senior associate for ethics at the Catholic Health Association, expressed great dissatisfaction not only with the teaching against direct sterilization, but with the harm that insisting on adherence to it causes.

Over the past two years, the Catholic church's condemnation of direct sterilization as intrinsically evil (that is, as evil in itself and therefore never justifiable for any reasons or circumstances) has become problematic (and an embarrassment) to me in ways it previously had not. I have long questioned this moral teaching and the theological and philosophical framework that supports it. But I had not realized acutely the conflict, anguish, and harm it inflicts on women and children, on providers of care, and on administrators of Catholic health care facilities.<sup>25</sup>

This same author offers his account of the facts, as he saw them in 1994, regarding the practice of direct sterilizations in Catholic hospitals across the country. He notes that direct sterilizations sometimes take place openly where ecclesiastical authorities choose not to interfere, or where there are courageous administrators and compassionate bishops. In other places, presumably where such courageous and compassionate persons are not found, direct sterilizations are more covert. Finally, there are some institutions who follow the directives, but who pay the price for doing so. The price is that they force physicians and others to act against their consciences and professional judgement, and, in refusing to allow direct sterilization, are also responsible for the harm that future pregnancies may cause. He concludes his article with this judgement:

Several of the documents cited above caution against the scandal that might result from Catholic hospitals' performing tubal ligations. But the scandal really lies in the Catholic church's refusal to permit direct sterilizations in the face of human tragedy and suffering, in its failure to recognize the harm that is often inflicted upon women and their children because of this, and in the lack of various forms of tangible support for women who have been turned away or for their children who have been harmed. It also lies in the burdens that the church's teaching imposes on the



consciences of physicians and other health professionals and in the way it compromises the mission of Catholic health care institutions to serve the "total good of the patient." What makes all this the worse is that it is done in the name of God and truth.<sup>26</sup>

The opinion offered above has been expressed in one form or another by many in Catholic health care. It is no surprise, therefore, that after the ERDs'94, as before, there continued to be cases reported by the media in which Catholic hospitals accommodated physicians who insisted on performing direct sterilizations in a Catholic facility. There were also reports of situations in which a Catholic institution, through some contractual arrangement, assisted in the establishment of, or was otherwise linked to, a facility outside of the Catholic institution where contraceptives were distributed, direct sterilizations performed and, in at least one case, abortion counseling was being given.<sup>27</sup> In every case, the Catholic parties cited the advice they had received from Catholic ethicists who argued that these arrangements were justified by the Principle of Cooperation and the presence of duress. The reported cases are by no means the only ones that could be cited.<sup>28</sup>

#### **SECTION IV: THE PROPOSED REVISIONS TO THE 1994 DIRECTIVES**

##### ***The Need for Greater Clarification***

Based on their own experience and in response to concerns raised by the Congregation for the Doctrine of the Faith (CDF) in April, 1999, the bishops of the United States are again taking steps to clarify the Principle of Cooperation especially as it relates to the question of such intrinsically immoral practices as contraception, direct sterilization and abortion.<sup>29</sup> A working group led by Archbishop Daniel E. Pilarczyk and Bishop Donald W. Wuerl is conducting the process of review and drafting the proposed changes. The committee's specific task is "...to review and modify the formulation of the principles governing cooperation in the ERD Appendix and, as necessary, in the two directives [69 and 70] bearing on this matter, as well as the NCCB *Commentary on Quaecumque Sterilizatio*."<sup>30</sup> The purpose of the revisions is to make both documents "...less susceptible to interpretations that are inconsistent with Catholic moral teaching and with the mission of Catholic health care."<sup>31</sup>

To get a better idea of the specifics that the bishops need to address, and of the reasons for the concerns raised by such groups as the Catholic

Health Association (CHA), we turn now to the CHA's account of the Congregation for the Doctrine of the Faith's direction. Citing a letter from Cardinal Ratzinger to Bishop Fiorenza about needed revisions to the ERDs<sup>94</sup>, and interventions made by the Holy See in recent partnerships between Catholic and non-Catholic health care organizations, the CHA sent its members a list of four specific concerns.<sup>32</sup> The concerns, which also apply to the *Commentary*, are these:

1.)...the Holy See objects to the "position that a form of cooperation which otherwise would be formal could be considered material and licit if the category of duress is present."

