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The Catholic Hospital and the Ethical and Religious Directives for Catholic Health Facilities

Charles E. Curran

Catholic hospitals are often identified as Catholic because they follow the *Ethical and Religious Directives for Catholic Health Facilities* which were approved by the American bishops in November 1971.¹ In Canada in 1970, the Canadian bishops promulgated a similar set of guidelines — *The Medico-Moral Guide*.²

Today, questions are being raised about the hospital code of ethics. Can any changes be made in the code? What about Catholics who might dissent from some of the teachings of the code?



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What about following the code in a pluralistic setting in which government funds support hospitals and the hospital is expected to serve all people in the area, Catholic as well as non-Catholic? What if following the code would seriously curtail the quality of the medical care given at the Catholic facility or perhaps even force it out of existence?

This paper will begin by situating the question of the hospital code in the broader context of the health care witness and service of the Catholic Church. Secondly, the tension of using a moral teaching proposed as a guide for individual conscience as a hospital code will be discussed. Thirdly, the problems arising from a Catholic hospital code in the context of a pluralistic society will be explored and appropriate conclusions drawn.

I. The Hospital Code in the General Context of Catholic Witness and Service. As a first step it is necessary to understand the question of the hospital code within the broader context of the mission of the Roman Catholic Church and its witness and service to the sick. Care for the sick constitutes a basic gospel imperative for the individual Chris-

tian. The Catholic tradition, for example, sees the care for the sick as one of the corporal works of mercy.

In addition, the Church as a community should give a community witness and service to the care of the sick, but such an apostolate and witness can be accomplished in many different ways. For example, the Church community can organize a group of dedicated Christians in the name of the Church to visit and console the sick. The sacrament of the sick, in its own way, constitutes an excellent witness to the care and concern for the sick. But there can be many other ways in which such a community or Church apostolate exists. The form of ecclesial community witness to the care of the sick which is the one we usually think of today, involves an institutional witness as such. The health care facility — hospital, clinic or retirement home — as institution, is owned and operated by a denomination or church or by a particular group within a church or denomination. Within the past few years there have been discussions about the proper legal incorporation for Catholic or religious institutions, but our concern does not include the legal aspects of incorporation.³

Catholic institutional presence in the health care apostolate, especially in the form of Catholic hospitals, has been a very significant and visible aspect of the Roman Catholic witness and service to the sick. Historically, the Church has been instrumental in

setting up and maintaining hospital facilities. Without contradiction, one can state that the Church has been a leader in this field and is generally recognized as such even in the secular world.

However, such institutional witness is not absolutely necessary for the Church to fulfill its community witness and service to the care of the sick. The question of priorities always enters into the determination of what forms of institutional service the Church should provide. There are many criteria which are appropriate in establishing such priorities, but one must always include the real needs of people and the ways in which society is already attempting to meet those needs. In changing historical circumstances, the priorities of institutional Church witness can, and even should, change. Even today a new form of Church apostolate has emerged in some areas of health care. The Church or a Church organization serves as a catalyst to bring people together and obtain government funding to build and staff nursing homes for senior citizens, which are established as private but non-religiously affiliated institutions.

The Church, in a process of corporate discernment, must constantly strive to ascertain its own priorities in the most fitting form of service in the light of the gospel and the signs of the times. There can be an ecclesial service, witness and apostolate to the dying without an institutional presence even though historically

the institutional presence has been a very significant part of the Church's witness. One cannot, in advance, rule out the possibility that the Roman Catholic Church should give up its institutional involvement in hospitals and health facilities for a number of different reasons, including the fact that the Church might not be able to carry out its own ethical commitments in these institutions.

Granted the existence of Catholic hospitals or health care facilities as such, the question naturally arises: what makes such institutions Catholic? Such a question would always be legitimate, but it becomes even more critical in the light of many contemporary events. Religious communities which once staffed Catholic hospitals do not have the number of vocations they had in the past and they might not be able to continue to staff the institutions. Funding today generally comes from public sources. Governmental regulations and planning exert great influences on all hospitals. Many patients and even staff and administrators in Catholic hospitals are not themselves Catholic.

