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Catholic Health Care in the Public Square: Resolving Moral Conflict with Integrity

Jennifer Heyl
University of Tennessee - Knoxville

To the Graduate Council:

I am submitting herewith a dissertation written by Jennifer Heyl entitled "Catholic Health Care in the Public Square: Resolving Moral Conflict with Integrity." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

Glenn C. Graber, Major Professor

We have read this dissertation and recommend its acceptance:

John Hardwig, James L. Nelson, Julia A. Malia

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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____James L. Nelson_____

____Julia A. Malia_____

Acceptance for the Council:

____Anne Mayhew_____
Vice Provost and
Dean of Graduate Studies

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CATHOLIC HEALTH CARE IN THE PUBLIC SQUARE:
Resolving Moral Conflict with Integrity

A Dissertation
Presented for the
Doctor of Philosophy Degree
The University of Tennessee, Knoxville

Jennifer A. Heyl
May 2004

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ABSTRACT

Catholic health care faces a difficult challenge in today's secular society. Because they are directed by the teachings of the Catholic Church, certain services, such as abortion, sterilization and contraception, cannot be provided at Catholic health care facilities. This limitation on services has placed Catholic health care providers at odds with many in the communities which they serve. This conflict was exacerbated in the 1990s during the active period of mergers and acquisitions which left some communities with only one hospital, which was now Catholic. These moral conflicts often seem intractable.

This dissertation examines the nature of moral conflict and how these conflicts might be resolved. Many times when moral conflicts seem intractable we are pressed to compromise. But in countenancing moral compromise there is usually concern over the loss of integrity. After examining the nature and importance of integrity to the resolution of intractable moral conflict (and when moral compromise might be countenanced), the conflicts over reproductive services at Catholic hospitals are addressed. In many of these conflicts moral compromise is found to not preserve integrity and so we are left to examine how Catholic moral theology addresses these conflicts.

Finally, the teachings of the Catholic Church on contraception, sterilization and abortion are explored and applied to some 'tough' cases present at Catholic hospitals. Despite what is often understood about Catholic teaching in these areas, I

show that Catholic moral teaching provides the tools to deal with these conflicts and, in some cases, can manage ‘compromise.’

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1. *THE SCENE IN 21ST CENTURY CATHOLIC HEALTH CARE*

Life at the beginning of the twenty-first century is anything but uncomplicated. We find ourselves craving simplicity while simultaneously living lives made more and more complex by advances in technology and science as well as social changes – ironically, the advances are all intended to make life simpler. In part due to the complexities of modern life, we also live in a time of inevitable moral conflict. Our heterogeneous society has plural and conflicting values. How are we to manage the inevitable conflicts? At one time it might have been hoped that a moral theory, unified and universal – the 'Holy Grail' at the end of what Richard Rorty calls the 'Platonic Quest' – could take the day. But despite 2500 years of this quest, ***the*** unified and universal moral theory eludes us. Other approaches to conflict resolution include force, persuasion, rational argumentation, emotional appeals, bargaining and compromises. In bargaining and compromises, the implication is that we will have to give a little, but we will also get a little in return or in exchange. In these cases, we find many conflicts are reducible to exchangeable interests.

But there are some compromises that do not, or perhaps **should** not, admit to exchangeable interests. These are conflicts that have at their base of disagreement deeply held and long-standing beliefs, principles and commitments, that is to say, moral values. When discussing these types of interests, we usually reject compromise because we see it as a form of betrayal – betrayal of both ourselves and our causes, and that somehow, by betraying ourselves in that way we show a lack of integrity. This loss of integrity manifests itself as an apparent unwillingness to stand behind our principles, beliefs and commitments when it involves great difficulty for ourselves.

What of conflicts that go beyond two individuals? What about conflicts that involve two or more groups of individuals, corporations, or causes? When assessing these conflicts and their proposed resolutions, we must closely examine the arguments in support of each position, as well as the overall integrity of these positions. Next, one might discuss how groups go about acting with integrity with regard to these beliefs. At some point in these seemingly intractable conflicts, perhaps compromises will be suggested. As many initially rebuff these suggestions, the next step might be to determine if there are some compromises that are morally permissible and which preserve integrity.

This dissertation will examine the nature of intractable moral conflicts and the moral compromises to which they might direct us. Because compromise is often rejected in favor of preserving one's integrity, the notion of integrity must be investigated. This will help us determine what moral space exists in which we might

enter moral compromises which preserve integrity. This investigation will be illuminated by an in-depth discussion of reproductive issues that involve Catholic health care providers and the *Ethical and Religious Directives for Catholic Health Care Services*[1] under which all Catholic health care providers must operate. In mergers and acquisitions where the facility maintains or takes on the Catholic identity, the *Directives* are in effect, and as a result, certain reproductive services are no longer offered. This is especially problematic in areas where the Catholic facility is the sole provider in the area. The following vignette will give us a taste of the types of conflicts that result from the mergers and acquisitions involving Catholic health care facilities.

I. CLAIRE'S CASE

Claire lives in a rural town in Florida. The only hospital in her community is a facility that has recently merged with a Catholic hospital system to gain market share and secure the benefits of larger purchasing power. The facility now operates under the Catholic Church's *Directives* for health care, a change not known to Claire. Claire is 22 weeks pregnant and her blood pressure is dangerously high. She has been on bed rest for six weeks with no reduction in her blood pressure. Claire's life is at risk if she chooses to continue the pregnancy because a stroke is a real possibility. She has the

[1] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition* (Washington, D.C.: United States Conference of Catholic Bishops, Inc, 2001). Hereafter abbreviated as *Directives* or *ERDs*.

option of prematurely delivering by C-section or having an abortion. To complicate matters the results of her alpha fetal protein (AFP) test indicated a greater than normal risk of a fetus with Downs Syndrome. Her options are limited at her hospital because abortion is proscribed by the Catholic *Directives*. Furthermore, Claire does not wish to deliver the baby at this point in her pregnancy. Chances for the baby's survival are virtually nonexistent and Claire does not believe that she can handle the stress of giving birth only to watch her baby die. Claire is left with the only option of traveling eighty miles by ambulance to the nearest facility that will perform an abortion. Or is she? As we shall see, due to common misperceptions of the *Directives,* this case might turn out differently than expected.

II. WHAT'S BEHIND CLAIRE'S CASE

That Catholic healthcare organizations and providers are directed by the *Ethical and Religious Directives for Catholic Health Care Services* "to remain faithful to their mission of healing carried out in the name of Christ and to offer healthcare to the community at large as a means of providing for the common good of the community"[2] is certainly at odds in many ways with both the 'business' of health care and our pluralistic society at the beginning of the twenty-first century. Unlike the cloistered religious who have a calling to serve the larger community by withdrawing from it and leading a life of prayer, Roman Catholics hold that all others must be in

[2] Jean de Blois and Kevin O'Rourke, "Healthcare and Social Responsibility," *Health Progress* May (1995):1.

the world to serve Christ. Christians are instructed, "You must be in the world but not of the world." While this tension is not new, the commodification of health care since the latter half of the twentieth century **is** new, and Catholic health care institutions find themselves struggling to stay financially viable in a radically changing economic environment. A common practice among both public and religiously affiliated hospitals in the 1960s and 1970s was what was called 'cost shifting.' This is a means whereby the costs paid by private pay patients subsidize the care that is provided to indigents, for whose treatment little or no reimbursement will be collected. But in the 1980s, the face of health care changed with the growth of managed health care plans. Now the Catholic hospitals' problems were twofold: they had to organize to become players in the managed care networks being developed, and they had to find means of funding indigent care because cost shifting was no longer possible with the reduced reimbursement from managed care. This situation has become dire for many Catholic hospitals, and the choices are all less than ideal. Some hospitals are left to decide to either sell-out to for-profit corporations or close their doors for good – in the words of the former president of the National Daughters of Charity System, Sister Irene Kraus, "no margin, no mission."[3]

Two ways in particular that Catholic health care facilities have remained viable are through mergers with other not-for-profit hospitals and mergers with or acquisitions by for-profit corporations. Neither of these two options is without serious

[3] Gloria Shur Bilchik. "When The Saints Go Marching Out: Is American Health Care Losing Its Religion?" *Hospitals & Health Network* vol. 72, no. 10:36.

problems. Should these mergers or acquisitions result in the hospital relinquishing its Catholic affiliation, then from the point of view of the Church the mission is lost; should that very hospital retain its Catholic-sounding name but not maintain its Catholic affiliation, then the possibility exists for misunderstandings, confusions, and even scandal from the point of view of the community. In cases where the institution retains its Catholic affiliation – its identity – the merged or acquired facilities are contractually bound to comply with the *Ethical and Religious Directives for Catholic Health Care Services,* a document of seventy-two directives authored by the National Conference of Catholic Bishops (NCCB) and most recently revised in 2001.

In cases where the Catholic identity is retained, other conflicts with regard to the mission of Catholic health care as well as adverse effects on the community arise, two of which are paramount to the subject of this work: first, the disparate underlying philosophies of for-profit health care and Catholic health care and second, the drastic curtailment of reproductive services offered to the community. The adverse effects can range from a reduction of indigent care to situations like Claire's. In Claire's case, some might be inclined to say that this is just an unfortunate situation for Claire and not the stuff of deep moral conflicts. But whether one considers health care to be a market commodity or a social good greatly affects how patients are treated and what services are provided them. Exacerbating this problem is the fact that the largest not-for-profit provider in this country is religiously affiliated (Catholic) and places restrictions on services which it finds morally objectionable.

III. FOR-PROFIT OR NOT-FOR-PROFIT?

To further grasp the first of these two conflicts, consider one of the normative principles that guide the *Directives*:

> ...the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured and the underinsured.[4]

This principle seems contrary to the goals of a for-profit corporation, which by design must ultimately and primarily be accountable to its shareholders. But those within Catholic health care who support such acquisitions contend that care for the indigent has remained at or above pre-acquisition rates, and further, that care in general has not been adversely affected. Most importantly, they say, by financially stabilizing the facility as well as agreeing to abide by the *Ethical and Religious Directives*, the for-profit corporation has enabled the Catholic health care providers to fulfill their mission. Others within the Catholic community believe that the disparate guiding philosophies of the mission of Catholic Health Care Providers, placing the patient first and for-profit corporations, placing profits first, are not so neatly reconciled despite the fact that, thus far, these disparate philosophies have not proven, in practice, to be irreconcilable. John Kavanaugh, S.J., reports on the changing milieu at a faith-based, not-for-profit hospital, "which seems forced by the logic of capitalist competition to

[4] *Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition,* Part One.

act more and more like a for-profit organization."[5] Many of these hospitals are forced to cut any unprofitable services that affect their competitive edge; often pastoral care is that unprofitable service. At one hospital, the pastoral care department reports that they **no longer:**

- have 24-hour priest backup for sacraments,
- see same-day surgery patients before surgery,
- provide regular coverage to the emergency room,
- provide regular coverage to psychiatric patients,
- do routine follow-up visits to inpatients,
- make pre-op visits to cardiac patients,
- provide regular coverage to maternity patients,
- have chaplains distributing Communion to inpatients,
- make the Eucharist available on Saturdays,
- celebrate 6:30 a.m. Mass during the week, and
- provide regular coverage to families awaiting serious cardiac procedures.[6]

The issue of whether Catholic Hospitals can fulfill their mission when purchased by a for-profit corporation can be framed as part of the larger question of whether health care should be treated as another marketplace product. Positions on this differ both within the Catholic Church and in the non-sectarian domain. Jean de Blois, the director of missions and senior associate for ethics at the Catholic Hospital Association, makes the stronger claim that health care is a basic human right like education or food. She says all three are "basic and universal human needs that must be met to some degree if persons are to have reasonably satisfying and fulfilling

[5] John Kavanaugh, "Capitalism's Cost to Care; Decline of Chaplaincy at Privatized Catholic Hospitals," *America* vol. 178, no. 8 (1998):37.
[6] Ibid., 37. This is only a portion of the complete list.

lives."[7] The lack of vision in seeing these similarities perpetuates the myth that health care is just another commodity on the market. As such, this maintains the connection between health care and affluence and perpetuates the plight of the poor and under-served. De Blois says that we should not treat health care as a commodity but rather accept it as a social good.

Additionally, when speaking of health care within the context of Catholic Health Care Services, de Blois claims that rather than a job, business or profession, Catholic Health Care is a ministry. "Ministry is a response in faith to the call to be, as Jesus was, a presence of radical healing in the world on behalf of the reign of God."[8] She sees Catholic health care as situated within the broader American health care system and within society as a strong and influential presence that offers services that reflect and promote values of the Catholic tradition while addressing social, political and other forces that undermine the health and well-being of all persons. De Blois' statement about ministry seems quite foreign when juxtaposing it to the notion of profession. After all, even if health care were provided in a socialized system, many of the caregivers would be considered professionals. What differentiates a ministry from a job, business or profession is how it is situated in one's life. In ministry, one no longer lives for self but for God; this is manifested by service to others. So one may still make a livelihood from one's ministry but it is how this livelihood is situated

[7] Jean de Blois, "Can For-Profit Hospitals be Catholic?" Panel Discussion, *National Catholic Reporter* vol. 34, no. 6 (December 5, 1997):20.
[8] Ibid., 20.

within one's life that is important. With this understanding, ministry would preclude injustice.

Others within the Catholic Health Care System see the concerns about health care as a commodity and the view of Catholic healthcare as a ministry as real and important; however, those already situated in systems that face dire decisions take a more sober view of the situation. James Clifton, the director of pastoral care at St. Joseph Hospital in Omaha, Nebraska, tells of their experiences. Founded in 1870 by the Sisters of Mercy, St. Joseph Mercy Hospital served the poor and trained health care providers in the Catholic tradition. In 1977, they built a new hospital and clinic, placing it near Omaha's central city. By that time most other hospitals had moved to the suburbs or had closed their doors. This left St. Joseph providing more care to the under-served while carrying massive debt for the new buildings. By the early 1980s, they were left with the decision to either stop providing care to the indigent or to close their doors. They were approached by American Medical International, one of the companies that would later become Tenet Corporation. Thirteen years after their acquisition by the for-profit Tenet, St. Joseph boasts the following:

- The hospital has maintained or increased its support for training students in medicine, pharmacy, nursing and allied health professions,
- Residency programs have held steady or grown,
- They have maintained the highest ratio of chaplains-to-patients of any hospital in the region,
- They have never experienced a conflict with AMI or Tenet related to hospital's adherence to Catholic teaching,

- They have maintained and actually increased commitment to indigent care...consistently providing more than half of the area's indigent care...[9]

Another problem often cited in this discussion is the question of the real distinction between for-profit hospitals and not-for-profit hospitals. In both the market and profitability determine what services will be offered. If not-for-profit hospitals make their decisions solely in that manner, then they can not claim to have a corner on the market of caring for the poor and defending the sacredness of human life. Catholic health care cannot merely claim that not-for-profit status resolves the problems inherent in for-profit hospitals. However, the proposition that a Catholic hospital, being true to the values of serving the poor and protecting the sacredness of human life, can be operated by a for-profit company, which by definition can embrace these values only as market decisions and not as first principles, seems dubious.

At this point several questions arise. Is there a way to reconcile these disparate philosophies? Can Catholic health care facilities maintain their integrity and values under the rapidly changing circumstances of our economy and society? Unless radical changes take place, Catholic health care must accept that health care has been commodified in this society and work within that system. As alluded to earlier, some have blamed the necessity of working within that system as the motivation for the "merger-mania" we saw peak at the end of the 1990s. Others might maintain that at least the market system fosters excellence in the field and drives out the mediocre.

[9] James Clifton, "Can For-Profit Hospitals be Catholic?" Panel Discussion, *National Catholic Reporter* vol. 34, no. 6 (December 5, 1997):20.

IV. REPRODUCTIVE SERVICES

The second major conflict resulting from Catholic hospital mergers occurs in cases where the merged facility becomes the sole provider in a given area. If the facility remains identified as a Catholic health care facility, then it must abide by the *Ethical and Religious Directives* which significantly curtail the reproductive services that can be provided. The *Ethical and Religious Directives* proscribe the following range of reproductive services, listed in what might be considered by many, including many Catholics, the least to the most morally troubling: the distribution of emergency contraception in cases of rape, all artificial forms of birth control, sterilizations, many fertility procedures, and abortion. By virtue of the hospital's mission, these services to which the members have a legal right are now excluded. Moreover, in some cases, forgoing any one of these services may have serious health consequences. In effect, people in the community are now forced to travel out of their area to procure these services. One might ask if this is merely a matter of inconvenience or if it makes members of a given community virtually unable to obtain these services. In some cases, for those without means of transportation or the ability to pay someone to transport them, this is more than just an inconvenience. Some might be inclined to say that Claire is just in an unfortunate situation, that this is merely a case of hard luck. Others might claim that this is a conspiracy masterminded by the hierarchy of the Catholic Church to systematically reduce women's access to reproductive services. More moderate voices might say that there is a basic issue of justice: why should a woman be deprived of a legally secured right by virtue of where she lives, or more

pointedly, because of the economics behind the hospitals in her region? Other moderate voices might claim that this is an issue of religious freedom, the freedom to follow one's conscience, and the freedom from providing a service one finds morally objectionable.

While many see this as an inter-communal conflict between the Catholic and non-Catholic communities, the intra-communal conflict within the Catholic Church on these issues should not be overlooked. Some questions in this regard may be beyond the scope of this work; however, their existence may shed light on how the inter-communal conflicts might be resolved by moral compromise. [10]

A. Intra-communal Conflicts within the Catholic Church

The Catholic Church's teaching on sexual morality is not obscure. "It can be summarized concisely and clearly. Human sexual acts have two intrinsic and natural ends or purposes: the *procreation* and education of children, and the union in *love* of

[10] It is not to be implied that the proscription of services of the *Ethical and Religious Directives* is limited to reproductive services but may affect whether the hospital can comply with certain advance directives as well. Traditionally, where the position of the Catholic Church has differed most radically from the secular community is on beginning-of-life and end-of-life issues. Certainly in places where physician-assisted suicide is permissible, this would be proscribed by the *ERD*. In the future, this might be the more telling problem. Stanley Hauerwas says, "Maybe in the future we will be able to tell Christians by the fact that they don't kill their babies or their old" (personal conversation). Physician-assisted suicide would be an option for twice the number of people, and the fact that those accounting for this increase are male might bring the issue to the fore earlier and with greater force than women's access to reproductive services.

Partners."[11] However, many sources emphasize the former, often to the detriment of the latter. A popular undergraduate textbook in applied ethics stresses,

> "That the Roman Catholic Church believes that the natural purpose of sex is reproduction is well known. Equally well known is one consequence that the church draws from that belief – that artificial means of birth control are immoral. Less well know are other, related, beliefs that are also directly related to sexual morality... – the ability to engage in fully human love...fully human love does not stop at romantic love; it naturally evolves into parental love."[12]

The Catholic Church's position on sexual morality and associated issues has remained historically constant[13] and is philosophically grounded in natural law. This moral basis for decisions on reproductive issues is then employed to address new medical ethical issues that result from advances in medical technology. This is not to imply that all members of the Church wholeheartedly embrace these teachings. In June 1964, Pope Paul VI formed a commission to study questions in dispute about marriage and birth control. The Pope was ostensibly looking for certainty in this teaching and used this justification in October 1966 for the continued work of the commission. This period of apparent indecision led many to conclude that there was doubt regarding traditional church teaching. But striking down a traditional Church

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[11] Lisa Sowle Cahill, "Catholic Sexual Teaching: Context, Function, and Authority," in *Vatican Authority and American Catholic Dissent, The Curran Case and its Consequences*, ed. William W. May (New York: Crossroads Publishing, 1987). 187. Some might question the suggested limitation on parents' responsibility to children; however, at this point the inclusion of 'education' in this statement shows the abiding responsibility of human sexual acts.

[12] Jeffrey Olen and Vincent Barry, *Applying Ethics; a Text with Readings, Sixth Edition* (Belmont, CA: Wadsworth Publishing Company, 1999):76.

[13] Allowing that there has been considerable debate on the teachings of Thomas Aquinas regarding 'quickening' and the 'ensoulment of the fetus' and the implications of this on the Church's prohibition of abortion.

teaching based on natural law is no small matter. Despite the commission's majority opinion that did not uphold the traditional norms forbidding the use of birth control (within sacramental marriages), Pope Paul VI in the encyclical *Humanae Vitae* (1968) overrode the majority and proscribed the use of artificial birth control.[14] This encyclical prompted a statement from a group of theologians, whose numbers grew to over 600, "recognizing that in theory and in practice Roman Catholics could dissent from the specific conclusion of the encyclical condemning artificial contraception."[15] This was one of the signals of the American Catholic Church's growing dissent with the Roman Catholic Church. This also accompanied changes in approaches to moral theology that resulted in a pluralism of Catholic moral theology. What stands out most starkly is that, by and large, Catholics disregard the official church teaching on artificial birth control.[16]

There are numerous published reports as well as personal accounts from both those who practice health care in Catholic facilities, and 'practicing' Catholics in secular institutions whose practice standards do not coincide with the *Directives*. One woman, a devout Catholic and nurse practitioner specializing in women's health, is employed at a community health department. There her responsibilities include family planning as well as care for obstetrical patients. As part of her family planning

[14] Richard A. McCormick, *Notes on Moral Theology 1965 through 1980* (Washington, D.C.: University Press of America, Inc., 1981):210-13.
[15] Charles E. Curran, *Transition and Tradition in Moral Theology* (Notre Dame, IN: Notre Dame Press, 1979):v.
[16] Benedict M. Ashley, OP and Kevin D. O'Rourke, OP. *Health Care Ethics: A Theological Analysis, Fourth Edition* (Washington, D.C.: Georgetown University Press, 1997):285.

duties, she prescribes and dispenses artificial birth control to her patients. She believes she is living her faith by helping to prevent the greater evil of abortion.

Another Catholic, a physician who specializes in infertility and practices in a secular institution, explains that, while he performs *in vitro* fertilization (a procedure proscribed by the *Directives*), he will only fertilize the number of eggs that will be implanted during one procedure and he will not freeze any fertilized eggs for later use. He hastens to add that he informs his patients of these self-imposed practice limitations and explains he is compelled to do this as a sign of his respect for the sacredness of human life. But some might question whether he has fully taken into moral consideration the additional cycles of ovulatory stimulants and retrievals that this woman and her partner may have to go through if there is no pregnancy resulting from this round of *in vitro* attempts.

Other published accounts in publications as diverse as *Playboy* and the Canadian, *Chatelaine* (a sort-of Canadian version of our *Better Homes and Garden* magazine), discuss loopholes as well as clandestine disregard for the *Directives.* *Playboy* reports that a rape victim taken to a Catholic facility in rural California is neither counseled about, nor given, emergency contraception in the ER. "She got the pills in the parking lot, in a paper bag, in the dark – standard operating procedures so long as the bishop doesn't find out."[17]

In Canada, a physician with privileges at both the Catholic and secular

[17] Stephen Rae, "Thy Will Be Done: Hospital Mergers Leave No Choice," *Playboy,* vol. 45, no. 4 (April 1998):50.

hospitals in his town decides to perform an abortion on a woman who is eight weeks pregnant at 'Saint X' because to get her on the waiting list at 'Crosstown General' might delay the procedure long enough that it would require an operating room surgical abortion. Having once been reprimanded by hospital officials, this physician says that the threat of losing hospital privileges pales in comparison to the death threats he has received. He says he is motivated by memories of botched abortions prior to their legalization in Canada in 1969.[18]

This last example of intra-communal conflict within the church will show a group that provides a natural transition to the inter-communal conflict. Catholics for a Free Choice (CFFC) is an independent not-for-profit advocacy group that supports the availability of reproductive services in Catholic hospitals. A major emphasis of their advocacy is for lower income women who, as a group, are the most seriously affected when the Catholic facility is the sole provider in an area. Frances Kissling, the group's president, states, "In general, lower income women... are the ones who use hospitals as their primary source of healthcare. Therefore, anything that happens in hospitals to limit services is going to disproportionately affect poor people."[19]

What can we make of these different health care practitioners and practices? Should a Catholic have the same responsibilities whether working in a Catholic or a secular institution? The nurse practitioner and fertility specialist might be commended

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[18] Ivor Shapiro, "Doctor of Choice; Abortion and Delivery of Babies," *Chatelaine* vol. 71, no. 9 (1988):38.

[19] Jennifer Baumgardner. "Immaculate Contraception: Programs Not Offered at Clinics Funded by Catholic Hospitals," *The Nation* vol.268, no. 3:11.

if, while working in secular institutions, they have maintained integrity by following their faith the best they can under the circumstances. But what if the nurse practitioner was the nurse in charge of the ER and was the one to deliver the emergency contraception in the parking lot? What light is shed on this problem if all of the above described situations are carried out by devout Catholics trying to find the best way to live out their faith? While the Magisterium of the Catholic Church speaks with a loud, and mostly unified voice, the same cannot be said of the members of the 'mystical body of Christ.' What implications does this have for the church and its *Ethical and Religious Directives*?

There must be a way for people to resolve their conflicting values – from the Catholic health care professionals working within the Catholic health care system to the patients who must receive medical services from a Catholic hospital and who may or may not be aware of the *Directives*. In our vignette, we might suppose that Claire is Catholic. She is then in need of a way to consider her personal situation and resolve this conflict *vis a vis* the Church's position in a way that she can live with the decision. As we will see in Chapter Five, an early induction of delivery would be permitted in Claire's case according to the *Directives*, although this is not always understood by all Catholics and unfortunately might not be interpreted in this way in all dioceses. If not available to her, she must secure access to the procedures she needs. A similar need is present in the health care professionals who are Catholic but working in secular institutions. They must have a way to resolve the dissonance between their faith, what the Church teaches, and the way they conduct their practices.

This study in moral conflict, integrity and the possibility of integrity-preserving moral compromise will provide a framework for situations such as these.

B. Inter-communal Conflicts: Catholic and Non-Catholic

The inter-communal conflicts are many and varied. The most immediately visible are limitations on reproductive services, which affect disproportionately poor women, who have fewer choices when it comes to health care in general. It might be helpful at this point to delineate the different conflicts occurring on different levels. The immediate, and perhaps most personal, is the curtailment of reproductive services felt most acutely in areas where the Catholic facility is the sole provider and the person seeking services does not share the same values as the Catholic Church. The next level is on the societal level as regards legal and constitutional rights, and finally, more broadly, the question of what rights and obligations one who provides a shared good has to the community.

One of the charges leveled by CFFC's Kissling is that often mergers take place in areas without a Catholic majority, so there is foreknowledge that this community may not share the values of the Catholic Church. In some cases, the unavailability of procedures may force women to undergo additional procedures that may be more than just an inconvenience but which may place her at a greater potential for harm. These cases include when the mother's life is in danger and on a lesser scale when a tubal ligation is most safely performed immediately after a C-section.

Some advocacy groups have framed this conflict in terms of legal and constitutional rights. The National Women's Law Center in Washington has

published a guide to assist communities in which mergers are threatened. The guide advises the use of antitrust laws to fight mergers they believe will threaten services. They advocate the involvement of the Federal Trade Commission and the Justice Department. Susan Berke Fogel, the legal director of the California Women's Law Center, claims that the tactics of Catholic health care is "stealth elimination" of reproductive services.[20] She is particularly incensed at the Catholic Church's claim to be exempt from antidiscrimination law because its hospitals are non-profits rather than businesses. Referring to a recent California Supreme Court case regarding compliance with fair employment laws in which the court ruled in favor of a Catholic hospital, Berke Fogel says, "Look, I don't argue with the importance of allowing hospitals to be non-profits so that the communities will reap the benefits rather than shareholders, but that shouldn't be license to discriminate, either in the types of services they provide or in hiring based on race or gender."[21] Statements made in response to charges of a conspiracy to eradicate services to which the church is morally opposed from Catholic health care administrators are incomplete in their argumentation.[22] Sister Diana Bader, senior vice president for mission at Denver's Catholic Health Initiatives, says, "If the desired partner were actually being coerced

[20] Jennifer Baumgardner, 11.
[21] Ibid., 11.
[22] While the issue of a whether the Church's actions constitute a conspiracy will not be resolved in this work, the discussion is included to show the lengths to which each side will go to paint their opponent.

into this relationship, you might have an argument."[23] The Rev. Michael Place, president of the Catholic Health Association, says facilities agree to sacrifice reproductive services because the proposed arrangement with the Catholic facility offers the best hope for financial health. He says, "They're making value judgments about what's in the best interest."[24] And this is where the market pressures need to be acknowledged and the health care system must share culpability. As Jennifer Baumgardner reports in *The Nation*, when referring to the secular hospital acquiescing to the Catholic *Ethical and Religious Directives* in financing arrangements, "Bring up women's rights, and many defenders of the hospitals in question respond with a blank stare. It isn't about sexism, they say, it's about cost. Reproductive care is just too expensive."[25] It is difficult to separate how the market influences are distinguished from the religious influences as they are inextricably bound.

This leads us to the issue of shared goods in the community – another of Susan Berke Fogel's criticisms is that Catholic facilities receive much of their funding from Medicaid and Medicare. "The reality is that they are accumulating a huge amount of money that is exempt from taxation: we, the taxpayers are subsidizing their expansion. Their revenues are not required to go back into health care but can go into religious

[23] Deanna Bellandi, "What Hospitals Won't Do for a Merger: Deals Involving Catholic Facilities Often Mean a Loss of Reproductive Services," *Modern Healthcare* (September 28, 1998):28.
[24] Ibid, 28.
[25] Jennifer Baumgardner, 12.

institutions. The public is simply not benefiting from these transactions."[26] These charges might easily be deflected by considering the amount of expenditures on indigent care; it seems like merely a matter of bookkeeping to show that the Church is not profiting from Medicare and Medicaid dollars. But it does raise the question of federal funding to a facility that does not provide a full range of services, especially when that facility is the only provider in the area.

