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The Movement Toward Physician-Assisted Suicide: A Step in the Wrong Direction

by

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The Catholic Church unequivocally and rightfully condemns both physician-assisted suicide (PAS) and euthanasia as grave violations of the moral law.¹ From the perspective of the patient, PAS and euthanasia exemplify morally equivalent actions as, in both cases, the moral object of the act is to destroy the basic good of one's life, to seek one's death for the ultimate purpose of ending suffering. Although a growing number of people in our society, including some moralists, would argue that such a course of action is ethically acceptable, I will presume that suicide represents an intrinsic and objective moral evil. Until recently, physicians trained in the Hippocratic tradition *equally* denounced and refused to participate in PAS and euthanasia. However, today more and more members of society and the medical community seem willing to accept PAS because it represents an exercise of the prized value of patient autonomy without requiring the immediate cooperation of the physician in the death.² The physician can claim: "I wouldn't do this myself, but if the patients want to do this, it is their choice." People have a different "feel" about PAS than they do about euthanasia. To some proponents, PAS seems to be a lesser and justifiable evil — or not even an evil at all. As potential evidence of this, in November 1994, voters in Oregon approved a bill legalizing PAS but not euthanasia.³ Does this preference to allow PAS and to restrict euthanasia reflect a subtle but real moral distinction between the two actions insofar as physician cooperation is concerned? Or a political/legal expediency? Or a slippery slope concern? Or a psychological discomfort? That is, does the distance created in PAS between the physician's action and the actual death of the patient legitimate physician cooperation? In its effort to protect the sanctity of life, the Catholic Church will need to attend more carefully to these purported differences between the two actions in order to demonstrate that any

type of intentional physician cooperation with the suicide of a patient is ethically untenable.

Before proceeding, clarification of terms is necessary. In PAS, a physician supplies the means for a patient to commit suicide, knowing that the patient will use such means for the purpose of committing suicide. The physician may be more or less involved in the process ranging from being present at the suicide itself, to prescribing drugs, to providing information. This does not include the situation wherein the patient covertly accumulates medications unbeknownst to the physician until a sufficient amount of drugs is collected to commit suicide. Euthanasia involves an "action or omission which by itself or by intention causes death, in order that all suffering may in this way be eliminated."⁴ In euthanasia, the physician kills the patient while in PAS the doctor makes the death of the patient possible. The two actions differ physically by the extent of physician cooperation. This article will examine whether significant moral differences emerge from this physical distinction in light of the principle of cooperation.

A Political/Legal Agenda

The state of Oregon's choice to legalize only PAS clearly reflected a politically and legally astute approach to the issue. Previously, initiatives which allowed for both euthanasia and PAS had failed in Washington state and California.⁵ Consequently, the writers of the bill in Oregon chose an incremental approach to passing legislation, learning from the mistakes of previous bills. In doing so, they reduced the chance of alienating voters. Voters would see the Oregon legislation as a moderate compromise between the two extremes of current law and legalized euthanasia. Additionally this approach offered a legal advantage because of the different legal sanctions against PAS versus euthanasia. All states have decriminalized suicide and only about thirty states have laws specifically against PAS. In contrast, euthanasia clearly would be illegal in all states in light of homicide laws.⁶ These pragmatic and legal distinctions do not necessarily demonstrate an intrinsic moral difference between the two actions insofar as cooperation is concerned. However, the distinctions in criminal penalties intimates that PAS is somehow a lesser crime and thereby a lesser evil.

Concerns Over the Slippery Slope

The decision to propose legislation aimed only at legalizing PAS also reflected a fear of the slippery slope. Concerns abound that if voluntary euthanasia were to be legalized, many abuses would follow.⁷ Slippery slope suspicions have been confirmed in recent studies of the great euthanasia social experiment in the Netherlands. Many physicians have euthanized people at one point or another without explicit consent from the patient.⁸

Moreover, by taking the final decision and death-dealing action out of the hands of patients, the terminally ill may be coerced subtly into euthanasia against their will by physicians or families.⁹ An action designed to promote autonomy could in fact compromise patient self-determination. Physicians would be viewed as

having too much power in an age when patients' rights groups struggle to curtail the power of the medical profession. Yet this cautionary approach of only legalizing PAS should not be *interpreted* necessarily as an assertion of an essential moral difference between the actions of PAS and euthanasia but more a reflection of the fear of resultant consequences. Many proponents believe that physicians theoretically could perform acts of euthanasia in a morally acceptable manner. They simply reject legalization or widespread use of euthanasia at this time because of the lack of enforceable and appropriate safeguards to guarantee patient sovereignty. In this sense, one could argue that PAS represents a lesser evil because of the diminished potential for abuse. However, this does not justify cooperation with the action. It merely indicates that with euthanasia, one has traversed farther down the slippery slope.