The question about the exact identity of a Catholic hospital must also be seen in the light of a broader questioning occurring in the Church today. There have been a number of symposia on the meaning and identity of Catholic colleges and universities.⁴ There exists an even more radical questioning about the ex-

istence of a specifically Christian ethic and on what precise level of ethical reality there is a specifically Christian ethic.⁵

An attempted solution to the problem of the identity and meaning of a Catholic hospital or health facility lies beyond the scope of this study, but it will be helpful to establish some parameters for this discussion. In the light of the subsequent discussion on the hospital code of ethics, it must be emphasized that the observance of the code alone is not a sufficient source of Catholic identity for the hospitals. Unfortunately, it seems that the Catholic identity of a health care facility was in the past often reduced to the observance of the prescribed Catholic hospital code. Lately, a number of articles have perceptively pointed out the need for something more.⁶ Kevin O'Rourke speaks of a threefold aspect to Catholic identity: 1) communicating a message with emphasis on the sacredness of human life, the meaning of suffering and death and Christ's love for the poor; 2) establishing a community within the hospital; 3) performing service.⁷

In attempting to discern the broader meaning and identity of the Catholic hospital there are two parameters that must be kept in mind. First, there is a danger of claiming certain things as specific to Catholic identity when they are not. For example, a respect for the human life and concern for the poor are not

uniquely Catholic. Elsewhere I have argued that in terms of specific content, conclusions and proximate content dispositions (such as care for the needy, self-sacrificing love), there is no specifically Christian content in ethics. The explicit Christian aspect affects the transcendental aspect of the human act and the areas of motivation and intentionality. This in no way denies that Christian love should become concrete, but non-Christians can arrive at the same conclusions and share the same proximate dispositions, attitudes and values.⁸ The second parameter exists in tension with the first. The culture and ethos of any one period are marked also by human limitation, finitude and sinfulness. There is the perennial danger of conforming the gospel to the contemporary culture. The relationship between gospel and culture always involves tension. On the one hand culture may support gospel values, but on the other hand it might impede the gospel. Anyone attempting to describe the meaning of a Catholic institution must be aware of the twofold danger of either claiming too much as specifically Christian or also forgetting that at times the gospel will be in opposition with the culture.

II. Tensions Arising from Medical-Moral Directives as Institutional Policy. The first source of tensions to be considered involves the fact that the *Ethical and Religious Directives for Catholic Health Facilities* apply

to institutional policy the moral directives and teaching which the Roman Catholic Church proposes for the conscience of its individual members.⁹ Moral directives cannot be transposed from directives for the individual Catholic conscience to institutional policy for a health care facility without some resulting tensions. As directives for the individual Catholic conscience, these norms admit a number of responses which are not now accepted in the area of institutional policy in Catholic health facilities in the United States. All these different responses place heavy emphasis on the person and the subjective aspect of the moral actor, but the existing institutional policy often does not allow such elements to be taken into consideration. The following three aspects will be considered: 1) the concept of invincible ignorance; 2) the possibility of counseling or choosing the lesser of two evils; 3) the right to dissent from authoritative, noninfallible hierarchical teaching.

Invincible Ignorance

Roman Catholic theology has traditionally acknowledged that the human act has a subjective and an objective aspect. The subjective aspect views the human act in its relationship to the person of the subject performing the action, whereas the objective aspect views the act in its relationship to whatever is proposed as the objective moral norm. An act can be objectively wrong, but

the institutional presence has been a very significant part of the Church's witness. One cannot, in advance, rule out the possibility that the Roman Catholic Church should give up its institutional involvement in hospitals and health facilities for a number of different reasons, including the fact that the Church might not be able to carry out its own ethical commitments in these institutions.

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not subjectively sinful. Legal systems have appropriated the same basic notion by recognizing that wrong actions can be done but subjectively excused because of temporary insanity or some other type of impediment.