V. MORAL COMPROMISE

What we have seen thus far are multi-layered and interlocking conflicts. In situations of conflict several options can be pursued. In the most extreme case, the stronger forces its position on the weaker without regard for the weaker side's wishes. This can be labeled the 'might makes right' approach. Another way conflict is approached is through exchangeable interests. Suppose my house is in the way of your proposed strip mall. There might be an amount of money that I will accept in exchange for my house and land. But, for some, that example might be an intractable moral conflict; a committed environmentalist might never sell his family's homestead and **especially** not for another strip mall. But in the end, most things, particularly material things, have exchangeable interest. In other conflicts, one might try to reason, cajole or persuade to win the other to her side. And sometimes this works – reason, humor and persuasion can be very effective. However, some conflicts admit of no exchangeable interest, and sometimes all the reason, humor, persuasion and

[26] Jennifer Baumgardner, 12.

threats will not prompt the other to capitulate. These are often conflicts over deeply held and long-standing beliefs, principles or commitments. I will claim that some of the conflicts resulting from the Catholic hospital mergers and acquisitions reach this level. How do we address these seemingly intractable moral conflicts? Is compromise a morally licit endeavor at this juncture?

Compromise is rarely considered or acted on as the first course of action. There are some cases of simple horse-trading and bargaining that might be considered advantageous, but compromise can be a treacherous landscape when it involves important interests or deeply held and long-standing beliefs, principles and commitments. Compromise can be viewed as prudence or betrayal.

In a prudential compromise, an external condition or circumstance presses a choice that one would not have made otherwise; this is distinguished from a compromise that is self-serving or cowardly. For example, I might forego playing on an injured foot in tonight's game in order to protect my long-term interest of playing in the WNBA, or an army might give up a town in order to secure the bridge that will ultimately lead to the end of the conflict. Often compromises in the market place or compromises in politics are prudential compromises. As such, it is easier to trade on issues when we believe they are market or political issues, which are usually assumed to involve non-moral values. It might be this tendency to see health care as just another cog in the market wheel that results in the problems we have seen in the Catholic hospital mergers and acquisitions. If health care is a social good that should not be commodified, then issues in health care should be approached has having moral

components that render them less amenable to horse-trading, and compromise would be approached with caution.

To consider compromise as betrayal is to see it in its most pejorative sense. In this sense, compromise can be a betrayal of oneself or one's causes. Why is this so problematic, after all, a compromise might bring about a better state of affairs than the one in which we currently find ourselves? People who fail to live by their beliefs, principles or commitments are seen variously as moral chameleons, opportunists, hypocrites, weak-willed, self-deceived or gullible. In short, many describe these kinds of people as those who lack integrity. We must pursue why most people resist compromising and what it is about integrity that leads some to dogmatically cling to their beliefs, while opportunists, hypocrites and others are free of its influence. Some philosophers have noted the identity-conferring nature of integrity. There are basic questions as to what constitutes integrity and why it seems so important in our self-concept as well as our views of others. I will be developing an account of integrity in which its identity-conferring character includes our deeply held and long-standing beliefs, principles and commitments, as well as our world view and our way of life that makes compromise in this area seem initially repugnant to us.

If we fear a loss of integrity in a compromise, it is usually perceived as a loss of personal integrity. But there is another sense in which we use the notion of integrity. We can talk about the integrity of steel, the integrity of a bridge, the integrity of a cause. In this sense, we get closer to the Latin root *integere,* which means whole, of a piece. So not only must we get a sense of personal integrity, in

what it consists, and the moral importance of it, but we must also be able to apply this notion to beliefs, principles, commitments, causes and missions around which people can focus their lives. A committed Nazi officer has focused his life around a pursuit that we find morally repulsive. Can that man, in being true to his deeply held and long-standing beliefs, principles and commitments, be a man of integrity? This is an important problem that must be addressed. Another aspect of integrity to be addressed is whether the notion of personal integrity can be transposed to a corporate body, and if so, how this affects the justification of moral compromise?

In the conflicts illustrated in the Catholic hospital mergers, all sides believe they are morally justified in holding their position and all sides base their positions on deeply held and long-standing beliefs, principles and commitments. To give an inch on any of these would seem to betray one's cause. Once the concept of integrity is better understood, we can judge the integrity of the position each side defends as well as the possible compromises that might result.

After exploring the nature and importance of integrity, we will look at how one acts with integrity when dealing with intractable moral conflict. We will also consider when moral compromise can be countenanced in these cases. This work will explore the concept of and moral space for compromise both within communities and in the broader context. This analysis is not solely, or even primarily, a study of the moral methodology of the Catholic Magisterium, but of what other methodologies might bring to the conflict as well. I will offer a way of understanding conflicts and integrity and the possibilities for compromise which is designed to be endorsable by all

reasonable parties to the conflicts.

To perform this task, the second chapter will start with a general introduction to the problems of compromise and then quickly delve into the notion of integrity, since the loss of integrity is what many fear most in compromise. What exactly is integrity? If it is to be considered a virtue, it certainly seems different than the first-order virtues like courage, honesty and loyalty. Are there criteria for integrity? We might wonder whether it is a trait which we possess, or rather, a way of acting. How do we translate or transfer the notion of the integrity of the individual to a corporate body, cause or mission?

Chapter Three will address how we can confront intractable moral conflict with integrity and when compromise is permissible. Chapter Four will then address the conflicts surrounding the delivery of reproductive services at Catholic hospitals. Finally, Chapter Five will explore in-depth three major issues in reproductive health care and how they are actually handled in Catholic hospitals.

2. *THE NATURE AND IMPORTANCE OF INTEGRITY*

Why is integrity important? With regard to the moral realm, it seems to be a virtue that is highly valued. It is something most of us strive for, jealously protect, reluctantly admit the loss of, and which can be rehabilitated by the way we handle the aftermath of moral wrongdoing, both our own and others. It also plays an important part in our personal identity.

Concern for integrity seems to be one of the primary reasons we resist compromise in general. The stakes only become higher when it comes to moral compromise. Our refusal to compromise morally on matters of deeply held and long-standing beliefs, commitments, and values seems rooted in efforts to keep ourselves intact, to refuse to betray our values, and thus to maintain our integrity. In order to understand which moral compromises preserve integrity, I will propose that we look at integrity as a virtue that moderates, and at times, constrains our actions. In this way, integrity can assist us in our approach to moral conflict, especially intractable moral conflict, which might lead to moral compromise. Integrity can also assist us with self-

evaluation. In self-evaluation, I can both reflect on the way in which I conduct my affairs and the positions that I hold and ask myself, 'Am I acting with integrity?' and 'Are the positions I hold positions of integrity?' Before I can consider defending my integrity, I must ascertain that I have something to lose and something that is worth defending. Part of this is allowing that I might be wrong.

In order to preserve integrity when compromising morally on matters of deeply held and long-standing beliefs, commitments, and values, it is important that those with whom I disagree hold positions that meet the demands of integrity. This is not to say that sometimes we aren't compelled to compromise on moral values with people who do not have integrity. A paradigmatic case of this type is the German woman who must choose between either sleeping with the SS Officer or seeing her family taken to the concentration camps where their deaths seem inevitable. She can reason morally that protecting the lives of the innocent is of greater value than protecting her own virtue by refusing to cooperate with evil, but I do not think that we can say here that her integrity is preserved, regardless of which choice she makes (either of which *may* be morally justifiable). In either choice she makes she becomes disintegrated, either internally or externally. So the distinction can be made between moral compromises that are morally licit and those morally licit moral compromises that preserve integrity. This distinction has far-reaching implications. One of the implications has to do with the identity-conferring role that integrity plays with the individual or organization.

We will begin with a discussion of integrity as a virtue. Once it is situated historically within moral theory, the discussion will expand to the contemporary

philosophical milieu. Two of the chief concerns found in the literature include whether integrity has content or is merely a formal concept and the related problem of the role it plays in personal identity.

The distinction between content and form allows for very different conceptions of integrity. Those who see integrity as a formal concept tend to relegate it to a minor role in the moral life; whereas, those who see integrity as having content assign it a more prominent role in the moral life. I will argue that integrity has content, but moreover, content of a specific sort. The *content* I will propose for integrity will be handled through an investigation of commitments and the significance of the inter-relationship of integrity, commitments and personal identity. This discussion will include an argument for content that is morally defensible as well as suggesting certain other elements or conditions that are necessary for integrity.

Next we will address other factors that underlie the importance of integrity. Some philosophers have claimed that integrity derives its importance from its identity-conferring nature.[1] This view is often allied with the formal view of integrity; put simply, the individual merely forms her own beliefs (or determines her own commitments) and then lives up to them. The formal view of integrity limits the moral acceptability of compromising because to do so in the moral arena would be akin to giving up one's very self. In much of the literature this position is shown to contradict, or at the very least, be in tension with the integrity as content view. I will argue that a position that emphasizes

[1] The main proponent of this position is Bernard Williams in "Integrity," *Utilitarianism: For and Against* (New York: Cambridge, 1973).

the importance of the identity-conferring nature of integrity need not be allied with the formal view; rather, the identity-conferring nature of integrity is compatible with content-full view. There are two realities that create problems for the identity-conferring content-full view of integrity that must be accounted for: 1) people do not remain fixed and static throughout their lifetimes, and 2) the moral life consists of a wide range of morally justifiable and morally reasonable positions that are in conflict with each other. The first points out that if we are to advocate the identity-conferring nature of integrity, then we will have to also account for individuals changing and growing throughout their lives. The second problem releases the supporter of the content view from having to defend moral absolutism. In a pluralistic world of competing and conflicting values it would be unreasonable to think that there would not be values in conflict.

Historically there is a paucity of philosophical literature on the subject of integrity. It is perhaps due to the resurgence of virtue theory that the majority of what is written on integrity is to be found in the past thirty years. This literature shows that a precise definition of integrity is elusive. Most will claim that, as a moral notion, integrity is closer to a virtue than to a principle or a rule.[2] Others claim that the best way to

[2] Daniel Putnam, "Integrity and Moral Development," *The Journal of Value Inquiry* 30: 237-246 (June 1996) and Mark Halfon, *Integrity: A Philosophical Inquiry.* Philadelphia: Temple University Press, 1989.

illuminate the concept of integrity is in relief and start their discussions by saying what integrity isn't, or rather, what type of person lacks integrity.[3] Others attempt to elucidate the basic question of whether integrity is a set of virtues, sometimes viewed as adherence to a socially accepted code, or whether it is a special application of virtues, sometimes described as adherence to standards the individual has come to accept. And further, regardless of whether we conceive it to be a socially accepted code or the individual's code, some address the question of whether there are criteria to be met.[4] These issues must be addressed for the individual before we can talk about institutional integrity, which will encompass integrity of groups, causes or missions. Perhaps most important of all will be the identity-conferring aspect of integrity and how this is fixed. Finally, some identify integrity with morality itself, but this certainly seems to overplay its importance.

The literature contains at least three competing views of integrity: the integrated-self picture, the identity picture, and the clean-hands picture.[5] At present there is no philosophical consensus on the concept of integrity despite the common themes that emerge. The understanding of integrity proposed in this work is supported in general in the literature; additionally, the proposed understanding of integrity gives us an

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[3] Gabriele Taylor, "Integrity" *Aristotle Society* 55:143-59 and Martin Benjamin, *Splitting the Difference: Compromise and Integrity in Ethics and Politics* (Lawrence, KS: University of Kansas Press, 1990) and Jeffrey Blustein, *Care and Commitment.* New York: Oxford University Press, 1991.

[4] Mark Halfon, as well as, Stephen Carter in his *Integrity* (New York: Harper Collins Publisher, 1996).

[5] Cheshire Calhoun, "Standing for Something," *The Journal of Philosophy* XCII, 5 (May 1995):235-61.

explanation of why we resist moral compromise, but it can also lay the groundwork for compromises that at the same time preserve integrity. That process will be discussed in Chapter Three on resolving moral conflict with integrity.

The ubiquity of ascriptions of integrity helps illustrate its complexity and varied usage. Its uses range from the description of a sound structure to the moral soundness of a person to a marketing tool for sports teams. In all uses, and perhaps most markedly in its advertising usage, it conjures up images of uprightness, soundness (both moral and physical), stability, steadfastness, dependability and wholeness. Among its synonyms in *Roget's Thesaurus* are: truthfulness, rightfulness, morals, virtue, whole, completeness, oneness.[6] However, these do not quite cover the myriad of uses, nor do they explain the importance of integrity to our lives. In this chapter, I will argue for a notion of integrity that: 1) has content which must be morally reasonable, 2) places its importance in its identity-conferring nature through the commitments that an individual chooses, which also accounts for identity over time allowing for growth and development; and 3) the elements of integrity will include deeply held, long-standing beliefs, commitments and values, and these must be publicly stated, and one must be willing to stand for these in the face of adversity. By way of illustration, this chapter will also include a preliminary discussion of how this notion of integrity can be applied to the problems resulting from the Catholic hospitals' mergers and acquisitions.

[6] *Bartlett's Roget's Thesaurus* (Boston: Little, Brown & Company, 1996), s.v. "integrity."

I. INTEGRITY AS A VIRTUE

This section serves to situate integrity historically and within moral theory. Once it is thus situated, the information gleaned may inform the other aspects of conceptualizing integrity. Philosophers disagree about integrity's status as a virtue. Among moral notions its classification is clearly closer to a virtue than a rule or a principle, but just what kind of virtue it might be is contested. Perhaps the disagreement over whether it functions as a formal concept or has content is at the base of the doubts about what kind of virtue it is. In his article "Integrity and Moral Development," Daniel Putnam claims that "integrity ranks near the top of any list of virtues"[7] while at the same time Mark Halfon, who dedicates an entire book to a philosophical inquiry into integrity, comments on the relative dearth of literature on integrity and surmises that philosophers have relegated its status to a minor virtue.[8] Regardless of which impression one favors, they both share the belief that integrity is a virtue. Gabriele Taylor observes that integrity is different from other first-order virtues such as honesty, fidelity, or loyalty.[9] In fact, several of these first-order virtues are often used in attempts to define the concept of integrity. As such, some philosophers are prone to describe it as a second-order virtue.

Is there something about the classical understanding of the nature of a virtue that gives us helpful information? Aristotle defines the virtue of man as a state of character which makes man good and which makes him do his own work well. This state of

[7] Daniel Putnam, 237.
[8] Mark Halfon, 6.
[9] Gabriele Taylor, 152.

character is concerned with choice, the mean between the vices of excess and deficit. This state of character is developed through habit. But Aristotle says that, although none of the virtues arises in us by nature, we are adapted by nature to receive them and we are made perfect by habit.[10] In his revival of virtue ethics, Alasdair MacIntyre describes a virtue as a learned human quality necessary to attain any goods internal to a practice.[11] These descriptions of virtue conceive integrity as a formal concept. But those analyses run head-on into the question of whether a Nazi can have integrity. This underscores the need for a better sense of whether integrity is formal concept or has content. Gabriele Taylor describes this distinction as a special application of the virtues (formal) or a selection of the virtues (content).

Taylor suggests that the first indication of integrity's difference from other virtues is that the ascription of integrity cannot be expressed in adjectival form. She says, "Those who have generosity are generous, those who have courage are brave, but what are those who possess integrity? On my account the gap would appropriately be filled by 'is integrated' or 'is intact', but in contrast to 'he is brave' etc. this would convey not specific information about the agent and would be of no practical use."[12] 'Integrated' and 'intact' give us no specific information on that person. Taylor uses this example to justify her position that no particular behavior is necessarily linked with ascriptions of integrity. Further, if integrity is a virtue at all, then it is a secondary virtue that seems to involve

[10] Aristotle, *Nichomachean Ethics*.
[11] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory* (Notre Dame, IN: University of Notre Dame Press, 1981).
[12] Taylor, 151.

possessing a set of other virtues. So we cannot get at integrity directly, and she suggests, "We think of it as a virtue perhaps because we assume that being virtuous is a consequence of possessing integrity."[13]

While Taylor's assessment may be *prima facie* plausible and Lynn McFall agrees that integrity is a higher-order virtue, McFall comes to a different preliminary conclusion than Taylor. That integrity is a higher-order virtue presupposes some lower-order moral commitments, and moral integrity in turn adds moral requirements to personal integrity. Her intention here is to clarify that they are not just any moral commitments, "So it is more plausible to say that moral integrity adds a moral requirement to personal integrity: one must adhere to some set of recognizable moral principles or commitments. This rules out a singular commitment to art, as well as to personal pleasure, approval and profit."[14] McFall's position on integrity will eventually take us to the point where she denies the distinction between personal and social morality.

There is consensus in the literature that, as a moral notion, integrity most resembles a virtue. As a virtue we can situate it within moral theory. Here we have the first hint of integrity as an ideal to which one aspires, and we have an introduction of the problem of whether integrity is a formal notion or has content. Aside from the form/content issue, one of the important implications of integrity being classified as a virtue is the association with depth of character. This underscores the importance of consistency as well as the importance of integrity to our identity. Sections II and III will

[13] Taylor, 151-2.
[14] McFall, 14-15.

discuss whether integrity involves some set of morally correct (or less strongly stated, morally reasonable) beliefs, or whether it is a matter of being true to oneself.

II. INTEGRITY: FORM OR CONTENT?

Honesty, sincerity, and loyalty are often considered to be elements of integrity. But are these hard and fast? Perhaps these are *prima facie* elements, but we can consider cases where our common sense tells us that acting with integrity would require us to lie. Consider the following scenarios:

A: The Nazi SS Officer is loudly rapping at your door. He asks you whether there are any Jews at your residence. You know that if you tell the truth, the family you are hiding in your attic will be taken to their certain deaths.

B: Later that same day, after a difficult day's work, the Nazi SS Officer is at home with his wife and two children. By all appearances he is a faithful and devoted husband and father. He reads stories to his children which inculcate the value of love for the motherland. He is firmly committed to the ideals of the Third Reich and is willing to die for these beliefs.

These two scenarios help illustrate the problems with the content notion of integrity (or adherence to a socially/morally accepted code of conduct, a set of virtues) and the formal notion of integrity (or adherence to one's own moral code, a special application of virtues). There also seems to be a further distinction to be made; if integrity has content, then is the content exceptionless? If we take the formal view, it seems that, from a moral perspective, both Scenario A: lying to protect the innocent thereby putting oneself in harm's way, and Scenario B: being a committed Nazi who has internalized these beliefs and is willing to act on them at risk to oneself are compatible with integrity. If we take

the content exceptionless view, where prohibitions of lying and racism comprise part of the contents, then neither you nor the Nazi are acting with integrity. However, if we allow for principled exceptions on the content-full view, then our moral perceptions seem to allow for an exception to honesty in scenario A because the principle to protect the lives of the innocent is a countervailing weight; whereas, genocide and racism, as part of nationalism, would not trump the principle of not killing the innocent. So integrity conceived as both a formal notion and a content-exceptionless notion lead us to conclusions that are counter-intuitive and which render the concept ineffective for the evaluation of moral acts. We must work toward the justification of integrity that overcomes these counter-intuitive results.

Gabriele Taylor characterizes this classic problem of integrity as whether it is a select set of virtues or rather a special application of virtues.[15] Virtues such as honesty, uprightness, loyalty, promise-keeping, and playing by the rules are usually mentioned when discussing integrity. As such, integrity can be described as adherence to a socially accepted code. Another way of looking at it, however, is to describe integrity as not necessarily being true to an accepted code, but rather to be true to the standards that the individual has come to accept. This would include loyalty to, or being honest about, one's own principles.

But Halfon and Putnam both find a problem with the traditional discussion of integrity. In the sense that integrity is seen as a formal notion, an absence of context

[15] Taylor, 143.

allows for devotion to our own principles regardless of what those principles might be.[16] If, as I am suggesting, integrity will be a guide for the moral licitness of compromise, integrity must have teeth. And short of requiring complete honesty at the expense of innocent lives, there must be some content.

Integrity as a formal notion (or a special application of the virtues) allows integrity to be ascribed to individuals who might have commitments to evil. As such, the only way this will inform the process of moral compromise is possibly to impede it or render it morally impermissible. Viewing integrity as having content, on the other hand, leaves it open to charges of inflexibility, not being representative of the real world and having the ability to lead to fanaticism. However, there is a conception of integrity that calls for some constraints on the content, is compatible with moral compromise, and does not entail moral absolutism. It is this third conception that will be defended in the following section and which will be supported by Christopher Gowan's moral remainder thesis that will be discussed in Chapter Three.

III. 'MORALLY CORRECT' OR 'TRUE TO SELF?'

Heretofore I have maintained that a conception of integrity with constraints on its content will perform an important role in decisions of moral compromise. This section will address the nature of this content through a discussion of commitments. The principal way of showing that one has integrity is through faithfulness to the commitments one has made. So, at the very least, we might say that one must have

[16] Halfon, 5 and Putnam, 238-9.

commitments to earn an ascription of integrity.[17] And our most important commitments are the ones that we believe help define who we are. So there is an interdependent relationship among integrity, commitments, and personal identity. The importance of the relationship to personal identity will be addressed in the next section. One way to frame the problem of this section is determining whether integrity is: a) consistently doing the morally correct thing, generally understood as the content view, b) consistently acting according to one's own beliefs, commitments and principles, understood as the formal view, or c) the position I will defend – consistently doing the morally defensible thing that one has internalized.

One might say that if I am arguing for integrity to have content and the content is important, then why not just say that integrity is consistently performing morally correct acts? The problems with that position are twofold. First, it assumes that we can determine what is morally correct, leading to a position of moral absolutism; and secondly, this account fails to appreciate the richness of integrity as a virtue which accounts for the requirements of consistency and depth of character. Mark Halfon begins his philosophical inquiry into integrity by asking a similar question about the relationship between integrity and morally right actions. He proposes that if integrity is a

[17] Mark Halfon defends this position against the criticisms that a) there seem to be persons who have moral integrity but who have not made an explicit commitment and b) there are persons who seem to lack integrity for the very reason that they have made no commitment. He defends against the first by drawing a distinction between explicit and implicit commitments. An example of the latter occurs when one does not make an explicit pledge to a person but has pledged to act in accordance with a general principle. As far as amoralists avoiding potential loss of integrity, Halfon says that in some difficult cases silence is complicity and can signal the loss of integrity.

matter of consistent performances of morally right acts, then normative ethics should focus on the standards for determining the difference between right and wrong acts. If that is the case, then there would be no special need to investigate the concept of integrity, and he surmises that this may be why integrity has not been addressed more directly by philosophers in the past. But Halfon proceeds to argue that this is wrong and that he wants to distinguish between conditions that must obtain for persons of moral integrity but not for persons who simply act consistently on principle, whether the principle is from an accepted canon or one's own. What gives integrity standing over "conformity to principles" is the element that ascriptions of integrity usually include "a willingness to maintain one's commitments under adverse conditions."[18]

The role of commitments is essential to the notion of integrity and it is here that Halfon introduces the nature of commitments. He argues that persons of integrity must be committed to some action, goal, ideal or principle. These commitments may be either explicit or implicit, but to be relevant to ascriptions of integrity they must be serious rather than frivolous. To exemplify the latter, he talks of the difference between fasting in protest of human rights violations and fasting to break the Guinness World Record. Having commitments is not enough; one must also be committed to them, have the intention and wherewithal to carry them out, and as stated above, be willing to carry them out in the face of adversity. Lynn McFall and Gabriele Taylor also agree that one must have something to lose, namely commitments, to have integrity. As McFall says, "To sell one's soul one must have something to sell." We must be committed to something; a

[18] Halfon, 4-5.

commitment to spinelessness, according to McFall, does not vitiate spinelessness.[19] For purposes of this discussion, I will use commitments to stand for 'beliefs, principles and commitments' that will figure prominently in the discussion of moral compromise.

It is virtually impossible to be equally committed to each of our commitments so there must be some way to rank their importance. The process of discerning defeasible from indefeasible might be the first step in an ordinal ranking of commitments. McFall considers indefeasible commitments to be identity-conferring commitments. Along these lines, she claims that some commitments must be unconditional because they are conditions of continuing as ourselves. Halfon proposes that the way to discern indefeasible commitments is to ask which commitments are bound up in our sense of self-respect.

Additionally our commitments can conflict with each other, and when they do, there must be a way to a) reconcile these commitments in a way that they are able to coexist within an integrated person, i.e. they must be consistent and coherent; and b) after meeting the requirements of (a), we must also be able to decide which commitment outranks the other. Two questions follow from this discussion that will be addressed in Chapter Three. First, should moral theory function as a guide to action such that when deciding between two acts there is not sense of regret or remorse for the action that remains undone? Sometimes regardless of our good reasons for choosing A, it might be morally appropriate for us to have regret over our inability to also perform B at the same time. Secondly, one might be able to simplify one's life in such a way that one's

[19] Lynn McFall, 5-9.

commitments do not conflict. However, we then have an analogous situation to the person who is so single-focused so as to be a fanatic. One who oversimplifies is as morally culpable as the fanatic.

We have said that, at the very least, the contents of integrity include commitments. But what, if any, constraints are there on beliefs, principles or values to which we are committed? Our choices for the content of commitments parallel those for integrity: 1) they must be morally correct, 2) they must be morally defensible, or 3) they are morally indifferent. We can see that this spectrum mirrors the moral absolutism and moral relativism debate. Contents which are morally indifferent are incompatible with the picture I have drawn thus far, and morally correct contents fail to account for the pluralistic world with competing and conflicting values in which we live.

Perhaps the most recalcitrant problem in the integrity literature involves the content of integrity. Most philosophers who write about integrity want to include some sort of constraints on the commitments a person of integrity can have. Some even refer to what I will call 'The Nazi Problem' when addressing this issue. As alluded to in an earlier section, there is something counter-intuitive to the ascription of integrity to a Nazi, one who is committed to a morally reprehensible goal.[20] Some, such as Taylor, admit outright that their analysis may not rule out such people:

[20] NB: for the purposes of this discussion my use of integrity should read as 'moral integrity.' Personal integrity might more closely resemble the formal notion of integrity. The Nazi, with consistent and coherent commitments which he pursues in the face of adversity would qualify as having personal integrity, whereas we would not want to ascribe 'moral integrity' to him.

> I have not ruled out the possibility that all the conditions I have given may be fulfilled by someone who ruthlessly and without regard for the well-being of others pursues his own aim, even if in doing so he behaves in ways we regard as morally wrong. Not every immoral action need be a sign of the agent's corruption. I am inclined to think, however, that the ruthless egoist will not in fact possess integrity. 'Being truly committed to a project' has no doubt more implications than I have been able to draw out.[21]

Others claim that they want to "justify the claim that the content of certain principles or commitments disqualifies their adherents as candidates for integrity"[22] or even less strongly stated, "A balance ... should be struck that allows for latitude in the choice of moral commitments but does not sanction an obviously intolerable moral position."[23] However, of these two, McFall, in the end, only justifies that moral integrity allows for a partialist ethic and so is a challenge to both personal and social ethics which are impartial. This does not come close to disqualifying the Nazi from the ascription of integrity. Likewise, when pushed on the subject (in a much later chapter), Halfon admits that there are certain Nazis, the young naive Nazi and the mature sophisticated Nazi, who might meet his conditions for integrity.[24]

Putnam and Blustein are the only ones who claim that they have eluded The Nazi Problem. Putnam utilizes the work on moral development by Carol Gilligan and concludes that, on Gilligan's 'Balance of Virtue' level, integrity, at the highest level of

[21] Taylor, 158.
[22] McFall, 14.
[23] Halfon, 32.
[24] Halfon, 134-6.

moral development, will exclude the Nazi. The Nazi fails at this level because he lacks any of the virtue of empathy.

Halfon comes to a similar position on this point. Rather than claiming that the commitments of persons of integrity are either a) any action, ideal or principle or b) 'right' actions, 'desirable' ideals or 'just principles,' he plumbs the middle ground and strikes a balance that allows for latitude in the choice of moral commitments while at the same time not sanctioning any obviously intolerable moral position. He defends this with the use of the commitments themselves. If the nature of commitments are, as he claims, a pledge to pursue some objective in the form of a promise, oath, vow or declaration and that at a minimum one intends to fulfill this promise and use what resources they have available to reach that end, then the commitments themselves pose restrictions on the behavior of persons of integrity. For example, for intellectual integrity, one must be committed to seeking the truth, and all relevant and available evidence must be acknowledged and examined. This implies that one must believe that one's commitments are true, or less strongly stated, that there is a commitment or intention to discover the truth.

Gabriele Taylor settles on a notion of integrity that rejects both that integrity is a select set of moral virtues or that it is a special application of these virtues. Her choice is the idea of the person who keeps her inmost self intact, whose life is 'of a piece' and whose self is whole and integrated. Taylor's first condition for the possession of integrity is that one must be rational in a number of related ways such that she will not ignore relevant evidence, her behavior is consistent, and she will not act on insufficient reasons.

The second condition is that the person who keeps her self intact will be under due influence of her past. This must, however, allow for a person to change and develop over time.