Interestingly, this consequentialist concern about the slippery slope is in theory yielding to the persuasiveness of logical consistency. Specifically, if one determines that patients have a right to be assisted in death and they desire this assistance, then logically and perhaps legally, it would be discriminatory not to kill those who are incapable of committing suicide because they lack the physical or psychological wherewithal to do so. In a recent article advocating the legalization of *both* assisted suicide and euthanasia, two of its authors, Timothy Quill and Diane Meier, utilized this type of reasoning in reversing their own restrictive conclusions from only two years previous.¹⁰

The Psychological and Moral Nuances

Political, legal, and slippery slope concerns provide credible reasons for the public and the medical profession to embrace PAS more readily than euthanasia. Yet, I contend that a more critical element in this debate is related to the lack of psychological comfort associated with direct complicity in another person's death. This in turn has generated an apparent moral difference between the two actions in the minds of many people.

A recent study of physicians in Washington state reveals the potential psychological distinction.¹¹ The survey indicated that 42% of physicians believed there were times when euthanasia would be ethically justified but only 33% would actually commit an act of euthanasia if it were legalized. 50% indicated that PAS is ethical in some situations and 40% stated their willingness to assist patients in suicide. Of course, one cannot say for sure if a physician would follow through on an opinion given in a survey. However, the numbers reveal two important insights.

First, the number of physicians who cognitively believe in the ethical acceptability of euthanasia and assisted suicide is higher than the number who would perform such actions. This suggests that there may be deep down psychological concerns about cooperating in the killing of innocent patients. In fact, the general public's push to medicalize death by embracing PAS and euthanasia reflects a reluctance on the part of patients and their families to be involved *directly* in the killing. They want others to do it for them. Certainly, part of the call for the medical sanitation of suicide stems from fears of "botched" suicide attempts. But it also undoubtedly reveals a desire to distance oneself from

killing. How many people would feel comfortable boasting: "I killed Mom?"

Second, the lower percentage associated with performing acts of euthanasia vis-a-vis PAS suggests that the more directly involved one is in the killing, the more reticent one becomes. Amending a previous policy, the Royal Dutch Medical Association recently indicated that it would be better for patients to kill themselves with physician aid rather than have physicians euthanize the patients. Although still allowing for cases of euthanasia, the policy revision reflects a recognition that euthanasia seems more at odds with the doctor's role as a healer than PAS. Dr. Robert Dillman of the association's ethics commission stated that:

Many doctors find euthanasia an extremely difficult and burdensome action, and the patient's participation diminishes this burden slightly. In the past we said that all things being equal, there was no difference between mercy killing and assisted suicide. But in practice, doctors say this is not the same, that there is a difference . . . Doctors regularly signal that they prefer the patient to do it if possible.¹²

Association representatives go on to explain that the new emphasis on patient responsibility flowed from a desire to relieve physicians of the emotional stress associated with acts of mercy killing.

The psychological considerations point to an issue which has a rich tradition in Catholic moral theology: cooperation with evil.¹³ In some people's minds, a sufficient distance from the evil action may legitimate cooperation in its performance. Thus, some people ask if a physician for good reason can cooperate licitly when assisting with suicide as opposed to performing an act of euthanasia? To answer this question clearly and with the appropriate distinctions is not merely an esoteric, hair-splitting academic question. Sadly, in Oregon and the Netherlands, physicians, legislators, and the public have already demonstrated a greater willingness to cooperate with PAS. This indicates that psychological perceptions produce some type of moral difference in the minds of individuals. In our overly individualistic society, physicians and other health care professionals may be persuaded to cooperate with morally distasteful actions under the guise of respecting patient autonomy. Because one does not directly end the life of the patient, people believe cooperation with suicide is exonerated. Robert Weir asserts that:

the intentional killing of patients is not the ethical issue involved in PAS. Physicians do not cause the death of patients in these cases; the patients cause their own deaths . . . critics of PAS who assert that physicians are thereby killing patients are either a) mistaken about the differences between assisted suicide and voluntary euthanasia or b) intentionally blurring the differences between these two acts to score points with the emotive language of "killing."¹⁴

Therefore, it behooves us to recognize and acknowledge the distinctions which people articulate between the two actions. However, do these distinctions validate one practice over the other? I would assert they do not. But we must be careful to utilize the appropriate ethical distinctions in order to demonstrate the moral turpitude of both actions for health care professionals.