The realization of these two aspects of the human act surfaced especially in the historical development of the possibility of invincible ignorance of the natural law. The manuals of moral theology generally acknowledge that there can be invincible ignorance of the more mediate or remote conclusions of the natural law which are deduced from the first principles only through a comparatively long discursive process.¹⁰

In the context of the debate about probabilism, St. Alphonsus was attacked for his teaching on the possibility of invincible ignorance of the natural law. Alphonsus' adversaries in this discussion were the Italian Dominican Giovanni Vincenzo Patuzzi who occasionally used the pen name Adelfo Dositeo, and the anonymous author of *La Regola de' costumi*.¹¹ Alphonsus maintained that even if one is doubtful about the existence of the natural law obligation, one can still be invincibly ignorant of it. Alphonsus' position rests on two reflex principles. First, doubtful law does not apply because it is not sufficiently promulgated. The second reflex principle maintains that a doubtful law does not oblige. The ultimate metaphysical reasons come from the distinction between the remote

law of human acts which the divine law and the dictate of conscience which is the proximate norm of human actions. By insisting on the proximate norm of human conduct, the essentially voluntary character of the human act, and the intention or the end as the foremost element of the act, St. Alphonsus acknowledges the possibility of an inculpable discrepancy between the remote and proximate norms of human action.¹²

Contemporary Catholic moral theologians have expanded the concept of invincible ignorance. Louis Monden argues that invincible ignorance or error cannot be restricted to a lack of information or a rational grasp of that information, but must be expanded to include the whole sphere of psychological incomprehension, unconscious assistance, invincible prejudice, wishful thinking and affective transferences of every kind.¹³

Bernard Häring distinguishes the level of moral theology from the level of pastoral counseling. Häring sees such a distinction in the older approach to invincible ignorance but realizes that invincible ignorance involves more than mere intellectualism. Invincible ignorance refers to the person's inability to realize a moral obligation because of the individual's total experience, the psychological impasses and the whole context of one's life. There exists a law of growth according to which the counselor might not be able to urge the fullness of the objective norm at

the present time but only look for a step forward which the individual can realistically take in the present situation. Häring sees this law of growth in the light of the tension between the demands of objective morality and the subjective possibilities of the person here and now. Häring applies this understanding to a particularly acute case of abortion after rape although he cautions that he would not go so far as to positively advise the person to abort the fetus.¹⁴ Theologians have continued to discuss such an approach and how it either agrees or differs with proposals put forward by some Protestant ethicists in response to the same basic problem.¹⁵ Thus a person, even in going against an objectively true moral precept, might not always be guilty of sin and in the forum of pastoral counseling such a decision can be accepted in the light of the principle of growth.

In their commentary on the encyclical *Humanae Vitae*, the Italian bishops, in directing their attention to Catholic spouses, refer to the law of growth. Christian spouses should not become discouraged. They should remember there are laws of growth in the attainment of virtue, and at times in striving for the ideal one will pass through stages of imperfection.¹⁶ A commentary on the statement of the Italian bishops speaks of a personalistic perception and the pastoral existential aspects of the Christian life which indicate the need to

accept a law of growth in these matters.¹⁷

In dealing with the individual person one can thus distinguish between the level of objective moral norms and the level of pastoral counseling. However, the *Ethical and Religious Directives for Catholic Health Facilities* do not seem, in themselves, to make room for such a distinction which is an accepted part of the Catholic tradition.

Lesser of Two Evils

Catholic moral theology has debated the question of counseling the lesser of two evils. One opinion claims that such counseling is not permitted. Whoever counsels or persuades to a lesser evil still truly persuades another to do evil and this is never licit. However, a more common opinion, which was also maintained by St. Alphonsus, permits the counseling of the lesser of two evils when, from the circumstances, it is obvious that the counselor is not proposing the lesser evil as something to be done in itself, but rather is dissuading the person from doing the greater evil. The object, then, of the counseling is not the lesser evil to be done but the greater evil to be avoided even though in the process the lesser evil must be tolerated. In this case it is important to recognize that both evils are acknowledged to be moral evils and the principal actor cannot be dissuaded from doing evil.

What about choosing, rather than just counseling, the lesser of

two evils? Traditional Catholic moral theology, again heavily relying on St. Alphonsus, speaks about the perplexed conscience in which the person believes that sin is involved in the two available alternative actions. One must delay the action and consult with experts to remove the doubt. If the action cannot be put off, then the lesser evil should be chosen. The impression is given that in actuality there is not objective moral evil in both cases, but the individual does not realize this fact. Again, Catholic moral theology upholds the principle that one can never directly do what is morally evil.¹⁹ Such an approach could also be reformulated into a case of expanded invincible ignorance if the person does not existentially appreciate the moral evil involved in the one act.

