

May 1977

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Recommended Citation

Smith, William B. (1977) "Catholic Hospitals and Sterilization," *The Linacre Quarterly*: Vol. 44: No. 2, Article 9.
Available at: <http://epublications.marquette.edu/lnq/vol44/iss2/9>



Catholic Hospitals and Sterilization

Rev. William B. Smith, S.T.D.

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This article is a revised version of a talk presented to the Health Affairs Committee of the New York Catholic Conference on March 1, 1977.

In the judgment of some, ours is an age of revisionist history. The question of direct sterilization in a Catholic health facility is certainly a question with a history. Some of that history has been written in this country and in our age. Most of the revisionist theories seem to thrive in this country, not because of any new medical information, but because so many moral theories are revised here.

These alleged "breakthroughs" in moral reasoning are often called "expansions" or "revisions." In fact, some of these very "revisions" played no small part in occasioning an authentic teaching response from the Sacred Congregation for the Doctrine of the Faith on this question of sterilization in Catholic hospitals. When that clear doctrinal response came, some concluded that things were never more unclear.

Recently, two different articles have appeared on this subject going clearly in different directions. Writing in this journal, Dr. Vitale H. Paganelli contributed an article¹ which, in my judgment, is substantially correct but which can be improved with some moral precision about material cooperation. On the other hand, Rev. Kevin D.

O'Rourke, writing in *Hospital Progress*, contributed an article² which, in my judgment, is substantially incorrect about material cooperation and can be disproved with some moral precision on the same point.

Let us locate the point under consideration. In the context of a Catholic discussion about Catholic facilities, the central point of reference here is the doctrinal teaching in the SCDF's "Document About Sterilization in Catholic Hospitals" of March 13, 1975 (Cf. following; while brief, it is necessary reading). The background of this authoritative teaching response is most instructive.

Directive No. 20 of the *Ethical and Religious Directives for Catholic Health Facilities*, approved by the bishops of the United States (NCCB) in 1971, was questioned by some sources. That directive reads:³

"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." (n.20).

Questions were posed either to the scope and meaning of this directive, or, to the fact that some theologians held the opinion that they could justify what this directive forbade by way of a so-called "expanded notion of the principle of totality."

The advisory committee on *Ethical and Religious Directives for Catholic Health Facilities* of the United States Catholic Conference was consulted. This advisory committee agreed unanimously that Directive No. 20, as written, did not permit sterilization in the new cases proposed. Nevertheless, some members of that advisory committee proposed that Directive No. 20 be changed. This was suggested either on the basis of the so-called expanded notion of the principle of totality, or, because many theologians dissented from this teaching and that dissent which is tolerated is tacitly approved. (The dissent, of course, concerns the teaching of the Church in the encyclical, *Humanae Vitae* (7/25/68) n.15; that number 15 is the cited reference for Directive No. 20 in the *Ethical and Religious Directives*.)

Since questions within the advisory committee recurred often on these points, they were referred to Archbishop John R. Quinn, then chairman of the Pastoral Research and Practices Committee of the NCCB. Archbishop Quinn decided to bring this to the entire Bishops' Conference for guidance, and, the Conference, in turn, decided to appeal to Rome for an authoritative clarification.

Four Questions

Basically, four questions were part of the documentation sent to

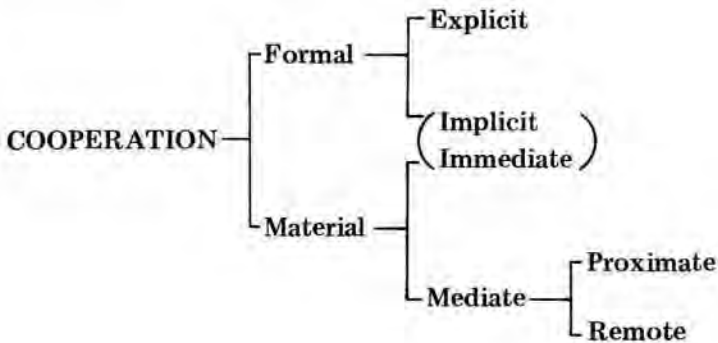
Rome, and it is the last of these which is the question at hand:

“Can we accept the general prohibition of direct sterilization in Catholic hospitals and still make a number of exceptions in particular cases to solve pastoral problems?”