Catholic Approaches

Insofar as the Catholic Church has taught on this matter, minimal attention has been given to potential nuances in the evaluation of euthanasia and assisted suicide which arise from the difference in their physical natures. In *Evangelium vitae*, Pope John Paul II distinguishes between the two in terms of their physical reality but does not in terms of their essential moral character. The pope's specific declaration of condemnation of euthanasia does not include assisted suicide *per se*. However, when read in context, John Paul II suggests an equal condemnation of assisted suicide as an "injustice which can never be excused even if requested."¹⁵ *The New Catechism of the Catholic Church* does not make any clear moral distinction between PAS and euthanasia.¹⁶ Theologians like Richard Gula have stated that PAS "is not morally different from euthanasia and need not be distinguished for purposes of understanding the moral vision and values at stake in the present debate."¹⁷ Physician/ethicist Leon Kass reflects traditional Catholic opinion on the matter by arguing that by assisting the patient with suicide, the physician "is as much in violation of the venerable proscription against euthanasia as were the physician to do it himself."¹⁸ However, I would maintain that a proper and thorough critique and condemnation of these two actions requires a more nuanced evaluation grounded in the principle of cooperation. That is, euthanasia and assisted suicide require two different types of physical and moral cooperation by the physician. Nevertheless, I hope to demonstrate that neither type of cooperation is acceptable.

Cooperation With Evil

At times in life, people cooperate with evil. The taxpayer in performing a good action (paying taxes) may simultaneously financially support the corrupt and evil practices of a government. Of course, one implicitly presumes that if one could discover a reasonable and accessible path to achieve the good effect without cooperating with the evil, one would be required to do so. Consequently, one initially presumes that cooperation with evil is illicit until proven otherwise. However, like the case of the taxpayer who risks going to jail for non-payment of taxes, there may be times when cooperation is required because of some type of external duress or constraint.

Cooperation with evil can be divided into formal and material cooperation. Formal cooperation occurs when one concurs or agrees with the proximate sinful intention of the principal agent. That is, the cooperator believes that the "evil" means employed by the wrongdoer to accomplish his ultimate purpose is acceptable or legitimate. As such, formal cooperation is always wrong. However, instances arise when one disagrees with the intention of the evil doer yet somehow materially contributes to the performance of the evil act. Moralists term this type of cooperation as material. Material cooperation can be subdivided into immediate and mediate material cooperation.

Immediate cooperation requires direct participation in the commission of the sinful action itself.¹⁹ Traditionally, a person may not immediately cooperate with

the principal agent or evil doer particularly when the moral object of the cooperator's action is intrinsically evil.²⁰ For example, this is why Catholic health care facilities have been prohibited from performing contraceptive sterilizations.²¹

On the other hand, actions which only lead up to or supply the means necessary for the wrongdoer to perform the immoral action constitute mediate material cooperation. Mediate material cooperation can be proximate or remote depending upon the proximity of the cooperator to the evil action. The determination of proximity relies on the prudential estimation of the cooperator based on a variety of sources including magisterial teaching, the moral manuals and experience. In addition, cooperation can be necessary or contingent. Necessary cooperation implies that the evil action would not occur were it not for the assistance of the cooperator. Contingent cooperation suggests that the person intending the evil action could easily enlist the help of other cooperators in order to accomplish the evil deed.

The principle of cooperation acknowledges that certain types of mediate material cooperation may be tolerated under limited circumstances. In order for mediate material cooperation to be morally acceptable, there must be sufficient justification in terms of the good achieved or evil avoided which results from cooperation. In addition, the goods achieved or evils avoided must be extrinsic to the salutary effects of the evil action. That is, the good achieved should not flow directly from the evil action. Otherwise one directly violates the principle of double effect in using the evil effect to achieve the good which automatically renders such cooperation as illicit.²²

The norms of material cooperation also require that one do all that is possible to prevent the evil action or to minimize one's cooperation. Finally, cooperation in evil must avoid scandal which might weaken the faith of believers by diminishing the authority and authenticity of a particular Church teaching.