In this connection, the reaction of the French bishops to *Humanae Vitae* poses some interesting questions. According to the statement issued by the French hierarchy, contraception can never be a good, for it is always a disorder. "But persons can be confronted by a true conflict of duty. On this subject we simply recall the constant moral teaching: When one faces a choice of duties, where one cannot avoid an evil whatever be the decision taken, traditional wisdom requires that one seeks before God which is the greater duty. The spouses will decide for themselves after reflecting together with all the care that the

grandeur of their conjugal occasion requires."²⁰

The exact meaning of the French bishops, in my judgment, is not clear. They seem to be doing more than merely counseling their people to choose the lesser of two moral evils. Perhaps they are invoking the case of the perplexed conscience, but the traditional interpretation of that maintains that if experts declare that both actions are intrinsically wrong (to use the terminology of the manuals), then the individual may not do what is intrinsically wrong. Perhaps they are in some way expanding the traditional concept of the perplexed conscience. Perhaps they are merely applying here an expanded concept of invincible ignorance which subjectively excuses the action of the person. Perhaps they are invoking a newer moral principle that contraception in this case is only a pre-moral evil which can be justified for a proportionate reason.

Is there any way of coping with the problems arising from the fact that on a pastoral level the law of growth or the counseling or choosing of the lesser of two evils might mean that an individual Catholic could do an action which is prescribed by the moral code? One possible way of trying to solve this difficulty can be found in the preamble which the Canadian bishops affixed to their moral guide: "The guidelines present a concise statement of these exigencies in the field of hospital work. They should be

read and understood not as commands imposed from without but as demands of the inner dynamism of human and Christian life. And precisely because they are that, their application for a particular situation will usually entail a great deal of prudence and wisdom. There, then, personal conscience will find its field of competence. The guidelines should serve to enlighten this judgment of conscience. They cannot replace it."

One could interpret this paragraph as acknowledging the two types of problems discussed above and recognizing that in practice, at least in some cases, the personal conscience might, without guilt, come to decisions in which the externally imposed objective norm is not fulfilled. Such an understanding of the hospital code of ethics would allow for approaches on a pastoral level which have been traditionally acknowledged as possible for the individual but which have not been allowed in Catholic health facilities following the letter of the *Ethical Directives* as proposed by the American bishops. There would be problems in implementing such approaches, but recognition in theory of such pastoral approaches should serve as the framework for trying to work out practical norms for the implementation.

Legitimate Dissent

In the context of the reaction to the encyclical *Humanae Vitae*, many Roman Catholics became

aware for the first time that there existed in the Roman Catholic Church the possibility of dissent from authoritative or authentic, noninfallible hierarchical teaching on moral questions. This is the type of teaching generally found in the guidelines or codes proposed for Catholic health facilities. Even some national bishops' conferences acknowledged that, after study and reflection, a Catholic could dissent from the encyclical's teaching on contraception.²¹

In speaking about those who cannot accept the encyclical's teaching on some points, the Canadian bishops pointed out: "Since they are not denying any point of divine or Catholic faith nor rejecting the teaching authority of the Church, these Catholics should not be considered or consider themselves shut off from the body of the faithful. But they should remember that their good faith will be dependent upon a sincere self-examination to determine the true motives and ground for such suspension of dissent and on continued effort to understand and deepen their knowledge of the teaching of the Church."²² Note that the Canadian bishops themselves do not dissent from the encyclical teaching, but they acknowledge the explicit right of Catholics to dissent.

The debate about dissent in the Roman Catholic Church from specific teachings of the authentic or authoritative, noninfallible hierarchical magisterium

continues. The ultimate theological reasons for such dissent can be reduced to two: 1) from the epistemological perspective, on such specific issues one cannot obtain the type of certitude that excludes the possibility of error; 2) from the ecclesiological perspective, the whole teaching and learning function of the Roman Catholic Church cannot be totally identified with the hierarchical teaching office of the Church. In my judgment, dissent is now and will be a more frequent occurrence in the Church, but not all agree.²³ At least in theory one has to maintain within the Roman Catholic Church the possibility of dissent from such authentic or authoritative, noninfallible Church teaching.

