

Needed, an Ethics Audit of Catholic Sterilization Policies

by

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Abstract

The author proposes an ethics audit of Catholic sterilization policies as a way to correct the disparity between the regnant moral directive prohibiting direct sterilization in Catholic health-care facilities and the policy and practice of allowing tubal ligations for "medical" or "therapeutic" purposes. The proposed four-step plan for the ethics audit involves dialogue and collaboration between U.S. bishops who have Catholic health-care facilities in their dioceses and the respective hospitals' administration, sponsors, and medical staff. First, bishops clarify for Catholic hospital administrators, sponsors, and system leadership the moral distinction between a direct sterilization and one that is therapeutic or indirect. Second, bishops instruct hospital CEOs to abide by directive 53 of the Ethical and Religious Directives for Catholic Health Care Services by providing only indirect sterilizations. Third, bishops encourage hospital leadership and medical/nursing staff to promote directive 53 in tandem with directive 52 and its call for providing natural family planning services within the hospital. And, fourth, bishops collaborate with the hospital or system leadership in conducting ongoing oversight of sterilization policy/procedures to insure that their Catholic health-care institutions practice durable compliance with directives 52 and 53.

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Introduction

I concur with a suggestion from John Haas, director of the National Catholic Bioethics Center.¹ After decades of questionable accountability and transparency, we need to conduct an ethics audit of sterilization policies in our Catholic hospitals.²

Two types of professional data demonstrate compelling reasons for such an audit. The first is anecdotal. Over the past thirteen years, I have had hundreds of ethics consultations with physicians employed by Catholic hospitals across the U.S.³ At least 80 percent of these teleconferences dealt with the frustrating disparity between theory (the regnant ethical directive prohibiting direct sterilizations in Catholic hospitals) and practice (the considerable number of tubal ligations provided under the banner of “medical necessity” or “therapy” within the physician’s respective Catholic health-care facility).

The second set of data⁴—completely objective in nature—is comprised of the hospital discharge records, including sterilization statistics, submitted by forty Catholic acute-care hospitals to the Texas Department of State Health Services over a four-year period.⁵ The data revealed that twenty-three of the forty Texas Catholic hospitals provided tubal ligations to a total of 10,597 women between the years 2000 and 2003.⁶ Preliminary analysis of public use data files from other states indicates that the tubal-ligation stats out of Texas are representative of, rather than an exception to, a nationwide trend in Catholic health care.

Given the implications of this data, I propose that local ordinaries who have Catholic hospitals under their jurisdiction implement the four-step ethics audit plan outlined in the body of this article. First, bishops clarify for Catholic hospital administrators, sponsors, and system leadership the moral distinction between a *direct* sterilization and one that is therapeutic or *indirect*.⁷ Second, bishops instruct hospital CEOs to abide by directive 53 of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) by providing only indirect sterilizations.⁸ Third, bishops encourage hospital leadership and medical/nursing staff to promote directive 53 in tandem with directive 52. That is, the ordinary instigates and sanctions efforts to position a department within the hospital(s) that provides women with a natural, moral alternative to what is currently being billed as a “medically necessary” or “therapeutic” tubal ligation. And, fourth, bishops collaborate with the hospital or system leadership in conducting ongoing oversight of sterilization policy/procedures to insure that their Catholic health-care institutions practice durable compliance with directives 52 and 53.

Preliminary Considerations

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.⁹

Recent developments in Texas illustrate what is ostensibly a pervasive theoretical and practical misunderstanding of directive 53 and its definition of direct/indirect sterilizations. After it was brought to his attention that the two hospitals under his jurisdiction had provided almost two thousand tubal ligations between the years 2000 and 2003, Alvaro Corrada, S.J., bishop of the diocese of Tyler, Texas, instructed the two Catholic hospitals (Christus St. Michael and Trinity Mother Frances) to cease doing tubal ligations and other *direct* sterilizations.¹⁰ Such procedures, the bishop contends, violate directive 53 and are intrinsically opposed to the dignity of the women being sterilized. Furthermore, Bishop Corrada and his representatives argue that the administrators and physicians of Trinity Mother Frances Hospital, despite “good faith,”¹¹ are misinterpreting the directive’s approval of indirect sterilization by applying that classification to tubal ligations.