It is important to note that the questions were not raised simply for speculative reasons, but also because of practical problems and because of problems of consistent implementation. In his request to Rome, Archbishop Quinn stressed some of the pastoral, practical problems that are involved in reaffirming previous teaching in a fully consistent way in this country: e.g., possibility of closing hospitals; conflicts with some theologians; conflicts with some hospital personnel; possible polarization, etc.

The covering letter of the reply from Rome made it clear that both Pope Paul VI and the Congregation for the Doctrine of the Faith were informed about and aware of problems created by pressures coming from society and from dissent from authentic Catholic teaching as taught by the Magisterium and expressed in the *Ethical and Religious Directives for Catholic Health Facilities* (1971). The SCDF document responded to these varied questions in the very context just outlined. As to the question about material cooperation in sterilizations in Catholic hospitals, the SCDF document response is in n.3, a,b,c.

For the sake of brevity, one can accept Dr. Paganelli's larger summary statements. The doctor is correct in saying that in view of this document and its preceding tradition, there can be no doubt as to the mind of the Catholic Church in its prohibition of direct sterilization.⁴ Further, while the concept of moral cooperation (here, complicity, assisting the evil deed of another) is ancient, more precise terms of added precision (“formal/material”; “free/necessary”; “proximate/remote”) are generally traced back to the time of St. Alphonsus.⁵ While there is to this day conceptual agreement on these points, not all authors use the same terms to express that agreement. Perhaps a rough schema could help:



In the above, all authors agree that *formal* cooperation in an immoral operation (e.g., direct sterilization) is never permitted. While some terms of further description differ here, the concept does not. Formal cooperation fundamentally means that one agrees with what is going on and helps in accomplishing it. *Explicit formal cooperation* means the cooperator intends the evil as does the primary agent. *Implicit formal cooperation* (what others call *immediate material cooperation*) means that, while not agreeing with the evil, the nature of the cooperation or assistance supplied is such that it can not be accomplished without such cooperation. Differences in the last mentioned are merely verbal, since authors agree that *implicit formal* and/or *immediate material* cooperation is never permissible with the possible exception of some matters of the 7th commandment because of the nature of some justice obligations.⁶

The question really under discussion is (*mediate*) *material cooperation* of a *proximate* kind and (*mediate*) *material cooperation* of a *remote* kind. For purposes of precision, it is important to recall that just because a type of cooperation is described as "material," it is not, for that reason alone, licit cooperation. Such cooperation in or with evil needs to be justified, i.e., the cooperator has to justify such close association with evil. Operatively, this is an application of the classic moral principle called "Double Effect" to factual, existing circumstance.

Since the principle of double effect is not the same as the so-called theory of the lesser of two evils, I would not summarize the matter simply as "tolerating evil" or "tolerating the lesser evil." Furthermore, it is true that circumstances loom very large in determining what is "proximate" and what is "remote" association. However, I would not say that the consideration of proportionality is truly "superimposed" on all of this, but rather, that the judgment about proportionality is relevant to several factors — sometimes in different ways, sometimes on different levels.

It is at this point that Father O'Rourke's presentation of "material cooperation" is seriously inadequate and misleading.⁷ His only operative consideration is one of intention: "if the cooperating individual does not in any way approve of the evil act or the intention of the principal agent but cooperates in order to avoid a greater evil or to achieve a greater good,"⁸ and where he says for the institution: "would be material provided the hospital did not consent to the objective evil."⁹

Certainly, Fr. O'Rourke must be aware that "non-approval" or "non-consent" is not the only relevant factor. If this were so, all Catholic facilities could state their formal disapproval (as their *Ethical and Religious Directives* do) and then furnish "space, equipment and

personnel" for any operation. Having stated our Catholic disapproval, we would then be in business to "facilitate," under Catholic auspices, just what the Catholic Church teaches is wrong.

Father O'Rourke cites Cunningham and Vermeersch¹⁰ as filling in the details of the application of the principle of double effect. But, this is not accurate. Both authors are explaining only the fourth condition of double effect — the proportionality of the grave reason for such close association with an evil effect indirectly voluntary. That fourth condition pertains when and if the previous three conditions have been fulfilled.

'Objectively Immoral Operation'

In O'Rourke's explanation they have not! The physician whom everyone seems to be "assisting" (cooperating with) is performing an objectively immoral operation in a Catholic facility. How the Catholic hospital could furnish "space, equipment and personnel" without seeing this as either *implicit formal cooperation* or *immediate material cooperation* truly eludes me.