At the present time in the United States the most significant issue in the area of medical morality and the hospital code involves direct sterilization. Directives 18 and 20 of the *Ethical and Religious Directives for Catholic Health Facilities* spell out the prohibition of direct sterilization which has been presented by the authoritative hierarchical teaching: "Sterilization, whether permanent or temporary, for man or for woman, may not be used as a means of contraception." This same prohibition is found in the *Medico-Moral Guide* proposed in 1970 by the Canadian bishops.²⁴

The *Directives*, passed by the American bishops in November 1971, contain a charge to the

Committee on Health Affairs of the United States Catholic Conference, using the widest consultation possible, to review suggestions from the field and to discuss periodically the need for an updated revision of the *Directives*. A committee was set up for this purpose. The topic of sterilization was discussed, but there were great divisions within the committee on this issue including the theologians who were members of the committee. The matter was brought to the attention of the Administrative Board of the National Conference of Catholic Bishops. A special review committee studied the issue, and it was decided in 1972 to send the issue to Rome for guidance. Both written and oral presentations were made to Rome early in 1974. On April 1, 1975, Archbishop Joseph Bernardin, president of the National Conference of Catholic Bishops, informed all bishops that the question of sterilization had been examined at length including consultation with the Holy See. He now writes: "... to give assurance that the 1971 Guidelines stand as written and that direct sterilization is not to be considered as justified by the common good, the principle of totality, the existence of contrary opinion, or any other argument. This means that Catholic hospitals, as a matter of institutional policy, may not authorize sterilization procedures for reasons other than those contained in the guidelines. If questions of material cooperation arise, the tradi-

tional norms of moral theology are to be applied."

On December 4, 1975, Bishop James S. Rausch, current general secretary of the National Conference of Catholic Bishops, sent to all American bishops a response from the Doctrinal Congregation dated March 13, 1975. This document was obviously the basis of Archbishop Bernardin's earlier letter. The document of the Doctrinal Congregation recognizes the dissent against this teaching from many theologians but "denies that doctrinal significance can be attributed to the fact as such so as to constitute a "theological source" which the faithful might invoke and thereby abandon the authentic magisterium, and follow the opinions of private theologians which dissent from it."²⁵

There exists a significant dissent from this teaching proscribing direct sterilization even though some do not acknowledge their position as a forum of dissent. Many Roman Catholic theologians have publicly justified the right to dissent from such teaching condemning direct sterilization.²⁶ The dissent also exists in practice. The *Policy Manual* of St. Joseph's Hospital, London, Ontario, acknowledges "in certain cases where the total medical health of a woman may be gravely jeopardized by a future pregnancy, a tubal ligation may be considered objectively a moral act different from a tubal ligation done where there are no

grave medical complications."²⁷ The policy for Catholic hospitals in Manitoba, Canada, also permits sterilization for serious medical reasons.²⁸ In many hospitals in the province of Ontario, Canada, sterilizations are performed.²⁹ In the United States there has also been much discussion on the issue of sterilization. A number of Catholic hospitals have been permitting sterilization under conditions often based on those used at St. Joseph's hospital in London, Ontario. Some hospitals have solved the problem by leaving the decision to a committee without any developed criteria proposed for the guidance of the committee.³⁰

In my judgment, sterilization involves basically the same moral issues as contraception. Whoever dissents from the teaching on contraception logically must also dissent from the prohibition of direct sterilization. The only difference is that sterilization tends to be permanent, and there should be a more permanent or serious reason to justify it. Consequently, sterilization, if permitted, cannot be restricted just to medical reasons, but any truly human reason which is of proportional seriousness suffices — sociological, psychological, economic, or other.

The recent letter of Archbishop Bernardin and the document from the Doctrinal Congregation do not take away the legitimacy of dissent from a Roman Catholic. One must be open to the teaching of these documents, but

the documents themselves claim only to be repeating the traditional teaching as already enunciated. If one, after prayerful and thoughtful consideration, has already dissented from such teaching, such dissent can continue to be a legitimate option for the loyal Roman Catholic.³¹

It is now necessary to address a question which heretofore has not received enough attention — the limits of dissent. The Commission of the Catholic Theological Society of America, of which I was a member, acknowledged the right to dissent and talked about its applications in the areas covered by the hospital code. However, the Commission did not delve deeply into the very significant question of the limits of dissent with regard to the hospital code.³² It is this important question which now needs to be addressed.

