May 2003

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Thomas Kopfensteiner

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Recommended Citation

Kopfensteiner, Thomas (2003) "The Meaning and Role of Duress in the Cooperation in Wrongdoing," *The Linacre Quarterly*: Vol. 70: No. 2, Article 7.

Available at: <http://epublications.marquette.edu/lnq/vol70/iss2/7>

The Meaning and Role of Duress in the Cooperation in Wrongdoing

by

Prof. Thomas Kopfensteiner

The author is an associate professor of moral theology at Fordham University, New York, and a priest of the Archdiocese of St. Louis. This paper is the result of work done by the author for discussions sponsored by the Catholic Health Association and the NCCB's Secretariat for Pastoral Practices.

When the *Ethical and Religious Directives for Catholic Health Care Services* were published by the National Conference of Catholic Bishops, new partnerships among health care organizations and providers were the focus of many Catholic sponsored health care systems.¹ Catholic and other-than-Catholic sponsored systems were in the process of forming partnerships based on a wide range of common principles and values. Partnerships were formed, for instance, with a focus on healthy communities, with a concern for the underserved and health care poor, or with a heightened sense of responsibility for the limited resources available for health care in the community.

At another level, however, new relationships among health care providers often revealed divergent ethical commitments. Those commitments affect how medicine is practiced. This means that when there is a partnership forged between a Catholic and other-than-Catholic providers, the question of the Catholic partner's cooperation in any proscribed procedure needs to be addressed. In the Appendix to the Directives, the bishops detail the principles governing cooperation; these are meant to help guide the objective analysis of partnerships involving activities judged morally wrong by the Church.

The purpose of this article is not to explain the various distinctions found in the principle of cooperation; nor is the purpose to review new partnerships between variously sponsored providers in order to show how

the principle has been effectively and legitimately applied.² With the proper legal, managerial and financial structures, many new partnerships are relatively unproblematic examples of cooperation. The purpose of this article is twofold. First, the article analyzes with greater precision the meaning of duress and its role in the legitimate application of the principle. Second, the article illustrates how the element of duress can be a morally relevant factor when dealing with provisions for sterilization in some new partnerships.³

What the Directives Say

As reflective of Catholic moral theology, the Directives are clear when they state that "direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution when its sole immediate effect is to prevent conception" (Directive 53). This prohibition is reflective of the kind of medicine that has always been practiced in Catholic institutions. The Directives, furthermore, make it clear that this absolute prohibition serves to protect the Church's understanding of human sexuality which holds that the unitive and procreative meanings of the conjugal act are inseparable. It is one of the positive aspects of the Directives to identify this kind of moral backing or rationale for individual proscriptions and prescriptions.

The Directives continue, however, "procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present pathology and a simpler treatment is not available" (Directive 53). These latter cases are known as "indirect" sterilizations and are legitimate applications of the principle of double effect where a single act has two effects, one good and one bad. This traditional principle is also behind Directive 47, which concerns abortion and Directive 61, which concerns euthanasia and pain management.

The principle of cooperation is another traditional principle that can be used when dealing with the issue of sterilization. It is the more relevant principle when sterilization is discussed in the context of new partnership among health care providers. The principle of cooperation differentiates "the action of the wrongdoer from the action of the cooperator through two major distinctions." The first major distinction is between formal and material cooperation. "If the cooperator intends the object of the wrongdoer's activity, then the cooperation is formal and, therefore, morally wrong. Since intention is not simply an explicit act of the will, formal cooperation can also be implicit. Implicit formal cooperation is attributed when, even though the cooperator denies intending the wrongdoer's object, no other explanation can distinguish the cooperator's object from the wrongdoer's object." Because the Directives are adopted as policy by every

Catholic health care service and institution, *explicit* formal cooperation is not really at issue; a further explanation of *implicit* formal cooperation, however, is needed to provide an objective appraisal of institutional partnerships.

The distinction between explicit and implicit formal cooperation was well known in the neoscholastic manuals of moral theology.⁴ Attention was drawn to the distinction after a review of the November 1993 draft of the Directives by the Congregation for the Doctrine of the Faith. Following the moral tradition, the Congregation underlined that "formal cooperation is verified not only when somebody cooperates from conscious approval of what a principal agent wrongly does, but also when the collaborating agent acts in a fashion directed to the achievement of the primary agent's goal." That is, one implicitly cooperates when "what the collaborating agent chooses to do is only properly intelligible *as directed to achieving* the end/purpose of the principal agent. One may so act without consciously approving; indeed one may do so while telling oneself one disapproves of what the principal agent is up to!"⁵ In other words, if the cooperator's action is unequivocally determined to contribute to the wrongdoing of another, then one's cooperation is implicitly formal.⁶ Try as one may to describe it otherwise, the cooperator's action can have no other reasonable explanation than sharing in the wrongdoing. Nevertheless, a word of caution is in place. If each and every circumstance or even the knowledge that wrongdoing will occur is exaggerated, then all distinctions between material and formal cooperation would collapse.

