FEATURE ARTICLE

A Theological Reflection on the Principle of Cooperation and the Catholic Health Care Ministry

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Introduction

Since the publication of the Third Edition of the *Ethical and Religious Directives for Catholic Health Care Services* in 1995, the principle of cooperation has become the primary lens through which potential partnerships, mergers or joint ventures between Catholic health care organizations and secular health care organizations have been assessed. Directive 70 stipulates that "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide and direct sterilization." In the vast majority of transactions between Catholic providers and their secular counterparts, the obstacle to their collaboration is the issue of direct sterilization. For such a transaction to go forward, the collaboration of the Catholic partner should be limited to remote mediate material cooperation.

I will argue in this paper that there are inherent limitations to the use of the principle of cooperation in evaluating transactions with non-Catholic organizations where direct sterilization is the major obstacle. An exclusive focus on the principle of cooperation in such instances can mask theologically rich elements latent in such transactions that can provide the grounds for the sufficient reason for the transaction to move forward, a transaction that might not be justified in the exclusive light of cooperation. First, then, what are the limitations associated with the use of the principle of cooperation vis-à-vis the operations of Catholic health care organizations?

Analytic Limitations of Cooperation

To begin, the principle is analytically act-centered and functions optimally in retrospective review. The principle of cooperation[1] was mediated to the contemporary Church through the manuals of moral theology. The purpose of the manuals was to prepare the next generation of priests for their role in the sacrament of reconciliation. A central element of this preparation, and indeed the source for the matter of the sacrament itself, was the ability of the priest to determine the species, the kind, and the number of sins confessed by the penitent. In this context, the principle of cooperation was a retrospective tool, a tool to look back upon the action of the penitent to determine whether or not his

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or her participation in the evil of another constituted matter for the sacrament. Retrospective reviews are factual and thick; they deal with actions and events that have already occurred and can be described and analyzed in detail. The object, end and circumstances of the action are basically open to reflection and review.

When the principle of cooperation is used to assess a merger or joint venture the principle is being used in a prospective manner. Assessments that look into the future are by that very fact much more opaque. The focus tends to be on the object of the act, the nature of the cooperation itself. What would the Catholic party actually be contributing to the moral evil of its potential partner? How essential would the role of the Catholic party be, would it constitute immediate or mediate cooperation? If it can be deemed "mediate," then would it be proximate or remote? In other words how far distanced would the cooperation of the Catholic partner be from the illicit actions of the principal moral agent? Even more importantly, how significant would the causal relationship be between the action of the cooperator and that of the principal agent? Indeed if it turns out that the role of the Catholic partner is remote, mediate cooperation is there really any evil left in its role? Does the cleaning of linen, the provision of security, or dietary services, all of which can be done in a generic manner and have no causal relationship to direct sterilization, constitute a culpable level of cooperation? Such services pertain to the circumstances surrounding direct sterilization, not the object or end of the action.

If one reaches this point, does the principle of cooperation still apply? The Catholic partner providing such services is not engaged directly or indirectly in supporting an objective moral evil. There is no causal relationship between the activity of the Catholic partner and the moral agent of the prohibited procedure. The Catholic partner has been removed from its role as a cooperator. The very existence of the principle presumes that there is some level of cooperation in the evil of another that can be tolerated. The logic of the principle is that cooperation in the evil of another should assess the end (formal cooperation) and/or the object (material cooperation in the intrinsically evil act) of the principal moral agent. If the actions of the cooperator pertain to the circumstances of the principal agent's act, but are so removed as to have no causal relationship to that act, is there really any cooperation in the prohibited act?

What then is the role of the principle of cooperation in the decision making of Catholic health care organizations? The prospective use of the principle needs to engage the issues of scandal and sufficient reason. The moral danger associated with scandal should not be readily dismissed, but in a culture such as that of contemporary America the likelihood of scandal is extremely difficult to assess prospectively. The sufficient reason to

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tolerate a level of cooperation in a potential partner's provision of a prohibited service is generally that the partnership or joint venture will benefit the common good. Again, this goes to good intention, but is not yet a fact.

More importantly, the prospective use of the principle can influence how a transaction is structured. In partnerships and joint ventures the deals can usually be framed in a manner so that there is no causal relationship between the activity of the Catholic organization and a partner who provides direct sterilizations. Mergers, however, are a more complex issue. In a merger two organizations become one and, if the survivor organization has Catholic identity, it could readily become involved in direct sterilizations. Currently, some Catholic organizations are avoiding the problem by creating a corporation which does not have Catholic identity but which manages one subsidiary composed of Catholic hospitals and another subsidiary that operates community hospitals that continue to provide direct sterilizations. There are no operational or managerial ties between the two subsidiaries. However, this is to apply a civil law solution to a theological problem. At best, such a resolution to an issue which is fundamentally a matter of ecclesiology is incomplete and unsatisfying. There is a need for further theological reflection that goes beyond the insights that can be drawn from the principle of cooperation. The nature of organizational or corporate decision making as well as the role of culture in such decision making can open the way to such reflection.

