

Catholicism, Cooperation, and Contraception

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Abstract. A Catholic physician practices in a world that condones the use of contraception. In the effort to be morally consistent, Catholic physicians are faced with questions about the extent to which their participation in providing contraceptives constitutes immoral cooperation in evil. Particular challenges face resident physicians, who practice under attending physicians and within the constraints of local and specialty-wide training requirements. The author examines the nature of the moral act of referring for contraception and argues that, in limited cases, there is a moral distinction between a referral and an intra-residency patient transfer, and the latter may be morally licit according to the principle of material cooperation. *National Catholic Bioethics Quarterly* 12.2 (Summer 2012): 283–309.

The physician–patient relationship is, like other relationships, prone to tension and disagreements. Patients may sometimes ask their providers for treatments that are inappropriate, impossible, useless, unnecessary, not indicated, outdated, experimental, harmful, outside the bounds of the physician’s competence, or even immoral. Physicians may recommend treatments or studies that are incompatible with a patient’s conception of her own good—her goals, finances, taste, sense of propriety, beliefs, or conscience.

Many tensions are easily resolved with good communication, consultation with a colleague, referral of the patient to an appropriate allied health provider or specialist, or involvement with other members of the health care team. Nevertheless,

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situations remain in which resolution of a conflict by the normal mechanisms available to providers places a physician in a morally compromising situation. Here one can think of the case of a patient who is requesting a “therapy” that the physician believes is morally objectionable, such as termination of pregnancy.

Intolerance toward True Conscientious Objection

For a physician to comply with a patient’s request to terminate her pregnancy would be a violation of the physician’s integrity and deeply held principles and would be gravely immoral. Nevertheless, some practitioners and secular ethicists would expect the physician to initiate normal conflict-resolution mechanisms to ensure that the patient receives the treatment she desires. It is argued that when a patient requests legally available options, especially those that constitute a “standard of care,” the conscientiously objecting physician should refer the patient to someone who can provide the desired option.¹

Catholic ethicists find this solution morally unacceptable, equivalent to “passing the buck.” Referring a patient for a morally wrong course of action involves a morally unacceptable degree of cooperation, making the physician complicit in the evil the patient chooses, not exculpating him from responsibility for the moral evil.² For this reason, people of good will have long argued that physicians should have the freedom to practice according to the dictates of their consciences and should be protected from sanction for not providing or not referring for legally available treatments that are contradictory to their beliefs. In the words of President Barack Obama, what is needed is a “robust conscience clause.”³ I have elsewhere argued that the authentic pluralism and freedoms so valued by American culture are best protected in health care by a liberal view of conscience that allows providers freedom to practice without worry about threats to medical licensure, board certification, or professional standing because of the beliefs that animate their medical practice.⁴

¹ See Bernard Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians*, 3rd ed. (Philadelphia: Lippincott Williams and Wilkins, 2005), 49, 250; F. A. Chervenak, “The Ethics of Direct and Indirect Referral for Termination of Pregnancy,” *American Journal of Obstetrics and Gynecology* 199.3 (September 2008): 232 e.1–3; American Congress of Obstetricians and Gynecologists Committee on Ethics, “The Limits of Conscientious Refusal in Reproductive Medicine: ACOG Committee Opinion 385,” *Obstetrics Gynecology* 110 (November 2007): 1203–1208.

² Germain Grisez, *The Way of the Lord Jesus*, vol. 3, *Difficult Moral Questions* (Quincy, IL: Franciscan Press, 1997); Thomas J. O’Donnell, “Contraception and the Catholic Doctor: The Question of Referrals,” *International Review of Natural Family Planning* (Collegeville, MN: Human Life Center) 10.3 (Fall 1986), 230–233, reprinted with modifications in Thomas J. O’Donnell, *Medicine and Christian Morality*, 3rd rev. ed. (New York: Alba House, 1996), 40–44; and Orville N. Griese, *Catholic Identity in Health Care: Principles and Practice* (Braintree, MA: Pope John XXIII Medical–Moral Research Center, 1987), 388, 409–410.

³ Jacqueline L. Salmon, “Obama Supports ‘a Robust’ Protection for Catholic Health-Care Workers,” *Washington Post*, July 3, 2009.

⁴ Patrick C. Beeman, “Applying the Concept of Judicious Dissent in Matters of Conscience,” *Virtual Mentor* 12.8 (August 2010): 628–633.

that is, with contraceptive intent, the physician's level of cooperation would be mediate material. If, on the other hand, the procedure was intended by the physician to dually treat menorrhagia and to reduce fertility, then his or her cooperation would become implicitly formal.

X Mediate material cooperation requires that the given action, which draws the cooperator into the morally objectionable act of the principal agent, be itself morally good or indifferent. There must be a "proportionately serious reason for cooperating as well as serious consideration of the scandal element."⁴¹ In the case of intra-residency transfer for contraception, proportionate reason might be continuance in the given residency program, evangelization by one's witness to moral truth, the need to provide for one's family, or many other morally legitimate reasons.