The Holy See believes that the "Appendix leads to the conclusion that actions which are intrinsically evil could be considered licit in the presence of duress" and emphasizes that this position is "incompatible with the teaching of *Evangelium Vitae*, (EV) 74 and *Veritatis Splendor* (VS) 71-83." The CDF notes that the Appendix does not explain how an institution as such is an acting person, and how an institution as such suffers duress. Nor, does it distinguish between duress in an isolated case from duress that is systematic or generalized.

2.) An understanding of material cooperation that might lend itself to a "proportionalist" interpretation. By this the Holy See means justifying the doing of evil in order to achieve good, that is, sterilization is treated as an action that can be justified by the circumstances (e.g., justifying sterilization to avoid the closure of a hospital). The documentation emphasizes that sterilization is an intrinsic evil and as such can never be justified under any circumstances as part of the medical treatment provided to patients in a hospital under Catholic administration. When it comes to intrinsic evil, "there are no privileges or exceptions for anyone" (VS, 96 and EV, 75).

3.) The Holy See believes that the Appendix seems to describe cooperation as if it were only a matter of cooperation by individuals and not institutions. While the CDF itself makes reference to the principle in conjunction with institutions in a March, 1975 document (*Quaecumque Sterilizatio*), it "absolutely and categorically 'forbids any cooperation institutionally approved or tolerated' in direct sterilization."

4.) Confusion about the meaning of scandal. The current definition in Directive # 70 is imprecise.<sup>33</sup>

Although Cardinal Ratzinger's letter and the other source material identified have not been published, the four concerns presented here by CHA strike a chord with information that can be gleaned from many sources. The Holy See rejects the idea that the Principle of Cooperation

applies to institutions in the same way that it does to individuals. The Holy See rejects the proposition that the category of duress, which has been considered by theologians as one of the factors justifying immediate material cooperation, can be systemic and ongoing as it would have to be in cases where Catholic institutions face the continuing threat of closure. The Holy See repeats Catholic teaching that acts which are intrinsically evil (and this would include unjustifiable cooperation in the immoral acts of others) cannot be done for any reason. The Holy See wants a better explanation of the moral concerns related to the question of scandal. These, then, are the specific tasks that need to be accomplished in the revisions to the ERDs'94 and to the *Commentary*.

### ***Preventing Entities of the Catholic Church From Doing Evil***

These latest steps in the history of interactions between the Holy See and particular bishops of the United States, as well as with the U. S. Bishops' Conference, reveal a dialogue whose purpose has been to stop direct sterilizations (and any other intrinsically evil practice) in Catholic facilities. A related task has been to undo and prevent agreements between Catholic and non-Catholic institutions that would involve formal cooperation or immediate material cooperation with the evil procedures performed in the non-Catholic facilities. Why? Because to cooperate in the doing of evil when it is not justified, is to do evil. What the Holy See and the U. S. bishops are trying to ensure is that no Catholic entity will be forced to do evil. Those who oppose or question this effort on the part of the Holy See and NCCB seem to miss this most important point. The proscription against direct sterilizations (and other intrinsically evil practices) in Catholic facilities, and/or formal or immediate material cooperation with them in the facilities of non-Catholic partners is not a matter of company policy. It is a matter of proclaiming the practical implications for the Catholic health care ministry of teaching and living the moral truth as it relates to these practices. The revisions to the ERDs'94 and *Commentary* are meant to accomplish this goal.

### ***The Revised Drafts and Opposition to Them***

The committee has distributed three drafts of the revised ERDs'94 to the bishops. The first draft, dated May 2000, was sent to the bishops on June 30, 2000; the second, dated September 8, 2000, was mailed in October 2000; and the third, dated November 8, 2000, was distributed at the bishops' meeting which began on November 13, 2000. They produced only one revised draft of the *Commentary* which was dated May 2000 and was included in the June 30, 2000, mailing. Footnote 44 of the November 8, 2000, draft of the ERDs'94 reveals that the bishops have decided to vacate

the *Commentary* rather than to attempt a revision. All their attention is now fixed on the ERDs'94. A draft of the ERDs'94 is scheduled to be discussed at the bishops' June 2001 meeting with a possible vote on the final text coming at that time. It is not now known whether the November 8<sup>th</sup> text, or some yet to be written draft, will be presented to the bishops in June.