Individual and Institutional Moral Agency

A discussion of corporate decision making highlights a third analytic feature of the principle, namely, its development as focused on individual acting agents. In the manuals of moral theology, the principle of cooperation was employed to determine whether or not the penitent had committed a sin and was morally culpable of that sin. In the prospective use of the principle, one is seeking to determine whether a Catholic organization will be cooperating in the moral evil of another organization as the result of some sort of affiliation. The switch in language from "sin" to "moral evil" is indicative of the difference in the moral agency of persons as opposed to institutions. The moral agency of persons was well studied in the manuals. Intellect and will were identified as the capacities that rendered a person a moral agent. Limitations of knowledge and duress on the will were recognized as factors that could mitigate or even eliminate a person's culpability for an objectively sinful act. The moral agency of corporations or institutions is a much more complex matter than the moral agency of individuals. Although corporate decision making has been studied by philosophers and business ethicists[2], it remains a matter little studied by theologians.[3]

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An exhaustive clarification of the moral agency of corporations far exceeds the limits of this paper. What is clear is that corporations and health care institutions are moral agents with a range of social and professional responsibilities. Corporations can be held accountable for moral evils and applauded for engendering moral goods; however, they cannot sin. Corporations lack intellect and will, the cognitive appetites that enable the moral agency of individuals. Corporations are moral persons only by analogy. Thus to understand the moral agency of a corporation it is helpful to identify the manner in which they are like and unlike persons.

First, decision making within health care institutions or corporations occurs within a horizon[4] constituted by contemporary standards and practices of both medicine and business. In faith-based organizations religious convictions, mission statements, core values and the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) contribute to the horizon in which decision making occurs. The reflective processes of health care organizations are shaped by shared understandings of the contemporary practice of medicine and the art and science of business as well as the religious convictions that also influence particular decisions. Such a horizon is not a given in nature, is not a metaphysical reality, but rather a construct of human ingenuity and labor. Decision making, in this context appeals to what is meaningful, what makes sense, what is of significance within the frame of reference created by the horizon. This is a framework for moral decision making that is distinct from that of an act centered morality. The ethical categories of object, end and circumstance are not immediately relevant in this context.

Health care institutions and corporations are the products of social systems. What constitutes a contemporary medical center is determined by the Joint Commission and the Center for Medicaid and Medicare Studies and other accrediting and licensing agencies. Corporate health care decision making is shaped by what is occurring in the market place, the type of care being promoted by payers, standards of care published by the various colleges of physicians and the Institute of Medicine's recommendations regarding quality and patient safety. In other words, the moral agency of health care organizations is primarily exercised in relationship to and in responses to components of the culture of American medicine. The options open to the moral agency of health care institutions are shaped by the culture of medicine. The moral categories in which the moral agency of institutions expresses itself are not that of sin or virtue, good or evil, but rather what is meaningful and significant. The criteria of what is meaningful and significant are assessed in terms of the guidance provided by the ERDs and Catholic social teaching as well as the mission and core values of the health care institution in relationship to the opportunities and threats latent in the culture of medicine and health care delivery.

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Second, the moral agency of corporations or institutions is primarily associated with the collective and collaborative activities of staff who produce strategic plans and budgets and who execute operational systems. Individual men and women exercise their intellects and wills in this process; but in corporations they have roles that contribute to a cumulative outcome, a decision that is the product of collaboration and coordination. Associated with these roles are specific competencies and skills that enable individuals to function as financial officers, human resource executives, general counsels or chief medical officers. The moral agency of corporations is essentially collaborative and collective whereas the moral agency of persons tends to be individualistic or at least functions within a narrower social environment. Cooperation in the latter case is more readily identifiable than in the former.

Third, health care institutions serve first the common good or the good of order[5] and only derivatively the needs of individuals. The "good of order" is a term coined by Bernard Longergan to emphasize the dynamic economic system that generates and sustains the particular goods provided by the common good. Institutions are social entities that act within social, economic and political areas. The moral agency of individuals is focused on the particular goods, housing, food, clothing, etc., that are essential for the well-being of individuals and families. Institutions exist to provide the goods that individuals cannot obtain directly through their own efforts, but rather they depend on the common good or the good of order to provide them. In the contemporary American environment health care, both preventive and acute care, are human goods that individuals cannot provide directly for themselves and their families.

These three reasons suggest that the moral agency of corporations should be more closely associated with a social ethic, with a notion of moral agency more closely aligned with efforts to produce change associated with Catholic social teaching than to the act-centered notion of moral agency articulated in the manuals of moral theology. Issues associated with Catholic social teaching such as access to health care and appropriate immigration/migration policies result from social and political action. Such changes are the product of social discourse and the exercise of power in response to injustices embodied in culture, society and law.