Clearly, as the cooperation becomes more proximate and necessary, and the evil with which one cooperates becomes more serious, a greater extrinsic justification is required in order to cooperate. For very close cooperation, a very grave cause would be required. If an evil is so great, there may be cases when no extrinsic reason justifies any type of proximate cooperation. The classic example of this involves any proximate mediate material cooperation with direct abortions.²³

Applying the Principle to PAS and Euthanasia

Today, many physicians sadly believe PAS and euthanasia are morally acceptable means to relieve suffering and would be willing to cooperate with such evils. Such cooperation is formal cooperation and is always morally unacceptable. However, in applying the principle of cooperation in this article, I am considering only the case of when a physician has concluded that euthanasia and PAS are inappropriate means to relieve suffering, yet asks: "To what extent may I cooperate with an action (causing the death of the patient) which I feel is wrong, but one which my patient nevertheless desires?" If there were no greater extrinsic good to be achieved or evil to be avoided through cooperation, then cooperation with evil is automatically proscribed. That is, one has an obligation to avoid even

material cooperation with evil unless under constraint to cooperate. A physician cannot say that he or she is just carrying out the patient's wishes. One has a *prima facie* obligation not to assist evil. One might argue that offering "aid in dying" provides an important extrinsic good, the protection of patient autonomy or freedom. However, this assertion reflects a corrupt understanding of autonomy and freedom. The patient's choice of suicide has never been recognized in Catholic teaching as an exercise of freedom but an abuse of it. The fact that a patient desires assistance in dying in no way warrants its provision based on the longstanding principle of cooperation, precisely because there seemingly is no justifiable reason to cooperate (i.e., a great good achieved or evil avoided through cooperation). Consequently, much of the psychological and moral relief generated by the more ready acceptance of PAS over against euthanasia is illusory.

However, could there be situations wherein an external constraint exists which might require a further application of the principle of cooperation? Given efforts to legalize PAS and euthanasia, one could imagine "aid in dying" as standard medical provision expected by patients and health care plans in the years to come. The physician's ability to practice medicine might be hampered if one were not able to offer these "services." This at least in theory would provide an extrinsic cause for cooperation.

In euthanasia, the physician would directly participate in the evil action. This would constitute at least immediate material cooperation and would be a sharing in an intrinsically evil moral object. Some would say this actually involves implicit formal cooperation. The physician and patient would share the same moral object albeit for different remote intentions.²⁴ However, in accord with *Veritatis splendor*, one may not perform an intrinsically evil action regardless of circumstances or remote intention.²⁵ Therefore, the principle of cooperation would prohibit any act of euthanasia on the part of the physician.

Some might argue that PAS likewise would involve immediate cooperation; however, the physician would not be directly involved in the commission of the evil act of killing but merely would contribute to the death. Therefore, it would involve proximate mediate material cooperation. For example, John McHugh and Charles Callan briefly refer to the selling of poison or drugs to one who contemplates suicide.²⁶ The physician would recognize that in prescribing the drug, the patient may or may not use the medication. The degree of proximity of the cooperation would depend upon whether the physician merely prescribed the drug or is present at the suicide. The cooperation would more likely be contingent, although this would depend upon availability of physicians practicing PAS in the future. The physician presumably would have made every effort to alleviate the suffering of the patient with moral means and tried to persuade the patient not to commit such an immoral act. Given this type of cooperation, would there be a justifying cause extrinsic to the purpose of the evil act? As in the case of euthanasia, one cannot justify cooperation with PAS because it relieves the suffering of the patient. Such argumentation would invoke the utilization of immoral means to achieve a good end. This would always be unethical. Nor could one justify cooperation on the basis of carrying out patient wishes because one would have a primary obligation not to cooperate with evil unless constrained to do so.

Let us return then to the possibility of a future in which PAS might become common practice wherein refusal to cooperate would threaten the job of the physician. In such a context, the extrinsic good achieved (maintaining the physician's practice) would pale in comparison with the evil which would result, the direct killing of innocent human life. Cooperation with PAS would be more akin to prescribing RU-486 (if or when it becomes marketed) for abortive purposes. Consequently, even though proximate mediate material cooperation can occur for a sufficiently grave cause, no such cause would exist in this case. Given the gravity of the evil with which one would cooperate, the lack of a concomitant and proportionate extrinsic justification, and the proximity to the evil, PAS could never be justified as an acceptable practice. The reasons for the unacceptability of PAS in comparison with euthanasia differ in light of the application of the principle of cooperation. Nevertheless, direct physician participation in suicide always remains gravely wrong regardless of its legal or societal acceptability. Furthermore, material cooperation with PAS and euthanasia would be proscribed because of the potential of grave scandal. Cooperation in these practices by physicians would give credence to their practice, implying that suicide was an acceptable moral response to terminal illness and suffering.