The revised drafts have not been published, but they have been widely circulated.<sup>34</sup> The drafting committee met with Catholic health care professionals, bishops, theologians and medical ethicists on July 14, 2000, and September 15, 2000. These two consultations were planned "in order to promote a positive reception for the modified texts among the Catholic health care professionals."<sup>35</sup> Comments made before and after each of these meetings suggest that the bishops have their work cut out for them.

The first two drafts of the ERDs'94 were met by strong opposition from various special interest groups.<sup>36</sup> Many, including this author, would evaluate the interventions made by CHA as opposition, but its president and executive director says that CHA has taken no position on the changes. Its goal, he states, is to help the bishops understand the issues involved.<sup>37</sup> Doubtless, the CHA was a major voice in articulating the 15 themes (issues) that the bishops were being told they should consider as they continue their deliberations. These themes are intended to show "...how the current amendments [September 8, 2000, draft] could jeopardize both the services provided to communities and the ability of the ministry to influence policies and programs in light of Catholic teaching."<sup>38</sup> These themes repeat concerns presented over the past thirty years regarding the consequences, dreaded by some, that could result from an outright refusal to provide direct sterilizations:

1. This will likely affect Catholic health care's ability to approach potential partners. Although significant parts of the communities we serve share our views on abortion and euthanasia, they do not share our views on sterilization as an intrinsic evil. Further, the proposed revisions of the directives are likely to put potential partners on the defensive.
2. Catholic sole provider hospitals could well be lost.
3. Many physicians might refuse to accept this new understanding because, from their perspective, it could make them vulnerable to malpractice suits and consequently they could take their practice elsewhere.
4. There is the likelihood of the loss of OB/GYN services in many of our hospitals.
5. The Church's redirection from the current understanding of the principle will further foster anti-Catholic sentiments that we see increasing across the country. This is an even more serious problem

in unchurched regions of the country.

6. Some will see the proposed change as an attempt to impose our religious beliefs upon the community.
7. Current practice has made possible the elimination of abortion and has enabled the continuation of a Catholic presence. These changes in the Directives could weaken the influence of Catholic health care in fostering a greater respect for life.
8. Women and children, especially the poor, will be most affected by these revisions.
9. The proposed changes will alienate Catholic health care from the rest of health care – patients, physicians, and payors.
10. The undoing of partnerships has very significant legal and financial implications that were explicated with great specificity.
11. The undoing of partnerships will negatively impact our trustworthiness as partners.
12. The revisions could well weaken the reliability and moral authority of the bishops. Many diocesan bishops have approved past partnerships. People will wonder why a particular arrangement was acceptable in the past and is now no longer acceptable.
13. The proposed revisions could jeopardize Catholic health care's ability to carry on our mission by eliminating our presence in some areas; weakening our influence on moral issues, especially life issues; affecting our provision of services to women, children, and the poor.
14. Sponsors will be forced to consider whether or not to continue their health care ministry as Catholics. The revisions may also create serious conflict within religious congregations.
15. The revisions could result in another *Humanae Vitae* type division within the Church.<sup>39</sup>

Responses could be made to these concerns challenging their accuracy and projecting a more positive outcome for Catholic health care and its moral influence on society if amendments such as those proposed in the September 8, 2000, draft were adopted. But, accepting for the moment that some of the truly regrettable consequences included among those listed actually would occur, should any entity of the Catholic Church be forced to do evil (this is what unjustifiable cooperation with intrinsically evil acts involves) in order to avoid them? Taken together the issues presented suggest that stopping unjustifiable cooperation with direct sterilization will have a very negative impact on Catholic health care. Is the solution then not to revise the ERDs'94 in a way that would actually stop direct sterilizations in Catholic facilities or those related to them? Should the bishops not put an end to a Catholic entity's formal or immediate material cooperation in such immoral acts?