Therefore, given the nature of the moral agency of institutions and given the fact that their moral agency is not act centered but rather a species of a social ethic, issues such as direct sterilization are more appropriately assessed as cultural issues rather than as moral issues relevant to individual moral agency. Moral issues that were once associated with the moral responsibility of individuals or married couples have become cultural issues as well. This sort of transition can occur for a variety of reasons. The prevalence of a moral practice within society is one source

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of such a transition. The medicalization of various aspects of human life, including reproduction, is yet another. Perhaps this is in part what the late John Paul II had in mind when he spoke of a culture of death. "In fact, while the climate of widespread moral uncertainty can in some ways be explained by the multiplicity and gravity of today's social problems, and these can sometimes mitigate the subjective responsibility of individuals, it is no less true that we are confronted by an even larger reality, which can be described as a veritable culture of sin. This really is characterized by the emergence of a culture which denies solidarity and in many cases takes the form of a veritable *culture of death*"[6] Clearly, John Paul II taught that the moral evil associated with direct sterilization was not simply a matter of personal morality, but had become a component of contemporary culture.

Engaging the Culture

How does the contemporary Church respond to and engage in a constructive manner the culture of death? There are at least two ways. The moral agency of individuals and of couples constitutes one level of response. The second level of response is through the interactions of the Church's institutions and the manner in which they engage the culture. H. Richard Niebuhr's *Christ and Culture* and Avery Dulles' *Models of the Church* both depict ways in which religious organizations can engage culture.

Christ and Culture[7] is a study of the various manners in which Christian churches have construed the relationship between Christian faith and the realities of secular culture. At the extremes are the churches that believe Christians ought to separate themselves from culture (the Mennonite and Amish traditions) and, on the other hand, churches that believe that culture is a reliable mirror of the values and beliefs of the Christian tradition (the Social Gospel/early 19th century Protestant liberalism). Niebuhr associates the Catholic tradition and St. Thomas in particular, with the Christ above culture model. In this model the Christian community finds itself in the abyss created by the Gospel's call to a life of holiness and the moral law established by the creator and the imperfection of the culture and society in which life is lived. The Christian is called to "a universal good which is not found in anything created."[8] The Christian life is lived in the tension between the perfection to which it is called and the limitations and sinful social structures that are a part of the human reality. Christian life is lived in a milieu of sin and grace. The tension between what Christians are called to and the sinful social structures define the parameters of the world in which Catholic health care makes decisions regarding merging or partnering with secular organizations that provide direct sterilization.

Avery Dulles wrote *Models of the Church*[9] with Niebuhr's *Christ and Culture* consciously in mind. Niebuhr the ethicist

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asked the question: How do various interpretations of Christianity construe the moral life vis-à-vis culture? Dulles posed the question: From an exclusively Catholic perspective, what types or models does the Church assume vis-à-vis the culture in which it lives? Clearly, the Church as a whole embraces all five of Dulles' proposed models. But are there models that are specifically germane to the Church's institutional ministry of health care? Catholic health care is grounded in the Church as institution, but receives its distinctive mark as herald and servant. As herald, Catholic health care "receives a message with the commission to pass it on."[10] Unlike a parish or Catholic education, Catholic health care mediates the kerygma to the wider society and culture of which it is a part. Its witness is embedded in culture. More importantly, however, the Catholic health care ministry is a servant. As such Catholic health care is engaged in what Dulles refers to as a secular-dialogic method, "secular because the Church takes the world as a properly theological locus, and seeks to discern the signs of the times; dialogic because it seeks to operate on the frontier between the contemporary world and the Christian tradition (including the Bible), rather than simply apply the latter as a measure of the former."[11] The nature of Catholic health care as servant requires that it function in a realm that is not without moral ambiguity. The ambiguity is not the result of a lack of clarity from the teaching Church, but rather from how that teaching can be implemented in a secular culture. What does that teaching mean, what is its significance in a culture in which "health care" is defined in other than religious language?