An evaluation of one's commitments is important to the concept of integrity. But there might also be a process by which one examines not only one's commitments but one's actions as well. In his book, *Integrity*, Stephen Carter claims that there are three steps that take one towards integrity: 1) discerning what is right from wrong, 2) acting on what one has discerned, even at one's own cost, and 3) saying openly that one is acting on one's understanding of right and wrong.[25] There is a clear indication that if not a notion of moral correctness, then at least there is an element of moral justification, in Carter's criteria for integrity. Carter places a great deal of importance on the act of discerning. Moral correctness is discerning right from wrong rather than just following our own beliefs, which can be evil. He claims that we have a general duty to do the right rather than the wrong. This rests on the assumption that some beliefs and some acts are morally better than others, but more importantly that it is possible to tell which are which. The methods for achieving this are through reflection, conscience, and received social knowledge. However, without some higher-order principle to follow, the Nazi might claim to have gone through this process and passed the test.

I will maintain that constraints on commitments can take several forms: a)

[25] Stephen Carter, 10-12.

constraints on the individual's deliberation, constraints on the person's behavior, and constraints on the commitments themselves.

Constraints on the individual's deliberation:

1. Willingness to investigate the truth of one's beliefs.
2. Willingness to consider all relevant evidence.
3. Willingness to take one's past into consideration.
4. Logical consistency.

Constraints on the individual's behavior:

1. The intention and wherewithal to follow through on commitments even in the face of adversity.
2. Free of hypocrisy, weak-will, shallow sincerity, self-deception or wantonness.

Constraints on acts or commitments themselves:

1. At a minimum, acts must pass the 'respect for the dignity of the person' principle.

It might be argued that this list will not preclude the Nazi from an ascription of integrity. The sincere Nazi might argue that the Jew does not meet the requirements of personhood. This, it seems, flies in the face of the constraint on deliberation of being willing to consider all the relevant evidence.

At this point some comment on process should be included. The 'process' to which I refer can be considered judgment or moral reasoning. Inherent in this are the notions of discernment, reflections, conscience, and considerations of social codes.

IV. INTEGRITY AS IDENTITY-CONFERRING

In her discussion of commitments, Lynn McFall says that some need to be unconditional because the commitments themselves are conditions of our continuing as ourselves. She distinguishes defeasible commitments from identity-conferring commitments; the latter she takes to reflect what to the individual are the most important

and determine to a large extent our moral identities. She says that the willingness to die for these is the clearest proof we have of these types of commitments. She continues this theme with regard to the alleged separation of personal and social morality. McFall concludes that, without integrity and the identity-conferring commitments it assumes, there would nothing to fear the loss of because there would be nothing to lose. Margaret Walker also emphasizes the role that commitments have in giving our lives meaning. Proceeding along these lines, I want to show that not only are our indefeasible commitments identity-conferring, but that this also supports the role that integrity plays in our personal identity.

Many start their discussion of integrity by giving examples of what it is not or examples of people who show a marked absence of it.[26] In each case, there is a disordered relationship among the individual's commitments, his or her self-perception and his or her motivations. Gabriele Taylor takes as the very base of integrity that a person must have commitments and be true to them. She then discusses the hypocrite, the shallowly sincere, the weak-willed and the self-deceiver. The hypocrite only pretends to others that he is so committed. In some sense he is able to maintain internal integrity (he knows that he is not really so committed) but lacks external integrity. The shallowly sincere are prompted by impulse and momentary enthusiasm. It is not that this person is insincere, but there is a total lack of self-knowledge. The weak-willed has

[26] Gabriele Taylor, "Integrity" and Martin Benjamin, *Splitting the Difference: Compromise and Integrity in Ethics and Politics* (Lawrence, KS: University of Kansas Press, 1990) and Jeffrey Blustein, *Care and Commitment* (New York: Oxford University Press, 1991).

commitments but is unable to be true to them. Unlike the shallowly sincere, he is aware of this failing. Martin Benjamin adds here that the weak-willed may have a coherent set of principles but lacks the courage of his convictions. The self-deceiver is, Taylor claims, the most important and fundamental case of the lack of integrity. Benjamin seems to concur on this point. In his description of the self-deceiver, Benjamin claims that she has to convince herself of an idealized self-conception. This drive is motivated by a desire to preserve integrity. However, it preserves only the internal appearance of integrity at the expense if a great deal of psychic energy.

In addition to those listed by Taylor, Benjamin includes the moral chameleon, the opportunist and those subject to coercion. The moral chameleon is anxious to accommodate others and is indisposed to moral controversy and disagreement. Left long enough, the moral chameleon is apt to betray herself as well as others. The opportunist has fluid values and principles, similar to the moral chameleon. The salient difference is that where the moral chameleon uses this fluidity to get along, the opportunist uses it to get ahead. Those subjected to coercion can lack integrity in different ways. They might display external integrity while disintegrating internally. Benjamin illustrates this with the example of the battered wife who stays with her husband. The example earlier in this chapter seems pertinent here. Certainly if the woman submits to the SS officer, she does so under coercion. Aristotle addresses cases like this and says that although these types of acts are done under compulsion, which he says normally renders them involuntary, they more resemble voluntary acts because "the movement of the limbs instrumental to the action originates in the agent himself, and when this is so it is in a man's own power

to act or not to act."[27]

Benjamin concludes from this excursion into those who lack integrity that integrity is an integrated triad: 1) coherent and stable values and principles, 2) verbal behavior expressing these values and principles, and 3) conduct which embodies these values and principles. These criteria allow for an internal and external integrity.[28]

Mark Halfon proposes that persons of integrity are: committed to some action goal, ideal or principle; are willing to persevere in the face of adversity; and maintain a consistent commitment to do what's best.[29]

Margaret Urban Walker begins her chapter on "Picking up Pieces: Lives, Stories and Integrity" by asking the question, does a well-ordered life necessarily involve the right kinds of content? She considers the two options of a principled consistency or an unconditional commitment to morally important matters. She expands on this by discussing three types of narratives that are central to living responsibly a life of one's own. One of the three is the narrative of moral identity, in which we have a "persistent history of valuation that can be seen in a good deal of what a person cares for, responds to and takes care of."[30] Most of us set priorities among values, develop highly selective responses, and pay acute attention to particular kinds of things as well as people. None

[27] Aristotle, *Nichomachean Ethics*, Book III.
[28] Benjamin, 51.
[29] Halfon, 13-37.
[30] Margaret Urban Walker. "Picking Up Pieces: Lives, Stories and Integrity" in *Moral Understandings: Feminist Study in Ethics* (New York: Routledge, 1998):112.

of these license avoidable cruelty, destructiveness or indecency to anyone. But these selections reflect and refine a moral identity. With regard to integrity, Walker favors a view of moral responsibility over coherence or continuity. What we are accountable for we must be willing to repair and restore dependability when the structure we have built teeters or fails. We must be reliably responsible in matters of our own and others' good and keep clear and vibrant shared understanding of them. Narratives are connected to integrity in that we can have multiple stories with identity; sometimes we must become differently reliable. This can also be a way to honor commitments or act credibly when the situation has been affected by someone else's bad behavior. For Walker, integrity does not have to be a whole life referent; it can be more or less local.

One of the pictures of integrity that Cheshire Calhoun describes is the identity picture of integrity. This view, she claims, equates the condition under which we can go on as the same self as equivalent to the conditions for integrity. But action on deep impulses that define psychological sense of self may have little integrity.

V. FROM PERSONAL INTEGRITY TO ORGANIZATIONAL INTEGRITY

This section will demonstrate how the requirements for personal integrity can be extrapolated to organizational integrity, and thus show us a working model for evaluating the individual's as well as an organization's integrity. Although there is little or no philosophical literature that directly addresses this issue, there are connections that can be made through moral theory literature, business ethics literature as well as organizational literature. In this section I will maintain that, as a virtue, integrity has a decidedly social

aspect. Most basically this is displayed in the way one maintains one's commitments. Furthermore, in the same way that commitments are identity-conferring to the individual, so do they help establish the true identity of the organization. The need to eliminate internal and external conflicts is also a key connection to be made in this discussion. Additionally, virtue theory will provide a vehicle to bridge the individual and the organization. Finally, a brief discussion of organizational behavior will illustrate why integrity becomes a more unwieldy concept at the organizational level. Because of the variables at the organizational level, we might have grounds to slightly weaken the demands of integrity that have been posited at the individual level.

Some philosophers distinguish among the different types of integrity: moral integrity, personal integrity, and social integrity, for example.[31] But it should be clear from our earlier discussion that if there is, in fact, a difference between personal and social integrity, then our understanding of commitments provides the bridge between the two. Cheshire Calhoun concludes her discussion of integrity pointing out that the three received views of integrity – the integrated self picture, the identity picture, the clean-hands picture – are ultimately inadequate because: 1) they both reduce integrity to conditions of unified agency, to conditions for continuing the same self, and to conditions for having a reason to refuse cooperating with some evils; and 2) they proceed on the assumption that integrity is a personal virtue and this assumption wrongly limits

[31] Blustein and Halfon are two of these.

what can be said about both the nature and value of integrity. She differentiates personal virtues from social virtues. An example of the former is temperance, which is to have proper relation to oneself, in this case to one's desires; an example of the latter is civility which consists in having proper relations to others. Some virtues, such as self-respect, can be both personal and social. Calhoun claims that it is necessary for integrity to have the social, as well as the personal, in order to explain the importance of 'standing for something;' and that, to say it is only personal does not make the other person central to the defense. Lynn McFall ultimately comes to a similar posture as Calhoun, but argues rather that there is no difference between personal and social integrity.

Commitments by their nature are a form of activity; activity that to some extent is social. Commitments, when upheld even at risk of harm or cost to oneself, are often the public manifestations that account for ascriptions of integrity. Even the most personal of our commitments, when upheld, are manifested in a public way. An example of this is the recovering alcoholic. Her continuing sobriety is a public manifestation of her commitment to address her alcoholism which can be an extremely personal commitment.

Another way that commitments can bridge the gap between personal and social comes from Bernard Williams with regard to our ground projects that give our lives meaning. "One can be committed to such things as a person, a cause, an institution, a career, one's own genius, or the pursuit of danger."[32]

[32] Bernard Williams, 112.

As with individual integrity we took note of the relationship between principles and actions. Does the individual live according to her principles, or is she a hypocrite? This same relationship applies to the organization: does it embrace principles that it lives by or is merely spin? Is 'image everything?' If not, then these organizations are shallowly sincere in the worst sort of way. Most advertisements cut right to the heart of the shallowly sincere.

There must be a balance between the external and the internal. Earlier in this chapter, I used the example of the woman forced to sleep with the SS officer in order to save the life of her family. Either choice might be morally justified, and with either choice she becomes disintegrated either internally or externally. Ideally there should be balance between the internal and the external. This is difficult at best with the individual; these difficulties increase exponentially within the organization which is made up of numerous individuals. We might infer that this signals a greater need for integrity or at least deserves greater attention to integrity. We might also argue that, because of the multi-valence within an organization, we might lessen the conditions for integrity.

Virtue theory provides another interesting bridge between the individual and the organization. In his book on business ethics, David Stewart says:

> By making only a few alterations we can use the language of Aristotle to describe the goals and purposes of business. What *eudamonia* is to the individual, profits are to the business organization. Without profits, a business dies. Without profits, a business cannot offer employment, make products, or pay investors a return on equity. And just as individuals achieve happiness by seeking other goals, there is growing evidence that the business goal of profit can be best sought if a company first pursues such goals as enduring quality of its product, service to its customers, and

a commitment to ensuring a stable community and work force.[33]

Another take on virtue theory might be that, if virtue theory emphasizes the development of the moral individual through a common cultural tradition that reinforces shared moral values, then we can see an analog in the contemporary corporate culture or organizational culture. This culture has a strong influence on both the direction of the organization as well as the actions of those individuals within the organization. As reported in O.C. Ferrell and John Fraedrich's text on business ethics, research was conducted on two basic dimensions of an organization's culture. The two dimensions included were concern for people and concern for performance. This study resulted in a classification of four cultures: apathetic, caring, exacting and integrative. Not surprisingly, it was the integrative culture that combined both a high concern for people and a high concern for performance.[34] Ferrell and Fraedrich also maintain that an organization's culture can be a factor in ethical decision making. It stands to reason that integrity is related to ethical decision making.

Throughout this work we will discuss the mission and values of Catholic health care: how those values are derived, how those values are expressed by the institution through its policies and procedures, how these values are inculcated in the co-workers, as

[33] David Stewart, *Business Ethics*, (St. Louis: McGraw-Hill, 1996):50.
[34] O.C. Ferrell and John Fraedrich, *Business Ethics: Ethical Decision Making and Cases* (Boston: Houghton Mifflin Company, 1997):118 -20.

well as how conflicts are addressed when co-workers **and** patients do not share those values.

Now we will turn to the subject of moral conflict and how one might act with integrity when confronting moral conflict, especially intractable moral conflict, and when one might countenance moral compromise.

3. *ACTING WITH INTEGRITY IN MORAL CONFLICT*

In the last chapter we discussed the importance of integrity to the moral life. I argued for a notion of integrity characterized by its content and identity-conferring aspects. One with integrity has a morally reasonable set of beliefs, commitments and projects that one has publicly stated and which one will defend even at risk to oneself. A person of integrity will *deliberate* in a reasonable way, consistent with logic, and with a willingness to consider the truth of her position as well as the truth of opposing positions. A person of integrity also *acts* in a way that shows respect for persons, and at a minimum, *the content* of her position must meet the demands of respect for persons. Our focus on integrity implies a reference to virtue theory. Virtue theory is usually criticized as an incomplete moral theory in that it instructs us as to what kind of person we should be but does not necessarily tell us how to act. I will argue that the notion of integrity I have described is morally important in that it benefits a pluralistic society, facilitates tolerance and guides us when confronting moral conflict, especially intractable moral conflict. Much of the conflict we experience everyday is a result of

wildly varying worldviews. Some societies are more conducive to peaceful coexistence of these worldviews. I will also discuss the role that democratic societies serve in the tolerance of different positions, as well as in handling dissent of those who feel oppressed.

This chapter will address some of the concerns one faces when confronted with moral conflict that is intractable, and how integrity can guide us when countenancing compromise. The following chapter will then address these moral conflicts as they often arise in the context of Catholic hospitals.

I. MORAL CONFLICT

When we are engaged in moral conflict and seeking resolution, our integrity can be challenged. These challenges can feel particularly acute when the moral conflict seems, after reasonable deliberation, to be intractable. In some circumstances, we can get to the point of thinking that we must morally compromise, but this terrain is treacherous and we must take care in navigating it. Integrity can assist us in this task.

In Chapter Two we discussed the constraints on *deliberation* of one who has integrity. They are: 1) willingness to investigate the truth of one's beliefs, 2) willingness to consider all relevant evidence, 3) willingness to take one's past into consideration and 4) logical consistency. In Chapter Two, these applied to the discussion of the commitments that one has, but they also hold true for the deliberation process when one is confronted with moral conflict. That discussion also included

constraints on how an individual *acts*: 1) the intention and wherewithal to follow through on commitments even in the face of adversity and 2) free of hypocrisy, weak-will, shallow sincerity, self-deception or wantonness. Again, these can apply in the way we go about deliberating in moral conflict. When we have acted according to these guidelines and can reach no agreement, we might be close to the claim of intractability. There are also other aspects we should consider.

Initially the non-moral concerns should be separated from the moral concerns. Non-moral concerns are more likely to be fungible or have exchangeable interest, in which case compromise does not present the same danger to our moral lives. Then of the moral concerns it should be determined that the conflict is not able to be resolved by a synthesis or middle-of-the-road position, which Martin Benjamin in his work, *Splitting the Difference: Compromise and Integrity in Ethics and Politics*, says is not a compromise in the strict sense. Another aspect is that the conflict will be between parties in which a relationship must, or should for the best interests of all parties, be maintained. One relationship of this sort, in a very broad sense, is the relationship between citizens in a democracy. This could be considered a non-voluntary relationship; however, this does not vitiate the responsibilities of its citizens. As Henry Richardson says in his article, "Democratic Deliberation about Final Ends,"[1] all citizens have the claim to equal respect and concern. These relationship-demands extend to voluntary relationships such as those between friends and spouses, as well as involuntary relationships: such as the teenager who might like to divorce his parents.

[1] Henry Richardson, "Democratic Deliberation about Final Ends," (Paper delivered at the meeting of American Philosophical Association (APA) Atlanta, GA 30 December 1996).

At the very basis of the requirements to maintain relationships is the treatment we owe to fellow rational beings worthy of respect. Concomitant with the responsibility to respect persons is that the parties to the moral conflict operate in good faith. They are both willing to act in response to the other party's argument as well as consider the other party's situation and need, but not to be unduly influenced by the latter. In a response to Richardson, Betsy Postow says that continued deliberation can keep that possibility in check.[2] Parties must be able to reflect on their own self-understanding – they must be able to question their motives and be willing to amend their position if their motivations are not morally reasonable.

II. INTRACTABLE MORAL CONFLICT

When one is confronting intractable moral conflict, one can choose from at least four options: 1) to not act at all, 2) to stand firm and maintain one's position, 3) to give in altogether, or 4) to engage in moral compromise. The first option is a live option for only a limited amount of time, if it is an option at all. The situation often degenerates to one where the refusal to make a decision, which is how this situation can be described, is itself a decision. The second option of standing firm has its own repercussions. Someone who stands her ground might be lauded as one who has maintained her integrity; however, she may be easily susceptible to the error of fanaticism. This type of situation might lead to either a non-violent conscientious

[2] Betsy Postow, "Response to Richardson's 'Democratic Deliberation about Final Ends'," (Paper delivered at the meeting of American Philosophical Association (APA) Atlanta, GA 30 December 1996).

objection or might provoke a violent response from others. In the third option, one who gives in might be seen as lacking integrity and being weak-willed, or on closer examination, it might be shown that the individual capitulating has done so under the coercive nature or position of the other. This problem of coercion due to a power differential will be addressed later in this chapter. The fourth option of moral compromise will be the focus of the remainder of this chapter. Figures 1 and 2 (on page 61) depict schematically the morally licit and morally illicit consents to compromise and refusals to compromise that will be discussed; e.g., the German woman who 'consents to compromise' by sleeping with the SS officer to save her family members' lives, consents to a morally licit compromise; however, we allow that externally her integrity has not been preserved. When the option of moral compromise is pursued it is usually because inaction is no longer an acceptable option.

III. COMPROMISE

On first blush, the most palatable rationale for accepting moral compromise is that it is 'best of the worst' options or the 'lesser of all the evils' available to us. Additionally, moral compromise should only be pursued when the second option of standing firm and the third option of giving in do not allow us to maintain integrity. We are then left with considering the possibility of morally compromising while maintaining our integrity.

We all face decisions in which we feel pressured to compromise. Often

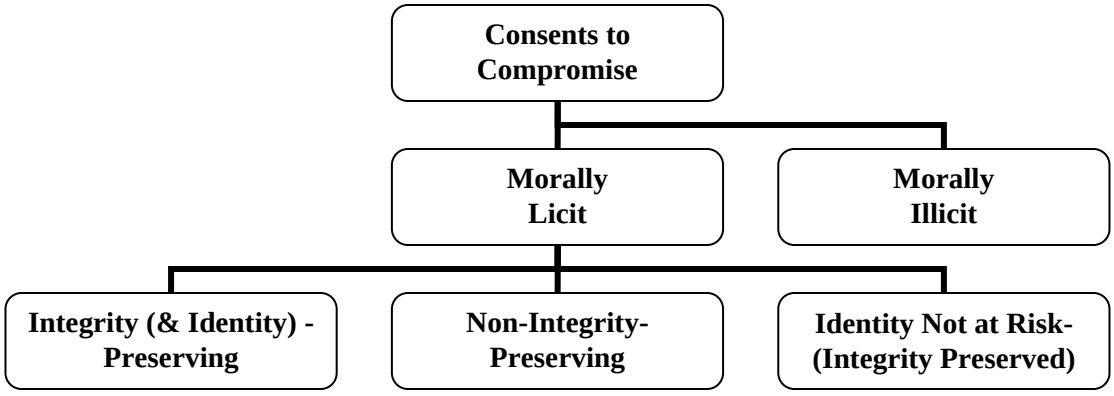

Figure 1. Consents to Compromise

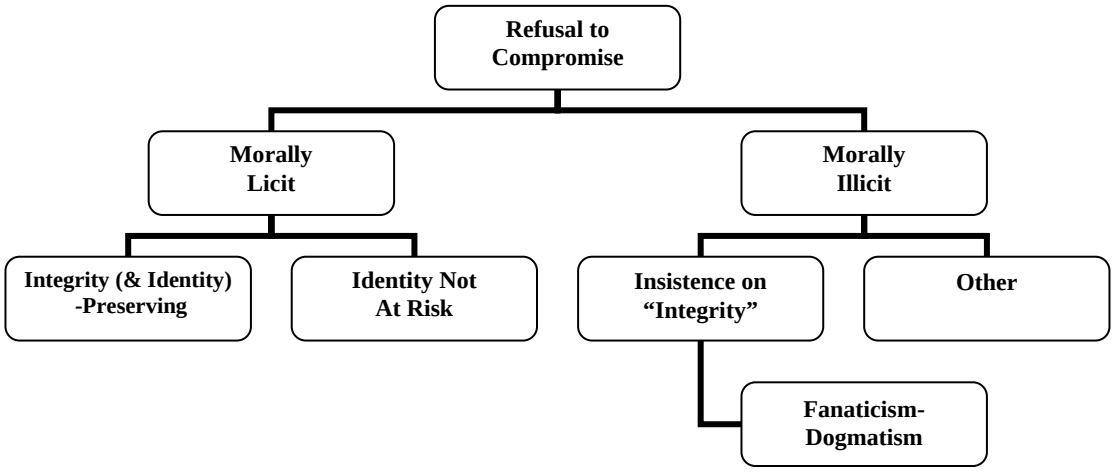

Figure 2. Refusals to Compromise

compromises challenge our most deeply held moral beliefs. However, there are costs to resisting compromise. Life can become more uncomfortable for ourselves or for those whom we love, and we can alienate ourselves and others. But there are often greater costs to acceding to moral compromise, such as: loss of our reputation, the respect of our family and friends, self-respect and sometimes, worst of all, we lose part of ourselves – our identity. In many ways these can be attacks on and do damage to our integrity. Furthermore, the integrity of institutions that hold absolutist ideals or principles is at greater risk in the case of compromise. How do institutions survive in this world and maintain their principles? Even more difficult, how do they provide services necessary to all in the community, such as healthcare, and operate on principles that do not coincide with those of the culture?

Prior to discussing what prevents us from compromising, a brief review of the nature of compromise is in order. In *Splitting the Difference,* Martin Benjamin begins by elucidating the varied meanings of compromise. In what Benjamin calls the standard sense, compromise is both a *process* (a settlement of differences by mutual concessions) and an *outcome* (a resolution that is reached where the parties more or less 'split the difference'). Not all compromises in the standard sense will necessarily contain both elements. If the conflicting parties to a compromise decide on an outcome that is superior to either party's original position without either party relinquishing any ground, then Benjamin considers this a synthesis position and not strictly a compromise. Strictly speaking, a compromise does not end the disagreement between the parties but rather ends up splitting the difference in some way. He

includes two conditions for compromise in the standard sense: 1) the disagreement is over a more or less indivisible or non-shareable good and 2) the initial procedure is an agreement to abide by the outcome of a subsequent procedure that gives equal respect considered to the interest of all the contending parties.[3]

In addition to the standard sense, compromise can sometimes be seen as a kind of betrayal in some cases, as well as a form of prudence in other cases. A prudential compromise is impelled by objective ends; it is neither cowardly nor self-serving. For example, I might forego playing basketball in the NCAA finals when my broken ankle is not completely healed in order to prevent permanent disability which would preclude a career in the WNBA. Benjamin also includes how acts of nature can force prudential compromise. We certainly would not say that the captain of a schooner betrayed his goals when turning back from a devastating storm.

When it is a betrayal, compromise does damage to our commitments to self, others, our projects, our community and perhaps most importantly, our sense of integrity. This is the form of compromise that we resist in order to keep ourselves whole, thus maintaining our integrity. Benjamin says, "It is this sense of compromise…that inclines us to regard compromise as morally questionable and to regard as exemplars those who have resisted various pressures or temptations to compromise."[4] Some of the exemplars he lists are Socrates, Gandhi and Martin Luther King, Jr. Benjamin admits that the distinction between compromise in the standard sense and compromise as a betrayal suggests the distinction between non-

[3] Benjamin, 67.
[4] Benjamin, 8.

moral legitimate interests and conflicts of moral principles. Therefore, it is necessary to consider the nature of the conflict. Is the conflict over something that can be represented by exchangeable interest? If so, a compromise need not be perceived as a betrayal and therefore integrity is not at stake. However, moral principles do not easily convert to exchangeable interests, and so, in what Benjamin says is the first substantive question, one asks "Are there any circumstances in which parties to a conflict involving rationally irreconcilable ethical commitments may devise mutually satisfactory compromise without compromising (or betraying) themselves or others?"[5] Compromise as betrayal can also take the passive voice, where one is compromised or made vulnerable with limits placed on one's future actions either through the actions of others, or by one's own failings or indiscretions.

A. Why Do We Avoid Moral Compromise?

It has been mentioned throughout Chapter Two that one of the primary reasons we resist compromise is that we fear the loss of integrity. However, there can be additional reasons for our reluctance to compromise. I have divided these reasons into two categories: impediments to compromise and constraints against compromise. If we could look at compromise in a non-pejorative sense, impediments are those obstacles that prevent us from reaching compromise, obstacles that we might wish to remove. Constraints will be those things that are normally employed to rightly direct our actions but which may bind us too strongly in favor of one direction. Either impediments or constraints, when taken to an extreme, become fanaticism.

[5] Benjamin, 23.

1. Impediments

Impediments to reaching a reasoned compromise include those traits that seem to protect what is often the most fragile part of our human nature – the ego. Pride, or more precisely, improper pride and hubris insulate us and our projects from the barbs of the world. Moreover, they often protect us to the detriment of others and their worlds and their projects. Hubris denotes a sense of pride that is scornful and overweening. Others and their ideas do not and cannot meet our level and our ideas. Compromise is not countenanced because we consider that the other party can bring nothing to the table. If our overly prideful selves acknowledge others' projects, at best, they do not reach the standard of ours. We see this, for example, in the researcher whose work could be augmented through collaboration with a colleague but who does not see the value in this because of an inflated sense of self.

Identifying pride and hubris in others is difficult to do in an objective way. Because they are attributes of the nature of a person, one can look to certain behaviors that indicate pride or hubris, but these are really attributes best revealed through self-reflection. Although humans are often good at self-deception and others may be good at seeing through each other, they are nonetheless in an epistemically privileged position to reason and reflect on their own motivations provided that they are diligent and rigorous in this self-reflection. Many who lack integrity have certain character defects. Thus, in the case of Catholic hospitals as the sole provider for a given area and the community's demand for increased reproductive services, it is difficult to objectively ascribe to the hospital motivations of improper pride or hubris. The same

can be said of those forces working to make reproductive services available. Certainly, we often describe one side or the other as acting out of pride or hubris such as when the head of the Catholic Hospital Association, Rev. Michael Place, in an interview with "60 Minutes" talks as if there is nothing more to the issue than the fact that, "… Every hospital does not provide every service. All women's services are not provided..."[6] A similar assessment is appropriate when pro-choice forces deny the humanity of a full-term fetus in the partial birth abortion debate.

2. Constraints

In addition to impediments, there are constraints which keep us from compromising. Constraints function to direct our actions rightly; they provide our moral compass. The primary constraint discussed so far has been integrity; however, constraints can also include first principles, individuals' moral beliefs, projects and identity – what makes them who they are, without which they would cease to be who they are. While it is best to heed constraints, if they are taken to an extreme, we can become uncompromising in the sense of a dogmatist, fanatic or ideologue. When taken to an extreme, pride, hubris and power can lead to fanaticism. In a cartoon by Chuck Jones, Wiley Coyote has once again been foiled in his attempts to catch the Road Runner and a series of road signs (which quote philosopher Georges Santayana) says, "A fanatic is someone who redoubles his effort when he has forgotten his aim." This might be aptly illustrated by one who clings more tenaciously to certain beliefs

[6] "60 Minutes" episode, fall season 2002. And yet, since this broadcast, it has become clear how the media sound bytes have distorted, at the very least, the messages of the Catholic Health Association of the United States (CHAUSA).

the more a resolution to the moral conflict is required. Mark Halfon groups fanatics along with dogmatists and ideologues as typically uncompromising (in the pejorative sense) while distinguishing them from those who are uncompromising in a non-pejorative sense.[7] Serious effort must be given to confronting the impediments of pride, hubris and power before moral compromise can be considered.

In the next chapter, we will deal with conflicts that arise in the context of Catholic health care. At the heart of many of the reproductive issues lies the abortion debate. The constraints for either side in this conflict seem clear. The Catholic Hospitals must operate according to the principles as set forth in the *Ethical and Religious Directives* as promulgated by the National Conference of Catholic Bishops (NCCB).[8] Catholic health care identifies itself in terms of a ministry, a mission to spread the Gospel and see the face of Christ in the poor and sick. The integrity of their mission in terms of the sanctity of life at the beginning, middle, and end of life shows a consistency that is rarely seen in politicized debates, i.e., no political party has seen it expedient to endorse both a pro-life stance as regards abortion and euthanasia as well as an anti-death penalty stance.