### ***The Most Recent Draft***

The NCCB committee charged with making the revisions has, as noted above, produced three drafts. The November 8, 2000, proposed changes to directives 53, 69, 70 (new), 71 (the original 70) and 72, with some further minor changes, would help to prevent Catholic institutions from engaging in unjustifiable cooperation with the immoral acts of others. However, the omission of an Appendix explaining the Principle of Cooperation raises some concerns. Let us first look at the specific directives as they are found in the November 8, 2000, draft which are presented here with the deletions and additions already made:

**Directive #53** Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Catholic health care institutions are not to provide direct sterilization, even based upon the principle of material cooperation. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.

Comment: The November 8, 2000, draft states that there is no change to be made to directive 53, but does not state if it intends to retain the original or the September 8, 2000, text. The September 8, 2000, text, quoted above, improves the original by explicitly forbidding direct sterilizations in a Catholic facility even on the basis of material cooperation.

**Directive #69** If a Catholic health care organization is considering entering into an arrangement with another organization that may be involved in activities judged morally wrong by the Church, participation in such activities, must be limited to what is in accord with the moral principles governing cooperation.

Comment: Since the only kind of cooperation that could be permissible is mediate material cooperation, the text would be clearer if the sentence ended "must be limited to what is in accord with the moral principles governing mediate material cooperation." This would be a positive statement of the point made in Directive #70, and would help to specify the limits of cooperation.

**Directive #70** Catholic health care organizations are not permitted to engage in immediate material cooperation in wrongdoing.<sup>44</sup>



<sup>44</sup>E.g., see "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (*Quaecumque sterilizatio*), 13 March 1975, *Origins* 10 (1976), 33-35; Any illicit cooperation "institutionally approved or tolerated in actions which are in themselves, that is by their nature and condition, directed to a contraceptive end...is absolutely forbidden." This Directive supersedes the "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" published by the National Conference of Catholic Bishops 15 September 1977, *Origins* 11 (1977), 399-400.

Comment: Wrongdoing can refer to behavior that is bad from many points of view, but not necessarily immoral. The concern here is immoral behavior or evil. Therefore, the use of the word wrongdoing rather than moral evil could add to the false impression that the concern is simply a matter of conduct that is contrary to company policy.

**Directive #70 71** The possibility of scandal must be considered when applying the principles governing cooperation.<sup>45</sup> Cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused. Scandal can sometimes be avoided by an appropriate explanation of what is in fact being done at the Catholic health care facility in question. The diocesan bishop has final responsibility for assessing and addressing issues of scandal, considering not only the circumstances in his local diocese but also the regional and national implications of his decision.<sup>46</sup>

<sup>45</sup>See *Catechism of the Catholic Church*: "Scandal is an attitude or behavior which leads another to do evil" (no. 2284); "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (no. 2287).

<sup>46</sup>See "The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry," *Origins* 26 (1997), 703.

Comment: Since the only type of cooperation that can be acceptable for a Catholic institution is mediate material cooperation, in the context of these directives it would be helpful to emphasize this point whenever there is reference to the use of the Principle of Cooperation. The first sentence of this directive would be clearer on this point if it finished: "the principles governing mediate material cooperation."

**Directive 72** The Catholic partner in an arrangement has the responsibility periodically to assess whether the binding agreement is being observed and implemented in a way that is consistent with Catholic teaching.

Comment: Agreements between Catholic and non-Catholic health care organizations have most often included a stipulation requiring compliance with the ERDs as they are written and periodically revised by the National Conference of Catholic Bishops. It would be helpful to include a requirement for such a stipulation in this directive. Additionally, it seems that the Catholic party's responsibility goes beyond assessing to ensuring that this particular stipulation is being observed.

These are the proposed revisions to the directives. The *Commentary*, in being superseded by *Directive #70*, is no longer valid. As the bishops review the latest draft they will need to decide if the proposed changes to specific directives will be sufficient to make them "...less susceptible to interpretations that are inconsistent with Catholic moral teaching and with the mission of Catholic health care."<sup>40</sup> It is a question that is very much complicated by the drafting committee's recommendation to omit an Appendix explaining the Principle of Cooperation.