The second major distinction of the principle excludes intention and, instead, deals with the object of the action. It is expressed by immediate and mediate material cooperation. "Material cooperation is immediate when the object of the cooperator is the same as the object of the wrongdoer." A traditional example from medical ethics is the doctor who performs a proscribed procedure; another example of immediate material cooperation would be when a sterilization procedure is performed at a Catholic health care institution. The bishops state that "immediate material cooperation is wrong, except in some instances of duress." The bishops, however, did not detail what they mean by duress.

The Element of Duress

Dealing with sterilizations on the basis of the principle of cooperation highlights an important dissimilarity to earlier discussions on sterilization. The principle of cooperation will require that there be institutional or social factors that go beyond any medical indications for a sterilization to be performed. "The reason for the cooperation must be something over and beyond the sterilization itself."⁷ Medical indications are a necessary but not

sufficient criteria for cooperating in a sterilization at a Catholic health care facility. To perform a sterilization for medical indications alone cannot be justified by Catholic moral theology. Earlier attempts to justify a sterilization on the basis of the principle of totality do not meet the more stringent evidentiary threshold demanded by the principle of cooperation. That is, invoking the principle of totality to justify sterilization procedures for medical indications fails to account for the legitimate ways of avoiding pregnancy that are available to the patient.⁸

Invoking the element of duress, then, will be based on the presence of outside factors that have so diminished or compromised the autonomy of the Catholic facility that greater and irreparable harm is risked if the facility refuses to cooperate. "Material cooperation will be justified only where the hospital because of duress or pressure cannot reasonably exercise the autonomy it has (i.e., when it will do more harm than good)... The allowance of material cooperation in extraordinary cases is based on dangers of an even more serious evil..."⁹

Putting aside the still evolving environment of today's health care, there is an undeniable ambiguity inherent in any assessment of duress as it is a factor in material cooperation. When assessing the level of duress present in a situation, we must balance the real and feasible options available to distance ourselves from the wrongdoing against the likelihood of greater and irreparable harm occurring. Do we have alternatives that would distinguish our action more clearly from the wrongdoer's so that our cooperation would be only mediately material? Are predictions of greater harm occurring unwarranted or does a deliberate analysis show that the dangers are real and likely to occur? Clearly, there is the need for a strategic weighing that takes into account not only the short term but also the long term effects of our decisions. To guide the assessment of duress as a morally relevant factor in our reasoning, perhaps an axiom can be formed: the more likely it is that greater harm will occur, the more likely it is that duress will be a factor in our application of the principle; and, the more alternatives that we have to distance ourselves from the wrongdoing, the less likely it is that duress will be a factor in our application of the principle.

To be sure, we cannot exaggerate what constitutes duress and that may be a particular temptation when we see how many new partnerships continue to be formed by health care providers. If we exaggerate the element of duress, however, we risk cooperating in an implicit formal way. According to the Directives, duress distinguishes immediate material cooperation from implicit formal cooperation. "Immediate material cooperation — without duress — is equivalent to implicit formal cooperation and, therefore, is morally wrong." In other words, if a new partnership is formed where there is an exaggerated understanding of duress or where any proscribed procedure is not sufficiently distinct from the Catholic

partner in terms of governance, management, performance and financial benefit, the Catholic partner cooperates in an implicit formal way.¹⁰ That is, despite efforts to do otherwise, the only legitimate explanation of the institution's action is a direct participation in the wrongdoing.

Case of Duress

The element of duress has always been a morally relevant factor in the application of the principle of cooperation. This, too, is evidenced in the neoscholastic manuals of moral theology.¹¹ The paradigm case was helping the thief rob the bank in order to avoid the loss of life; the more fundamental good of life was weighed against the good of private property. As a factor in the application of the principle of cooperation, however, the element of duress was not limited to the area of justice nor was duress a relevant factor only when human life was the good to be protected.¹² For example, when dealing with legitimate applications of the principle of cooperation, the manuals spoke of a woman's participation in onanistic intercourse in order to avoid the greater harm of adultery; or giving a liquor to a drunkard in order to prevent a brawl; or a person in need asking for a Sacrament from a priest who is unworthy and will sin by conferring it. In each of these cases, the legitimacy of such a strictly circumscribed application of the principle of cooperation was found in the manual's determination that the person's cooperation in the wrongdoing was in order to prevent harms that could not be repaired or to protect goods that could not otherwise be preserved.