Catholic health care as servant also enables one to identify what is at the very core of the ministry and to identify the signs of the times within American health care that can serve as the focal point of the secular-dialogic method. Among the beatitudes preached by Jesus in Matthew's Gospel is the care of the sick. In the Gospel, Jesus makes it clear that in practicing the beatitudes one is not simply caring for the sick, hungry and thirsty, but in doing so one is caring for Him. "Lord, when did we see you hungry, thirsty, sick or naked?" (*cf*. Mt 25: 31-46). The message of the beatitudes is the same as the message of the Good Samaritan. In caring for the sick one is caring for Jesus. There is an inherent link between an act of love toward one's neighbor and love of God.[12] Modern health care is enormously complex with its array of machines and pharmacology, with its specialists and subspecialists and multiple sites of service. But beneath and behind all the complexity there are care givers taking care of the sick. There are men and women who devote much of their lives to living the beatitudes. Many of these care givers are engaged in anonymous Christianity, in loving and serving God in their love and service to their neighbor. Perhaps Catholic health care organizations can enable their medical staff and associates to begin to comprehend the fullness, the real meaning and significance of their ministry to the sick and dying. However, one does

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not need to be a Catholic or a Christian to be engaged in a service to the sick that also brings one into engagement with mystery and the source of ultimate meaning. Call it a good deed. Call it a life in accord with the Fifth Pillar of Islam. Call it simply a life of service to others.

Conclusion

Health care is a world of service. It is also an area of American culture that is loaded with ambiguity and uncertainty. Perhaps the most basic characteristic of contemporary American health care is that it has introduced choice and the need for decision making that were not available to previous generations. Neither Catholic health care nor its secular counterparts can function in this environment and keep one's hands totally clean. The Church teaches that direct sterilization is an intrinsically evil act. That teaching is not accepted by large segments of American society or American medicine. Precisely because of issues like this, but also all the other issues surrounding the sacredness of life from conception to natural death, the Church through its institutional health care ministry must be present in American society as both herald and servant. And it must engage in a secular-dialogic methodology that begins with what is the common link within American medicine, care of the sick and the unity of love of God and love of neighbor. Recognition of the need for the Church through its health care institutions to be engaged in secular-dialogic discourse with the wider practice of medicine within American society may, in some circumstances, lead a bishop to tolerate a merger between a Catholic and secular health care organization that continues to provide direct sterilization.

But more important than any decision regarding a questionable merger, is the larger issue of decision making regarding the Catholic health care ministry. There is an old Thomistic adage, "unum, verum et bonum convertuntur" (one, the truth and the good come together in God). Ethical decision making regarding the institutional ministries of the Church that are conducted independent of a comprehensive theological discernment fail to consider the broader impact of such decisions on the life and vitality of the Church. This, as noted earlier, is the danger of an exclusive focus on the principle of cooperation when discerning the moral appropriateness or justifiability of transactions between Catholic providers and their secular counterparts.

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[1]In this discussion of cooperation I am following the language and usage in "Cooperation with Non-Catholic Partners" in *Catholic Health Care Ethics: A Manual for Practitioners*, Second Edition. Edited by Edward J. Furton with Peter J. Cataldo and Albert Moraczewski, O.P.(Philadelphia: The National Catholic Bioethics Center, 2009)p. 265-270.

[2] Patricia Werhane, *Moral Imagination and Management Decision Making*, (New York: Oxford University Press, 1999); Edwin Hartman, *Organizational Ethics and the Good Life*, (New York: Oxford University Press, 1996); Dawn-Marie Driscoll and W. Michael Hoffman, *Ethics Matter: How to Implement Values-Driven Management,* (Waltham: The Center for Business Ethics, 1999); John A. Gallagher and Jerry Goodstein," Fulfilling Institutional Responsibilities in Health Care: Organizational

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Ethics and the Role of Mission Discernment," *Business Ethics Quarterly* Vol. 12, No. 4, October 2002, p 433-450.

[3] A few Catholic theologians have explored the moral agency of institutions in the context discussing institutional conscience. *Cf*. Daniel Sulmasy, "What is Conscience and Why is Respect for It So Important?" *Theoretical Medicine and Bioethics* Vol. 29 No. 3 (2008); Kevin Wildes, "Institutional Identity, Integrity, and Conscience," *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, (1997); Grattan Brown, "Institutional Conscience and Catholic Health Care," in *Life and Learning XVI: Proceedings of the Sixteenth University Faculty for Life Conference* (2006).

[4] Regarding the notion of "horizon' in theological and ethical thought see, Bernard Lonergan, *Method in Theology*, (New York: Herder and Herder, 1972), p. 57- 99; Charles Taylor, *The Ethics of Authenticity*, (Cambridge: Harvard University Press, 1991).

[5] *Method in Theology,* p. 49

[6] John Paul II, *Evangelium Vitae,* no. 12.

[7] H. Richard Niebuhr, *Christ and Culture*, (New York: Harper Torch Books, 1951).

[8] *Christ and Culture*, 131.

[9] Avery Dulles, *Models of the Church*, (new York: Doubleday, 1974).

[10] *Models of the Church*, p.76.

[11] *Models of the Church, p.92.*

[12] Karl Rahner, "Reflections on the Unity of the Love of Neighbor and the Love of God," *Theological Investigations VI*, trans Karl H and Boniface Kruger, (Baltimore: Helicon Press, 1967. *VI*, trans Karl H and Boniface Kruger, (Baltimore: Helicon Press, 1967.

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