### ***Should the Revised Directives Include an Explanation of the Principle of Cooperation?***

The drafting committee has recommended that the revised directives omit the Appendix explaining the Principle of Cooperation. They have provided these reasons for their recommendation:

It is difficult to find an articulation of the principles governing cooperation that enjoys a consensus among theologians. In addition, even though the appendix was carefully crafted, experience has shown that it was open to unforeseen misinterpretations and misapplications. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation, with the proviso that, as a rule, Catholic partners should avoid entering into partnerships that would involve them in cooperation with the wrongdoing of other providers.<sup>41</sup>

Given the history of the past thirty years and the various missteps that have resulted in interpretations of the ERDs that were inconsistent with Catholic moral teaching, the bishops are likely to be particularly attentive to the recommendation not to include a statement explaining the Principle of Cooperation. Even as they acknowledge the reasons presented by the drafting committee in support of its recommendation, the bishops will want to be sure that omitting an Appendix explaining the Principle of Cooperation will not end up undermining the improvements made to the individual directives. In making this judgement, they will keep in mind the very costly mistake of writing a *Commentary* that impeded *Quaecumque Sterilizatio* from achieving its goal. The bishops will also ask whether the committee's reasons preclude them from writing an explanation of the Principle of

Cooperation as it is understood and used in the document. Finally they will have to ponder whether it would be prudent to leave the interpretation of the Principle of Cooperation to individual ethicists given the many misinterpretations such individuals have provided in the past.

### ***The Principle of Cooperation Needs to be Defined***

Although it is difficult to find a consensus on a statement of the Principle of Cooperation, its major premises are known to all.<sup>42</sup> This author believes that the reasons presented by the drafting committee in support of their recommendation to omit the Appendix argue instead for its inclusion. Thus, there are three principal reasons for the bishops to provide an explanation of the Principle of Cooperation:

First, although there will be disagreements about some of the specific terminology and about the significance some distinctions had in the past or have now, the bishops are free to present their own understanding of the Principle; that is, the one envisioned by the directives. The bishops certainly know what they mean by immediate material cooperation when they exclude it even for reasons of duress. Likewise, they know what they intend by mediate material cooperation and the circumstances in which it would be justified. They also know what they mean by scandal. Defining these terms is necessary to the proper formation of the consciences of those who find it very difficult to distinguish between justifiable and unjustifiable cooperation. This sort of pastoral guidance is essential to the proper application of those directives that exclude all cooperation other than mediate material cooperation. Without a proper theological explanation, the directives that address cooperation may seem like an arbitrary company policy that has no rational basis in a universal objective moral truth. Such legalism would likely result in a dismissal of the policy as too restrictive of the rights of others, rather than as a moral norm that protects Catholic personnel and institutions from being forced to do what is immoral.

Second, the bishops' own statement of the Principle of Cooperation would be the reference point to which all ethicists advising health care organizations and diocesan bishops would have to defer. Leaving the interpretation of the ERDs and the application of the Principle of Cooperation to the question of hospital mergers in the hands of moralists and ethicists would likely result in the same sorts of differing interpretations that the revisions to the directives are meant to prevent. Some, of course, would be pleased with this sort of latitude. This may be the very reason that those who had so many issues with the May 2000 and September 2000 revised drafts have been virtually silent about the November 2000 draft. Leaving the definition and interpretation to ethicists seems to have removed the threat to Catholic health care that the earlier drafts represented. The opposition

seems to have been almost entirely quieted by the proposal to omit an Appendix defining the Principle of Cooperation. Perhaps, those who held objections believe that, like the *Commentary* and ERD'94 Appendix, the omission of a definition and explanation of the Principle of Cooperation will in fact leave untouched the *status quo*. That is, direct sterilizations will continue in Catholic facilities and in those non-Catholic facilities linked to Catholic institutions by some particular arrangement.

Third, since the application of the directives will beg for an explanation of the Principle of Cooperation, others will be asked to supply the explanation that the bishops omit. In 1995, the CHA distributed a handbook for leadership that included a treatment of the Principle of Cooperation with three written resources discussing its interpretation and application.<sup>43</sup> The presentation given there, much like the ERDs'94 Appendix and the *Commentary on Quaecumque Sterilizatio*, would support arrangements now judged as unacceptable by the Holy See. If the Appendix is omitted from the revised ERDs, other individuals and groups, such as the CHA, will step in to answer the questions of those who are not sure of the difference between immediate and mediate material cooperation. There is no reason to believe that such specialists will be able to give an interpretation of the Principle of Cooperation more compatible with Catholic moral teaching than they have in the past.