The question, then, is whether there are situations when duress can be a morally relevant factor when considering the institutional cooperation of a Catholic health care facility in sterilization? Are there factors above and beyond any medical indication for a sterilization that limit the autonomy of the Catholic health care facility and threaten to bring about greater and irreparable harm, such as the closing of the facility or of an obstetrics unit which, traditionally, handled high risk pregnancies in a way that was consistent with Catholic moral teaching? For instance, in the context of managed care — where providers must contract with third party payers to provide a continuum of health care services and where payers limit the providers to which their members have access — the presence of a Catholic facility could be jeopardized by its not being able to contract with third party payers because it offers an insufficient range of services. When a health care payer must decide between two institutions to provide health care services to its members, it would seem reasonable to assume that the area's population would prefer the provider who, while excluding abortion services, offered the broadest range of services, particularly in the area of gynecology and obstetrics. How would the loss of a facility or its

obstetrics unit impact not only the health of the community but the Church's mission and influence in that community, perhaps one in which there is a minority Catholic population and no other institutional Church presence?

These questions do not have ready answers but require sober and deliberate analysis on the part of health care and Church leaders. When that analysis is guided by the principle of cooperation, it will account not only for the evil that is done, but also for the good that is achieved. Is the good valued highly enough or is there a sufficient sense of urgency to protect it to outweigh the evil caused by our cooperation?¹³ Since that evil cannot be abolished completely, we aim to contain and limit it as much as possible. Surely, the closer we are to the evil, the more serious a reason we must have to cooperate; and when duress is a morally relevant factor, that reason is not *any* reason, but it is that we have no feasible alternatives to prevent greater and irreparable harm occurring.¹⁴

Again, the issue here is not elective or voluntary sterilizations; if those are performed, they would be clearly separate from the services provided by a Catholic health care institution. The issue, rather, is the performance of a sterilization under duress; that is, in a situation where the Catholic facility has a diminished autonomy due to constrictions imposed by factors that are above and beyond any medical indications for the sterilization, and that threaten to bring about greater harm. Do we risk bringing about greater and irreparable harm by losing a presence in health care if we refuse to cooperate in a sterilization during, for instance, a Cesarean section delivery or other abdominal surgery? If greater and irreparable harm is calculable in such strictly circumscribed situations, we could resolve the dilemma by having recourse to the principle of cooperation.

The Issue of Scandal

A prudential application of the principle of cooperation will also consider the possibility of cooperation leading to scandal. Scandal has been traditionally defined as leading another into sin.¹⁵ Scandal is of such importance in the application of the principle that cooperation, which in all other respects is morally appropriate, may be refused because of the scandal that would be caused in the circumstances (Directive 70). Keeping the issue of scandal in mind will ensure that institutional survival does not depend upon sacrificing Catholic identity by wholesale accommodation or by diluting any sense of wrongdoing. Yet, at the same time, the ambiguity often caused by partnering with others must not be exaggerated to preclude legitimate forms of cooperation. The bishops rightly encourage "an increased collaboration among Catholic-sponsored health care institutions"

but, by all means, we should resist the temptation to fall into a ghetto-like mentality in Catholic health care.

Many new partnerships present a two-edged sword so that the context in which scandal must be determined can be ambiguous. As the bishops observe, "new partnerships can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments ... New partnerships can help implement the Church's social teaching." Yet, at the same time, "new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way..." While this ambiguity is present when partnerships are formed with those who do not share Catholic moral convictions, "the danger of creating misunderstanding must be carefully avoided with the help of suitable explanation of what is going on."¹⁶

In addition, the assessment of the possibility of scandal requires a nuanced consideration of the evil that may be involved in our cooperation. For instance, to help in the determination of scandal, a distinction can be made in terms of the gravity of the evil involved. Abortion and assisted suicide are, for example, graver evils than reproductive technologies or, in this case, sterilization. To attack and destroy human life is a graver evil than bringing life about or suppressing the reproductive function. In light of the distinction about the gravity of the matter, perhaps another axiom can be formed to help guide a prudential assessment of the possibility of scandal: the graver the evil, the higher the risk of scandal; and the higher the risk of scandal, the more distant the Catholic partner must be from the wrongdoing.