Likewise, those in favor of reproductive liberties, although quite varied in ideologies, can base their arguments within consistent principled positions, be it a feminist or a libertarian stance. Feminist arguments in favor of reproductive liberties, also many and varied, have as their base notions that historically (and still today),

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[7] Halfon, 63.

[8] Whose work is decided in conjunction with Catholic moral theologians as well as encyclicals and writings of the various popes. The basis for the prohibition of abortion is found in *Donum Vitae*, and reiterated in *Humanae Vitae* and *Evangelium Vitae.*

women have not been treated as equals to men (some label this as oppression), that we should work to end this oppression, that one of the primary forms this oppression takes is to deny women the right to control their reproductive abilities, and therefore, women should have the right to reproductive choice. Libertarians, while coming to a similar conclusion, frame the argument within the role of the state in individual's lives. Libertarians would maintain that, other than the minimal police state developed to protect citizens from threats to their individual liberties, there is no role for the government. Therefore, woman's right to decide what happens to her body should not be any concern of the state.

The message to be taken from this discussion is that we must work to remove impediments while at the same time giving proper attention to those principles, morals, and projects that form our identity and constitute integrity.

B. Why We Compromise

There are several reasons why we do compromise, and it is interesting how these different reasons map onto the different types of individuals, all of whom, according to Benjamin, lack integrity in varying degrees. There are those who will do most anything to get along, and there are those who will do likewise to get ahead. Benjamin labels these types the moral chameleon and the opportunist. The moral chameleon finds that she has been identified as someone protesting outside an abortion clinic. Realizing that she is in a group of pro-choice advocates (and perhaps acting out of insecurity) she quickly, and before hearing any reasoned arguments from the group, admits that she was there, but contends that she was merely talking to the protestors to

come to a better understanding of *their* position. While the opportunist, looking for maximum gain with minimal input, has no real position on whether abortion is moral or not, she sees that the group most able to help her in her graduate career is pro-choice and so she adopts that position publicly. Additionally, there is the hypocrite who will try to convince us that she maintains certain positions but does not really act on them, the weak-willed who has principles but not the fortitude to live up to them,[9] the self-deceivers who have convinced themselves that they are something they are not, as well as those who fall prey to coercion. The hypocrite and the self-deceiver are sometimes hard to distinguish from each other. Take the politician who runs his campaign on 'family values' and reproaches another politician for an extra-marital affair with a young intern and then is caught in the same entanglement himself. Further, he might try to convince himself and others that what transpired between him and his paramour did not constitute 'sexual relations.' And therefore of the hypocrite one must ask, does he really believe that he is acting according to his professed beliefs? Perhaps his brand of 'family values' is constituted by continuing the marriage to his high school sweetheart, thus maintaining the family unit, but acting independently otherwise. The moral chameleon, the opportunist, and the hypocrite, in some sense, all act out of a sense of expedience.

Those who compromise due to coercion present a different scenario than the aforementioned. We might allow that those subject to coercion are not necessarily

[9] The weak-willed is certainly compatible with the moral chameleon; however, the moral chameleon is less likely to have a coherent set of values because she is forever accommodating others to avoid conflict. The weak-willed may have a coherent set of beliefs but lack the courage to carry them out.

responsible for their actions in the same way the others are. In particular, the hierarchical nature of the power structure might lead to the weaker party being coerced into a compromise; this would encompass compromises pursued out of financial necessity. For example, the sales manager instructs the new sales representative to release misleading information to their clients. If her prospects for another job were better, she would stand up to the manger and refuse; however, as the sole provider for her family and somewhat unemployable, she acquiesces and distributes the information. One of the problems in determining the extent of culpability is determining why one has changed positions. Politically, Southern Democrats prior to the 1990s were often pro-life candidates, in particular when the office that they sought was on the local or state level. However, when pursuing a national position, they switched to a pro-choice position.[10] Was this switch a moral compromise, a result of further consideration of reasoned arguments, a result of the political hierarchy of power on a national level, a matter of expedience, or some combination?

C. Why We Should Compromise

Next we turn to reasons why we should compromise. One of the strongest and prevailing justifications that we can give for compromising is that we live in a pluralistic world. Pluralism says that ultimate values and first principles may differ according to one's worldview, culture, or religious beliefs. The acknowledgment that people of goodwill hold different worldviews, different religious beliefs and have different ways of life, thereby coming to different conclusions in moral deliberation,

[10] The three most visible of these 'southern Democrats' are Rev. Jesse Jackson, Al Gore and Bill Clinton.

provides the grounds for a moral compromise. Pluralism coupled with the inevitable moral conflicts that will ensue provides additional incentive for moral compromise.

While the acceptance of pluralism provides the grounds, and perhaps incentive, for moral compromise, could monism provide a similar incentive? Perhaps. Moral monism claims "there is one ultimate moral value to which whatever apparent diversity of moral values there is may be reduced."[11] It is reasonable to think that monism would provide a conclusion to moral deliberation to which all could agree and which would leave no remainder. However, Christopher Gowans claims that even in a monistic system there can be moral 'remainders.' He argues that there are cases where moral wrongdoing is inescapable, even in a monistic system. While on the surface that might not seem to provide the same motivation for compromise as the acknowledgment of pluralism, this might be more compelling. Compromising to acknowledge pluralism depends on my respect for your moral views, which may involve trying to preserve my own integrity. This may speak to the phenomenological experience of moral distress that we feel over these moral remainders. This, in turn, may influence our approach to the opposing party in an intractable moral conflict.

Other reasons that justify compromise include its intrinsic and instrumental values, its treatment of other parties in a conflict as rational beings worthy of respect, and the desire, or even obligation, to maintain a long-term relationship. As discussed in chapter two, often long-term relationships can speak to our sense of identity in the same way that principles and projects do. To adhere to a principle at the expense of a

[11] Gowans, 145. However, this also suggests room for different interpretations of the single principle or value.

relationship can lead to a loss of integrity in a similar way as betraying that principle. Additionally, conflicts may seem intractable, inexorable and the situation demands that action be taken. These are all incentives to moral compromise. At this point it might be helpful to see where pluralism is situated within what some see as the goals of moral philosophy.

1. Moral Theory and Pluralism

The goal of Western philosophy has been described as a Platonic Quest seeking to transcend the contingent "in order to identify foundations of knowledge, reality and moral value that are independent of any particular social, cultural, historical or linguistic point of view."[12] Richard Rorty, an outspoken critic of the conception of philosophy as the 'Platonic Quest' describes it as

> …the search for a way in which one can avoid the need for conversation and deliberation and simply tick off the way things are. The idea is to acquire beliefs about interesting and important matters in a way as much like visual perception as possible – by confronting an object and responding to it as programmed.[13]

Rorty opposes this view by stating that we are situated within traditions, language, history and culture, which can not help but shape our thinking and self-criticism. As such, we are unable to compare ourselves to an absolute; we *cannot* transcend the contingent. As part of the Platonic Quest of philosophy, the goal of moral theory has been to develop a "fully consistent, comprehensive set of values and principles that when embraced by all, would – at least in principle – eliminate rationally irresolvable

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[12] Benjamin, 77.
[13] Richard Rorty, "Pragmatism, Relativism, and Irrationalism," in *Consequences of Pragmatism* (1980):164.

(or incommensurable) moral conflict." Benjamin goes on to say, "Discovery or development of the single true ethical theory that commends itself to all insofar as they are rational would enable us to resolve all disagreements without remainder."[14] However, Benjamin allows that the abandonment of the Platonic Quest does not rule out the possibility of harmonizing moral values and principles.

Benjamin borrows a phrase from Stuart Hampshire, "the doctrine of moral harmony," to describe the goal of some moral theorists to harmonize our ethical values and principles. By viewing the successes wrought through the process of ethical inquiry, these moral theorists are hopeful that through further reflection and understanding, we will "devise a consistent and comprehensive theory that will be capable, at least in principle, of resolving all moral conflicts without remainder."[15] Hampshire identifies Hume, Kant, the Utilitarians, the deontologists and the ideal social contract theorists with the doctrine of moral harmony. Despite their differences they share a belief in agreement with Aristotle: 1) in stating or implying that moral judgments are ultimately to be justified in reference to some feature of human beings which is common throughout the species and 2) by implying or stating that a morally competent and clear-headed person has, in principle, the means to resolve all moral problems as they present themselves, and that he need not encounter irresoluble problems.[16] Hampshire disagrees, saying that these two main candidates for this common feature among the species prove to always underdetermine a way of life and

[14] Benjamin, 75.
[15] Benjamin, 82.
[16] Stuart Hampshire, *Morality and Conflict* (Cambridge, MA: Harvard University Press, 1983):144.

underdetermine the moral prohibitions and injunctions that support a way of life.[17] Moral theory thus becomes too abstract and theoretical to be of practical use. If we agree that the Platonic Quest for the one true moral theory to which all willingly subscribe has not yet succeeded in moral theory along with the impractical results of the search for the 'doctrine of moral harmony,' then we can accept pluralism.

What place does pluralism occupy in a democracy, and how do power and dissent affect moral conflict in a pluralistic society? Part of the acceptance of pluralism is the tolerance of moral theories and moral principles that one does not endorse. More broadly, one reason moral theories can conflict is because they are often rooted in different worldviews. Benjamin defines a worldview as "…a complex, often unarticulated (and perhaps not fully able to be articulated) set of deeply held and highly cherished beliefs about the nature and organization of the universe and one's place in it."[18] Additionally a way of life is often associated with a particular worldview. Stuart Hampshire defines ways of life as,

> …coherent totalities of customs, attitudes, beliefs, institutions, which are interconnected and mutually dependent in patterns that are sometimes evident and sometimes subtle and concealed. …Alongside repeated patterns of behavior, a way of life includes admired ideal types of men and women, standards of taste, family relationships, styles of education and upbringing, religious practices and other dominant concerns.[19]

So we see that pluralism encompasses not only a plurality of values and principles but also of worldviews and ways of life. In the next section, this topic will be revisited to

[17] One should remember that there will still be prohibitions in other realms such as law, manners and even professional standards.
[18] Benjamin, 88.
[19] Hampshire, 5-6.

connect the particular issues that arise in societies where pluralism is most likely to flourish.

IV. DEMOCRACY – THE ENVIRONMENT MOST CONDUCIVE TO PRESERVING INTEGRITY IN MORAL CONFLICT

For purposes of this work, it will be helpful to consider where a plurality of worldviews and ways of life can best flourish. Democratic societies seem the best able to accommodate this plurality. The United States of America might appear more 'plural' than other democracies because, since its inception, it has been a melting pot of many races and cultures and was initially colonized by groups seeking freedom to practice their religion. The point here is not to justify the concept of democracy but rather to situate moral conflict within this type of society with a plurality of worldviews and ways of life and show how moral compromise can be recommended in cases of moral conflict in policies affecting the public. Many conflicts and particularly moral conflicts are clashes that come from different religious, metaphysical or epistemological beliefs. As for a conception of democracy, we can use Henry Richardson's broadly accepted and minimally described notion of democracy as:

> a form of government in which the people rule (1) by means of elections in which each citizen gets one vote and (2) by the use of some form of majority rule in elections and legislatures. These procedures, in turn, require a stably, and perhaps constitutionally implemented, rule of law.[20]

[20] Richardson, 8.

A. Democracy

In Stephen L. Carter's work, *The Dissent of the Governed; A Meditation on Law, Religion and Loyalty,* he explores the problem of dissent, especially as it is manifested in a democracy. While introducing his thesis he observes that throughout America's history and past, "people who hold power, whatever their politics, will not listen to those who disagree with them unless they are forced to,"[21] He also maintains that Americans tend to dislike dissent, most notably in causes we despise. He talks particularly about the ways in which whoever happens to control the apparatus of the sovereign uses its authority to manipulate language and policy. They also make dissenters seem un-American. He gives several examples of this beginning with the Sedition Acts when the U.S. was in its infancy. In the first of his three lectures, Carter shows that what the founding fathers did in the writing of the Declaration of Independence was to present a justification for America's act of disallegiance. He quotes both the beginning and the end of the Declaration of Independence:

> We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. – That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed.

And after they have enumerated their grievances, the Founding Fathers end with:

> In every stage of these Oppressions We have Petitioned for Redress in the most humble terms: Our repeated Petitions have been answered only by repeated injury. A Prince, whose character is thus marked by every act which may define a Tyrant, is unfit to be the ruler of a free people.

[21] Stephen L. Carter, *The Dissent of the Governed: A Meditation on Law, Religion and Loyalty* (Cambridge, MA: Harvard University Press, 1998):x.

Carter's point here is that in reviewing the list of complaints, none of them has its roots in the lack of *consent* to the government apparatus, but rather he believes it is the repeated petitions for redress that have been met with injury that forms the basis and justification of their act of disallegiance. So a sovereign's practical (as opposed to theoretical) legitimacy may evaporate if the citizens' repeated petitions for redress of oppression are only met with repeated injury. Carter believes that we may be reaching that point in America, and he focuses in particular on the alienation felt by religious groups.

B. Tolerance of Communities

Carter discusses several sources for feelings of alienation among different groups in America: economic dislocation as the labor market changes, the flight from towns and the ensuing suburban consumerist complacency, the persistence of crime and poverty and social wars, which include issues like euthanasia, abortion, and gay rights. Carter notes that many of these wars boil down to a battle of two very different ways of looking at the world: one the deeply secular committed to change and the other the deeply religious committed to tradition. One source of alienation Carter emphasizes is what he calls 'liberal constitutionalism,' which he defines as "the effort to use the power of the federal government, and to interpret the Constitution, in a way that creates a single, nationwide community with shared values and shared, enforceable understandings of how local communities of all descriptions should be organized."[22] He claims the project of liberal constitutionalism is both anti-

[22] Carter (1998), 19.

democratic and anti-communitarian, and that it flies in the face of multiculturalism and diversity. A particularly telling example, used by both Carter and Benjamin but to illustrate different aspects, and which Carter would says illustrates his point exactly, is the request of some Christian communities asking for prayer to be permitted in public schools. Benjamin characterizes these Christians as feeling oppressed by secular humanists, a group which they consider tantamount to a religion. Benjamin objects to the characterization of secular humanism as a religion as that does a disservice to the concept of religion; but what Benjamin does not acknowledge is that many Christian groups feel that much of the power in the U.S. seems to be in the hands of secular humanists.

A democracy must be able to protect communities. Carter defines a community in terms of community of meaning rather than a geographical community. Such a community can be

> self-defining or self-constituted, not in the sense that its members constantly reinvent themselves – although indeed they might do so – but in the sense that the community, as it struggles against the world for meaning, is defining itself according to a set of understandings that might be radically different for those that motivate the larger society in which it is embedded.[23]

These self-defined communities of meaning must be able to transmit their narrative. Carter cites several cases where the court's ruling has served to eradicate the religious community.

Carter's framework allows for a pluralistic system and welcomes dissent. He virtually encourages the existence of separate communities, and he believes that these

[23] Carter (1998), 27.

different communities should not be silenced in their dissent. Everyone should have a voice, even if that voice is grounded in religious beliefs. With regard to the civil rights movement, Carter says,

> Certainly [Martin Luther] King and other religious leaders showed no reluctance to claim for their positions an 'exclusive alignment with the Almighty.' Nor is there any reason that they should have been reluctant, provided that they had come in a prayerful way to a sincere belief that they had discovered the will of God.[24]

C. Power and Dissent

Dissent is vital to a democracy; that is, citizens should be able, and even encouraged, to petition for redress of injuries. However, it is difficult to get those who wield power to listen to the dissenters, much less act in their concerns. Power of both the sovereign and the individual poses particular problems in moral conflict. The effects of pride and hubris are compounded when we are in a position of power, formal or informal, over others. Thomas Hobbes says, "The power of a man, to take it universally, is his present means to obtain some future apparent good, and is either original or instrumental" and says of its nature, "…power is, in this point, like to fame, increasing as it proceeds…"[25] For Hobbes, the greatest of human powers culminates in the sovereign, which has the compounded powers of all men, united by consent, in one entity and that has use of all their powers. A man's value or worth is the extent of the value of his power, and this value is shown in the many ways man can be honored. Hobbes takes the original meaning of power, from the Latin verb, *potere* (to be able)

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[24] Stephen L. Carter, *The Culture of Disbelief: How American Law and Politics Trivializes Religious Devotions* (New York: Anchor Books, Doubleday, 1993):48-49.
[25] Thomas Hobbes, *Leviathan*, chap x.

and contextualizes it as an asset. He then proceeds to list the various ways in which a man can be honored and thus increase in power. It is easy to see how the pejorative sense of power can be found in Hobbes. It does not matter to him *how* one obtains wealth, office or great actions, but rather that one has these things are all signs of power. View the events of the twentieth century in light of Hobbes' discussion of power and it is not difficult to see why much of contemporary discussion of power is in terms of its corrupting influences.

Hierarchical forms of power infuse every sphere of life; it is so insidious we are often unaware of the way it affects and sometimes oppresses us. There have been various perspectives on power: feminist, liberationist, afro-centrists, but none of the resulting paradigms have been capable of overthrowing that of hierarchical power. Feminist literature is rich with critiques of power. In general, feminist perspectives on power can be broadly divided into the domination theory and empowerment theory. Domination theory looks at power in terms of the ways in which men have power over women. It fights the conventional view that the hierarchy of power is based on natural and innate differences saying that it is the costs and benefits attached to these differences that is problematic. Domination theory is based on the model of the master-slave relationship. This conception of power is described as 'power-over.' One of the primary objections to this theory of power is that in claiming that women are powerless, domination theorists deny themselves the theoretical resources for an adequate conception of women's resistance to oppression.

Empowerment theorists, on the other hand, focus on the power that women do have. This is often discussed in terms of women's abilities to care, nurture and mother. Out of these experiences comes a concept of power that is transforming and empowers oneself and others. This conception of power is described as 'power-to.' One of the primary objections to this theory of power is that it glorifies practices, such as nurturing and mothering which, according to some feminists, have been instruments of oppression.

Amy Allen says that the problem with ascribing either of theories is that they are one-sided. Domination theories neglect the power that women do have, and empowerment theories neglect the ways in which men dominate women. She suggests that not only does the one-sidedness need to be addressed, but also the other forms of oppression, i.e., racial, class, as well as the complex and multifarious relationships that women have. She wants an account of power that makes sense of male domination, feminine empowerment *and* feminist solidarity and coalition building. To that end, she discusses three senses of power: 'power-over,' 'power-to,' and 'power-with.'

Another way of looking at power is through the different societal sources of power: political, professional and institutional. If, as will be discussed later, freedom from coercion is important for integrity preserving moral compromise, power differentials will need to be addressed. While Benjamin does not discuss power, he does mention coercion, but only insofar as an example of one who lacks integrity. He discusses the battered wife who stays with her husband for the sake of keeping the family together. Benjamin calls her the 'alienated victim of external coercion'

observing that she maintains external integrity while lacking internal integrity.[26] Externally this woman presents an integrated view of her family and her life to others, but internally she hates her husband and continues to suppress her values and her desires to live a life free of his oppression.

Now there are several incentives that might prompt the party in power to compromise. One might be the party's sense of justice and fair play. Also the party might be prompted to compromise because it serves the party's short or long-term interests. We find the former to be somewhat unlikely, and the latter to be obvious. As we will return to the issue of power later, let us at least acknowledge now that the party in power is less motivated to compromise than the party not in power.

The balance of power in the fight for women's reproductive liberties has shifted over the years.[27] How Catholic hospitals operate within a society where women have legal rights to reproductive freedom will be discussed in-depth in the next chapter. This is mentioned to point out power differentials need to be acknowledged between the parties. While parity need not be a requirement, the combination of treating others with respect, acting in good faith and with morally reasonable goals, the recognition of the power differential between the two parties should be enough to modify self-motivated activities.

At the risk of pursuing a method that was eschewed in the previous sections, we now turn to look at what integrity-preserving moral compromise might look like.

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[26] Benjamin, 50.

[27] For purposes of this discussion I will conflate 'reproductive liberties' with the accessibility of abortion.

However, at this point it is worthwhile to review what constitutes a compromise. Henry Richardson distinguishes between a *compromise,* a *bare compromise* and a *principled compromise*. He defines a *compromise* as a change in one's practical commitments that responds to the commitments of another person and is made partly in an effort to arrive at a fuller agreement with that person. A *bare compromise* is a change in one's support of policies or implementing means without a corresponding change in one's ends. By contrast, *principled compromise* is a change in one's support of policies or implementing means that is accompanied and explained or supported by a change in one's ends that itself counts as a compromise. Meanwhile Martin Benjamin claims that a *synthesis* or *middle-of-the-road position* where both parties agree to a third position that combines the strongest features of the original two positions while avoiding their agreed upon drawback, is not, strictly speaking, a compromise. In a compromise the third position splits the difference between the two original positions. For Benjamin, a compromise never fully settles the matter; it does not end the disagreement. Benjamin says that it makes the best of what both parties regard as a bad situation. Benjamin also discussed the different sense of compromise: compromise as a process and compromise as an outcome. As a process, compromise consists of the parties engaging in dialogue – give and take – and preparation to make concession for the sake of coming to terms. Compromise as an outcome is the result of such a process that appears to split the difference.

So what counts as a successful compromise? First, I think we must dismiss Richardson's principled compromise in favor of Benjamin's splitting the difference

definition or Postow's *bare-but-respectful compromise*. In one sense it is too much to expect that parties to a conflict will be able to agree on the ends. As Postow says, this might necessitate a vision of the good which is less than ideal. On the other hand, to reach agreement the ends might have to be so vague as to be ineffective. Synthesis positions paint compromise too widely because by definition, all parties agree that the synthesis is preferable to either original position.

Compromise involves bargaining and negotiation, which even in non-moral conflicts has certain rules of fairness that are observed. Bargaining and negotiations can be patterned on an adversarial paradigm that pits one party against the other in a zero-sum game, or it can be patterned on a cooperative paradigm in which the result can be a positive-sum game.

At the very least, integrity should be preserved – the integrity of each party to the conflict as well as the integrity of the relationship. To that end, each party will have treated the other as a fellow human worthy of respect. If one abides by these, it seems clear that agreement alone cannot justify successful compromise. In an example adapted from D. Luban, Benjamin describes the case where two people, Rich and Poor, are given $1000 on the condition that they agree on its distribution. Now Rich does not need the money so she proposes that she will take $900 and give Poor $100. She says that is the only offer she will entertain. Because Poor is desperately so, he grudgingly accepts. Both Rich and Poor have reached agreement, but this is not a successful compromise in terms of preserving integrity. One could argue that each is

not respecting the dignity of the other person; more pointedly, Rich does not need the money and so can be seen as acting out of avarice.

V. CONCLUSION

Because of the damage that moral compromise can do to the very core of who we are, it is important to approach it with care and attention. When confronting moral conflict we must first separate the moral from non-moral concerns. Then, if it is a moral conflict, we must thoroughly deliberate in good faith and with actions consonant with integrity. If after careful deliberation we find the conflict to be intractable and we are in relationship that must be maintained, we may consider moral compromise. This chapter has carved out the moral space within which moral compromise can be considered. In the next chapter we will see how this might apply to moral conflicts found within the context of Catholic health care.

4. *REPRODUCTIVE SERVICES IN CATHOLIC HOSPITALS*

So far we have discussed the importance of integrity and the demands it places on us, especially when dealing with moral conflict. When faced with intractable moral conflict, integrity can also guide us when considering moral compromise. This chapter will consider the case of Catholic hospitals serving the needs of a society that is pluralistic. We will begin by assessing the nature of the moral conflicts that result from the administration of health care according to the teachings of the Catholic Church and discuss whether they are intractable. If some of these conflicts are intractable, we will discuss when and how Catholic hospitals might consider moral compromise. If Catholic hospitals are still prohibited from moral compromise, we will then discuss the methodologies available within Catholic moral theology, comparing these to the process for handling moral compromise that was discussed in the last chapter. Chapter Five will then examine in-depth three specific types of reproductive services that put Catholic hospitals at odds with many in the communities they serve and how these conflicts are handled.

All Catholic healthcare facilities in the United States must operate under the *Ethical and Religious Directives for Catholic Health Care Facilities*[1] as promulgated by the United States Conference of Catholic Bishops (USCCB).[2] The two most recent updates of these *Directives* were in 1994 and 2001; the 2001 update was driven by some of the problems voiced over various concerns with Catholic hospital mergers and acquisitions.[3] We will look at both this most recent edition as well as the prior edition to see if any of the issues we will cover are ameliorated with the advent of these new *Directives*.

An institution that operates according to a set of directives based on moral and religious beliefs seems to be at particular risk in a secular society. On one hand, if the institution is perceived as compromising too much then it is in danger of losing its reputation, being seen as acting without integrity, or involving the Church in scandal; and on the other hand, by resisting the requests of some of the public it becomes the target of organized movements that might risk its overall mission. This risk is increasing rapidly with various moves to limit 'conscience clauses' throughout the states, as well as other legislative actions. How do institutions survive in this world and maintain their principles? Even more difficult, how do they perform 'public'

[1] Hereafter abbreviated as *ERDs* or *Directives*.
[2] Formerly known as the National Conference of Catholic Bishops (NCCB); On July 1, 2003 the NCCB and the United States Catholic Conference (USCC) were combined to form the USCCB.
[3] These *Directives* were not revisited at the June 2002 or 2003 meetings most likely due to the sex scandal in the Church the time. That scandal will likely serve to place the Church under even greater scrutiny in its various ministries. No doubt there will be repercussions to Catholic Health Care, and may they may now be experiencing some.

services such as health care and operate on principles that do not always coincide with those of the culture? In the previous chapter, it was argued that a democracy is the society in which that scenario can most effectively be obtained. And yet, some of the actions available to groups in a democracy might prove to be the downfall of Catholic health care. What we hope to determine in this chapter are ways in which compromise might be countenanced by Catholic hospitals. Absent the moral advisability to do that, we will consider what methods Catholic moral theology has to handle these conflicts.

I. MORAL CONFLICT

The differences between the teachings that the Catholic hospital must follow and the values of a secular society can be broadly attributed to differences in world view. From a Catholic perspective, life is seen as a gift from God, a gift that comes with certain obligations to maintain it and for which autonomy is limited: individuals are not the ultimate arbiters of their lives. This can be generally compared to the (arguably) dominant paradigm of twenty-first century America with the individual as ultimate arbiter over his or her life, autonomy is generally valued above interdependence, and obligations to society come after obligations to self. To fully examine the moral conflict arising from these different world views, we need to consider the histories of both the ongoing moral debate that has grown out of issues surrounding abortion, as well as the historical development of the modern hospital and especially the roles played by various groups of women religious.

A. The Backdrop to Conflicts Regarding Reproductive Services

Many of the moral conflicts arising at Catholic Hospitals concern reproductive services, and have at their base, moral issues relating to the long and rancorous abortion debate. That debate with its far-reaching implications presents many of the impediments to compromise in this case.[4] So perhaps it is fitting to set this stage with a brief historical overview of the abortion debate to help understand the charged environment in which Catholic Hospitals now operate.

What is it, in particular, that makes the provision of reproductive services, or lack thereof, such a volatile issue? On one side there is the belief that the ability to conceive is the co-creative process that humans share with God. As such, it holds an almost sacred place in human life, and the range of morally permissible sexual acts is quite limited: usually placing the act of sexual intercourse within the bonds of a heterosexual marriage and limited use (or complete proscription) of artificial means of birth control, sterilization, and abortive remedies.

On the other hand, the biological fact that women have the unique ability to bear the burden of childbirth, as well as socially bearing the primary burden of child-rearing, has been a persistent obstacle for women to earn equal rights and equal opportunities. As such, the fight for women's reproductive rights has been front and center in the women's movement of the twentieth century and continues into the twenty-first. In 1973, *Roe v. Wade* recognized the privacy issues inherent in a

[4] The summer of 2001 illustrated how the abortion debate, and the polarized positions, has affected the political debate over stem cell research as well as cloning.

woman's decision of whether to abort her developing fetus and was a milestone in this movement. Now, over thirty years later, any moves to restrict this right to abort are met with vehement opposition. This fight started out hostile and has, at many turns, been violent. In the intervening years, the Supreme Court has reaffirmed *Roe v. Wade*. *Roe v. Wade* gave the woman what is tantamount to unrestricted choice in the first trimester of her pregnancy, in the second trimester the state 'may' regulate abortion procedures in ways that are related to maternal health, but in practice, abortion remains virtually unrestricted during the second trimester. However, *Roe v. Wade* established that in the third trimester, after the 24th week of gestation when the fetus is viable, the state has a compelling interest in the viable fetus and so "…may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."[5] The words "life or health of the mother" have led many on the 'pro-life' side to argue that the wide-ranging meanings of 'health' have worked to render abortions virtually unrestricted, even in the third trimester.

To many, the right to choose to terminate a pregnancy has become part and parcel of the women's movement. Many claim that if a woman truly wants to be considered a feminist she must be pro-choice. This position is politicized (many say it is merely a political issue) to the extent that the Democratic Party, as well as the National Organization of Women (NOW) have it as one of their party planks. It was

[5] *Roe v. Wade*, 410 U.S. 113, 151-158 (1973).

often mentioned during the 2000 presidential race that the Republican Party should consider changing to a more pro-choice-friendly position to attract more women.