✓ It is important to remember that mediate material cooperation is not commission of an evil so that good may come of it; this is universally immoral (see Romans 3:8). Rather, as Griese explains, "Since the cooperator does not share in the evil, he or she is not sharing in the sin of another. It is more accurate to say that the principal agent is using the good or indifferent act of the cooperator as an occasion of or assistance in the performance of an immoral deed."⁴² The wrongness proceeds from the principal agent even as the cooperating physician is drawn into the action of the principal agent.

A Greater Good to Be Achieved or a Greater Evil to Be Avoided

X Mediate material cooperation in a patient's contraceptive intent may become an occasion of sin for a Catholic resident, but it is not sinful in itself. St. Alphonsus de Liguori explained that when "when you place an indifferent act without an evil intention, if the other person chooses to abuse it so as to accomplish his sin, you are not bound to prevent that sin except by the law of charity. And since charity does not obligate with a grave inconvenience, you do not sin by providing your cooperation with a just reason; then the sin of the other person does not proceed from your cooperation, but by the malice of that person who abused your act."⁴³ Helpfully, Griese concludes, "the principle behind the exonerating effect of a 'grave inconvenience' is that a person is not obliged to prevent harm from coming to another if in doing so, he or she would suffer equivalent harm himself or herself."⁴⁴ This does not mean that any action is excusable if its commission is done for the purpose of avoiding harm to oneself. Rather, one need not place oneself at risk of serious harm in attempting to prevent others from committing some wrong. Hence, though a resident may know that a patient is being seen by another doctor in the next room in order to procure

of birth control because their doctor told them they could not become pregnant after the procedure. Hence, though it would be uncommon, it is within the realm of possibility that someone might use this non-contraceptive procedure with a contraceptive intent.

⁴¹ Griese, *Catholic Identity*, 389.

⁴² *Ibid.*

⁴³ Alphonsus de Liguori, *Theologia moralis*, vol. 1, ed. Leonard Gaude (Rome: Typographia Vaticana, 1905), 357, quoted in Griese, *Catholic Identity*, 389.

⁴⁴ *Ibid.*

practices via intra-residency transfer requires a good reason, which should be determined according to potential harm that will occur or potential good that cannot be obtained by non-cooperation. Moreover, the greater one's proximity to the contraceptive act, the more serious the required reason would need to be to justify cooperation. Helpfully, Griese offers the following four analyses.

Practical Considerations in Mediate Material Cooperation

1) First, Griese notes that "actions which are *remote* with regard to facilitating the prohibited procedure, but *not at all necessary* or indispensable to that end, are justified for any *reasonable cause*."⁴⁷ The example he offers is of a custodian cleaning an operating room where sterilizations are performed or preparing a patient in a hospital room for a scheduled procedure. Actions that would be performed on all patients regardless of their contraceptive desire are morally permissible and are a form of remote material cooperation in evil if, beyond the general reasons for a given action, a patient is also was seeking contraception. For instance, performing a post-partum examination on a patient who will then obtain contraception from another physician at the same clinic would seem to fall under remote material cooperation in evil. So, too, would presenting a patient's history and physical at a pre-operative conference for sterilization or performing a gonorrhea or chlamydia test on a patient because the hospital requires it before insertion of an IUD.

2) Second, Griese states, "actions which are *proximate* with regard to facilitating the prohibited procedure, but *not at all necessary* or indispensable to that end, require a *serious reason* for performing the act of cooperation."⁴⁸ Griese gives the example of sterilizing surgical instruments for an immoral procedure, preparing the operating table for the procedure, or administering the anesthetic for the procedure. Serious reasons for cooperation in the aforementioned circumstances might include "permanent termination of employment in that hospital . . . even temporary but relatively long-term loss of employment (three months or more) for an employee who is the sole support of a family; definite indications from the hospital administration that such a 'refusing' nurse [or physician] would either be demoted or would lose all rights to promotions (and hence substantial salary increases) in the future."⁴⁹ There is here an obligation to make one's opposition to such acts explicitly known and to avoid occasions of cooperation. This might mean seeking employment elsewhere, even if this would mean a decrease in income or other monetary benefits. For a resident, transferring to another program is often not possible. And even where it is, there are at most a few residency programs in the country where no sterilizations are performed and no contraception is practiced.

e.g. An intra-residency transfer of care for contraception seems to be an instance of mediate material cooperation that is proximate but not necessary to the accomplishment of the contraceptive end (as, on the other hand, writing the prescription for an oral contraceptive pill would be). On Griese's immediately preceding analysis,

⁴⁷ Ibid., 399, original emphasis.

⁴⁸ Ibid., original emphasis.

⁴⁹ Ibid., 399–400.

it would be permissible for reasons such as those mentioned above.⁵⁰ Similarly, for resident physicians we might add the following reasons to the list of adduced reasons for cooperating: termination from the program; rejection as an applicant; or inability to complete the program, achieve procedural facility, attain sufficient competence to practice the specialty, or obtain board certification.