Finally, other health care professionals like nurses who might be asked to be involved *proximately* in "aid in dying" could not do so (even if their job were at risk) because of the magnitude of the evil involved. Even more remote cooperation such as referring a patient to a colleague who would offer "aid in dying" would likewise be unacceptable. Very distant and remote cooperation would have to be scrutinized carefully (e.g., working in a hospital where such practices like euthanasia were carried out). As such, the analysis appears quite similar to the Church's longstanding teaching on cooperation with abortion.

Conclusion

Most ethical analyses have inadvertently lumped together the issues of PAS and euthanasia. Yet even from a physical perspective, one is an act of killing, the other makes possible the death. In addition, the law in its distinction of crimes and penalties between suicide and murder, legislative approaches to legalizing PAS, and the general psychological perceptions of the two acts suggest an existential difference between the two deadly realities. Many people feel less repugnance at merely giving people the ability to exercise their autonomy — it's the American way! Physicians and other health care professionals may be enticed to support PAS rather than euthanasia precisely because they are not directly involved in the deadly deed. It seems like a "lesser evil." Nevertheless, it is an evil — a grave evil! The longstanding Catholic teaching on cooperation with evil provides the necessary and nuanced theoretical approach which demonstrates the moral illicitness of cooperating with either euthanasia or PAS. The physical distance created between the physician's action and the patient's death does not excuse its practices.

Much is at stake in this debate, even beyond the tragic destruction of life. The

contemporary societal movement towards the acceptance of PAS will irreversibly pervert the nature of the physician/patient relationship. Additionally, participation in PAS will dull the ethical senses of physicians, eventually removing the last vestiges of inhibition to immediate cooperation with killing in euthanasia. Primarily, in order to counter this attraction to PAS and euthanasia, John Paul II has insisted that we take steps to provide appropriate care for dying patients in order to mute the voices calling for such deadly actions.²⁷ But secondarily, after acknowledging the intrinsic evil of suicide and euthanasia, one must utilize the classic principle of cooperation to demonstrate that PAS is no more morally acceptable than euthanasia. In creating this nuanced argument, one recognizes that people may have a "different feel" about PAS, but this would not justify cooperation with an action which merely serves to perpetuate a culture of death.

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2. C.f., F. Miller, et al., "Regulating Physician-Assisted Death," *New England Journal of Medicine* 331 (1994) : 119-23; T. Quill, C. Cassel, and D. Meier, "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," *New England Journal of Medicine* 327 (1992): 1380-84; H. Brody, "Assisted Death — A Compassionate Response to a Medical Failure," *New England Journal of Medicine* 327 (1992): 1384-88; R. Weir, "The Morality of Physician-Assisted Suicide," *Law Medicine and Health Care* 20 (1992): 116-26; D. Orentlicher, "Physician Participation in Assisted Suicide," *Journal of the American Medical Association* 262 (1989): 1844-45; and M. Simons, "Dutch Doctors to Tighten Rules on Mercy Killings," *New York Times* (Sept. 11, 1995), A3.
3. Voters passed Measure 16 by a slim margin. Recently, a U.S. District Court in Oregon issued an opinion that the Oregon Death with Dignity Act was unconstitutional.
4. Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," (May 5, 1980).
5. Washington Initiative 119 failed in November, 1991. California Proposition 161 failed in November 1992. Both propositions lost by a 54%-46% margin.
6. See F. Miller, et. al. "Regulating Physician-Assisted Death," 119.
7. C. Gomez, *Regulating Death* (New York: Free Press, 1991).
8. L. Pijnenborg, et al., "Life-Terminating Acts without Explicit Request of Patient," *Lancet* 341 (1993): 1196-99. Also see, P. van der Maas, et al. "Euthanasia and Other Medical Decisions Concerning the End of Life," *Lancet* 338 (1991): 669-74.
9. H. Brody, "Assisted Death," 1386.
10. See F. Miller, et al., "Regulating Physician-Assisted Death," 120. Compare this to the previous article which Quill and Meier co-authored: T. Quill, C. Cassel, and D. Meier, "Proposed Clinical Criteria for Physician-Assisted Suicide," 1380.
11. J. Cohen, et al., "Attitudes Toward Assisted Suicide and Euthanasia among Physicians in Washington State," *New England Journal of Medicine* 331 (1994): 89-94.
12. M. Simons, "Dutch Doctors to Tighten Rules on Mercy Killings," A3.
13. See T. O'Donnell, *Medicine and Christian Morality* (New York: Alba House, 1976), 31-35. C.f., C. McFadden "Assistance at Immoral Operations," *Linacre Quarterly* 37 (November, 1970): 243-51.
14. R. Weir, "The Morality of Physician-Assisted Suicide," 122.
15. John Paul II, *Evangelium vitae*, nos. 64-66.
16. *Catechism of the Catholic Church*, nos. 2276-2282.
17. R. Gula, *Euthanasia and Assisted Suicide: Positioning the Debate* (St. Louis: Catholic Health Association, 1994), 3.
18. L. Kass, "Physician Aids in Suicide," *Chicago Tribune* (June 6, 1990), A1.