In any moralist's terminology, this is most proximate cooperation: it is on Catholic premises, with space, equipment and personnel supplied. It is fully free cooperation: because the Catholic facility, contrary to its chartered purposes, offers space, equipment and personnel to a physician so that he or she can contravene the stated ethical norms of the Catholic facility. These ethical norms should be part of the agreed protocols of ethical practice in that Catholic facility.

Further, the question of scandal always pertains (cf. SCDF, Document, n.3, c.). Theologically, scandal is not mere shock or surprise, rather scandal is any action — word, deed, omission — which is either evil or has the appearance of evil and is likely to furnish an occasion of sin to others; a spiritual hazard; a snare for another person.¹¹

There is just no way to avoid scandal in the O'Rourke analysis because there is no way to maintain credibility in that arrangement. Material cooperation is not just a matter of stating individual or institutional disapproval and then providing all the ways and means for accomplishing what the individual or institution disapprove of. That is closer to pure semantics than it is to sound moral reasoning. In fact, it is an inaccurate and inadequate explanation of material cooperation. Had Fr. O'Rourke continued reading one of the authorities he cites (A. Vermeersch), he would have come upon a correct resolution of the very point under discussion (cf. below).

I am certainly aware that several writers today do try to explain the conventional principle of double effect entirely in terms of "proportionate reason," or, as a Catholic version of the so-called theory of the lesser of two evils.¹² Such attempts have not been without serious and, in my judgment, accurate criticism.¹³

In any event, just as revisionist versions of the principle of totality helped to occasion this question, revisionist versions of the principle of double effect will not help resolve it any more than a new version of the principles of material cooperation will. One problem throughout is that very conventional terminology is used, but used in a way that is different from and even contrary to what those terms have meant and do mean.

Now, since the SCDF document states explicitly that any cooperation with direct sterilization is absolutely forbidden (n.3,a.), and, since indirect sterilization is not treated explicitly¹⁴ in the document, what conceivable application is there of the principles of material cooperation to direct sterilization in Catholic hospitals?

This is actually Dr. Paganelli's question to which he concludes that the mention of material cooperation in the SCDF document must be assumed to refer to Catholic personnel in non-Catholic institutions. While the thrust of that statement may be true, I do not think it says all that's true.

First, the title of the SCDF document is "Sterilization in Catholic Hospitals" (*In Nosocomiis Catholicis*). Secondly, this is not truly a brand new question; it is a question with a history. The SCDF document refers to "traditional doctrine regarding material cooperation" (n.3,b.). The mention of "traditional doctrine" in authoritative ecclesiastical documents refers to and presupposes an accepted terminology, rationale and exposition which can be found in great detail and at some length in what are referred to as "approved authors."

Thus, such authors as Aertnys-Damen-Visser, Noldin-Schmitt-Heinzel, Zalba, Davis, Vermeersch,¹⁵ are authors whose works in moral theology have been published with ecclesiastical approbation. A correct explanation of the principles of cooperation and the application of same can be found in these "approved authors" and that exposition can be taken as an accurate explanation of "traditional doctrine."

Since the moral expressions employed in the SCDF document are neither novel nor idle terms, the accepted treatment by the "approved authors" is a most useful place to obtain needed clarification. Thus, a brief examination of the "approved authors" reveals at least this much:

- (1) All of these authors explain the principles of cooperation at some length and in extensive detail.¹⁶
- (2) All the authors take up the area under consideration, i.e., cooperation in an objectively immoral operation.¹⁷ It is for this reason that I stated above that the question is not truly a new one; it has a history. Religious orders of women have long been involved in health care and nursing, as has the Church and many of her members. Long ago, questions of cooperation arose in which religious

sisters could be involved in objectively immoral procedures.

The "approved authors" held and hold to this distinction:

- Sisters in *their own hospitals*, i.e., Catholic hospitals. Here there would be no problem because objectively immoral procedures are not permitted under religious auspices and sponsorship.
- Sisters in *private but non-Catholic*, or, *public* hospitals. Here, the degree of proximity and necessity of cooperation had to be justified, if at all, on the basis of the common good and the good of souls that was actual or to be hoped for by continued religious presence and continued religious service.

Proximate cooperation, of a mediate and material nature, that was frequent and/or repeated precluded continued employment in such situations.

Isolated and more remote material cooperation was or was not justified on a case by case evaluation of real and relevant factors.