### Conclusion

We have examined the Principle of Cooperation especially as it applies to the participation of Catholic health care entities in acts which are intrinsically evil. Over the past thirty years the specific immoral practices at issue have been contraception, direct sterilization and abortion counseling. The efforts of the Magisterium represented in the documents examined in the four sections of this article reveal its pastoral concern for the proper formation of the consciences of health care professionals, patients and the Church at large. Every effort has been made to ensure a unity of belief and practice in Catholic health care. The proscription against unjustifiable cooperation in direct sterilization is not simply a company policy intended to guarantee good order, it is a mandate of the moral law meant to ensure that Catholic entities will not, for any reason, do evil.

The interventions on the part of the Holy See and the United States bishops have not yet succeeded in eliminating the unjustifiable cooperation of Catholic entities in direct sterilizations. The process underway to revise the ERDs'94 is a new opportunity to accomplish this illusive objective. This author believes that the mistakes of the past which have permitted

unjustifiable cooperation to continue are well on the way to correction as the ERDs'94 are revised. The revised directives presented in the November 2000 draft should prove very helpful to all who seek moral guidance from the bishops. The full positive effect of the directives, however, would be better ensured if the bishops decide to include an expanded explanation of the Principle of Cooperation that defines all the relevant terms as they are used in the ERDs.

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## References

1. The National Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," in *Origins*, December 15, 1994.
2. United States Catholic Conference Department of Health Affairs, "Ethical and Religious Directives for Catholic Health Facilities," in *Origins*, December 2, 1971.
3. The Sacred Congregation for the Doctrine of the Faith, "The Reply of the Sacred Congregation for the Doctrine of the Faith to the National Conference of Catholic Bishops on Sterilization in Catholic Hospitals (*Quaecumque Sterilizatio*)," March 13, 1975, in *Origins*, June 10, 1977.
4. The National Conference of Catholic Bishops, "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith to National Conference of Catholic Bishops on Sterilization in Catholic Hospitals," September 15, 1977, in *Origins*, December 8, 1977.
5. ERDs'94.
6. For a basic outline of the history of ethical norms, see: Steven P. Rohlf, "Theological Weight and the Directives," *Ethics and Medics*, July, 1997.
7. ERDs'71, Preamble.
8. See, for example, the debate that took place at the November 27-28, 1971, meeting of the National Federation of Catholic Physicians Guilds in New Orleans reported in the December 9, 1971, issue of *Origins*. For other examples of the theological debate on this topic see the December 16, 1971, and December 23, 1971, issues of *Origins*, and the entire Fall 1972 issue of *Chicago Studies*.
9. For a report on the dialogue between the Sisters of Mercy and the Congregation for the Doctrine of the Faith on direct sterilization see: Margaret Farley, R.S.M.,

"Power and Powerlessness: A Case in Point," *Proceedings of the Catholic Theological Society of America* 37 (1982) pp. 116-119.

10. The procedure known as "Uterine Isolation," was viewed by some as indirect sterilization. This position remained uncorrected until a judgement was made about it by the CDF. See, Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," July 31, 1993, in *Origins* 24 (1994): 211-212.

11. The Fathers of the Second Vatican Council, "*Gaudium et Spes*," in *the Documents of Vatican II*, 1965; Pope Paul VI, *Humanae Vitae*, 1968.

12. By contrast, Catholic physicians and hospital administrators did not dissent from Church teaching on the immorality of direct abortion and continued to refuse to do abortions even after it became legalized in 1973. In subsequent years special interest groups would present arguments similar to those used to justify direct sterilization in an effort to force Catholic institutions to perform abortions.

13. See, for example, the Report of the Commission on Ethical and Religious Directives of the Catholic Theological Society of America in *Linacre Quarterly*, November, 1972, and Charles Curran, "Cooperation: Toward a Revision of the Concept and Its Application," in *Linacre Quarterly*, August, 1974.

14. ERDs'71, directives 18 and 19.

15. *Quaecumque Sterilizatio*.

16. *Ibid*.

17. *Quaecumque Sterilizatio*, n. 3 b).

18. *Commentary*.

19. *Commentary*, n. 2.

20. *Commentary*, n. 4.