In the realm of practical reality the question is often phrased: if it is legitimate for a Roman Catholic to dissent on contraception and sterilization, is it also legitimate to dissent on abortion and euthanasia? Already there are some Roman Catholic theologians who are questioning the traditional teaching and dissenting from it in the areas both of abortion and euthanasia.³³ At the present time, the sterilization issue seems to be the one which is receiving all the attention, but is this merely the foot in the door? Once the sterilization issue is solved and direct sterilization is permitted in Catholic hospitals,

then will abortion and euthanasia follow?

The reasons briefly mentioned justifying the possibility of dissent from authoritative, authentic, noninfallible Church teaching are also present with regard to the possibility of dissent on abortion and on euthanasia. Legitimate dissent in these areas remains a possibility because of the complexity and specificity of the material with which we are dealing and the fact that one cannot obtain the degree of certitude that excludes the possibility of error. One can, and in any judgment must, apply to the denying the hierarchical teaching on abortion and euthanasia what the Canadian bishops said about those dissenting from *Humanae Vitae*: "Since they are not denying any point of divine and Catholic faith nor rejecting the teaching authority of the Church, these Catholics should not be considered, or consider themselves, shut off from the body of the faithful." For this reason I have urged that ultimate Roman Catholic identity cannot be sought in terms of absolute acceptance of specific moral teachings including the teaching on abortion and euthanasia.

Although dissent from specific moral teachings always remains a possibility for the Roman Catholic, this does not mean that such dissent is always justified and right. There must be reasons to justify the dissent, but this does not limit dissent only to theologians. Theology by definition

operates on the level of the systematic, the thematic and the reflexive, but every Christian can and must arrive at ethical judgments. The ordinary Christian makes decisions in a nonthematic, nonreflexive, and nonsystematic way, but these are not pejorative terms. One does not have to be a theologian in order to be able to dissent from hierarchical teaching, but prudence calls for one to seek out how theologians and other people in the Church have approached the particular point in question.

However, if one emphasizes only the possibility of dissent on specific moral questions, then it becomes impossible for the Church or its teaching to take on any incarnational existence in a given historical time and place. The historical Roman Catholic community cannot be restricted merely to the realm of infallible or of *de fide* statements. If this were true, it would overly restrict the existence of the Church as a community which should have an incarnational existence in time and place. Catholic identity would be reduced to a small, a-historical core in much the same way as liberal theology reduced the core or essence of Christianity. The dilemma involves the classical case of the rights of the individual and the legitimate needs of the community. There must be a way in which both aspects are given their due.

In the historical reality of human and Christian existence, Roman Catholic moral teaching

and identity can be gauged by the reaction of the whole Church in its teaching and in its learning as well as in its living. Not only the teaching of the hierarchical magisterium but also the *praxis* of the community and the teaching of theologians must be considered. It is always difficult to assess adequately the *praxis* of the whole Church, but the difficulty does not eliminate the importance and significance of the norm. The historical self-identification and *praxis* of the Church in any given moment never furnish an absolute criterion of truth; but, nonetheless, it is the only acceptable norm of the identity of the historical community as such. A conflict between the conscientious belief of the individual Catholic and the *praxis* of the historical Church community remains possible, and such a conflict merely mirrors the tension which will always exist within the Church community, between the community itself and the individual.

Praxis itself has changed on some matters and might change in the future. Thirty years ago one could not appeal to any practice against the teaching of the Roman Catholic Church on sterilization, but today, in my judgment, one can. The method of determining the *praxis* of the Church at any one given time cannot be reduced just to a majority vote. One is here trying to discern the work of the Spirit in and through the *praxis* of the Church. In this context one must

pay significant attention to all the aspects of the Church. Where there begins to be a change in the *praxis* of the Church on a particular teaching, the tension and conflict will become more acute.

At the present time I do not think that the *praxis* of the Church on most aspects of the questions of abortion and euthanasia differs from the teaching of the hierarchical magisterium. (I say most aspects because it seems that at the present time the older application of the theory of double effect to conflict situations involving abortion is not accepted in the *praxis* of the Church as illustrated in the case of aborting the fetus to save the life of the mother.)

Personally, I have proposed positions which dissent to some extent from the teaching of the hierarchical magisterium on abortion and euthanasia. Other Roman Catholic theologians have proposed opinions which dissent even more from that teaching, but at the present time, the *praxis* of the Roman Catholic Church does not seem to have moved away from the accepted teachings. The process of discerning the *praxis* of the total Church will always be difficult, but in this way one tries to balance the rights of the individual member of the Church and the life of the community incarnated in the historical times and culture of a given period. Thus, one could conclude that Catholic hospitals today should allow sterilizations but that does not entail the gen-

eral acceptance of abortion or euthanasia.