To further exacerbate the animosity between 'pro-life' forces and 'pro-choice'[6] forces, the conservative position is usually identified with the religious right and attitudes that are considered regressive when it comes to women's rights in general. Sue Sherwin lumps together conservatives and the Christian right, describing them as homophobic, misogynistic, and elitist. She sees a relation between those beliefs and the fact that the system advocated by conservatives is especially harmful to poor women and children. According to Sherwin, the conservatives are usually pushing not only a conservative social agenda, but also an elitist economic system. In this way, advocates of women's rights see poor women as bearing twice the burden.[7]

Primary to the most conservative positions regarding abortion, as well as possibly abortifacient methods of birth control, is the unwavering belief that after the 'moment'[8] of conception, the genetically unique individual that is formed is worthy of respect and protection. As the most vulnerable of all human life, it is worthy of the most protection. While many see the developing fetus possessing a corresponding

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[6] Although there has been much written on the appropriate monikers for each of the sides in this battle, (i.e. some pro-lifers describe their opponents as 'anti-life,' likewise some pro-choice advocates label their opponents 'anti-choice,' names that each side would respectively deny) I am using the conventional names which each side has adopted as their own descriptor.

[7] Sue Sherwin, *No Longer Patient; Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992):113.

[8] Most holding a conservative position acknowledge that conception is a process and not an instant in time, however, they still maintain that there is a point prior to implantation that an individual, genetically distinct from either of its progenitors, comes into existence and which deserves protection.

developing moral status throughout gestation, one holding a conservative position might employ the argument from potential holding that even at its most minute existence, it contains all of the genetic substance that it needs to become an actualized human. And because conception occurs prior to implantation, one holding this position is likewise opposed to any drug or procedure that prevents implantation as well as having limitations on how that embryo can be treated which will have implications for infertility treatments, use of stem cells and therapeutic cloning, to name a few.

In this charged environment, it is easy to see why decisions by institutions to provide or restrict reproductive services are so incendiary. In many places where hospital mergers are being considered, these decisions have become front-page news for several weeks and months at a time.[9] The explosive nature of the issues of women's reproductive rights, including decisions regarding when life is worthy of defense and who gets the right to make that decision, lays the groundwork for some of the problems arising from Catholic hospitals' acquisitions of and mergers with other hospitals as well as their general operations absent merger or acquisition activity. However, almost ten years after the flurry of merger and acquisition activity the environment has become hostile to Catholic health care in general. In numerous state

[9] Tom Flynn, "Can Secular Patients Survive Catholic Hospitals?" *Free Inquiry* vol. 21, iss. 1 (Winter 2000):32. The merger of Bayfront Medical Center in St. Petersburg, FL with seven other Tampa Bay hospitals to form BayCare Health System in 1997 had stories printed almost continuously from July 1997 through the following January. The story became heightened when a lawsuit was filed to stop the merger and continued through 2001.

legislatures bills have been proposed to require all health care institutions to offer all reproductive services. This will be discussed in more detail later in this chapter.

B. A Brief History of the Modern Hospital and the Roles of Women Religious

The Ursuline Sisters from France were the first group of Catholic women religious to arrive in the new world. Shortly after 1727, they opened their hospital in New Orleans. When Thomas Jefferson purchased Louisiana and the Western Territory from France in 1803, The Ursuline Sisters wanted reassurance that they would be welcome and independent in the United States. According to Arthur Jones,

> Jefferson told the Ursulines their property was "sacred and inviolate" and that their institution would be "permitted to govern itself according to its own voluntary rules and without interference from the civil authority."[10]

Jones notes the irony that what would be the first hospital established on the continental United States was the result of a merger. Over the years the number of women religious who came to America grew. In 1809, Elizabeth Ann Seton founded the Sisters of Charity, and shortly after her death, five Sisters of Charity managed and staffed the 50-bed Baltimore infirmary. Many of the women religious coming to America were trained as educators; but they soon found that other social problems inhibited their ability to educate. Overwhelming poverty, illness, homelessness and the number of orphans prompted them to build almshouses and orphanages. They visited the sick in their homes but, given the number of homeless, they soon built

[10] Arthur Jones, "Catholic Aim: Aid Poor, Survive," *National Catholic Register* vol. 39, no. 31 (6 June 2003).

modest infirmaries to care for the sick. This was the beginning of the Catholic health system.

It was not until the 1960s with the advent of Medicare and Medicaid that what was considered a social service became a business. Now hospitals that were once 'voluntary,' and often provided services with no compensation were able to be profitable; Wall Street and the corporate world saw profits and the health care landscape was radically changed. Employer-sponsored health care benefits and a lack of utilization review or even questioning of medical necessity fed into the profitability of health care. However, costly advances in medical technology, an increased percentage of the Gross National Product (GNP) going to health care, the aging population, who was living longer and not always in better health, as well as the recession of the 1980s prompted new changes to the health care landscape. Another trend during that time was the aging of many religious orders with fewer sisters to take their places. These were the same orders which had established the hospital systems. It became clear to many of them that they had to consolidate for economies of scale.

During the 1980s, the Government lowered its Medicare and Medicaid reimbursements. Additionally, ways to better utilize health care resources were explored: mechanisms such as utilization review committees and managed health care insurance plans became commonplace. By the end of the decade, mergers and acquisitions among hospitals also became commonplace. But the Catholic hospital systems were not merging only with their own kind, so to speak. New challenges arose when Catholic hospitals merged with other-than-Catholic hospitals.

The 1990s became the decade of a financial Darwinian struggle to eat or be eaten. This was the time of the consolation and merging of several of the large Catholic hospital systems as well. Ordinarily, these mergers and acquisitions would be newsworthy, but combine that with the fact that when mergers were between a Catholic facility and a non-Catholic facility, it became front page news. Some groups already in existence, such as the ACLU, gave it close attention; other groups, such as Catholics for a Free Choice (CFFC) and MergerWatch, organized to deal with the 'threat' of Catholic health care to reproductive rights. Perhaps due to the work of these groups, there have been organized actions to both obstruct mergers in process as well as introduce legislation to mandate reproductive services by Catholic facilities and contraceptive coverage by all insurance plans. The Catholic healthcare system has become one of the largest healthcare providers in the country, controlling 10 percent of the market.[11] This has led some to level charges that this is a stealth attempt to eradicate women's reproductive freedom.

Concurrent with the development of the modern Catholic hospital system was the growth of the field of bioethics. The Catholic Church has a long history of taking positions on social issues; in the 1960s, when issues involving the clash between advancing medical technology and accepted notions of life and death emerged, Catholic moral theologians were some of the first 'bioethicists' writing and practicing in the nascent field. For over forty years, the Catholic Church has spoken on virtually every issue regarding the ethical delivery of health care through writings by the Pope,

[11] However, this percentage has remained constant for at least the past twenty years.

by the National Conference of Catholic Bishops (NCCB),[12] and by individual Catholics, ordained and lay, writing within the field. But the Church, through its vast healthcare system, is able to take a stand in a more direct way. Its healthcare facilities can participate in the healing ministry of Jesus in the way the facilities are operated, by the services that are provided and the individuals who are served. One way the ways the healing ministry of Jesus is lived is by following the *Ethical and Religious Directives*. The *Directives* are developed in conjunction with Catholic moral theologians and promulgated by the USCCB. They are based on Catholic moral theology (which has natural law theory as its philosophical base), scripture, and tradition. The general argument in favor of life is often referred to as the 'Seamless Garment' argument. This is a scriptural reference to Jesus' seamless cloak, for which dice were thrown, rather than being torn into pieces because to tear a seamless garment would destroy its integrity. From the beginning of life, conception, to the natural end of life, *The Gospel of Life (Evangelium Vitae)* gives a clear and consistent position on issues such as genetic screening, abortion, euthanasia and the death penalty.[13]

Specifically, in some of the services that are proscribed, the church's position is surely counter-cultural. As mentioned in Chapter One, if one were to discuss the increasing moral gravity of reproductive issues, with artificial means of birth control at one end and third trimester abortions on the other, we would see that, according to

[12] Now known as the United States Conference of Catholic Bishops (USCCB).
[13] Pope John Paul II, *The Gospel of Life (Evangelium Vitae)* English translation by the Vatican (New York: Random House, 1995).

opinion polls, very few people have moral concerns with the former whereas the majority have concerns with the latter (albeit not when the life of the mother is at stake).[14] Catholic healthcare facilities are proscribed from providing any of these services. But the Catholic Church does not view this entire range of morally proscribed services as morally equivalent; moral distinctions can be made between the prevention of life and the taking of an existing life.

By conceptualizing healthcare as a ministry, its practice becomes increasingly difficult in a secular society. Because so much of American life has been defined in terms of rights – many of which run counter to basic Christian beliefs – Catholic healthcare increasingly comes under attack when it tries to operate within its *Directives.* But it is just this principled approach which constitutes Catholic health care's identity and ultimately the method by which it is able to provide health care with integrity. These are essential components that cannot be lost to moral compromise.

C. Mergers and Acquisitions

1. 'No Margin, No Mission'

If the hospitals fail to become players in the market, which increasingly implies acquiring or merging with other facilities, the mission is at risk of being eliminated. If Catholic healthcare facilities cease to exist, then a ministry vital to the

[14] For example: LeMoyne College of Syracuse, NY and *Zogby International* of Utica, NY surveyed the beliefs of 1508 Roamn Catholics between October 25 and November 1, 2001 (as reported by Cathy Lynn Grossman in *USA Today)* with similar findings.

Church is lost; that ministry being a way to directly exemplify the teachings of Christ in caring for the sick, elderly and poor.

One might argue that to truly fulfill the mission of Christ, the healthcare facilities should not be reliant on the market economy. One might even say that Catholic health care has compromised and has been compromised by being players in what is arguably an unjust system of health care delivery. However, it should be noted that the Catholic health care system started as a voluntary system, and it has only been in the past four decades where health care has become more like a commodity; the injustice of the system has developed gradually over that time. There is also evidence that the Catholic Health Association has consistently advocated on behalf of health care reform with an eye toward the poorest and most vulnerable.

If, as now is the case, the hospitals are players in the market they are forced to act that way. One of the casualties of this situation directly involves which services are offered. To be a market player means that one must be competitive. To be competitive a facility may find itself offering only those services which are profitable – or in some cases – they may find themselves offering services that operate at a loss for various reasons, but often because they are necessary to stay in the market. However, Michael Place, STD president of the Catholic Hospital Association states:

> On average, Catholic Hospitals offer a larger array of clinical services than facilities offered by for-profit corporations or by other not-for-profit sponsors. Examples include neonatal intensive care units for preterm and other infants, trauma units, obstetric care, hospice and other end-of-life services, and HIV/AIDS

> services. While these services are important to most communities, frequently they do not pay for themselves.[15]

So where these decisions might be governed by the bottom line, Catholic hospitals have shown that in several areas they let mission influence their 'business' decisions.

2. Sole Provider Status and Groups Working to Oppose

When it became known that the availability of many reproductive services was the primary casualty of the mergers of Catholic and non-Catholic hospitals, groups such as Catholics for a Free Choice (CFFC) and MergerWatch were formed to fight such mergers and acquisitions. The main charge leveled against the Catholic facilities was that they were steadfastly gaining market share through acquisitions and mergers, sometimes becoming the 'only game in town,' and then restricting reproductive services, often in communities not predominantly Catholic. This is seen as tantamount to forcing the Catholic Church's moral beliefs on the members of the community. The increased attention to mergers and acquisitions involving Catholic hospitals only served to bring these issues to the fore in the popular media.[16] This has these facilities the target of much criticism, including:

- the poor are usually most affected by the unavailability of services,
- emergency contraception is not given to rape victims, (or when it is, it is given covertly in the parking lot),[17] and

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[15] Father Michael Place, "Conscience Clauses and Catholic Health Care," *Origins* vol. 33, no. 14 (September 11, 2003):225-229.

[16] In fact, it was a discussion with a professor and a piece on National Public Radio regarding the limitation of reproductive services by a hospital which was a sole provider in a community that piqued my interest in this topic in the mid 1990s.

[17] It became clear during research for this work that this claim, effective at rousing indignation, was actually very misleading. This issue will be discussed more fully at the end of this chapter.

- not providing certain reproductive services when the Catholic facility is the only provider in the region.

The 'fact' about the increased number of areas where mergers left a Catholic facility as the sole provider received a great deal of attention at the time. However, varying presentations of the statistics give very different pictures. Catholics for a Free Choice (CFFC) state in their publication *When Catholic and Non-Catholic Hospitals Merge: Reproductive Health Compromised:*

> In 1994, CFFC identified 46 Catholic sole provider hospitals dispersed across 17 states. The number has now *shot up* to 76 Catholic sole provider hospitals, spread across 26 states. Some of these hospitals serve counties (most of them rural) where Catholics make up less than 1 percent of the population. These Catholic hospitals are essentially rewarded, through higher rates of Medicare reimbursement, while they deny reproductive health care to an entire county.[18]

However, this is not the case. First, the Health Care Financing Administration (HCFA) does not consider 'sole provider hospital' in a county as designation for special reimbursement. HCFA *does* reimburse providers who meet the criterion for "sole community hospital" status which is based primarily on travel distance to another like hospital. And so, for example, in 1997 of the 1600 hospitals which were the only hospital in their county:

- 50 percent were within 17 miles or less from their nearest hospital neighbor,
- 75 percent were within 22 miles or less from their nearest hospital neighbor,
- 90 percent were within 31 miles or less from their nearest hospital neighbor**.**

Additionally, if you look at the actual figures of those Catholic hospitals who met the

[18] Liz Bucar for Catholics For a Free Choice, *When Catholic and Non-Catholic Hospitals Merge: Reproductive Health Compromised* (Catholics For a Free Choice, 1998) emphasis mine.

criteria of sole provider status according to HCFA, you see that the number of Catholic sole providers in a community "shot up" from 81 in 1994 to 84 by 1999.[19]

3. Compromises

As discussed in Chapter Three there are forces at work that often impel us to compromise at the cost of our integrity, or other identity-conferring values. To do so might be the expedient course of action, but rarely does that sustain for the long term.

In some cases, Catholic hospitals in certain dioceses were able to get around the proscription of surgical sterilizations by claiming that they were under duress, a condition which then permits immediate material cooperation. The Fourth Edition of the *Directives* were amended in 2001 to address just this type of issue; those hospital systems now find themselves trying to get the water back over the damn (this topic will be covered in-depth later in this chapter). Exceptions claimed under duress could also be categorized as prudent, but that ground is questionable, especially when integrity is at stake.

Some creative solutions to the challenges of mergers between Catholic and non-Catholic in the early 1990s included:

- the Catholic partner forgoes its share of net income derived from reproductive health services,
- the partners lease space in one hospital to a separate corporate entity that provides reproductive health services with no participation from the Catholic partner,
- the hospitals designate on-site physician offices as private practices and invoke doctor-patient confidentiality to cover family planning and sterilization,

[19] Lewin Group analysis of Medicare PPS Impact File for 1997, December 1998 and March 1999.

- the merger agreement exempts personnel of the formerly Catholic facility from providing reproductive health services,
- the non-Catholic partner creates an endowment, prior to the merger, to fund abortion-related services through the local Planned Parenthood, and
- two hospitals enter a "virtual merger," collaborating closely without merging assets, and therefore neither applying the *Directives* to the non-Catholic partner nor associating the Catholic facility with services provided at the non-Catholic facility.[20]

One such compromise took place in Austin, Texas in the mid-1990s. There the public hospital, Brackenridge, was facing a crushing $38 million debt, primarily due to the 20 percent of the population without insurance. The proposed solution called for the city to lease Brackenridge and the adjoining Children's Hospital to the Seton Healthcare Network. To address the proscription of sterilization and contraceptive services, "the initial solution…in 1995 was a 'wall of separation' – meaning that Seton Staff didn't provide proscribed services, city staff did."[21] However, after several of these creative compromises were in place, bishops in some dioceses received complaints by individuals in those communities. This topic was taken up prior to the June 2001 meeting of the USCCB, where the *Directives* were amended to close the loophole of 'duress.' This drew additional attention to other compromises that didn't seem to meet the requirements of material cooperation. So the administrators of Seton Health Care and Austin city officials went back to the negotiating table where they devised the idea of a 'condominium hospital,' a sort of hospital-within-a-hospital. At

[20] Catholics for a Free Choice, *When Catholic and Non-Catholic Hospitals Merge.* These 'compromises' *may* preserve integrity; however, how these arrangements are presented to the public and its coworkers is key to whether they maintain integrity. .
[21] Suzanne Batchelor, "Clash and Compromise: Ethics at Issue when Public Hospital is Put into Catholic Hands," *National Catholic Register* vol. 39, no. 33 (4 July 2003).

Brackenridge, the fifth floor was leased back to the city and all the reproductive services proscribed by the *Directives* were performed there. This agreement met with the approval of the bishop, however, when the Vatican reviewed it they found it 'minimally acceptable' and others were told not to use it as a model.

D. Organized Opposition to Catholic Health Care – Two Main Directions

The sequelae of the mergers and acquisitions have become dire for the Catholic health care system. The strategies of those who oppose the limitation of reproductive services will be discussed in this section. The organized opposition has two main thrusts to their activities: the first encompasses attempts to impede and ultimately prevent mergers from occurring; the second includes activities to facilitate the development of mandates that certain reproductive services be provided by all hospitals as well as mandates of contraceptive benefits with all health care insurance. We will explore each of these categories in turn. I hope to show that one sort of activity is more conducive to 'compromise' than the other.

The coordinated activities of the ACLU and other groups[22] have made both compromising and standing firm virtual losing propositions for Catholic health care. To compromise would bring the wrath of avid pro-life groups upon the hospitals as well as local bishops; to stand firm provokes the wrath and added legislative activity

[22] The list of groups actively working in this area include: The Alan Guttmacher Institute, American Public Health Association, CARAL Pro-choice Educations Fund, Catholics for a Free Choice, Center for Reproductive Law and Policy, Feminist Majority Foundation, MergerWatch, NARAL Pro-Choice Resource Center, Inc., National Health Law Program, National Women's Law Center, Planned Parenthood Federation of America, The ProChoice Resource Center, Inc. and Religious Coalition for Reproductive Choice.

of the groups who oppose. These areas of activity include: regulation, legislation, adjudication and public relations. Each of these will be discussed with examples in the following sections.

1. Work to Hamper Mergers

a. If Carried Out with Integrity, This is Democracy in Action

One of the ways the groups opposed to the limitations of Catholic health care have approached the problem is through information sharing. The attempts to educate the public to the subtleties (and not-so-subtle aspects) of prospective mergers in their areas to enable democratic deliberation, their actions are admirable. This type of education can empower an often alienated public. And if the public forms a grass-roots campaign to resist the merger in their area or to hold the government officials (if a publicly owned facility is on the block) or the corporate executives to accountability, this is democracy in action. In this case then, a group often without power, becomes empowered and expresses their dissent from what might appear to be a *fait accompli*; this is an act to be treasured in a pluralistic democracy. Some of the news reports of the BayCare Health System merger resemble this. A coalition of community activists was able to motivate city officials to file suit in federal court to have the municipal hospital, Bayfront, released from its contract. One of their points of contention involved misleading information regarding the *Directives.* There were eight hospitals in the merger, and according to news reports, they were told explicitly that the

Directives would not apply to BayFront Medical Center.[23] It is imperative that these actions be carried out with integrity, and this sort of process lives up to those demands. This process also has to its credit that it allows for dissent, works through the system and is conducive to maintaining communities.

b. Circumstances Are Such that Catholic Hospitals Should Cooperate and Even 'Compromise'

In the above case, one can legitimately question why the Catholic network must insist that all eight of the facilities in the Tampa Bay area be designated as Catholic facilities, especially when the questioning is prompted by the citizens of that community.

In each diocese the bishop is the ultimate arbiter of the how the *Directives* are applied in his diocese. This can lead to variations in practice; what is a legitimate interpretation of the *Directives* in one diocese is not applicable in another. One might argue that this allows for variations in customs and traditions specific to certain populations or distinct geographic areas. Perhaps a more convincing argument is that this allows for the pastoral capability of the bishop. However, either justification leaves Catholic health care open to criticism, and the onus is on them (all of the players: bishops and Catholic hospitals administrators) to justify why 'an exception' or 'compromise' was valid in one situation and not in another. In Chapter One we talked about Claire who went to the hospital in her community, which unbeknownst to her, had been merged with the Catholic hospital and was now practicing under the

[23] However, a companion suit was filed by the ACLU and other groups that may fall into the other category of actions; that case will be discussed later.

Directives. Perhaps what is most frustrating (to all involved) is that, according most individuals involved in these decisions at Catholic hospitals, in this case an early induction of delivery would be acceptable according to Directive 47:

> Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

To justify compromise, each side should have a position that at the very least meets the demand for respect for the dignity of the human person. As well, each side should approach the other with this respect.

c. Other Options

The Catholic Health Association (CHA) has been a vocal advocate for all facets of Catholic Health Care, from defending the conscience clause to lobbying for reform of the health care system.

As a ministry, Catholic healthcare might return to an eleemosynary system, subsidized only through charitable contributions. Those able to pay through insurance or other means would be required to pay; those unable to pay would be served. The Church would then be able to stand by its beliefs and clearly make these *Directives* known (as sometimes is NOT the case presently) and provide only those services that abide by the *Directives*. In this way, the message is clearly stated, the facility stands up for their mission, and they are only at risk of criticism from those who disagree with their mission, rather than criticisms regarding justice issues. As the system stands now, this is not feasible.

Some Catholic health systems have had to face dire situations and reassess their ability to continue to fund hospitals continually operating at a loss. One such move was the Sisters of Mercy Hospital in Laredo, Texas. The hospital could not continue to operate at a deficit, nor could the other hospitals in the system continue to keep it afloat. After much thought and involvement from the various stakeholders, the decision was made to sell the hospital to a for-profit corporation. The Sisters of Mercy were then able to take the proceeds from the sale to set up a fund to minister to the health care and social service needs of a largely immigrant community. A similar situation had occurred for the in the Mercy System a few years prior to this in New Orleans, Louisiana. This chapter ends with what may be a prophetic statement by a Catholic theologian regarding the Church's continued ability to participate in this country's health care system.

2. Work to Mandate Services and Coverage

As mentioned earlier, the actions of groups opposed to the limitation of Catholic health care services includes the areas of regulation, legislation, adjudication, and public relations. The scope of the changes pursued extend to mandating that certain reproductive services be provided at hospitals as well as mandating health insurance coverage by those employers who provide health care insurance. Examples of these will follow in this section.

What this area of opposition points to is the larger issue of the role of religion in the public square – which is certainly beyond the scope of this work – but which is clearly important. How do we reconcile public policy when it concerns moral and

religious beliefs without getting to the point of acceding to the project of 'liberal constitutionalism' as defined by Stephen Carter:

> …the effort to use the power of the federal government, and to interpret the Constitution, in a way that creates a single, nationwide community with shared values and shared, enforceable understandings of how local communities of all descriptions should be organized.[24]

a. Examples of the Project of Liberal Constitutionalism

To use the language of Stephen Carter, we should explore the coordinated actions against Catholic health services to determine if these are instances of attempts for redress of injury. In cases where mergers are clearly leaving members of a community with services they use, the citizens of the community object, and the organized activists offer to assist the citizens in their 'petitions for redress of injuries' it does not meet the level of completing the liberal constitutionalist project. However, to have clearly stated goals of activities that will lead to, and in some cases intend, the eradication of Catholic health care services appear to go beyond the redress of injury.

The concerted moves strive for uniformity across all communities; this not only destroys communities of meaning, it does damage to diversity as well. One might legitimately question why it is important for these communities of meaning to survive, especially one that is said to oppress women. What seems unreasonable in these cases is that all of Catholic health care services are reduced to the terms of what they **do not** provide, rather than considering it in entirety: its history, tradition, and continued service to the poor and vulnerable. What does it mean to have a community

[24] Carter, *Dissent of the Governed,* 19.

of meaning? Health care is a ministry of the Catholic Church, but why **must** it be maintained in its current form? Some would say it need not. But first consider the study by the Georgetown University Institute for Health Care Research and Policy that concluded that Catholic hospitals form a safety-net to the American health care system. This study pointed out the amount of charity care provided by Catholic health care provider and what a vital role they play as a safety-net to the 44 million uninsured or low-income Americans.[25] Catholic institutions are not only ways to carry out the Church's mission to

> teach the young, care for the sick, and serve the poor…They are good for society at large…[and which] argues for voluntary societies mediating between government and the individual person…[making] it possible for the characteristic Catholic values of the dignity of the individual, the importance of the common good, and special concern for the poor to become more present in our institutional structure and contemporary ethos.[26]

What does not seem to be considered by those in the organized opposition is, what will be lost if Catholic hospitals must choose between honoring their faith and continuing to operate hospitals?

b. Demanding an Overreaching of the Courts

As stated, the organized activities involve the areas of regulation, legislation, adjudication, and public relations. It should be noted that some of these conflicts make their way into professional society statements and activities; three in particular

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[25] Georgetown University Institute for Health Care Research and Policy, *A Commitment To Caring: The Role of Catholic Hospitals in the Health Care Safety Net* (November 2002).
[26] Charles Curran, "The Catholic Identity of Catholic Institutions," *Theological Studies* vol. 58, no.1 (March 1997) 90-109.

at the American Medical Association (AMA), the American College of Obstetrics and Gynecology (ACOG) and the American Bar Association (ABA).

At the June 2000 meeting of the AMA, Resolution 218 was presented that would have made hospitals offer a full complement of reproductive services if they offered any perinatal services.[27] After testimony from a Catholic Cardinal opposing the resolution, it was passed in an amended form allowing for exceptions based on reasons of conscience. If the AMA had been able to push this through the federal legislative branch then the sanction for not abiding by this would be the loss of Medicare and Medicaid funding. This would, in effect, force the closing of sectarian hospitals or force them to provide services against their stated beliefs. Might this be a good case for compromise – and what compromise might preserve integrity? But first we should ask, what was the real intent of Resolution 218? It might have been designed to prompt a negotiation on these issues, to perhaps further a compromise. This is possibly a good impetus to compromise, to push someone to the edge. This resembles the 'horsetrading' paradigm where I demand more than I know my opposition will give me, but we 'settle' on an amount that I was aiming for. However, this is not conducive to an integrity-preserving moral compromise because, as we discussed in earlier chapters, matters of moral concern should not be bartered like exchangeable interests.

[27] This resolution was proposed by a physician from California in direct response to the problems resulting from mergers and acquisitions in his state.

During the 'partial birth abortion' debate, ACOG issued a statement. While defending physicians' rights to make these difficult decisions with their patients and without government involvement, they at the same time include:

> The policy statement notes that although a select panel convened by ACOG could identify no circumstances under which intact D&X would be the only option to protect the life or health of a woman, intact D&X "*may be the best or most appropriate procedure* in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, *based upon the woman's particular circumstances*, can make this decision."[28]

In the area of regulation activities, the opposing groups use spheres of influence to get government officials involved. For example, these groups have involved state attorneys general to have an ultimate say as to whether a merger should be finalized. Most recently, a news report from Massachusetts indicated that the Massachusetts attorney general was recommending that he have a say as to which Catholic seminarians should be ordained priests.[29] This latest move is clearly an indication of the lack of leadership from church officials during the sex scandal, but the involvement of a state attorney general is a big step to take in the realm of church-state relations.

In the legislative area, there are moves to link Medicare certification with the provisions of "full services," which means a provision of all reproductive services similar to the AMA's resolution 218. There have also been legislative moves to

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[28] ACOG News Release, "Statement on So-Called 'Partial Birth Abortion' Law" (October 3, 2003).
[29] Zenit News Agency, "Cardinal George Warns of Trend in Church-State Ties" (November 13, 2003).

mandate the provision of emergency contraception by all hospitals, in some cases by any woman requesting it, and not limited to women who have been sexually assaulted. This latter case will be covered in detail in Chapter Five.

In the adjudication arena, there are moves to influence rulings on mergers through challenges of charitable asset laws. In effect, to derail a sale or merger of a secular not-for-profit to a Catholic not-for-profit they claim that a change of the secular hospital to follow the Catholic Directives is a legally impermissible change of the mission of the secular not-for-profit.

The public relations area possibly has the most opposition activity on any given day. The ongoing attacks on Catholic health care in the public forum are most effective on websites and in the popular media. There are numerous examples:

- A study published which claims that victims of sexual attacks were denied care at Catholic hospitals,
- Language changes: shifting 'conscience clause' to 'refusal clause' gives these laws a starkly different connotation; attempting to change to definition of 'religious' for religious exemptions, whereby the other institutions that meet that standard are those that employ primarily members of that faith and minister primarily to members of that faith. Catholic hospitals, nor Catholic Schools nor Catholic social service agencies would meet that requirement. Nor would the work of Mother Theresa, i.e., her work would not be covered under a 'religious' exemption because she did not serve primarily *Catholic* persons with AIDS!
- Groups arguing that because Catholic hospitals do not provide abortions or sterilizations, patients do not receive accepted medical "standards of care" and then are, by implication, receiving substandard care.

c. Misuse of Power

Moral compromise when battled in the public arena leaves little room for integrity. Perhaps the residual effects of the antagonistic nature of the abortion debate

make it virtually impossible to meet some of the conditions for compromise which were set forth in Chapter Three. When misinformation and spin are the currency, there is not much room for democratic deliberations. It is difficult to deny the acrimony present in many of the media presentations. It was earlier stated that, in democratic deliberations, a willingness to act in response to another's argument, to show respect for fellow rational beings, to lessen strife, and to promote good will were all necessary conditions for any moral compromise with the chance to preserve integrity. Instead of moral deliberation where fine distinctions are made, in today's public discussion, spin is the currency, and swaying public opinion is the goal. This does not get us to the better epistemic credentials of which Postow speaks.[30]

Each side has mobilized its members and it is hard to hear through the chatter. Lest it appear that the left is taking undue criticism here, similar points can be made with the case of Terri Schiavo, the 39-year-old woman who has been in a confirmed Persistent Vegetative State for the past thirteen years.

d. No Obligation to Compromise, Call to Get Out the 'Rest of the Story'

However, the most questionable justification for compromise comes when one compromises while being coerced. Many would claim that these groups have attacked the wrong target. In many cases, the Catholic hospitals are really stuck in the middle between the avid pro-life groups and ACLU and other strong opposition groups.