Conclusion

The moral tradition presented the principle of cooperation in the language of wrongdoing. For a more positive understanding of the principle, this grammar of wrongdoing needs to be completed by a grammar of responsibility. This is particularly true when a public good like health care is at stake. A grammar of responsibility does not lessen the need for a careful scrutiny and an exact analysis of wrongdoing, but rather completes it by focusing on the shared sense of the good life to be held in common with all members of the community. A grammar of responsibility would provide a broader and more adequate context in which to weigh the goods and evils involved in any application of the principle, especially though when the element of duress is a morally relevant factor in our deliberations. Focusing on our responsibility to work with others is not meant to compromise our moral integrity or water down our moral teaching. The grammar of responsibility, rather, provides the proper

perspective in which to consider the long term effects of our decisions, to calculate the harms that we might bring about, and to realize the importance of the goods that are threatened to be lost.

References

1. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington: The United States Catholic Conference, 1994).
2. For an overview of the principle of cooperation, see James F. Keenan and Thomas R. Kopfensteiner, "The Principle of Cooperation and The Formation of New Partnerships in Health Care," *Health Progress*, April 1995, 23-27. A more restrictive interpretation is given by Germain Grisez, "In Answer to Critics: The Revised, Final Version of a Difficult Moral Question About Cooperation by Catholic Hospitals," *Linacre Quarterly*, 65 (August, 1998) 59-76.
3. The issue here was the focus of a CHA task force which dealt with Catholic identity and moral integrity. Part of those discussions is captured in "Catholic Health Ministry in a Changing Environment: Maintaining Ethical Integrity," in *Catholic Health Ministry in Transition, A Handbook for Responsible Leadership* (Silver Spring, MD: National Coalition on Catholic Health Care Ministry, 1995) Resource 10. For a different interpretation of the issue see Lawrence Walsh, "An Excessive Claim: Sterilization and Immediate Material Cooperation," *Linacre Quarterly* 66 (November, 1999) 4-25; Walsh deals with the issue from an ecclesiological point of view; the case is much more difficult from a moral point of view.
4. See, for instance, Marcellinus Zalba, *Theologiae Moralis Summa*, vol. 1 (Matriti: Biblioteca de Autores Cristianos, 1957) § 1612.
5. The Congregation for the Doctrine of the Faith, "Some Observations of the November 1993 Draft of the *Ethical and Religious Directives for Catholic Health Care Facilities* of the U.S. Bishops' Committee on Doctrine," emphasis in the original.
6. Though no example is given, this is made clear by the ethicists at the National Catholic Bioethics Center, "Cooperation with Non-Catholic Partners," *Ethics and Medics* 23 (November, 1998) 1-5. Implicit formal cooperation can be illustrated by a case from the manuals. The tradition exemplified it as when a person boosts another through a window so that it can be robbed, that person cannot argue that he did not cooperate in the evil done. He cannot abstractly separate himself from the robbery by saying he only "helped someone through the window of the house."

7. United States Catholic Conference, "Sterilization Policy for Catholic Hospitals," *Origins* 7 (December 8, 1977) 399.
8. Pope Pius XII, "Allocution to Urologists," October 8, 1953, *Acta Apostolica Sedis* 45 (1953) 673-79, AT 695.
9. USCC, "Sterilization Policy for Catholic Hospitals," 399-400.
10. For the variety of institutional arrangements that distance the Catholic hospital from the evil, see M. Kathleen Kaveny and James F. Keenan, "Ethical Issues in Health Care Restructuring," *Theological Studies* 56 (1996) 145-50.
11. See, for instance, John McHugh, O.P. and Charles Callan, O.P., *Moral Theology: A Complete Course*, revised and edited by Edward Farrell, O.P., vol. 1 (London: Herder, 1958) 1506-46. Also, Charles Curran, "The Catholic Identity of Catholic Institutions," *Theological Studies* 58 (1997) 94-100.
12. The way goods other than human life can come into play is overlooked in "Cooperation With Non-Catholic Partners," 4.
13. These two criteria cannot be separated artificially. What we truly value will become clear when it is threatened or its loss becomes possible, and what we resolve to protect or refuse to lose will reflect what we truly value and esteem.
14. This is overlooked by Russell E. Smith, "Duress and Cooperation," *Ethics and Medics* 21, no. 11 (1996) 1-2; similarly see his "Immediate Material Cooperation," *Ethics and Medics* 23, no. 1 (1998) 1-2.
15. *Catechism of the Catholic Church* (Washington: United States Catholic Conference, 1994) no. 2284.
16. Congregation for the Doctrine of the Faith, "Sterilization in Catholic Hospitals," *Origins* 6 (June 10, 1976) 35.