- (3) The "approved authors" also make this point throughout their treatment: questions of cooperation are basically concerned with the actions of individuals, not institutions. This is clear because they agree that material cooperation is never justified when it would cause great harm to the Church or to the country since the greater good takes precedence over the good of the individual.¹⁸

Return to a Central Question

In view of this, let us return again to a central question: what conceivable licit application could there be of material cooperation in a direct sterilization in a Catholic hospital?

First, we should note just what the SCDF document mentions: "if the case warrants" (*si casus ferat*, n.3,b.) and "where the case warrants" (*ubi casus ferat*, n.3,c.). This subjunctive mention of a possibility does not mean, nor need it infer, that there ever has to be such a case at all. Some who seem to find material cooperation applying regularly, seem to take it for granted that since the SCDF document mentions a possibility, that they are duty bound to "discover" and/or "invent" factual applications.

Second, it is essential that direct-and-indirect sterilization not be confused with formal-and-material cooperation. Direct sterilizations are absolutely forbidden in Catholic hospitals. Since they are forbidden, they should not be done. When they are done, there can be no question of cooperation of any kind because there will be no procedure performed with which to cooperate. (Indirect sterilizations that are morally permissible can be performed in a Catholic hospital in accord with Directive No. 20. One can cooperate in these, and, obviously some must, but there is no moral objection here.)

Thus, we return to the question: is there any conceivable application in a Catholic hospital? While agreeing with a general "no," perhaps two situations could arise:

- (1) Some of the conventional authors consider the case where, unexpectedly and contrary to regulations a surgeon proceeds to do what the policy of the Catholic facility prohibits, in which instance nurses and others can continue their assistance by material cooperation to avoid worse evils.¹⁹
- (2) Other than that, nothing short of a one-instance court order could justify material cooperation in a Catholic facility. That court order should be opposed and resisted, but given the aggressive nature of certain allegedly "libertarian" units in our society some Catholic facility could be initially "coerced" to perform some morally objectionable procedure on very short notice and seem to have little choice in the matter.

The fact that it is court ordered could resolve the question of scandal and misunderstanding (SCDF, Document, n.3,c.) in such a single instance because it could be made clear to the public and to private persons that institutional and individual choice were not honored in this case but coerced. (Repeated or a series of court orders would be a different situation requiring different action.)

I do not consider the above as fanciful. By that I do not mean that it or anything like it should be encouraged, but rather that the Catholic facility should be prepared for such an eventuality.

Apart from the possibilities mentioned, it seems to me that moral, practical and legal realism should prevail. Some have entertained a possible policy of individual exceptions in which some morally direct sterilizations are thought to be justified on a case by case basis. This too has a legal history in our age and on this continent. By non-Catholic standards such alleged "exceptions" will be perceived as an arbitrary application of stated ethical policy. However well-intentioned or highly-motivated, exceptions contrary to Catholic policy in a Catholic facility will render subsequent legal defense of that Catholic institution very weak, if not completely untenable.

In this regard, a recent (11/12/76) case decided in the Supreme Court of the State of New Jersey, *Roe & Doe v. Bridgetown, Newcomb & Salem County Hospitals*, set a dangerous and dangerously close precedent that is likely to become a rallying point for allegedly "libertarian" units in our society. All three hospitals are private, non-profit, albeit non-sectarian, institutions, but the judgment was and reads:

"Moral concepts cannot be the basis of a non-sectarian non-profit eleemosynary hospital's regulations where that hospital is holding out the use of its facilities to the general public." (p. 13)

While the Court in question clearly distinguished religiously affiliated

hospitals as separate, the logic of a decision is not always contained by the words of a decision. Thus, all the more reason that religiously affiliated institutions fulfill that affiliation in fact, lest exceptions to religious policy leave them legally vulnerable and defenseless.

Conclusion

Thus, I conclude that there is no licit application of material cooperation in direct sterilizations in a Catholic hospital. I consider the two possibilities above as illicit coercion in which licit material cooperation could be justified. I do not see this as a particularly strained or impractical understanding of the SCDF document's mention of "traditional doctrine" concerning material cooperation because the questions originally posed to that Congregation involved such practical complications.