What is the cost of this activity? Not only will important social services be threatened, there are costs to reason. Their attacks have served to privilege the part

[30] See Chapter Three and Postow's notion of bare-but-respectful compromise.

(reproductive rights) over the whole (health care system) which might possibly lead to the death of the whole.

Other less than honorable reasons that might constrain us from compromising include the shifting of power. The one in power may be unwilling to level the playing field; from the position of power there is little incentive to compromise. And even if the Catholic hospitals, which hold the power in this situation, were inclined to level the playing field, to want these services to be provided elsewhere may constitute cooperation, which will be discussed later in the chapter.

As will be discussed in the next chapter, Catholic moral theology and the *Directives* never require the health care provider to abandon the patient. One of the most common misconceptions is that Catholic hospitals are required to privilege fetal life over the life of the mother.

The preceding discussion shows some of the problems with navigating moral conflict by considering compromise and the attendant challenges it makes to integrity, both institutional and individual. There are various factors at work that indicate moral compromise may not be especially advisable for Catholic hospitals. Now let us turn to Catholic moral theology to determine if there are some moral tools with which to deal with this morass.

II. PROCESS OF COMPROMISING: HOW DOES CATHOLIC MORAL THEOLOGY HANDLE THIS?

The Principle of Cooperation might be viewed as the tool for moral compromise in Catholic Moral Theology. Originally designed as a pastoral tool to guide individuals on how closely they could participate in the evil actions of others, the principle of cooperation has been expanded to include how Catholic institutions can operate in a pluralistic society and maintain the integrity of their mission. Whether applied to individual or institution, it helps negotiate ways to be in the world but not of the world. In June 2001, this tool of compromise was significantly dulled by the actions of the USCCB with the newly revised ERDs. In this revision of the ERDs, surgical sterilization, heretofore the most morally perplexing case of material cooperation in the hospital mergers and acquisitions, has been moved to the category of "should not be considered for potential cooperation regardless of *duress*." This places it in the same category as abortion and euthanasia, which has led some to question whether the bishops are now equating the moral evil of these actions. But to bring us to the present use of this principle it is important to explore its original intended application, its development to the present and the problems it has encountered along the way.

A. A Brief Overview of the Principle of Cooperation

The principle of cooperation differentiates the action of the potential cooperator from the action of the wrongdoer through two major distinctions: the first concerns the *intentions* of the cooperator, and the second concerns the *object* of the

action. To determine to what extent I may cooperate in another's wrongdoing, the first question I must ask is, 'do I intend the object of the wrongdoer's activity?' If the answer to this question is in the affirmative, then my cooperation is considered *formal* and therefore morally impermissible. However, intention is not just an explicit act of the will. I may say that I do not intend the object of the wrongdoer's activity, but in the absence of another explanation that will distinguish my object from the wrongdoer's object I am said to be in *implicit formal cooperation with* the wrongdoer, which is morally impermissible, e.g. the judge who believes divorce to be immoral and yet who adjudicates only divorce cases. If I do not intend the object of the wrongdoer's activity, then my cooperation is *material,* and it *may* be morally permissible.

To determine if *material cooperation* is morally permissible, a further distinction must be made regarding the object of the action in question. If the object of the cooperator is the same as the object of the wrongdoer, this is considered *immediate material cooperation* and is morally impermissible except in some cases of duress. "The matter of duress distinguishes immediate material cooperation from implicit formal cooperation."[31] However, without the intervening conditions of duress, *immediate material cooperation* is equivalent to *implicit formal cooperation*, and both are morally impermissible. The nurse who works for an abortion clinic and who assists in abortion procedures without any countervailing pressures is an example of this. If the object of the cooperator's action is distinguishable from the object of the

[31] *ERDs,* in Appendix "The Principles Governing Cooperation," 1994.

wrongdoer's action, then this is considered *mediate material cooperation* and *may* be morally permissible. "Mediate material cooperation can be justified if there is a significant reason to engage in the proposed course of action and if scandal can be avoided."[32] Under mediated material cooperation we are to be as remote and the least proximate as possible from the act of wrongdoing; and the reason for cooperation must be serious. Later we will see that it is at this juncture that determining "serious" in itself is problematic.

B. Origins and Intended Usage

Once confined to a single lecture in fundamental moral theology for use in private counseling, the principle of cooperation is now a staple in the Catholic bioethicist's analysis kit. In the past it focused on single all-too-human agents to advise private persons about involvement in cooperative enterprises with others whose intentions harbored ethical impropriety. The principles of cooperation are tricky and inevitably involve dispute and disagreement. Moral theologians since the eighteenth century have agreed that they are the most difficult of all principles to apply because they concern the borderline between the realm of prudential decision and the realm of violation of principle. A theologian quoted by Richard McCormick in this *Notes on Theology* describes this area whose "demarcation [is] infinitesimally narrow, but always infinitely deep." Other noted theologians have said about the principle of cooperation that "there is no more difficult question than this in the whole range of

[32] Russell E. Smith, "Ethical Quandary: Forming Hospital Partnerships," *Linacre Quarterly* (May 1996):89.

Moral Theology," and regarding the disagreement among theologians, "this disagreement happens among the most competent moral theologians."[33]

James Keenan allows that until recent years the principle was used to help individuals; however, he maintains that in today's reconfiguring of healthcare it is acceptable and advisable to apply in analogous and legitimate ways. Keenan discusses three categories of individuals with whom one might need to employ the principle: superiors, partners and clients. Classic examples he cites for each include: the servant transporting letters to a woman with whom his master was having an affair, the spouse who practices birth control against the will of the partner, and the nurse who assists the physician in an illicit operation. In a later article, Keenan included two other classes of cooperation cases. The first of these two concerns is when someone has the right to perform a particular act, but others who perform the same act have wrong intentions. The other class of case includes those who cooperate in order to diminish the physically evil effects of another's morally wrong actions. The classic example he supplies is the belt-offering wife of the husband intent on beating his children with a baseball bat.

> Similar instances of material cooperation for the sake of diminishing the physical effects of moral evil are found in the cases of priests giving communion to unworthy recipients, judges presiding over divorce cases, doctors working in clinics that provide birth control instruction, nurses assisting in illicit operation, etc. Effectively, in each case the agent asks at some point in her deliberations whether more harm than good could occur by her failure to cooperate materially.[34]

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[33] James Keenan, "Institutional Cooperation and the *Ethical and Religious Directives*," *Linacre Quarterly* (August 1997):54-61.
[34] Keenan, 1997, 60-61.

These examples illustrate that the principle evolved in its application in context-specific cases. But this last class of cases differs considerably from the classes of cases with subordinates. Keenan gives us four foundational insights for approaching the principle. First it is a guiding principle rather than a permitting principle. Second, we should avoid situations that employ this principle as much as possible. Third, one of the basic reasons for the use of the principle is to contain evil, and fourth, the principle cannot be applied mechanistically.[35]

C. Problems with the Application of the Principle of Cooperation

All commentators on the principle of cooperation seem to agree on the fine distinctions it must make, its complexity and its easily misunderstood nature that can lead to scandal. Accusations of 'wink, wink, nudge, nudge-ing,' rationalizations and even 'phariseeism' are made by many, and Russell Smith acknowledges, "The careful distinctions that have certain clarity on the blackboard of the theology department lose their focus in the minds of practical Anglo-Saxons."[36] It is notable that the 1994 revision of the *ERDs* contains an explanation of the principle of cooperation in the appendix whereas it has been removed in the 2001 edition. A brief history of the process by which the appendix was added in 1994, as well as why it was removed in 2001, are good indications of the complexity and problematic nature of the principle.

James Keenan reports that it took six years and eleven drafts of the *ERDs* before the NCCB Committee on Doctrine was ready to offer it to the full assembly of

[35] Keenan, 1997, 56-57.
[36] Smith, 1996, 92.

bishops. The explanation of the principle of cooperation went from a "modest description of each of the principle's conditions" to a "virtual skeletal outline" which was deemed not user-friendly, to including several cases, both personal and institutional, but "when faced with these cases the bishops fell into disagreement with one another."[37] They eventually removed the cases, returned to the original version and labored over the wording of the text. Finally, it was presented to the NCCB assembly. Keenan summarizes the process,

> But, consensus was eventually achieved in an atmosphere of mutual trust and respect. That atmosphere must be promoted today among negotiating boards, ethicists and chanceries, if Catholic health care is to survive into the next century, for the principle of cooperation is a major guide in the present negotiations of joint ventures, mergers and partnerships.[38]

D. Individual Versus Institutional

It is often questioned whether a principle intended to guide individual actions can legitimately be applied to the actions of an institution. James Keenan brings together two notions: that the principle has historically allowed for individuals of conscience within institutions the ability to prevent further morally wrong behavior with the idea that today the principle of cooperation allows institutions "to maintain their distinctive moral contribution to a pluralistic society that increasingly permits and promotes morally unacceptable practice."[39] Keenan also says this notion is exemplified by the Vatican's negotiation of concordances and treaties with foreign powers. This was also exemplified in the NCCB's support of the Hyde Amendment of

[37] Keenan, 1997, 55.
[38] Keenan, 1997, 55-56.

recent years, where the action was not to end abortion but to limit it. By its hierarchical nature, the Roman Catholic Church it would seem would be particularly comfortable with applying this principle at the institutional level.

Another Catholic moral theologian, Germain Grisez, claims that the application of the principle of cooperation to institutions makes the likelihood and seriousness of possible scandal all the worse. A Catholic institution claims to be different from other institutions by virtue of its Catholic mission, "whatever it does is taken by many non-Catholics and even less sophisticated Catholics to be the Church's own act; and its acts are presumed to be fully deliberate and free, not the product of ignorance or weakness."[40] This in turn will also mitigate the institution's capacity to provide credible witness.

E. Material Cooperation

Germain Grisez seems most concerned that what many determine to be material cooperation is actually formal cooperation. He does not limit the cooperation to the delivery of services after the arrangements are made, but also to making the arrangement:

> The arrangement seemingly will establish a neat division of responsibility, isolating the Catholic hospital from immoral activities. In agreeing on this way of providing the full range of services, however, the Catholic negotiators will have intended that the excluded services be supplied by others under the conditions agreed upon, and that intention will constitute formal cooperation. Moreover, it will be embodied in the arrangement established; in virtue of it, the Catholic

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[39] James Keenan, "The Principle of Cooperation," *Health Progress* (April 1995).
[40] Germain Grisez, "Difficult Moral Questions: How Far May Catholic Hospitals Cooperate with Non-Catholic Providers?" *Linacre Quarterly* vol. 62, no 4:67-72.

> hospital, simply by keeping its commitment to the arrangements and continuing in it, will formally cooperate in providing those services.[41]

Russell Smith takes exception to this point, saying that any agreement negotiations are prompted by the desire of the Catholic hospital to provide health care and "that deliberation *about* prohibited services is aimed precisely at removing the Catholic partner from *involvement* with prohibited services."[42] Grisez then continues to list the possible evils that can obtain in material cooperation, which include: it may occasion formal cooperation, it may lead to scandal, it may impair ability to give credible witness, and it can lead to injustice. Grisez includes three aspects of health care that make it easy to move from material to formal cooperation. These include: the fact that health care providers often share the intentions of those they serve, particular services that are prohibited are integrated into a comprehensive health plan, and in prohibited services often a bad means is chosen for an appropriate end. He uses the example of a woman who must limit reproduction for her physical health, but who refuses morally acceptable means. The Catholic physician, even if not the one to prescribe the unacceptable means, must still encourage and try to ensure that the woman uses her chosen means regularly and effectively.

F. Immediate Material Cooperation and Duress

The 1994 *ERDs* state, "Immediate material cooperation is morally impermissible except in cases of duress." It has become apparent that this exception has created the majority of the problems in the mergers and acquisitions. Just what

[41] Grisez, 67-72.
[42] Smith, 1996, 90 (emphasis mine).

constitutes duress and the frequency with which it is encountered are the enduring questions here. In his article regarding hospital arrangements, Germain Grisez does not even discuss the exception of duress. His prohibition of activities begins before one is able to consider duress. Russell Smith in his May 1996 article seemingly contradicts the language and intent of the *ERDs* by dismissing circumstances that would allow for immediate material cooperation. He does this by quoting from the 1975 Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith in Sterilization in Catholic Hospitals,

> Material cooperation will be justified only in situations where the hospital because of some kind of duress or pressure cannot reasonably exercise the autonomy it has… Direct sterilization is a grave evil. The allowance of material cooperation in extraordinary cases is based on the danger of an even more serious evil, e.g., the closing of the hospital could be under certain circumstances a more serious evil…In making judgments about the morality of cooperation each case must be decided on its own merits. Since hospital situations, and even individual cases, differ so much, it would not be prudent to apply automatically a decision made in one hospital, or in even one case, to apply to another.[43]

From this selection, Smith emphasizes the following points. First, because duress appears in the presence of coercion or compulsion, the cooperating actions are removed from the realm of the voluntary, thus creating a situation in which the principles of cooperation were never intended to apply. Secondly, Smith takes from the last three lines of the selection above that duress should be considered *episodic* thus not supporting a policy that could be shared among hospitals, rather than *systemic duress* that might be understood as market pressure or physician demands. Third, he

[43] As quoted in Smith, 93.

turns to the discipline of philosophy where duress has both episodic and systemic features. An example that would be a clear cut example of the systemic duress is when the agent is compelled to perform a prohibited act that is mandated and sanctioned by the legal authority of the state, e.g., States requiring HMOs to provide contraception services by force of law.

G. Scandal

The scandal which must be avoided is defined as:

> The proposal or execution of a course of action which either is or has the potential of being perceived as constituting a contradiction or compromise of the Church's teaching with the effect that the Catholic partner is or appears to be doing evil, giving bad example, making evil appear to be good or upright, and/or suggesting that others can embark upon this evil with impunity.[44]

Keenan focuses on the duty to demonstrate to the community that in cooperating we are not undermining the tradition but rather protecting it. When the principle is applied appropriately, we enter into health care partnerships to protect Catholic values in health care and to contain wrong-doing.

H. 'Not Doing Wrong' Versus 'Containing Wrongdoing'

Keenan is the one theologian who apparently wants to expand the application of the principle of cooperation. In particular, he questions the wisdom of not cooperating in certain aspects of reproductive technology that could have stemmed the tide of 'excess embryos' which are now in excess of 10,000 in this country alone. In 1987, prior to the release of the Vatican encyclical dealing with reproductive

[44] Smith, 92.

technology, *Donum Vita,* there were five internationally known Catholic heath care facilities involved in *in vitro* fertilization. *Donum Vita* determined the moral unacceptability of *in vitro* fertilization because it separates the unitive and procreative dimensions of reproduction. Some theologians believed that the moral permissibility should depend on the procreative partners and not the procreative act; thus, as long as the husband and wife became the (genetic) mother and (genetic) father, the act would be morally acceptable. However, most all theologians were concerned with the repercussions of oocyte retrieval: that because of the pain, difficulty and cost of oocyte retrieval, several eggs are retrieved at once, and after fertilization, the 'spares' are frozen for later use or marked for disposal. Of the five Catholic Universities participating in *in vitro* only one ceased its *in vitro* activities. That one was in the U.S., whereas the others were in Europe. Now, fourteen years later, Keenan asks what evil might have been prevented had the Catholic university in the U.S. had some influence on the status on the spare embryos whose disposition at this point is questionable.

I. Was the Principle Misapplied?

Should cooperation even be countenanced? Germain Grisez's answer to this in many of the cases of hospital acquisitions and mergers is a resounding 'NO.' Grisez maintains that participation in an integrated delivery system or HMO constitutes formal cooperation, "agreeing on this way of providing a full range of services…the Catholic negotiators will have intended that the excluded services be supplied by

others under the conditions agreed upon, and that intention will constitute formal cooperation."[45]

One of the important and not fully explained problems with the prohibition of participation in any "prohibited service" is the range of moral seriousness of the acts. Russel Smith talks about the moral spectrum of seriousness that ranges from tubal ligation to abortion and euthanasia, none of which can be offered by a Catholic facility. But Smith tells us not to ignore the vast "difference in the degrees of seriousness."[46] This is why compatibility studies of potential mergers focus on sterilizations rather than abortion. But this does not explain the justification of the differences, nor why cooperation with one, albeit under duress or for serious reason, is permissible with one when not with the other.

Russell Smith and James Keenan have significant differences on *immediate material cooperation*. Smith says Keenan advocates *proportionality* which Smith states has been one of the justifications for dissent from *Humanae Vitae.* Smith says that regardless of magisterial intervention, proportionality denies the objective moral order and the existence of intrinsic meaning of rational action. Smith blames part of this on what he calls the "laconic explanation" of the Principle of Cooperation in the appendix of the 1994 *ERD*s.

[45] Grisez, 67-72.
[46] Smith, 1996, 91.

J. The Upshot

Grisez suggests that administrators of Catholic hospitals should be willing to give up some of their hospitals (perhaps all of them), suggesting that if the mission is to be taken seriously and the mission cannot proceed as the mission in the current health care environment, then the energy and money now expended at Catholic hospitals can be shifted to serve those who are least served by the present system:

> …the unborn baby whose abortion the system would provide and whose mother needs help to choose an alternative, the individual whose quality of life falls below some arbitrarily set limit, couples who need instruction in natural family planning, people too disorganized to make use of the health care system, the mentally ill who have been "freed" from institutions to wander in the streets, and other victims of ideological fashions.[47]

[47] Grisez, 72.

5. *CONTRACEPTION, STERILIZATION AND ABORTION*

Contraception, sterilization and abortion are three reproductive services that are a source of conflict both within Catholic health care as well as between Catholic hospitals and the communities which they serve. Chapter Four discussed how these conflicts could be addressed with integrity and whether moral compromise was morally permissible. Concluding that in some of these cases moral compromise could not be permitted, we then discussed the ways in which Catholic moral theology approaches these issues. This chapter will now discuss the Catholic teaching in each of these areas and how these tough cases are handled at Catholic hospitals. As groundwork to that discussion, let us first consider the Catholic Church's teaching regarding human sexual relations.

I. CHURCH TEACHING REGARDING HUMAN SEXUAL RELATIONS

Catholic moral theology is based on the search for truth through faith and reason utilizing both scripture and the moral tradition of natural law. Natural law

theory was developed in its Christian formulation by St. Thomas Aquinas. As Thomas Aquinas developed it, God has imprinted on each person's soul the natural law. All things, including persons, have a natural end. In terms of human sexuality, the natural end of sexual intercourse is the possibility of reproduction. But it is also more than that. Because God created man and woman in his likeness, the mutual love between a man and a woman is an image of the absolute and unfailing love of God. This mutual love between a man and a woman should be unbreakable. However, the fall of humanity brought other characteristics, such as lust, greed and envy, into this relationship. Marriage brought about an ecclesial order to the relationship which includes both rights and responsibilities. The aims of the institution of marriage and marital love were ordered to the procreation and education of children. But sexual intercourse is also a way for husband and wife to demonstrate that mutual love. It is this 'secondary' aim that is has been underemphasized throughout the history of the Church, but which was always present in some form. The church's position on human sexual intercourse is that it should be found only within a sacramental marriage that is blessed by God and whose bonds are unbreakable and that the unitive and procreative aspects should not be separated nor either aspect negated.

In their book, *Health Care Ethics: A Theological Approach*,[1] Benedict Ashley and Kevin O'Rourke discuss the two senses of sexuality. In the first sense, every person is a social, sexual person. As a social and sexual person, sexuality is one of our principle formative influences in our childhood and is the developmental source of our

[1] Benedict M. Ashley, OP and Kevin D. O'Rourke, OP, *Health Care Ethics: A Theological Analysis, Fourth Edition.* Washington, D.C.: Georgetown University Press, 1997.

relationality. The second sense of sexuality includes those actions which are genital and seek orgasmic satisfaction. It is the second sense that is most frequently addressed in moral discussions and, particularly, the one which has the most implications for Catholic health care. Ashley and O'Rourke describe the Christian understanding of sexuality as an application of the principle of stewardship and creativity,[2] which serves as a guide to the use of modern medical technology, "Its aim is to guide sexual behavior in cooperation with the purposes of the Creator in designing us as sexual beings."[3] Interestingly, they make the case that the current Church teaching on human sexuality is not essentially different from early Church teachings on these matters. St. Augustine taught that God intended sex for marriage and marriage remains a gift from God with a three-fold moral goodness: 1) procreation, 2) mutual fidelity and help of the spouses, and 3) sacramentality. Where Augustine is most often seen as professing a negative view of sex, Ashley and O'Rourke claim that this view was prevalent in his early work which was influenced by early Greek spiritualism and Stoic disdain for the passions, and when applied to scripture, Augustine interpreted Genesis 1-3 to mean that if Adam and Eve had not sinned, the human race would have been multiplied by divine creations. However, in later works Augustine gave up this notion and taught that a sinless humanity would have multiplied sexually, although Ashley and O'Rourke note, "Yet pessimistically he still believed that in our fallen state sexual

[2] *Principle of stewardship and creativity:* The gifts of multidimensional human nature and its natural environment should be used with profound respect for their intrinsic teleology. The gift of human creativity especially should be used to cultivate nature and environment with a care set by the limits of our actual knowledge and the risks of destroying these gifts. Ashley and O'Rourke, 202.
[3] Ashley and O'Rourke, 207.

intercourse is always flawed by venial sins of selfishness and excess."[4] Thomas Aquinas taught more positively that even if humans had not sinned they would have multiplied sexually but with even more pleasure, and that because humans are almost equally divided male and female all would have married. After Aquinas, theologians taught that marital sex can promote virtuous self-giving as well as be free of sin.

Through the ages theologians asked of human sexuality, 'What is God's purpose in dividing the human race into male and female?' Consulting scripture, the answer is found in Genesis 1:28 as God tells Adam and Eve, "Be fruitful and multiply." However, God also says in Genesis 2:18, "It is not good for man to be alone. I will make a suitable helper for him." Unfortunately, the first command is given priority, resulting in the procreation and education of children being ranked as the primary end of marriage with loving companionship as secondary. Along with the fruits of the human sexual relationship came the inextricable risks. The risks of sexual intercourse, i.e. the danger of subsequent child bearing and the tasks of child rearing would best be moderated within a monogamous union and intact family unit. Ashley and O'Rourke respond, "Therefore, the only obvious answer to the question, 'Why did God make us male and female?' is to be found in the advantages of the heterosexual family society for human procreation and education. …In fact the Church never intended to teach that the loving companionship of married couples is simply a *means* to beget children."[5] While the loving companionship is an end in itself it is still a means to a higher good, that being the procreation and education of children.

[4] Ashley and O'Rourke, 207.
[5] Ashley and O'Rourke, 208.

Towards the mid twentieth century, a new formulation of the purposes of marriage which balanced the social and personal meanings of the institution emerged and was given authoritative status. Rather than the "primary end of marriage" described as procreation, the principle of the "inseparability of the unitive and procreative meanings of marriage" was substituted. And while today it may seem that this teaching has changed substantially, the primary shift here is that marriage is not emphasized as a means to procreation, but rather as an end in itself with the unitive function placed on par with the procreative. However, some individuals have incorrectly interpreted this to mean that procreation is an optional consequence of the primary end of love.[6]

Now with this background of the Catholic Church's moral teaching on the purposes of human sexuality and marriage, we will move forward to address some of the moral issues that arise from the brute reality of our existence as sexual beings. Specifically, in subsequent sections of this chapter we will discuss contraception, sterilization and abortion – the Church's teaching on each, as well as when there might be 'exceptions' or 'compromises' made.

II. CONTRACEPTIVES

A. Preventing Pregnancy, In Normal Course of Events

1. History

By the twentieth century, with fewer marriages arranged by the couples' families, there was more emphasis on the ways that individuals were fulfilled through

[6] Ashley and O'Rourke, 209.

the marriage covenant – now conceived of a covenant rather than contract as it was heretofore known. Theologians began to ask, 'What do persons as individuals gain from sex?' The principle of the "inseparability of the unitive and procreative meanings of marriage" clearly prohibits any form of contraception when contraception is defined as "the performance of sexual intercourse with the deliberate intention of rendering infertile an act which could be fertile."[7]

The Christian tradition against birth control can be traced back to the Old Testament story of Onan, who was punished for spilling his seed outside of his wife's body. The sinfulness of contraception was accepted by all Christian denominations until the twentieth century when new scientific understandings and medications brought about greater availability. It was in 1930 at the Lambeth Conference that the Anglican Church "declared that contraception in marriage might be morally justified for economic or health reasons."[8] Pope Pius IX responded with the publication of *Casti Connubi*, in which he reiterated the Christian tradition. About the time of that publication came the first *scientific* method for predicting the infertile period of the woman's menstrual cycle. With this came the understanding that conception could be controlled by restricting intercourse to the infertile period. That this was morally acceptable was not immediately evident. But Pope Pius XII answered this in 1951, saying that methods that sought to control conception by limiting intercourse to the infertile periods are acceptable when justified by serious medical, eugenic, economic or social reasons. This system, referred to as the "rhythm method" which was merely

[7] Ashley and O'Rourke, 272.
[8] Ashley and O'Rourke, 273.

a calendar method and suffered under the assumption that all women's menstrual cycles were regular and of the same approximate length, was welcomed but the failure rate disillusioned many. About this time came the development of the first progesterone pill which supplied a new wrinkle in the discussion on the permissibility of different methods of family planning. Now that the Pope had spoken on the moral permissibility of regulating conception in limited situations by limiting intercourse to the infertile period of the menstrual cycle, it was posed by some that *the Pill* worked in just that way by extending the infertile period. By that reasoning, as long as the couple had a significantly weighty justification for regulating children, then use of the Pill would be morally acceptable. This reasoning was not accepted by all, or even most. By the 1960s, it was clear that the Vatican needed to speak to the issue.

Pope John XXIII convened a Pontifical Study Commission on Family, Population and Birth Problems (hereafter referred to as the Commission) to examine population policies of the United Nations and to advise the Church. This Commission met once in 1963 and twice in 1964. As Vatican II continued, Pope Paul VI expanded the Commission to 58 members, including lay individuals. The Commission met a fourth time in 1965. As the Vatican II Council closed, it released *The Church in the Modern World (Gaudium et Spes)* but reserved the issue of licit and illicit uses of birth control until the conclusion of the Commission. The Commission met for the fifth and final time in the spring of 1966, at which time they issued a final majority report, "An Outline for a Document on Responsible Parenthood." The report primarily argued that the Pope might use his authority to allow contraception in some instances. However,

it based its argument on the underlying reasoning that an act cannot be evil by reason of its moral object alone, but only when taken with its intention and circumstances.

Pope Paul VI took another two years of study to prepare an encyclical, *Humanae Vitae* (hereafter denoted as *HV*) to address all of these issues. The conclusions of *HV* ran contrary to the results of the Commission and served to reaffirm the condemnation of contraception. Ashley and O'Rourke report that some believed that Pope Paul VI never had any doubts about the intrinsic evil of contraception but only whether the use of anovulents (such as the Pill) constituted contraception or should be viewed as extending the infertile period of the woman's cycle. However, during the years after the release of the Commission's majority report and before release of *HV*, many Catholics changed their practices with regard to contraception believing that changes were coming from the Vatican. Many claim that it was during this time that the dissent of the American Catholic Church was born. Now those who had adopted the use of contraceptives in anticipation of the Pope's encyclical were being told that they could not continue those practices and remain in good standing in the Church. This resulted in many Catholics who had accepted Vatican II now being alienated by *Humanae Vitae.* Even after the publication of *HV,* many couples began to use artificial means of birth control with the belief that this was an unsettled question in the Church for which they could form a proper conscience.

2. Dissent

In the near forty years since the publication of *HV*, there have been numerous arguments against the position of *HV*; the two that have been most enduring and

divisive are the argument for proportionalism and the argument of *Sensus Fidelium.* The argument for proportionalism reignited a debate from the time of Thomas Aquinas that takes into account the nature of intrinsically evil acts. In effect, the majority report of the commission argued from a proportionalist position: i.e., an act cannot be determined to be evil on the basis of its moral object but only after its intention and circumstances have been taken into account; whereas *HV* reiterated that, by its moral object alone, contraception is an intrinsically evil act.

The argument from *Sensus Fidelium* (literally "sense of the faith" but interpreted as "faith intuition")[9] says that the teaching on birth control has not been "received" in practice by the faithful, even by otherwise devout Catholics. One of the main points of dissenters' justification for the use of birth control is that its proper use will serve to strengthen the marital. While Ashley and O'Rourke acknowledge that married Catholics can add a great deal to this understanding, they point out that, when the divorce rates of Catholics are as high as those of the general public, they question the conformity of the practice of contraception to the Gospel.