III. Tensions Arising from the Pluralistic Context. A second source of tension involves the pluralistic society in which Catholic institutions exist. Many Catholic hospitals and health facilities have non-Catholic on their staffs. Catholic hospitals serve non-Catholic patients as well as Catholic patients. Catholic hospitals like other private hospitals often receive various forms of government funding. How is the Catholic health facility with its institutional code of ethics to relate to the other persons who do not subscribe to such an ethical code?

There are a number of pressing practical dilemmas which illustrate the types of problems that can and have arisen. At the present time in the United States the most pressing problems are associated with sterilization (tubal ligation) and affect both large hospitals in metropolitan areas and hospitals in smaller communities. In large Catholic hospitals in metropolitan areas, physicians with privileges at the Catholic hospital often have privileges at other hospitals where they will do tubal ligations. Multiple staff appointments erode the obstetricians' loyalty to the Catholic hospital. Time pressures, exacerbated by transportation problems, may force the doctor to concentrate most of his practice in institutions which allow the performance of all accepted operations and procedures, inclu-

ding tubal ligations. The loss of good Ob/Gyn staff will also have repercussions on the quality of medical care offered at the Catholic hospital. Expertise will be lacking for other specialties. No one service — medicine, surgery, pediatrics, Ob/Gyn — exists in a vacuum. If the hospital is a teaching hospital with medical and nursing education units, its very existence could be threatened.

Problems also exist on the level of smaller communities. Regional health planning units are now organizing health care in particular areas. Often the Catholic hospital might be the designated place for Ob/Gyn, but the refusal to do tubal ligations often prevents a Catholic institution from having such a unit for the total area. If Catholic institutions are unable to allow such operations, they will lose their Ob/Gyn units and perhaps put their total existence in jeopardy.

Another illustration involves the situation where the Catholic hospital is the only hospital in the area. What, then, about the rights of non-Catholics in that particular area? Is it just and fair that they cannot have the medical operations which good medical practice calls for, at least in the eyes of the individuals and their physicians? Legal cases have been brought against Catholic hospitals for refusing to do abortions and sterilizations, but final decisions have ruled in favor of the hospitals.³⁴

Two important generic consid-

erations shed light on possible solutions to these cases — the question of cooperation and the question of pluralism in our society.

Cooperation

The older approach understood cooperation in terms of cooperating with an act which is wrong. On the basis of a more personalistic understanding and in the light of the newer approach to the question of conscience and religious liberty, I have proposed a different theory of cooperation. One does not cooperate with an act which is wrong, but rather with a person who is usually convinced that the action is good.³⁵

In the question of religious liberty, contemporary Catholic teaching expressed in the Second Vatican Council recognizes that individuals should be free to act in accord with the dictates of their conscience in religious matters; that is, they should be free from external coercion which prevents them from acting in the way they want or forces them to act in a way contrary to their conscientious conviction. The approach to religious liberty within Roman Catholicism was changed precisely because it was recognized that in this case one is not cooperating with an act which is intrinsically wrong, but rather with a person who has in religious matters the civil and juridical right to act in accord with one's own conscience in these matters.

Even in the matter of religious liberty (which as a civil and mor-

al right is not exactly the same as the moral right of a person to act in accord with a sincere conscience) there are certain limits placed on that liberty. In the juridical order the state can intervene and restrict the exercise of religious liberty on the basis of the criterion of public order which embraces an order of peace, of justice and of morality (Declaration of Religious Freedom, n. 7). Our life with others in a pluralistic society should follow the same basic approach. Often in our society we must cooperate in some way with others with whom we are in disagreement. Limits to our cooperation should be based on the same criterion of the public order with its threefold aspect of an order of peace, of justice and of basic morality necessary for living in society. We thus respect the rights of others in our society to perform certain actions, but one can refuse to cooperate if the act, in the judgment of personal conscience, interferes with the public order, especially the rights of others.

Within the parameters of this approach a proportionate reason is necessary to justify the cooperation, but often I would judge that the rights of the other person could constitute such a reason although some might demand a stronger reason to justify the person who cooperates in an act thought to be morally wrong but not harmful to the public order. Such an approach to cooperation tries to respect all the many values present in the situa-

tion — the conscience and rights of the principal actor, the conscience and rights of the cooperator and the effect of the action on others and on society.