19. Some authors recognize a further type of cooperation, implicit formal cooperation. Implicit formal and immediate material cooperation involve a sharing of the same moral object by the wrongdoer and the cooperator. However, the authors indicate that implicit formal cooperation occurs when no explanation can distinguish the cooperator's moral object from the wrongdoer's. In such cases one cannot meaningfully say that one is doing the evil deed but does not share the evil intention (c.f., NCCB, *Ethical and Religious Directives for Catholic Health Care Services* (Washington, DC: USCC, 1995), 29; R. Smith "Formal and Material Cooperation," *Ethics & Medics* 20 (June, 1995): 1-2; and J. Keenan and T. Kopfensteiner, "The Principle of Cooperation: Theologians Explain Material and Formal Cooperation," *Health Progress* 76 (April, 1995): 23-27). The Directives point out that in the absence of duress, immediate material cooperation is equivalent to implicit formal cooperation. Other authors use the term implicit formal cooperation interchangeably with immediate cooperation, (c.f., W. Smith, "Catholic Hospitals and Sterilization," *Linacre Quarterly* 44 (May, 1977): 109-110, n. 6). I personally find the use of the term "implicit formal cooperation" problematic because if one has the genus of cooperation, it seems problematic to separate them into the species of formal and material yet at the same time indicate that a type of formal cooperation is equivalent to a type of material cooperation. Unfortunately, the principle of cooperation is one of the more convoluted ones in the history of moral theology and it still seeks a clear and coherent explanation.

20. J. McHugh and C. Callan, *Moral Theology: A Complete Course*, vol. 1 (New York: Joseph Wagner, Inc., 1958), 627-28. The authors indicate that there may be very rare cases of acceptable immediate cooperation when the cooperator does not share the same moral object as the agent. The classical example is the person who cooperates with a robber if his life is in danger. In such a case, a reasonable owner would be willing to have the cooperator assist with the robbery rather than risk death. Consequently, the moral object of the cooperator is no longer theft because that involves taking property against the reasonable will of the owner. The moral object of the wrongdoer remains theft. However, they indicate that immediate cooperation is *always* unlawful when the cooperator's moral object is intrinsically evil. The new *Ethical and Religious Directives for Catholic Health Care Services* in its Appendix on cooperation has indicated that immediate cooperation is always wrong "except in some instances of duress." Unfortunately, the Directives in this regard are incomplete and fail to make a critical distinction with regard to immediate cooperation when the moral object of the cooperator is intrinsically evil. That is, external circumstances like duress (or intention for that matter) cannot justify the commission of an action by a cooperator whose moral object along with the wrongdoer is intrinsically evil. A failure to understand this directive may tempt people to justify actions like contraceptive sterilizations in Catholic facilities because of market forces which create duress on the facility. However, the moral object in performing a contraceptive sterilization is to render a person sterile for the purpose of preventing pregnancy. Thus, the moral object of the cooperator is intrinsically evil and may not be done.

21. NCCB, *Ethical and Religious Directives*, no. 53.

22. C.f., NCCB, *Commentary on Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals* (Washington, DC: USCC, 1977), 7.

23. NCCB, *Ethical and Religious Directives*, no. 45.

24. The wrongdoer's remote intention would be to relieve suffering. The physician's remote intention would be to maintain his or her medical practice.

25. John Paul II, *Veritatis splendor*, nos. 75-82.

26. J. McHugh and C. Callan, *Moral Theology*, 633.

27. John Paul II, *Evangelium vitae*, no. 88.