Also, the question of individual Catholics in non-Catholic institutions supports, I think, the above conclusion. Matters of material cooperation remain for them, some permissible, some impermissible, depending in large part, on the presence and/or absence of a cluster of factual and relevant circumstances. Indeed, the fact that there certainly are situations of impermissible material cooperation for individual Catholics in non-Catholic facilities supports the above. Surely, we could not maintain with consistency that forms of material cooperation forbidden to Catholics in a non-Catholic hospital could somehow be permissible in a Catholic one.

I have made little mention of those writers who propose opposite solutions.²⁰ Some dissent from the teaching of the Church as authentically confirmed in the SCDF document²¹ while not being so explicitly radical on the question of Catholic institutional policy.²² In either case, the competent and authoritative teaching office in the Church repudiates and disqualifies such opinions from being considered as or constituting a "theological source" (*locum theologicum*, n.2) which the faithful might invoke in practice.

I should think that the proper concern of the New York State Catholic Conference (to which this paper was first presented) is how actual Catholic teaching applies to actually Catholic hospitals. Our proper concern here is not individual or collective theological units nor especially persons who dissent from authentic Catholic teaching — these persons and/or units sponsor no hospital that I know of — rather, our legitimate concern is for Catholic hospitals whose chartered and incorporated purposes rest on, reflect and witness to the sacred and certain teaching doctrine of the Roman Catholic Church.²³

Kindly refer to "Text of Doctrinal Congregation Statement on Sterilization," reprinted from the August, 1976 Linacre Quarterly, on page 117.

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7. O'Rourke, *op.cit.*, pp. 73-74.
8. *Ibid.*, p. 73.
9. *Ibid.*, p. 74.
10. *Ibid.*, p. 73.
11. *Cf.*, *New Catholic Encyclopedia*, Vol 12; pp.1112-1113.
12. Originally P. Knauer in *Nouvelle Revue Theologique*. 87 (1965), 356-376; then, R. A. McCormick at first critical in *Theological Studies* 26 (1965), 603-608; then warm *TS* 32(1971), 86-97; warmer *TS* 33 (1973), 68-78; now hot endorsement *TS* 36 (1975), 85-93. Apparently, for McCormick, applications of double effect are another version of the theory of the lesser of two evils or what is viewed as the lesser human evil in the situation, *cf.*, *TS* 35 (1974), 354.
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- Odd as it sounds, a pretty fair critique of the post-*Humanae Vitae* McCormick (*TS* 36:85-93) is the pre-*Humanae Vitae* McCormick (*TS* 26:603-608).
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23. *Cf.*, Vatican Council II, *Dignitatis Humanae* (12/7/65), n.14.

Text of Doctrinal Congregation Statement on Sterilization

Following is a translation of the statement, A Document about Sterilization in Catholic Hospitals, issued March 13, 1975, by the Vatican's Doctrinal Congregation in response to questions from the U. S. National Conference of Catholic Bishops.

This sacred congregation has diligently considered not only the problem of contraceptive sterilization for therapeutic purposes but also the opinions indicated by different people toward a solution, and the conflicts relative to requests for cooperation in such sterilizations in Catholic hospitals. The congregation has resolved to respond to these questions in this way:

1. Any sterilization which of itself, that is, of its own nature and condition, has the sole immediate effect of rendering the generative faculty incapable of procreation is to be considered direct sterilization, as the term is understood in the declarations of the pontifical magisterium, especially of Pius XII.¹ Therefore, notwithstanding any subjectively right intention of those whose actions are prompted by the care or prevention of physical or mental illness which is foreseen or feared as a result of pregnancy, such sterilization remains absolutely forbidden according to the doctrine of the Church. And indeed the sterili-

zation of the faculty itself is forbidden for an even graver reason than the sterilization of individual acts, since it induces a state of sterility in the person which is almost always irreversible.

Neither can any mandate of public authority, which would seek to impose direct sterilization as necessary for the common good, be invoked, for such sterilization damages the dignity and inviolability of the human person.² Likewise, neither can one invoke the principle of totality in this case, in virtue of which principle interference with organs is justified for the greater good of the person: sterility intended in itself is not oriented to the integral good of the person as rightly pursued "the proper order of goods being preserved"³ inasmuch as it damages the ethical good of the person, which is the highest good, since it deliberately deprives foreseen and freely chosen sexual activity of an essential element. Thus article 20 of the medical-ethics code promulgated by the conference in 1971 faithfully reflects the doctrine which is to be held, and its observance should be urged.

2. The congregation, while it confirms this traditional doctrine of the Church, is not unaware of the dissent against this teaching from many theologians. The con-