21. *Commentary*, paragraph following n. 6.

22. *Quaecumque Sterilizatio*, n. 3. a., (*emphasis added*)

23. Archbishop Daniel E. Pilarczyk and Bishop Donald Wuerl, Memorandum to the Bishops of the United States, June 30, 2000.

24. Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," July 31, 1993, in *Origins* 24 (1994), pp. 211-212.



25. Ron Hamel, "In the Name of God and Truth: The Catholic Ban on Sterilization," *Second Opinion*, January 1994, p. 93.

26. Ron Hamel, "In the Name of God and Truth: The Catholic Ban on Sterilization," p. 96.

27. The packet sent by Father Michael Place to Colleagues in the Catholic Health Care Ministry on September 26, 2000, also included three examples of such cases that were judged unacceptable by the Holy See. The descriptions of the cases and the critiques provided in "Concerns of the Congregation for the Doctrine of the Faith with Some Partnerships: Examples and Critique," are attributed to the Holy See.

28. See, Matt McDonald, "The Limits of Cooperation," in *The Catholic World Report*, December 2000, pp. 48-50, for an account of the number and types of mergers among health care institutions that have been proposed or have actually taken place in the United States over the past several years. Some of the agreements reached between Catholic and non-Catholic facilities have resulted in similar arrangements to those made in the more publicized cases.

29. Pilarczyk and Wuerl, Memorandum to the Bishops of the United States, June 30, 2000.

30. *Ibid.*

31. *Ibid.*

32. "The Congregation for the Doctrine of the Faith's Concerns Regarding the Application of the Principle of Cooperation," included in packet sent by Father Michael D. Place under cover memorandum to Colleagues in the Catholic Health Care Ministry, September 26, 2000.

33. *Ibid.*

34. First drafts of the revised ERDs'94 and *Commentary* were sent to all the bishops for their review and comment in June, 2000, and were subsequently shared with staff of the Catholic Health Association. A second draft of the revised ERDs'94 was sent to the bishops in September, 2000. Copies of this draft and related documentation were sent to CHA members by Father Michael D. Place on September 26, 2000.

35. Pilarczyk and Wuerl, Memorandum to the Bishops of the United States, June 30, 2000.

36. Consider the statements and actions made by such groups as Merger Watch of Albany, New York, Advocates for Reproductive Choice in Healthcare working out of Los Angeles, Catholics for Free Choice and Planned Parenthood.

37. Comments made by Father Michael Place as reported in, Matt McDonald, "The Limits of Cooperation," in *The Catholic World Report*, December, 2000, p. 51. In reading the materials on the proposed revisions to the ERDs'94 sent by CHA to its members on July 25, 2000, and September 26, 2000, it would seem that the CHA took a practical, though perhaps not formal, position against the May and September drafts. By contrast, there have not yet been any mailings critical of the November 8<sup>th</sup> draft. In fact, according to Father Place's memorandum to CHA colleagues dated November 15, 2000, the draft "reflects the work of the theologian/ethicist resource group that met on November 1<sup>st</sup> and of Archbishop Pilarczyk, Bishop Wuerl, several other NCCB staff and ten representatives from the ministry who met on November 8<sup>th</sup>." (Ron Hamel, whose views regarding the Church's teaching on direct sterilization were presented above – "In the Name of God and Truth: The Catholic Ban on Sterilization," *Second Opinion*, January 1994 – was a representative of CHA at least at one meeting.) Father Place seems happier with the November 8<sup>th</sup> draft and comments that "We are in a very different place today than we were at the end of June."

38. "Themes from the NCCB Consultation, September 14, 2000," included in the CHA mailing under cover memorandum from Father Michael D. Place to colleagues in Catholic health care ministry, dated September 26, 2000.

39. *Ibid.*

40. Pilarczyk and Wuerl, Memorandum to the Bishops of the United States, June 30, 2000.

41. November 8, 2000, revised draft of the ERDs'94, Part VI.

42. The Principle of Cooperation is used to evaluate the morality of a secondary agent's actions that in some way contribute to the immoral acts of a primary agent. Since a basic principle of Catholic moral teaching is that evil cannot be done for any reason including the pursuit of good, the Principle of Cooperation could never justify a secondary agent's agreement with the evil intended by the primary agent. Both the primary and secondary agents' intentions, it should be noted, are present in *what* they do and in the motive *for which* they do it.