What about the cooperation of a Catholic hospital in operations and procedures which are opposed to Catholic teaching? In a true sense, the hospital as a moral or legal person does not perform operations, but allows them to be done. It would seem that even fewer reasons are required to justify cooperation in this case, but the meaning of cooperation by a legal or moral person needs greater study. Applying the principles of cooperation outlined above, the Catholic hospital is justified in permitting sterilization and other procedures which do not harm the public order when there are sufficient reasons, such as a serious violation of the rights of others. However, the Catholic hospital ordinarily could refuse to perform abortions or other procedures which are judged to take human life or harm public order.

Pluralistic Society

A second consideration involves the functioning of pluralism in society. If possible, society should foster and encourage the right of peoples or groups to act according to their conscientious convictions. In practice, such a principle means that individuals or groups should not be forced to cooperate (as distinguished from voluntary cooperation considered above) in actions which they deem to be wrong.

However, this principle of encouraging groups to act in accord with their own conscientious conviction obviously exists alongside other values. Conflicts will arise when the rights of some groups and individuals to act in accord with the dictates of their consciences, collide with the rights of other people to act in accord with their consciences.

In many cases, especially in large urban areas, society can foster this pluralism without curtailing the rights of others. Catholic hospitals coexist with non-Catholic hospitals. Catholic hospitals can adhere to their institutional ethical code without harming the rights of others who have easy access to other health facilities. Conflicts can become more acute in situations involving the consolidation and coordination of health care facilities which are taking place not only in small areas but even in urban areas. Acute problems also exist where the Catholic health facility is the only one serving a particular area.

As already mentioned in considering cooperation, it seems that Catholic hospitals can and should, where necessary, cooperate in operations such as sterilization and other operations in which there is no harm being done to other innocent persons. Within civil society, everything possible should be done to support the conscientious decisions of individuals not to participate in what they believe to be the taking of human life. The primary purpose of human society

is to protect and enhance human life, which is a most fundamental value in society. If at all possible, individuals and groups within society should not be forced to engage in or cooperate with what they believe to be the morally wrong taking of life. This fundamental line of reason also argues for the need for selective conscientious objection to military service. For example, the bishops of the United States have issued a statement urging such selective conscientious objection precisely because of the fact that unjust war involves the wrong taking of life.³⁶ Whenever one believes that human life is wrongly being taken, the state should go as far as possible to see that such a conscience is protected. It could be that at times it will be impossible to do this, but cooperation in such matters should be required only as a last resort.

Conclusion

This paper has touched on the meaning of the Catholic identity of health care facilities and examined the problems connected with the institutional Catholic medico-moral code resulting from two different sources. Often the problems will overlap so that one could justify direct sterilization in Catholic hospitals either on the basis of dissent or counseling the lesser of two evils or on the basis of cooperation. To avoid the problem resulting from the fact that norms for the individual conscience are now posed as institutional policy, it

should be recognized in the hospital code that these norms are to be applied and interpreted in the light of accepted pastoral practices and interpretations. To solve the problems resulting from the pluralistic nature of the contemporary situation, the principle of cooperation should be applied as explained above. In all these matters there will still be tensions, but the application and interpretation of the suggested approaches should be worked out on the local level in the light of the existing circumstances.

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24. Article 18 of the Canadian Guide condemns sterilization as a means of birth control. Article 19 condemns artificial contraception employing a citation from *Humanae Vitae*: but an N.B. is added in italics: "Reference should be made to the Canadian bishops' documents on the pastoral application of this general direction." Logically the statement of the Canadian bishops in which they acknowledge the rightful possibility of dissent from *Humanae Vitae* should also apply to direct sterilization which is condemned when "used as a means of birth control."
25. The document issued on March 13 and signed by Cardinal Seper, the Prefect of the Doctrinal Congregation and Archbishop Hamer, its Secretary, is entitled: "Documentum circa Sterilizationem in Nosocomiis Catholicis: Res-

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29. Young, Gladys Shirley, "Family Life Services in Catholic Hospitals in Ontario," an unpublished M.A. thesis for the School of Hygiene at the University of Toronto (1975).

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