31 Third, Griese states that “actions which are *necessary or indispensable*—and to the extent that the prohibited procedure would not take place at all without that act of cooperation—require a *very serious reason*, even if the act itself is only remotely connected with the procedure.”⁵¹ A necessary or indispensable act that is remote from the procedure might include calling the scheduling nurse to place a patient on the e.g. books for a sterilization, placing an NPO (nothing by mouth) order the night before a postpartum tubal ligation, completing the patient’s history and physical form, or examining the patient’s abdomen/habitus the morning of surgery to decide if the procedure is doable or safe, after which another person will perform the surgery. With respect to the provision of contraceptives, this might be a physician’s reporting a patient’s contraceptive preference on rounds or his counseling them on the risks of a given method (i.e., increased chance of venous thromboembolic disease with estrogen-containing contraceptives). Very serious reasons indeed would be required to permit cooperation in these circumstances. For one, participation in and performance of these might leave the impression that the resident morally approves of contraception. Moreover, if these “supportive” acts become routine, there is the risk that the resident’s conscience will be inured to what is morally evil. But what is a “very serious” reason? Rev. Francis Connell offered the following: “A well-founded fear that [one] might be dismissed from the hospital and be barred from continuing in [one’s] profession,” or further, “actual threats of serious physical harm . . . or serious threats to ruin [one’s] reputation in the community.”⁵² In today’s circumstances, while physical harm seems unlikely, damage to one’s reputation and dismissal from training seem well within the realm of possibility. This will, of course, depend on

⁵⁰ I have tried to draw examples from common experiences in residency training and day-to-day practice. Mostly this is to provide practical guidance on difficult and very specific questions that often vex Catholic colleagues and Catholic medical students who are considering obstetrics/gynecology as a specialty. Often there is a fatalistic notion that obstetrics/gynecology cannot be practiced as a faithful Catholic, which drives students away from entering the specialty and drives Catholic residents into compromising their beliefs on the conviction that there is no other way to obtain obstetrics/gynecology training than to embrace the contraceptive mentality of the wider specialty. My conclusions about the rightness or wrongness of a given action are my personal convictions drawn from experience, prayer, and study. I believe they are in line with Catholic teaching, but I recognize they may be controversial and that faithful Catholics may disagree with some of these conclusions. Of course, if I am wrong, I would gladly defer to the Church and her wisdom. Importantly, the issues treated here are so common and important but are without substantive and practical treatment in the literature and thus even some sincere Catholic physicians unwittingly engage in morally problematic actions. As Sacred Scripture says, “My people are ruined for lack of knowledge” (Hos. 4:6 NAB).

⁵¹ Griese, *Catholic Identity*, 400.

⁵² *Ibid.*, 400–401.

local circumstances, as some programs may be more tolerant of a Catholic resident's "alternative viewpoint" than others. Importantly, as with all discussions concerning cooperation, it is not simply any proffered reason that justifies a given instance of cooperation. Not wanting to "make waves" is hardly ever, if at all, a good enough reason to justify cooperation in morally objectionable activities. Some of the additional reasons I adduced earlier for justifying cooperation might apply to the performance of necessary but remote acts. While I have tried to provide concrete examples to give guidance, particular application will depend on specific situations.

Fourth, Griese notes that we must consider actions that would be considered *very proximate* and also *necessary*, which he defines as "actions which come perilously close to being actual participation in the prohibited procedure itself." In fact, however, such acts are distinguished from participation *per se* but do fall under what all would agree to be facilitation of a given act, for example, "standing by during the procedure and handing the surgical instruments to the physician, or standing by to keep the patient quiet by administering anesthetics or narcotics as may be required during the procedure."⁵³ Consider the following specific situations that a resident could encounter: being assigned to surgery on a day when only sterilizations are performed, being the primary surgical resident on the obstetrics service for cesarean sections in the case of a cesarean section with concomitant bilateral tubal ligation, or being assigned to a patient whose chief complaint is that she wants to switch contraceptive methods.

Sterilization and Cooperation

At my institution, residents assist private physicians with cesarean sections, getting to act as primary surgeons, thereby learning surgical technique under the direct supervision of an experienced obstetrician/gynecologist, but often with little prior knowledge of the patient before meeting her immediately before surgery. The situation often proceeds along the lines of a pager beeping the words "Dr. Smith needs help in OR 1." Sometimes, once the baby is delivered and the uterus is surgically closed, the surgeon will say "Babcock," indicating the instrument needed to perform a sterilization during a cesarean section. To the resident's surprise, the case is a combined cesarean and sterilization. Of course, in such cases, a resident cannot be morally faulted for not knowing beforehand that the sterilization procedure was also going to be performed and thereby proximately and necessarily cooperating in its accomplishment. In such instances, a polite refusal to the attending physician, "You can go ahead and perform this part of the surgery. I don't do sterilizations because I'm Catholic" often suffices.

More often, however, the resident speaks with the patient and then with the private attending physician and thus learns, before the surgery, that a sterilization will be included in the case. Since this is a primary way in which residents obtain surgical experience at my institution, and since the program requires that residents assist the private physicians, it is not practical to simply avoid all cesareans with bilateral tubal ligation, especially since up to a quarter of cesareans include both procedures and one does not know about the sterilization until minutes before the

⁵³ *Ibid.*, 401