3. Reaffirmation

If there was doubt post-Vatican II regarding the authentic teaching of the Magisterium of the Church, the encyclicals of Pope John Paul II, named Pope in 1978, and the numerous reiterations from the Congregation of the Doctrine of the Faithful have made it abundantly clear that artificial means of birth control are not acceptable within Church teaching. Furthermore in the encyclical *Splendor of the Truth,* the current Pope addressed proportionalism determining that it is not a legitimate form of

[9] Ashley and O'Rourke, 285.

argument in Catholic moral theology. Likewise, he countered the arguments of *Sensus Fidelium* in that same encyclical.

The most recent edition of the Catechism of the Catholic Church, published in 1994, teaches that the regulation of births is acceptable as long as the couple is not motivated by selfishness and is in conformity with the generosity appropriate to responsible parenthood.[10] The only acceptable means of birth regulation is a natural method which has developed over the years to a scientifically sound practice with a high degree of success.[11] The natural method of birth regulation was first known as "the rhythm method" and was essentially a calendar method where the couple abstained from intercourse on certain days of the woman's menstrual cycle if they were trying to prevent pregnancy. The old saw went, "What do you call a couple practicing the Rhythm Method?" Answer: "Parents!" The calendar method was improved with the Basal Body Temperature (BBT) Method whereby the time of ovulation could be predicted more accurately by charting the woman's basal body temperature immediately upon waking. In this method, a noted spike in temperature indicates that ovulation has just occurred. After several months of charting her basal body temperature immediately upon waking, it was presumed she could, while continuing to record her temperature, accurately predict the nadir of her BBT which most closely correlated with the time of ovulation. The decision could then be made by the couple to abstain from intercourse if trying to prevent pregnancy, or have intercourse if trying to conceive.

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[10] *Catechism of the Catholic Church* (1994), Paragraph 2368.
[11] Albeit for highly motivated and compliant couples.

The BBT Method was further improved upon with the Billings Method. The Billings Method utilizes a visual analysis of cervical mucus to determine peak time of fertility. Women are taught to observe their cervical mucus discharge with white tissue at the opening of the vagina. Dry or cloudy and sticky discharge indicates an infertile period; whereas clear, stretchy and lubricative indicates a fertile period. It was suggested that a combination of the BBT method and the Billings method would yield the most effective results, but studies conducted by Thomas Hilgers and his associates since the late 1970s indicate that the peak mucus system method alone is the most accurate indicator of the estimated time of ovulation as confirmed by serum blood tests and that to add the BBT method does not enhance its effectiveness.[12]

Hilgers et al. have developed their methodology into a standardized medical model of natural procreation education (which they abbreviate to 'NaProEducation'). In some places, it is referred to as the 'Creighton Model;' in Hilgers' publications, it is referred to as the Creighton Model (CrM) NaProEducation Technology. While it can boast an effectiveness of 99.5% and 96.8% in preventing pregnancy after twelve months and 99.5% and 96.4% at the end of the eighteen month, this method presupposes a couple who has agreed on their procreative goals, has expressed a willingness to abstain on certain days if the goal is to avoid conception and then has the wherewithal to follow through on this. For this method to be truly within Church

[12] Thomas W. Hilgers, Guy Abraham and Denis Cavanagh, "Natural Family Planning, 1. The Peak System and Estimated Time of Ovulation," *Obstetrics and Gynecology* vol. 52, no. 5 (Nov 1978):575-582; and Thomas W. Hilgers and Alan Bailey, "Natural Family Planning. II. Basal Body Temperature and Estimated Time of Ovulation," *Obstetrics and Gynecology* vol. 55, no. 3 (Mar 1980):333-339.

teaching, the couple must also keep their family planning goals within the teaching of the Magisterium.

Artificial means of preventing pregnancy are not permitted. In doing so, the procreative function is severed from the unitive function of sexual intercourse, which is never permitted. Some have countered the official teaching of the Church by discounting the moral significance of artificial means versus natural means by pointing to the intention of each. Whether naturally occurring infertile periods or artificial means of extending the infertile period are utilized, the intention is the same: to have intercourse without conception occurring. *HV* answers this objection stating, "…in the former case, the married couple use an opportunity given them by nature; but in the other, the couple prevent the order of generation from having its natural processes."[13] Those couples using any of the natural family planning (NFP) methods to regulate the birth of children must always remain open to the possibility that they may conceive.

4. Practice

In a survey from 1980, 76.5% of individuals who identified themselves as Catholic indicated that they practiced contraception and at the same time only 29% of American priests surveyed considered that sinful. However, it was also commented that the minority who practiced NFP were very committed to their beliefs and is a minority that deserves to be heard. However, in the modern practice of medicine as well as in a society which craves immediate solutions to their problems and a drug to relieve all their ills, the practice of NFP is seen as too onerous. Many might accept in

[13] *HV*, translated in Ashley & O'Rourke, 281.

theory the Church's prohibition against artificial means of birth control, but when it comes to practice, it is a different story.

Now what do the *Directives* say? The language in the most recent edition appears so vague that one may question whether this is intentional. Directive 52 states:

> Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.[14]

One could ask if this is a dodge. Perhaps not. Oral contraceptives are used for many medical indications other than for contraceptive purposes. Additionally, oral contraceptives, IUDs and other forms of birth control are most often prescribed in physicians' offices, which keeps those practices remote from the hospital. One might also speculate that the wording in Directive 52 is one example of what must have been many compromises within the document.

Additionally, there is the medical/physiological ambiguity about the mechanism of the drugs – does it merely work as an anovluant *or* can the mechanism act as an abortifacient? This distinction gets at the heart of the difference in belief between medicine's definition of pregnancy and the church's belief of when new life begins. Medicine does not see conception as significant in terms of a pregnancy achieved; it is implantation that is significant. Because the church sees conception as the time of a new being coming into existence, the period between conception and implantation is significant. Any action which serves to render implantation impossible

[14] *Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition.*

is proscribed. It is just that action that is the mechanism of several methods of birth control: the intrauterine device and the mechanism of emergency contraception (EC) during some parts of the menstrual cycle. If taken daily for the first fourteen days, the mechanism of the oral contraceptive pills containing both estrogen and progesterone cannot act as an abortifacient. However, the progesterone only pill can act as an abortifacient so some physicians refuse to prescribe that pill.

5. Integrity

How does the Church maintain integrity with stated beliefs and practices that are prescribed by these beliefs, but which are so widely disregarded by the 'faithful?' Many Catholic physicians have dealt with the tension between their church's teachings and the medical 'standards of care' under which they professionally practice through examination of conscience. Most likely, they highlight and then honor the distinction between contraceptive practices and abortive practices. They will participate in the former but not the latter. And as was discussed in Chapter One, some Catholic Health Care provider participate in treatments proscribed by the *Directives*, but do so with an eye toward containing or preventing a greater evil. Now the Catholic hospital which represents, in a formal capacity, the Catholic Church cannot reason in an analogous way; the hospital must practice according to the *Directives*.[15] In this analysis, the distinction between pastoral and doctrinal becomes important.

Many Catholics understand the phrase, "shopping for a priest." This can be interpreted as a cynical way of indicating how one finds a priest who is very pastoral.

[15] Although as stated earlier and as will be discussed later, each bishop has say over how the *Directives* will be interpreted and practiced in his diocese.

In this realm, the priest is responsible for guiding his flock in the path of the right. In some cases this guidance is in areas of morals. It is often in this realm that the individual comes to grips with how she can live the best life according to God's plan. Aquinas taught that all human acts are comprised of three parts: the object, the intention and the circumstances. When a priest acts pastorally, he assists the individual in the examination of these aspects, and this is often where latitude in decision making is found. When counseled by a priest or other religious person, the individual is guided through the process of forming a correct conscience. The priest or other, in his or her capacity, can approach the individual pastorally whereby doctrine is explained and understood in light of the individual's unique circumstances. In no way is pastoral counseling intended to deny or mitigate the objective teaching of the Church. This pastoral role acknowledges the distinction between objective disorder and subjective guilt. And while it is not the Church's role to impose guilt, the role of the advisor in moral matters is to make clear the teachings of the Church which spell out the intrinsic evil of certain actions, while helping the individual determine her subjective moral culpability. Along these lines, but specifically in response to the theologians criticizing *Humana Vitae*, the Vatican newspaper responded,

> [The] Christian moral tradition has always maintained the distinction – not the separation from, much less the contraposition – between objective disorder and subjective guilt. For this reason when it becomes a matter of judging subjective moral behavior, within the unavoidable framework of the norm which prohibits the intrinsic disorder or contraception, it is perfectly legitimate to give due consideration to actions of individuals, not only to their intentions and motivations, but also to the various circumstances of their lives, and above all, to the causes that might impair their conscience and free will. This subjective situation, which can never change into "order" what is

> intrinsically "disorder," can have some bearing on the responsibility of the individual's behavior. As we know, this is a general principle which is applicable therefore to the issue of contraception.[16]

The 1980 Synod of Bishops generated instructions and reassurances to married people as well as to priests. To married people, the bishops acknowledged the frailty of the human condition and the difficult and trying situations that might prevent married couples from following Church teaching while still exhorting them to "continue along the difficult way toward a more complete fidelity to the commands of the Lord."[17] Priests are advised to employ the "law of gradualness," which recognizes, "a need frequently for 'patience, sympathy, and time' in educating couples to an understanding of the papal teaching, but at the same time insisting on the normative nature of this teaching."[18] Ashley and O'Rourke comment that health care providers should be able to sympathize with the pastoral dilemma which priests and spiritual directors find themselves in by drawing on the analogous dilemma they may find themselves in. After all, not all patients are compliant with the directives they prescribe; physicians must then decide if they will refuse to treat patients who cannot (or will not) cooperate in activities that are healthy or avoid activities that are unhealthy. Most physicians will confront patients about unhealthy behaviors and will attempt to encourage and persuade patients to act in more healthy ways; all of this done in the hope that the patient will come around to a more healthy way of living without resorting to quackery. One remedy would be to train physicians at Catholic hospitals to include this pastoral role in their practice; some, in fact, do practice in this manner. However,

[16] Ashley and O'Rourke, 309-310.
[17] Ashley and O'Rourke, 310.
[18] Ashley and O'Rourke, 310.

considering the vast diversity of religious beliefs among physicians at a Catholic hospital, not to mention the time and attention this skill requires, this option is virtually unfeasible. And if this *were* to be a possibility, there remains the problem of the institution not being able to act in a pastoral role.

Where the priest is able to function in a pastoral role, the institution is not. What perhaps is needed is for some 'body' or entity within the hospital to be able to function in a pastoral capacity. However, that role (within a Catholic hospital) is reserved for the bishop of that diocese. This would present serious logistical, not to mention political, problems for the diocese. As we will see in the third type of case arguing in favor of a tubal ligation for medical indications, this last scenario is what might be needed most.

6. Range of Cases

At this point of the ethical analysis, it would normally be apropos to discuss a range of cases that, on the moral continuum, range from the least morally problematic to the most morally egregious. However, as it is very difficult to find a Catholic obstetrician/gynecologist who does not prescribe the use of contraceptives to his or her patients, the issue is much broader than a range of cases. This issue goes to the very heart of tension between the Church's teaching and the *standard of care* that must be provided by all obstetricians and gynecologists. Finding the compromise in their practices has been discussed, but finding this middle ground by the institution was pointed out as not so easily rendered. One way the Catholic hospital can stay true to Church teaching is by distancing itself from the physicians' practices. If that is not

feasible, i.e. the medical practices are owned or managed by the hospital, then one might reason that the nature of the patient-physician relationship is such that the institution cannot insinuate itself in it. In this way, the physician may act 'pastorally' with his or her patients. However, this last option calls for a specific responsibility for physicians who are affiliated with Catholic hospitals. They, whether Catholic or not, are then relied upon to give pastoral counseling to their patients. This could prove to be difficult, if not impossible, in most instances.

B. Emergency Contraception in Case of Sexual Assault

We saw in the last section that because of the principle of personalized sexuality, as well as the principle of inseparability of the unitive and procreative functions of the marital act, contraception is not permitted. This would seemingly put the Church in an untenable position when addressing the needs of a woman who has been sexually assaulted and who may be at risk of becoming pregnant from this attack, an act which can be described as both a violent act as well as a non-consensual act of sexual intercourse. Catholic teaching has always permitted the individual the right to defend oneself against unjust aggressors, and in this case it is no different. A woman may defend herself against a possible conception from the unnatural act of rape. One commentator says,

> It has been long recognized in the Catholic moral tradition that if it is morally justifiable for a woman to take measures to prevent a sexual attack then it is justifiable for her to prevent any continuation of the same attack. Every aspect of the act (including the attacker's semen and the risk of fertilization) is forced upon her, and is against her free choice of the will and free consent. As an act of self-defense, the woman may take measures to prevent

> fertilization. She may stop the lingering effect of the attack by not allowing her fertility to be integrated with that of her attacker.[19]

This position is reflected in Directive 36 (which it should be noted is found in "Part Three: The Professional-Patient Relationship" rather than where one might expect to find it in "Part Four: Issues at the Beginning of Life," illustrating how the bishops categorize the care of such individuals):

> Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization.[20]

An endnote to Directive 36 gives further direction,

> It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810.[21]

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[19] Peter Cataldo, "A Moral Analysis of Pregnancy Prevention after Sexual Assault," in *What Is Man, O Lord? The Human Person in a Biotech Age* Eds. E.J. Furton and L.A. Mitchell (Boston: The National Catholic Bioethics Center, 2002):243-259.

[20] *Ethical and Religious Directives* (2001), #36. Additionally, some ethicists are uncomfortable using the term 'contraception,' which is the intentional interference in the natural process of intercourse and conception, in discussing a woman's response to a sexual assault which is an act of violence, not an act of intercourse. See Daniel Sulmasy, "A Reasonable, Realistic and Ethical Proposal," *Health Progress* (September-October 2002).

[21] Endnote 19 in the *ERDs*. Although when considering that the *Directives* are themselves a compromise document, one can imagine the process by which it was decided to place this information in the endnote rather than contained in the directive. It should be mentioned that the Pennsylvania Catholic Conference Guidelines incorporate the 'ovulation method' which will be discussed in this section.

This endnote illustrates an important feature of the *Directives*: each directive gives guidance without mandating the specific way each should be implemented. This leads to variations in practice among facilities as well as widely differing practices in many dioceses. Some view these variations in a positive light, allowing for varying cultural practices of the faith extending even to different interpretations and applications of the principles in different regions of the country; while others, especially those in dioceses in which the *Directives* are interpreted in their most restrictive way, see this as an inconsistency which undermines the principles of the Church. Another way to phrase this latter concern is that it attacks the integrity of the set of beliefs propagated by the Church. While there may be some ambiguity in how one carries out Directive 36, it is clear that one is morally directed to care for the survivor of the attack while at the same time protecting any life which may have already been conceived, either from a previous act of intercourse or from the recent attack. So one might say that the Church's willingness to move from an initial principle (which broadly and absolutely prohibits a practice) to employ another principle (which more accurately addresses the circumstances of the case) is an act of compromise. However, even within this 'exception' or 'compromise' there is an unsettled question that has far-reaching implications.

While there is a group who would maintain that contraception, as an intrinsic evil, may never be justified, that issue will not be the focus of this section.[22] I mention this because it illustrates the broad range of thinking of Catholic moral theologians.

[22] This first position is not explored within this work, because it is a position that is not embraced by the United States Conference of Catholic Bishops, nor within their document, *Ethical and Religious Directives.*

Some Catholics adopt an intransigent absolutist position identifying an act as an intrinsic evil, which cannot be directly intended or the sole act performed regardless of what good might come of it. Another group takes the position that says the description of the act does not match that of the identified intrinsic evil. Additionally, they would say that the intention is different, rendering this a different moral act. The second group stops short of a third way, whereby it is allowed that an intrinsic evil may need to be countenanced in light of a more tragic result. This third way represents a proportionalist position and is not recognized as acceptable by the Magisterium. Rather, the issue of how Directive 36 is carried out in the clinical setting to address the moral concern that the mechanism of emergency contraception act as an anovulent rather than an abortifacient will be addressed. This 'disputed question' is set within the second methodology described above.

Because Directive 36 is "ambiguous,"[23] two primary approaches have been developed to implement this directive. These can be described as the *ovulation method* and the *pregnancy method*. Those who propose the ovulation method are primarily concerned with providing compassionate care for the survivor of a sexual assault while at the same time protecting nascent life resulting from either the attack or a preexisting pregnancy. The medical evidence to date is inconclusive on the precise mechanism of emergency contraceptives (hereafter abbreviated EC). Most agree that its primary action is to inhibit ovulation but disagree on its action when given during the preovulatory phase. Some claim it can (or can only) act as an abortifacient by

[23] Daniel O'Brien and John Paul Slosar, "An Issue of Moral Certitude," *Health Progress* (September-October 2002):1.

making the lining of the uterus hostile to the conceptus. If there are serious moral concerns that it will act as an abortifacient, then special care must be taken that it not be distributed during that phase of a woman's menstrual cycle. The ovulation method first tests for a preexisting pregnancy. If the pregnancy test is positive, which could only indicate if a preexisting pregnancy was in place, then EC cannot be offered. However, if it is negative, then further tests are performed to determine the likelihood of a conception resulting from the sexual assault. The woman is questioned about her menstrual cycle history, and then various tests are performed to see if she is in the pre-ovulatory or ovulatory phase of her cycle. These tests might include a urine dip-stick test to determine if she is in the luteinizing hormone surge, a blood test to determine her progesterone level or a ferning test to determine the ability for sperm to penetrate the cervical mucus. A positive result on any of these would indicate that she is in the ovulatory phase of her cycle and emergency contraceptive cannot be administered. She may be given information where she can get this medication if it is refused at a Catholic hospital, although this practice can vary. Some theologians argue against a referral, saying that to do so would violate the principle of legitimate cooperation.

The pregnancy method tests the woman to see if there is a preexisting pregnancy. In addition, the woman is questioned about the history of her menstrual cycles. If the pregnancy test is negative and the woman is not certain whether she is in the ovulatory phase of her cycle, then she may be offered emergency contraception. Clearly, the pregnancy method is more conducive to the operations of most emergency departments. In fact, one of the lines of argument in favor of the 'pregnancy method'

reasons that to perform all of the required tests and to await the results may put the woman well past the 72-hour limit on the efficacy of the emergency contraceptive. This would fail the moral dictum of "ought implies can."

However, one of the more recent articles in favor of the pregnancy approach avoids that argument, and instead, the authors, Hamel and Panicola, discuss five major concerns with the ovulation method. Their first concern is that the ovulation method limits Directive 36 in that the directive does not say that EC *cannot* be administered to a woman in the ovulatory phase but rather discusses the condition of ascertaining that there is "no evidence that conception has already occurred,"[24] then she can be given medications that would prevent "ovulation, sperm capacitation, or fertilization."[25] Hamel and Panicola maintain that to forbid the distribution of EC during the ovulatory phase unnecessarily restricts the woman's options. However, it is difficult to deny that Church teaching never allows for abortion unless it is a case that fits into the principle of double effect, which this does not. In this case, we are considering whether a drug regimen acts to suppress or delay ovulation (which is permissible) **or** whether it acts to prohibit implantation of a conceptus, thus having an abortifacient effect (which is not permissible); it is not the case that both effects will happen with one being intended and the other unintended. If it was the case that we know that the drug will act as an abortifacient, we would certainly infer from Directive 36 that we were prohibited from using that regimen. It appears that Hamel and Panicola misstep here. However, they

[24] At present there is no way to test for a conception from the recent attack. The earliest a pregnancy can be detected is eleven days post-coital, by which time 72 hour post-coital window for the effective use of emergency contraceptive would have passed.
[25] *Ethical and Religious Directives*, quotes taken from Directive 36.

do include that when one considers fertilization as a process which unfolds over a 24-hour period, and if the woman presents in the emergency department (ED) within that first 24 hours after the attack, then EC will act to prevent fertilization from ultimately occurring, which is permissible according to the directive.

Their second concern is that the ovulation approach gives too much weight to ovulation in the moral decision-making procedure. The indication of ovulation is only an indication that conception *may* occur, not that it has occurred. And the degree of certainty to which this prediction can be made is morally significant. Thirdly, they take on the argument that EC can (or can only) act as an abortifacient at ovulation by citing scientific studies indicating that the data are inconclusive on this point. Daniel Sulmasy, in his response to their article, agrees with their overall position but disagrees with this line of argumentation saying, "I think they have overstated the case against the abortifacient effects of high-dose estrogen-progestin pills. Unfortunately, there is 'advocate science' on both sides of this issue, and the sources they cite may well provide an example."[26] Their fourth concern, and perhaps the strongest argument against the ovulation method, is that it seeks a degree of certitude that is more in line with absolute certainty rather than with moral certainty (no reasonable fear of error). And finally, their fifth concern is that the ovulation method mischaracterizes the moral object of the act. By assuming that EC can (or can only) act as an abortifacient at ovulation, one must reason that the object of the act is the destruction of a conceptus

[26] Daniel Sulmasy, "A Reasonable, Realistic, and Ethical Proposal," *Health Progress* (September-October 2002). Perhaps it is of note that Sulmasy is a member of a Catholic religious order, OFM, as well having the following degrees: M.D. and Ph.D. in philosophy.

and is therefore morally impermissible. They do not believe the evidence supports this assumption.

The degree of moral certainty to which they refer in their fourth area of concern is supported by what they call a "constellation of factors:" 1) the risk of pregnancy from sexual attack is small (less than 1 % to 5 %), 2) scientific literature indicates that EC most likely prevents ovulation and fertilization and has little, if any, post-fertilization effects, 3) the probable direct effect (moral object) is prevention of ovulation rather inhibiting implantation of a conceptus, 4) the intention in administering EC is to prevent ovulation and not inhibit implantation and 5) a proportionate reason exists for administering the EC, specifically, the prevention of pregnancy from the attack and the woman's well-being in light of the severely traumatizing event she has survived.

The aforementioned moral discussions have taken place with the backdrop of very active forces in the state and federal legislative arenas (as discussed in Chapter Four) who have been working for laws which will mandate that EC be provided to all victims of sexual assault and in some cases lobbying for these medications to be available over-the-counter. In an article published in 2000 in the *American Journal of Public Health*, wide variability in treatment standards for rape victims at 58 large urban hospitals (not all Catholic) was reported. This, in part, prompted Catholics for a Free Choice (CFFC) to commission their own survey of the availability of EC at Catholic hospitals around the country. They also found wide variability; not only are there different interpretations of the *Directives* throughout the country, but also

misunderstandings among coworkers (who are both Catholic and non-Catholic alike) at Catholic hospitals. Arguably, this variability has worked against the Church's mission in the poplar media.[27] Shortly after their survey was completed, CFFC published a report, "Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms." This report fueled the fires of those seeking remedy through legislation and, in turn, prompted the Catholic Health Association to commission their own survey of all Catholic hospital emergency departments. This survey showed that Catholic hospitals are sensitive to the needs of women who have been sexually assaulted by having policies in place (similar to the ones discussed) whereby, even if the woman is not given EC because the provider believes to the best of his or her information that it will act as an abortifacient, the patient is referred to a facility where she can obtain EC. Important to integrity in that instance is that the provider explain to the woman why EC cannot be given to her at a Catholic hospital. My educated guess is that this explanation in many cases is inadequate to the circumstances. This leads to concerns of the integrity of the institution.

Clearly Catholic teaching attempts to be sensitive to the horrendous circumstances in which the female victim of sexual assault finds herself. Whether the sexual assault policies of Catholic hospital emergency departments follow the ovulation method or the pregnancy method (both to be considered morally sound

[27] Recall the citation in an earlier chapter where the debate on mergers and acquisitions and the resulting diminution of reproductive services found its way into the pages of *Playboy* magazine.

policies),[28] there are other conditions that must be in place for the institution to operate with integrity. For either of the methods, it must be clear to those who must implement the policy that the pregnancy test is to determine whether a **preexisting** pregnancy is present and is **not** testing for a pregnancy resulting from the recent sexual assault. Secondly, it should clear to the providers the degree of certainty to which they are held in determining the estimated time of ovulation. Each provider should understand the moral significance of this timing and have the chance to participate or not in the referral of the patient to another facility if necessary. Thirdly, the lack of physiological certitude as to the action of EC should mitigate the prohibition of referral according to the principle of cooperation. In this case, the provider should understand the distinction; if the individual still cannot participate in the referral, another coworker must be available to do such. While these conditions might appear minimal in theory, in practice it is quite a different story. In both of the aforementioned surveys, it was not just Catholic hospitals that had inconsistencies and misunderstandings among their coworkers. The fact that Catholic moral reasoning must be understood and implemented by coworkers who may or may not have a disposition to personally accept the teaching makes this process all the more challenging. This is merely a practical way that Catholic hospitals can find the moral middle ground in holding true to its principles and caring for women facing an extremely difficult situation.

[28] Although if the demands of the policy in determining the certainty of ovulation exceed the capabilities of that facility to provide the services and if there is not another facility to which the patient can be referred, the policy is not morally sound in the it obligates the agent to do something that is not physically possible.

III. SURGICAL STERILIZATION

Often in the reproductive life of a woman there comes a time, when either for elective reasons or medical necessity, she opts for surgical sterilization. In fact, one standard medical text says, "Surgical sterilization is the most popular form of contraception among couples of reproductive age,"[29] while another says, "By 1990, tubal sterilization became the most common method of contraception among women in the U.S."[30] Despite this popular and seemingly commonplace practice, the Church proscribes most all surgical sterilizations. Directive 53 of the *ERDs* states:

> Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.

So what is a woman to do when her physician advises her that, should she become pregnant again, her life or health will be seriously jeopardized? In the not so distant past, hysterectomies were more commonplace. And while there were many medical indications to justify the medical necessity for a hysterectomy, there is evidence that hysterectomies were also performed for contraceptive purposes. An obstetrics textbook published in 2002 states:

> Permanent sterilization combined with elimination of potential long-term risks for later uterine pathology were acceptable indications for cesarean hysterectomy in the 1950s and 1960s. Elective procedures were commonly performed for sterilization.

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[29] F. Gary Cunningham, et al., editors, "Sterilization," *Williams Obstetrics – 21st Edition,* (New York: The McGraw-Hill Companies, Inc., 2001), Section XII – Family Planning:59.
[30] Dipika Dandade, MD, L. Russell Malinak, MD and James M. Eheeler, MD, MPH, "Therapeutic Gynecologic Procedures," in *Current Obstetric and Gynecologic Diagnosis & Treatment – 9th Edition.* Alan H. DeCherney, MD U Lauren Nathan, MD et al., editors. (New York: The McGraw-Hill Companies, Inc., 2003):chapter 45.

> Justification for hysterectomy was based on an observed need for hysterectomy in 20 percent of patients within a mean interval of 6.3 years from the most recent cesarean delivery. Several reports supported the safety of the planned/elective hysterectomy subset based on a low morbidity rate. Despite the relative safety of this subset, the incidence of elective cesarean hysterectomy has fallen dramatically in recent years. As other contraceptive options became available, authors such as Brenner et al. suggested that if hysterectomy is performed primarily for sterilization, the morbidity of a scheduled procedure will outweigh its benefits.[31]

A. Hysterectomies, the 'Catholic Sterilization'

This section will address the background of the Church's prohibition of surgical sterilization for contraceptive purposes, a discussion of those cases which would meet the criteria of 'indirect sterilization,' as well as a discussion of the practice of performing hysterectomies on Catholic women (although they need not be Catholic) as a form of contraceptive sterilization and why this does not meet the demands of an integrity-preserving moral compromise.

To get an historical perspective of the Church's position on sterilization, one must look to other than *therapeutic* sterilization. Historically, court eunuchs were entrusted with protecting the king's harem after being castrated. In the Church, boys were castrated to maintain their prepubescent voices. This was seemingly acceptable to the Church, even though the early Church condemned as heresy Origen's self-castration in order to control his desires. St. Alphonsus Liguori, a Catholic moralist in the eighteenth century did not object to the mutilations of the *castrati* but did allow that the opinions of those who rejected it as morally wrong were "more probable." The setting of the moral discussion of castration arose within the terms of the liceity of

[31] Gabbe, *Obstetrics – Normal and Problem Pregnancies, 4th edition,* (Churchill Livingstone, Inc., 2002):589.

mutilation. When discussing the morality of mutilation the principle of totality was invoked so that mutilations done for the sake of or the good of the whole were morally permissible. And so it is curious that the mutilation of young men for the betterment of Church music was tolerated but becoming a eunuch for the Kingdom of God was not. Additionally, there was never a prohibition of mutilation in the case where the castration (or mutilation) was punitive, i.e., a man convicted of a sexual offense. The Church's silence on the liceity of sterilization for medical indications is explained by the lack of scientific understanding of the human reproductive system. It was not until "... 1834 that James Blundel suggested the sectioning of the fallopian tubes but it was only between 1880 and 1910 that successful techniques of tubal ligation were developed."[32] It is here that Boyle notes the shift in rationale for the proscription from the prohibition of mutilation to the prohibition of contraception. But he also wants to give another layer to this background. Boyle thinks it wrong to discount the historical context of the discussion of therapeutic sterilization.