Although evil can never be directly intended, the Catholic moral tradition has recognized that evil may sometimes be tolerated. Both the Principle of Double Effect and the Principle of Cooperation address situations in which the pursuit of good may well involve the toleration of evil. In all cases the moral agents must be truly reluctant to do something that requires the toleration of evil. Obviously, neither principle should be employed as a method to rationalize participation in evil.

The Principle of Cooperation addresses situations in which a secondary agent's pursuit of some good necessitates the toleration of the evil done by the primary agent. The Principle of Cooperation assists the secondary agent in evaluating his participation in evil by stating those conditions that make cooperation morally justifiable. These conditions are well stated by a series of questions. Is it necessary to pursue this good here and now if it involves cooperation in evil? Do the circumstances make it clear that the evil is only tolerated? Is the good that is pursued proportionate to the evil that is tolerated? Will cooperation with evil contribute in any way to the spread of evil; that is, will it make it seem less evil and lead others to perform the same evil action themselves? By answering such questions, one is able to distinguish cooperation that is the same as doing evil, from cooperation that demonstrates a toleration of evil necessitated by an obligation to pursue some proportionate good that cannot otherwise be reasonably achieved.

If the secondary agent claims to be pursuing some necessary good and only tolerating the evil the primary agent is engaged in, then the Principle assesses the validity of this claim. It does so by examining the secondary agent's intention as it is found in *what* he does (object of the act) and in *why* he does it (motive). Regarding *what* the agent does, the Principle asks if the cooperation is necessary or essential to the primary agent's action, or whether it helps in some material but non-essential way. Regarding *why* the secondary agent cooperates, the Principle asks if there is any obligation to pursue the good and if the good pursued is proportionate to the evil tolerated.

Since evil can never be directly intended, the will of the secondary agent can never be in agreement with the evil will of the primary agent. This level of cooperation is called *formal* and is always forbidden. Such formal agreement with the immoral will of the primary agent is *explicit* when the secondary agent makes no claim to the contrary. It is *implicit* when, even if he claims otherwise, no other plausible explanation can be given for his level of participation in the primary agent's evil action.

Still there are circumstances in which a secondary agent's cooperation, though essential to the evil act, is provided despite his opposition to the evil will of the primary agent. For example, an anesthesiologist who would never willingly assist with a direct abortion provides anesthesia to a pregnant woman who is undergoing surgery for injuries sustained in an automobile accident. During the course of the operation, the surgeon decides that the woman's chances for survival would be improved if he aborts the fetus. There are no other anesthesiologists available and the attending anesthesiologist has no alternative but to continue participating in the operation. His cooperation in the immoral act of the surgeon is essential and necessary, yet his claim not to agree with the evil will of the primary agent is made credible by the duress under which he is made to cooperate. This is called *immediate material cooperation* and is permissible in such circumstances as those described here. (The Holy See has rightly denied the claim that duress – such as the continuing threat of closure – can justify *immediate material cooperation* on the part of a Catholic institution.)

When the secondary agent's will is not in agreement with the evil intention of the primary agent and his cooperation is non-essential to the evil act, the

cooperation is *mediate* and *material*. He cooperates in this fashion because of some good that he is obligated to pursue and cannot otherwise reasonably attain. Theologians have introduced two other categories to test the credibility of the secondary agent's claim not to agree with the evil intention of the primary agent. These deal with the physical relationship of the secondary agent to the evil action itself. The closer the secondary agent is to the immoral act of the primary agent, the more compelling must be his reasons for cooperating. This is the basis for the distinction between *remote mediate material cooperation* and *proximate mediate material cooperation*.

The tradition has allowed for *mediate material cooperation* (proximate or remote) when the good at stake is proportionate to the evil tolerated and every effort is made to avoid giving scandal. When scandal; that is, leading others to sin by making it seem less immoral or more acceptable is likely, then even *mediate material cooperation* is impermissible.

43. National Coalition on Catholic Health Care Ministry, *Catholic Health Ministry in Transition: A Handbook for Responsible Leadership*, (Silver Spring, Maryland: National Coalition on Catholic Health Care Ministry), 1995.