At the beginning of the twentieth century when the techniques for vasectomies were being developed at the Indiana State Reformatory, it was clear that this location was not random. The purpose behind these sterilizations was eugenic. Shortly thereafter states began implementing laws that permitted the sterilization of the mentally retarded. In *Buck v. Bell,* laws of this type were declared constitutional with the now infamous quote from U.S. Supreme Court Justice Holmes, "Three generations

[32] John P. Boyle, "Church Teaching on Sterilization," in *Readings in Moral Theology No. 8* eds. C.E. Curran and R. A. McCormick, SJ (New York: Paulist Press, 1993):177-200.

of imbeciles are enough."[33] One must allow that the Popes' moral evaluations were taking place in a milieu that was inimical to human freedom. At the same time, the population rates had declined precipitously, and so not only the Church, but many European nations, were prohibiting contraceptive practices (while several of these nations were at the same time employing eugenic practices). Nations needed to repopulate, but they wanted to do so with so with 'good stock.'

In 1930, Pius XI issued *Casti Conubii,* which condemned strongly eugenic sterilization. In later years, other Popes' encyclicals as well as Sacred Congregation for the Doctrine of the Faith extended this condemnation to contraceptive sterilizations, as well as eugenic sterilizations. However, they continued to allow for punitive sterilizations.

Directive 53 does allow for indirect sterilizations: "Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." This allows for a range of cases in which pathology is present in a reproductive organ and that organ must be excised. One of the paradigmatic examples of this is the cancerous uterus; its surgical removal will remove the cancer as its intended effect, and its unintended result is that the woman will be sterile. This use of the principle of double effect illustrates that the removal of the cancerous uterus is an indirect sterilization. Other cases for which this would be an indirect sterilization include: cervical carcinoma, ovarian carcinoma, and certain fibroid tumors. However, these lines are not always so clear cut.

[33] Boyle, 180.

Methods, medications and techniques for contraception improved greatly throughout the twentieth century. To many Catholics' chagrin this did not change the Church's position on contraception; newer and more improved versions of the rhythm method were the only permissible methods for regulating births, or in certain dire cases, avoiding childbirth altogether – that is, unless your physician could justify a hysterectomy. At the same time that surgical procedures to sterilize became safer, the morbidity and mortality associated with hysterectomies decreased. During the 1950s, 1960s and perhaps into the 1970s, the often referred to 'Catholic Sterilization' was the hysterectomy. It was so-called because given the 'right' medical justification the surgery and subsequent sterility would morally be considered an indirect sterilization.

Most of the evidence for this is anecdotal, perhaps for the very reason that it was subversive of Church teaching. The other factor that permitted this practice to continue reasonably unchecked was the method of reimbursement: physicians' charges were not scrutinized in those decades they way they have been since the 1980s. In an article on hysterectomies and autonomy published in 1988, Ellen Bernal cites evidence of unnecessary hysterectomies. "Hysterectomies are sometimes performed unnecessarily for these reasons: small fibroids, first and second trimester abortions, sterilization, cervicitis, mild dysfunctional uterine bleeding, and pelvic congestion."[34] In 1983 the Center for Disease Control was quoted as stating, "15 percent of all hysterectomies were questionable."[35] Another article on the variation of hysterectomies rates across Canada found that, in areas with higher rates of

[34] Ellen Bernal, "Hysterectomy and Autonomy," *Theoretical Medicine* 9 (1988):73-88.
[35] Bernal, 76.

hysterectomies, there were also larger populations of French, Polish and Italian, all groups that are largely Catholic.

The following discussion from a 1970 article in *The American Journal of Obstetrics and Gynecology* is worth including despite its length:

> During the past decade there has been a gradual increase in the number of sterilization procedures performed and a more liberal broadening for their indications. Many factors have contributed to the above trend, but the increase in liberality has been strongly influenced by a socioeconomic awareness as well as by other external social and legal forces.
>
> This renaissance in cesarean hysterectomy as a safe and effective method of elective sterilization has been stimulated by the vast experience in the procedure by the obstetricians in New Orleans. Religious restrictions on sterilization procedures from several groups in Louisiana may have caused a reluctance to do tubal ligations, and this has been a major factor in the number of cesarean hysterectomies performed within that locale. Although analysis of Ward and Smith's review of 254 elective hysterectomies at the time of cesarean section revealed a 20 percent complication rate, it was concluded that this is the procedure of choice when both cesarean section and sterilization are required. Their study has prompted members of their staff to consider the advisability of primary cesarean section with hysterectomy instead of vaginal delivery plus postpartum tubal sterilization or subsequent hysterectomy.
>
> The advantages of cesarean hysterectomy include certainty of sterility, avoidance of future tubal pregnancies, and preclusion of subsequent uterine pathology. Nevertheless it is a more difficult operative procedure than tubal ligation and carries with it added operative risks.[36]

There are several elements at work here that render this method of surgical sterilization unable to meet the demand of integrity-preserving moral compromise. First, one might question this on grounds of medical necessity. In 1970, the practice

[36] Paul Brenner, Sanford Sall and Bernard Sonnenblick, "Evaluaton of cesarean section hysterectomy as a sterilization procedure," *American Journal of Obstetrics and Gynecology* vol. 108(3) (1970):338-339.

was being challenged on the medical appropriateness of elective hysterectomies at the time of cesarean delivery. That study also hinted at the impropriety of this medical decision being influenced by socioeconomic factors as well as religious prohibitions of less invasive procedures. However, on medical indications, it is clear that by the end of the twentieth century the tide had turned, with a clear medical preference for tubal ligations over cesarean hysterectomies as a form of surgical sterilization.

Secondly, from a moral perspective, it is unclear how complicit the patients were in this subversion of Church teaching. Did the physicians paternalistically convince these patients that they medically needed the hysterectomies with the ulterior motive of sparing their patients any moral concern over their impending state of sterility? Perhaps there were cases where the patients participated in this 'wink, wink, nudge, nudge' aspect of the consent process. However, it deserves emphasizing that, although the hospital where the study from New Orleans took place was not a Catholic hospital, but rather Charity Hospital funded by the city, the population of New Orleans was predominantly Catholic, and to exacerbate the situation, the patients of Charity Hospital were largely poor and black, presenting the 'trifecta' for physicians with certain social leanings. The deception of patients and the subversion of Church teaching preclude this practice from any degree of integrity.

B. Tubal Ligations for Medical Indications

In the previous section, we saw that surgical sterilization is the most popular form of contraception. Sometimes a particular kind of surgical sterilization, a tubal ligation, is recommended by a physician for medical indications. How this is handled

in a Catholic hospital is discussed in this section. To review, Directive 53 of the *Ethical and Religious Directives* states:

> Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.

Footnoted at the end of directive 53 is an article from the Congregation of the Doctrine of the Faith (CDF), "Responses on Uterine Isolation and Related Matters," in which three questions are posed on the moral liceity of surgical sterilization. The second and third questions read as:

> Q.2. When the uterus (e.g. as a result of previous Caesarean sections) is in a state such that while not constituting in itself a present risk to the life or health of the woman, nevertheless is foreseeably incapable of carrying a future pregnancy to term without danger to the mother, danger which in some cases could be serious, is it licit to remove the uterus (hysterectomy) in order to prevent a possible future danger deriving from conception?
>
> R. Negative.
>
> Q.3. In the same situation as in No. 2, is it licit to substitute tubal ligation, also called *uterine isolation,* for the hysterectomy since the same end would be attained of averting the risks of a possible pregnancy by means of a procedure which is much simpler for the doctor and less serious for the woman, and since in addition, in some cases, the ensuing sterility might be reversible?
>
> R. Negative.[37]

While one can imagine several "present and serious pathologies" whose "cure or alleviation" would be addressed by a hysterectomy or oopherectomy, the same cannot be said of a tubal ligation. One might imagine a case in which the fallopian tubes are cancerous – and to carry this out further – a case in which only the tubes and no other

[37] Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," *Origins* v. 24 (7/31/93):211-213.

organs are involved; however, physicians admit this would be extremely rare.[38] Taking into account both Directive 53 and the article from the CDF it is clear that there is **very** little latitude for making exceptions for tubal ligations.

As discussed earlier in this chapter, Church teaching as regards surgical sterilization is based on the principle of totality, or as Ashley and O'Rourke would call it, the principle of totality and integrity. Ashley and O'Rourke admit that, if this principle is conceived of as the principle of totality, then on proportionalist grounds there might be more justification for certain exceptions to the proscription of tubal ligations. However, the addition of integrity to the principle brings to the whole the notion that one basic function cannot be sacrificed for another basic function, but rather to maintain integrity of the whole, a basic function may only be sacrifice to preserve the whole. Accordingly, it is acceptable to remove a cancerous uterus to save the life of a woman; but it is not acceptable to remove a healthy uterus just because it would be better for her as a total person not to have anymore children. Ashley and O'Rourke conclude that discussion, "It may indeed be better for her not to have another child, but she must solve this problem by changing her *behavior*, not by *mutilating* her body" (emphasis mine).[39] This fails to account for the fact that it is not always within the woman's control to avoid the possibility of getting pregnant. I would claim that there are several ways to argue for a principled exception for medically necessary tubal ligations; but the purpose of this section is to discuss, in

[38] An ectopic pregnancy that necessitates the removal of part of the fallopian tube might also be included in this scenario; however, usually only one tube is affected and would not necessarily render the woman sterile.
[39] Ashley & O'Rourke, 291.

light of the intransigent position of the Magisterium, an integrity-preserving moral compromise on these cases.

To that end, I will suggest a range of cases and circumstances that leads to a woman's decision to seek a tubal ligation, as well as what might count as mitigating circumstances for the Catholic health care facility to allow for exceptions. The first type might be a woman who has either decided never to have a child or who is content with the number of children she presently has, the second type might be a woman who is currently pregnant without serious complications to her pregnancy but who feels fairly certain that she wants no more children after she is delivered of this current pregnancy. We might add that other forms of contraception are contraindicated for her. The third type of case is a pregnant woman, currently at high-risk for serious co-morbidities or mortality for both herself and her fetus. A future pregnancy will risk her life as well as the lives of future fetuses.

In the first case, the woman, not being pregnant, is pursuing an interval tubal ligation that will most likely be done during a laparoscopy in an ambulatory surgical center. This is an elective procedure, her life is not currently at risk, nor would future pregnancies seem to place her at any greater-than-normal risk for pregnancy. This woman can easily obtain this procedure from another hospital or surgical center. Even the fact that she is required to travel some distance to obtain these services does not place an obligation on the Catholic health care facility to provide these services provided that the patient has been informed of the reason why this cannot be done at the Catholic hospital. This position acknowledges the claim that institutional integrity

can militate against an individual's right to obtain services that run contrary to the values of the institution. In this case, since the risk to the patient may be classified as an inconvenience the onus for finding and procuring these services may rightfully fall on the woman.

In the second case, the currently pregnant woman is advised by her physician to have this procedure done puerperally, that is, shortly after the delivery of her baby, whether a vaginal or a Caesarean delivery. Depending on the health of this woman, the obligations that the Catholic health care facility has to her might be measurable. Do the medical benefits of performing this procedure in the puerperal period outweigh the risks of this woman having this procedure done as an interval tubal ligation? And if so, is this the only hospital within a reasonable distance at which she can deliver? An affirmative answer to these questions might indicate an obligation for the Catholic facility to assist this woman in getting services at another facility or provide them in their own facility. It is exactly this type of case that led many OB/Gyn physician groups to threaten to pull their practices from admitting at the Catholic hospital if they were not permitted to perform tubal ligations, at the very least, on their patients for whom C-section deliveries were indicated or scheduled. In these cases and in accord with the 1994 edition of the *Directives*, hospitals claimed duress and were permitted to have tubal ligations done at the time of C-section delivery at their facilities as justified under the principle of cooperation. As discussed in Chapter 4, this use of duress on a systemic level came under severe criticism by many in the Church, so that by the annual meeting of the U.S. Conference of Catholic Bishops in 2001, this apparent

loophole was closed and the *Directives* reflected this change. Now many Catholic facilities are finding it difficult to put the lid back on Pandora's Box, especially as regards physicians' behavior. It should be reiterated that while it is imperative for the physicians to get informed consent, this is especially difficult when the physician, Catholic or non-Catholic alike, does not believe in nor follow this teaching of the Catholic Church. The physician must often advocate for his or her patient while at the same time supporting the beliefs of the hospital which may run counter to the advice given to the patient. In the areas where the OB/Gyns have been able to practice with latitude on those patients scheduled for C-section deliveries desiring a tubal ligation, it is not always their behavior that is required to change, but often times the hospital must devise a different special, financial, and legal relationship to a facility which can offer these services proscribed by the *Directives*. One of these 'arrangements' is in Breckenridge, Colorado. One floor of the hospital has been designated as a 'condominium hospital;' it is financially and legally removed from the hospital but certainly not spatially removed. The Vatican has indicated that this arrangement is ***minimally acceptable*** according to the Church and is in **no way** to be considered the model that other areas should emulate.

The third type of case illustrates the most difficult position for the Catholic facility. The patient's physician has determined that her life will be at risk should she become pregnant in the future, notwithstanding the fact that her life is at risk with this current pregnancy. Depending on the services offered by this Catholic hospital and the availability of the necessary services at an other-than-Catholic facility, the

Catholic facility's obligations may increase. To point, if this patient is under the care of a maternal-fetal medicine specialist at the Catholic facility, and that perinatologist group does not admit to another facility, the Catholic facility must determine the moral acceptability of requiring that woman to change physicians in the midst of a high-risk pregnancy. Concomitant with that, if in conjunction with the maternal-fetal medicine services the hospital also offers a high-level neonatal intensive care unit (NICU), then the facility's obligation to this patient is even higher. How can a facility which knowingly provides the services which treat the most difficult of cases and furthermore, which actively seeks these types of cases, turn around and not provide a service that will prevent a future life-threatening situation? Integrity demands that the facility reassess its need to offer those services or provide the medically necessary services that the patient requires. Intransigent positions on the impermissibility of tubal ligations by the Catholic facility in this third type of case will lead to disintegration somewhere in the system. This might manifest itself in several ways. One might be a blatant disregard of the rules by the perinatologists who might then rely on the 'don't ask, don't tell' approach. But inevitably, someone finds out. Another disingenuous approach might be to exaggerate or manipulate the medical information so that the patients appear worse than they are in an attempt to game the system; this nurtures cynicism and deception. Finally, it might lead to the perinatologists refusing to admit any patients to the Catholic hospital leaving the hospital without that population's business; although I would maintain that this last step gets everyone closer to a position of integrity *sans* the moral compromise.

But perhaps what is called for in this last example is that an individual or group within the hospital, perhaps the ethics committee, could function in a pastoral role. Without denying the objective moral evil of the act; the intentions of the individual and the circumstances in which she finds herself can be examined. These particulars would be considered in addition to the role the hospital has played in creating these circumstances, e.g., the hospital, in order to serve the common good, maintains a level III neonatal intensive care unit and has maternal fetal medicine specialists available to treat high risk pregnancies. These intentions and circumstances could be weighed and 'pastoral exceptions' could be countenanced.

IV. ABORTION

A. Elective Abortion (Elective Termination of Pregnancy)

The elective termination of pregnancy of a healthy fetus borne by a healthy woman should not be permitted at a Catholic hospital. This clearly violates the prohibition of direct killing and, as described, presents no mitigating circumstances to argue for any exceptions. The purpose of this section is not to justify the Church's position against abortion; rather, it is to show that when one compares the three types of cases we have discussed: contraception, sterilization and abortion, abortion is the most morally grave act along the continuum. That being said, the following section will show that there are cases involving the early induced delivery of previable fetuses that may allow for exceptions to the prohibition against abortion. There are two directives that specifically address the issue of abortion, numbers 45 and 47.

> Directive 45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

Possible criticisms of this approach might include the following: obligations owed to indigent patients who are receiving their care at a Catholic hospital, obligations to women who have no resources to go elsewhere, obligations to women whose life situations are not conducive to being parents right now, e.g., drug addicted, women with HIV/AIDS; and obligations to the children born to these woman. Church teaching, as well as the practice at Catholic hospitals, is to minister to the women who find themselves in any of the aforementioned situations, as well as the children they bear, and they would do so without resorting to an abortion. These same cases ***might*** call for an exception or compromise when discussing contraception or surgical sterilization, but not in the case for abortion where a life has already come into being.

B. Induction of Labor on a Previable Fetus

In a normal, healthy pregnancy, the induction of labor of a previable fetus would be considered the direct killing of the innocent which would never be permitted according to Church teaching. However, directive 47 allows that when a proportionately serious pathology exists for the mother, early induction can be countenanced:

> Directive 47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

In all of the following cases, the Principle of Double Effect can be utilized to determine whether the action that will bring about both a good effect and an evil effect is morally acceptable. Briefly, the requirements for the moral permissibility of an act which allows both good and evil include: 1) the act itself must be morally good or at least morally neutral, 2) the good effect must be intended, the evil effect is foreseen but unintended, 3) the evil effect cannot be the means by which the good effect is achieved, and 4) the good that is achieved must be proportionate to the evil that is countenanced.[40] In the following cases, the medical facts inform and often drive the moral decision to be made.

1. Membrane Rupture

There are cases when a pregnant woman presents at the emergency department indicating that her 'water has broken.' This is a sign that her membrane has ruptured and the amniotic fluid has drained out. In many cases, labor has begun, but often it is too early to deliver the fetus with any chance its survival. One of the dangers here is that infection can ascend up the vaginal wall and in a very short period of time rage into a systemic infection that can kill the woman and fetus in a matter of hours. The primary determination must be made as to *any* sign of infection. Without any signs of infection, the woman can be placed on expectant management in order to give the

[40] Some renderings of the principle of double effect, sometimes referred to as the doctrine of double effect, contain a fifth condition. However, within Catholic literature it is usually stated with these four conditions.

fetus a better chance of survival outside the womb. During this time the woman is given antibiotics, hospitalized or sent home on bed rest and monitored closely for signs of infection.

If upon presentation at the emergency department, the woman's membrane has ruptured *and* there are signs of infection, then immediate action needs to be taken to remove the infection. Usually signs of infection indicate chorioamniontis, an infection of the amniotic sac, is present. To remove the infection, steps must be taken to remove the amniotic sac, unfortunately a foreseen but unintended effect is that the fetus will be removed along with the amniotic sac. This case meets the criteria of the principle of double effect: 1) the removal of an infected amniotic sac is a morally good (or at least morally neutral) act, 2) saving the life of the mother is our intended effect, delivering a fetus which cannot survive outside the womb is a foreseen but unintended effect, 3) saving the life of the mother is not achieved by means of the fetus' non-survival – had the fetus been able to survive outside the womb, all the better, and 4) saving the life of the mother was proportionate to the unintended death of the fetus. Therefore, this instance of an early induction of labor and delivery of a previable fetus is not to be considered an abortion and is morally licit.

2. Signs of Infection, Membrane Intact

In the case where the pregnant woman presents at the emergency department with fever and cramping with her membrane intact, steps must be taken to ascertain whether this is a case of chorioamnionitis. If that is the case, then according to the reasoning in the case above, her physician would be justified in rupturing the

membrane and taking steps to remove the infection. However, in the absence of chorioamnionitis or other clinical signs of infection, the physician is required to first consider if the infection can be treated in a less invasive way and the pregnancy maintained.

There might also be the case where a pregnant woman presents with an intact sac that is bulging through an incompetent cervix. In many cases the physician is able to replace the sac into the uterus and perform a cerclage, which stitches together the incompetent cervix. However, rupturing the amniotic sac is one of the risks of a cerclage, and so the risks and potential benefits of this procedure must be weighed.

In the case of an incompetent cervix and a patient who is not a candidate for a cerclage, care must be taken to assure that the decision not to perform the cerclage is not made on prejudicial grounds, e.g., if the woman has a history of drug abuse and the physician questions her fitness as a mother. The decision not to attempt to save the fetus cannot be based on grounds that this fetus would be better off not being born. These decisions can be difficult for it may be easy for the physician to justify her actions by saying that labor has begun and cannot be stopped, and so in this case, she is merely assisting an inevitable process that has already begun.

3. Preeclampsia

Often a woman will present with preeclampsia:

> Preeclampsia is fundamentally a disease of the placenta. Although the ultimate cause of preeclamsia is unknown, it is known that some agent produced by the placenta causes the hypertension and

> end-organ destruction in the mother which is characteristic of this disease, usually of the vasculature or the kidneys.[41]

The symptoms of preeclampsia can range from the mild (blood pressure at or above 140/90, protein in the urine, swelling from fluid retention) to the severe (blood pressure at or above 160/110, protein in the urine, eye or brain disorders, bluish skin and fluid in the lungs).[42] Symptoms of preeclampsia usually appear after the sixth month of pregnancy. The most serious concern is that preeclampsia not develop into eclampsia, which is characterized by grand mal convulsions and coma. This can lead to the deaths of the mother and the fetus. As most cases of preeclampsia occur after six months, at which time the fetus is just at viability, it becomes a matter of balancing the risk to the mother while trying to give the fetus as much time *in utero* as possible to increase its chances of survival. The more dire cases occur prior to viability when the death of the fetus outside the womb is certain. Because preecplamsia is considered a disease of the placenta, in any case where the life of the mother hangs in the balance, the principle of double effect will apply.

One issue that has not been discussed thus far is the case where the mother freely chooses to risk her own life to save that of her fetus. Care must be taken that she is making an informed decision. If this is a last minute request made in the 'heat of the moment,' there may be concern that it is not a freely made decision which reflects her values and commitments to her other children and family. However, there

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[41] T. Murphy Goodwin, M.D., "Medical and Ethical Considerations Regarding Early Induction of Labor," *Gospel of Life and the Vision of Health Care*, ed. Russell E. Smith (Braintree, MA: Pope John Center, 1996):38.

[42] *The Mosby Medical Encyclopedia, Revised Edition* (New York: Penguin Books USA Inc, 1992).

may be cases where a woman feels thus and this disposition is well know to her family and physicians so that if the occasion arises, her wishes should be reflected. It should be added, that should she change her mind in this latter case, she should be respected, for we can justifiably defer to the position that when life can be saved, it is acceptable to try.

4. Anencephaly

The early induction of a fetus with a confirmed diagnosis of anencephaly is still a disputed question in Church teaching; recent discussions have moved from the acceptability of early induction to the advisability of waiting until full term, delivering, baptizing, and allowing the mother to hold her baby until he dies.

Anencephaly is a neural tube defect whereby the anterior end of the neural groove fails to close. The neural groove would normally develop into the brain, but by remaining open the developing differentiating brain is exposed to amniotic fluid which causes it to degenerate and collapse. The fetus is left with no cerebral hemispheres and it is believed that this leads to the failure of the cranial vault to form. The fetus will never experience 'upper brain' functions (cognition, rationality, etc.), but its 'lower brain,' the brain stem, that part which governs autonomic functions of the body such as respiration, wake/sleep cycles, assimilation and elimination of food will continue to function. In most confirmed cases of anencephaly the neonate dies within twelve hours of birth. It is suggested that those babies, who with intensive neonatal support, have lived longer than a couple of weeks are actually not anencephalic, but

rather suffer from microencephaly. This points to the imperative of obtaining a confirmed diagnosis of anencephaly.

The moral question that arises in cases of confirmed anencephaly, given the above understanding of this condition which is incompatible with life, is what are our obligations to the anencephalic fetus as well as to the woman carrying this fetus? Perhaps the first response to this question is yet another question – why should our obligations be any different than those to a normal, healthy fetus? From a medical perspective, there **are** differences:

> Labor and delivery of fetuses with anencephaly at term is excessively difficult because brow presentation and shoulder dystocia is likely to cause the baby to be stuck in the birth canal, and cause extreme trauma to the mother as well as a high risk of pre-eclampsia, hypertension, hemorrhage, and subsequent difficulties in pregnancy or delivery.[43]

Because of these foreseen difficulties of labor, a cesarean section is indicated. However, the actual procedure of a C-section may kill the baby because of its lack of a cranial vault and the change in atmospheric pressure. Psychologically, the differences are difficult to enumerate. A process which, under normal circumstances with normal expectations, is physically and emotionally challenging to almost any woman is now experienced knowing that the fetus she carries has a condition which is incompatible with life. One can only guess that the feelings of futility in this situation are overwhelming. Armed with this information, induction prior to full term is indicated, but at what point?

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[43] Norman M. Ford, S.D.B., "Early Induction of Anencephalic Infant," *Ethics and Medics* (June 2003):1.

It has been suggested that this pregnancy is morally different from a normal pregnancy because we lack certain obligations to non-persons than we do to persons. An anencepahlic fetus will never be able to fulfill the purpose of a human (to know, love and serve God and to know and love self and others), whereas a normal fetus has that potential. Because life's purpose can never be realized in an anencephalic, why must its continued existence be supported, especially in light of the psychological distress this must place on the potential parents? First, Church teaching would not permit the fetus to be designated as a non-person. This fetus, being conceived of a human man and woman, is a human being worthy of the respect and dignity owed all human life. As such, any induction of labor prior to viability absent a proportionately serious risk to the mother (which would then render it an *indirect* killing) would be the *direct* killing of a human, which is proscribed.

In the case of the anencephalic fetus, two questions arise in relation to this proscription. First, we can challenge the use of the term 'viability' for a fetus having a condition that is incompatible with life. When considering the sense of viability as 'ability to survive outside the womb' then the anencephalic fetus will never be viable.[44] That might lead one to conclude that either the fetus may then be induced at the moment the diagnosis of anencephaly is confirmed or that since it is never viable then it must be carried to term. Secondly, direct killing of the innocent is always proscribed. Under normal circumstances in a healthy pregnancy, any delivery of a

[44] Some will maintain that any length of survival outside of the womb contradicts this statement; however, one must also take into account the *confirmed* diagnosis of anencephaly, a physiological state that is incompatible with continued life outside of the womb. Surely, the hours or days that the parents might have with this infant can be meaningful in many ways; it does not negate the medical facts of the case.

previable fetus is considered a direct killing. Since it cannot exist outside the healthy womb, then intentionally removing the fetus with no proportionate reason is a direct killing. However, by the medical facts of the condition of anencephaly, *any* delivery at *any* time during gestation will result in the imminent death of the fetus, so we must question if *any* delivery is a direct killing. Surely this cannot be. So might we return to the options of induction that extend from the moment the diagnosis of anencephaly is confirmed to delivery at full term? Neither of these extremes seems morally acceptable. We have already determined that we are justified to deliver prior to full term because of the risks to the mother. Because 'viability' and 'direct killing' do not apply with the same cogency in the case of anencephaly, we must determine what values or principles will guide us. At the very least, we should treat the anencephalic fetus with the respect shown to any human life, which would argue against induction prior to the stage of viability of a healthy fetus. Viability is generally accepted as 23 weeks gestation. However, a fetus delivered at 23 weeks without a lethal abnormality would receive intensive support in a neonatal intensive care unit (NICU), care that would be medically inappropriate for a neonate with anencephaly. A fetus at 23 weeks gestation would never be induced without a proportionately grave reason. Here we must decide whether the psychological harm that will come to the mother to continue what she and many others will consider as a futile pregnancy outweighs any continued obligations to the fetus.

Psychological harm has never been justified as a proportionately grave reason to take the life of another. But it is impossible to assess the effects of such to women

in this situation in a sweeping generalization. Care and compassion require that assistance is provided to the woman who finds herself in this situation. Absent physical harm to the mother, labor should not be induced prior to 23 weeks for the above stated reasons. However, after 23 weeks it should depend on the needs of the mother. A sufficient interval should be required after the confirmed diagnosis of anencephaly so the woman may be offered counseling and assistance to come to terms with the diagnosis and the effects this will have on her and her family. If the diagnosis is made prior to 23 weeks gestation, she would be required to wait until that time. If the diagnosis is made after 23 weeks, she should be required to wait at least one week, during which time she should be provided with counseling and support. Some women will choose to carry their baby to term, at which point her physician will then have the responsibility to inform her of the risks to both herself and the fetus attendant with each additional week that passes after 37 weeks. Other women may not be able to deal with carrying the fetus much past viability, as long as adequate counseling has been made available and it is the case that she is making as free and as informed a decision as possible, she should be supported in this decision. Likewise, the consciences of health care professionals involved in these cases should be respected. There will be those who cannot countenance the intentional delivery of a baby prior to term without a serious threat to the life or physical health of the mother as well as those who see no moral issue here past what the mother is choosing. From Church teaching, it might be considered the heroic act for a mother to care for her

anencephalic fetus *in utero* until the pregnancy presents significant harm to her, but it should not be obligatory. Catholic hospital policy should reflect this.

V. CONCLUSION

Moral conflict is an unavoidable part of our lives. Many of these conflicts involve those areas that are integral to who we are and how we go about living a good life. Some times conflicts with other parties are seemingly intractable. Intractable moral conflicts often push our moral belief systems to their limit; especially if our moral systems apply principles or values in what might be considered an absolutist manner. This dissertation has explored ways that these intractable conflicts might be resolved with integrity.

Catholic health care faces difficult challenges in today's secular society. Operating according to a religious belief system places limitations on the services they will provide, and yet they serve communities which do not necessarily share those values. There are ways that these conflicts can be handled with integrity; there are even circumstances that should permit compromise on the part of the Catholic facility. However, Catholic hospitals should be able to continue to operate according to their beliefs. This work has discussed ways in which Catholic hospitals do cooperate with their communities and ways in which they are able to 'compromise.' The larger question which will confront us more boldly in the coming decade is how do we find room for religion in the public square? Events of the first few years of the 21st century have aptly illustrated the dangers of religious fanaticism. And yet, democratic ideals

allow for the presence of religion in the public square while at the same time protecting the public square from being destroyed. I believe the issues that have been discussed in this work will be integral to continuing the other conversation.

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