St. Michael Hospital immediately agreed to discontinue all tubal ligation procedures. While Trinity Mother Frances Hospital did eventually obey the bishop’s directive, they initially refused to do so.¹² Trinity Mother Frances defended its original position by arguing that the tubal sterilizations they performed were therapeutic (indirect) and, therefore, permitted under directive 53.

Faced with these contradictory positions, the question is: Which one correctly interprets directive 53? 1) tubal ligations are always directly sterilizing and, therefore, impermissible. Or, 2) some (most) tubal ligations done for “therapeutic” purposes qualify as indirect sterilizations and, therefore, are permissible. To answer that question, we need to examine pertinent moral principles that will help to resolve the current dispute over the liceity of tubal ligations in Catholic hospitals.

The first principle of morality, the fundamental canon of living a moral life, instructs me (the patient or physician) to “seek out and do the good and avoid evil.” I am “doing good” when I take those means that will lead me, and assist others, to attain the happiness for which God has created us. What this principle means by “avoiding or not intending evil” is that I ought not act so as to stand in the way of my and others’ attainment of the happiness that God has willed for us. Hence, if I want to *be* a good person, that is, if

I want to pursue a good moral life, I must also *do* good in my actions, i.e., intend or realize the good and not evil in practical living.

It is important that I comprehensively understand the term “intention” or “intending,” since it can be used to refer to three different kinds of “intending.” 1) In everything I deliberately and freely do, I intend to strive to attain true happiness for myself and for others. This is *my intention of the ultimate end*—that for which I do everything else and, thus, what is most important to me in life. 2) But I can achieve happiness only by choosing to do some particular act as *a means to that end*. This is *my intention of the moral object*, the action I choose to do in order to achieve my end. These two intentions (1 and 2) are coincidental: one as the end; the other as a means to that end. So, if my end is an intention of the *true* ultimate end and my intention of the moral object is a *good means* to that good end, my action is primarily and essentially good, that is, both as an end and as a means. 3) Sometimes I also have one or more accidental or circumstantial intentions or motives that color and qualify the morality of what I primarily and essentially intend. Good circumstantial intentions, however, can never make an essentially evil action good.

If my action has only one effect—its moral object is essentially either good or bad—the task of identifying whether I am doing good or evil by executing that action is quite straightforward. If what I intend to do is simply good, i.e., its sole effect is good, then I am doing good (and becoming a better person proportionately). Thus, in choosing to make a donation to a truly ethical charitable organization, I am doing a wholly good act; my contribution helps the poor or disadvantaged without also causing bad effects. On the other hand, if what I intend to do is totally bad, then I am doing a morally evil action. So, in intending to embezzle money from the charitable organization, I am doing something that has only one effect, and that is a bad one; my action, therefore, is thoroughly bad.

But how can I be sure that I am doing good and avoiding evil when a prospective good action of mine would result in *double* effects, one or more good and one or more bad? If what I directly intend to do in that double effect action is good, would I really be avoiding evil if the action would also have a bad effect, albeit one that I do not intend but only tolerate?

The *principle of double effect*, which is really a set of norms or conditions, is designed to help me discern if I am doing good and avoiding evil even *when my action produces—simultaneously—both good and bad effects*. This principle assists me to differentiate between a) a prospective double-effect action that would be morally acceptable because, in choosing it, I would be directly intending the good and only tolerating the wrongdoing as an evil

side effect and b) a double-effect action that would be morally unacceptable because, in choosing it, I would be directly intending the evil. The principle of double effect has four conditions: 1) the act itself can not be morally evil; 2) any bad effect may be foreseen but must be unintended; 3) the bad effect cannot be the cause of the good effect; 4) the good effect must be morally proportionate to the bad effect.¹³

Applying the first principle of morality and the principle of double effect to the question of tubal ligation (and vasectomy), I draw the following conclusions. A tubal ligation or vasectomy is an action that has the *sole* effect of rendering the patient sterile.¹⁴ Therefore, since the physician recommending the tubal ligation or vasectomy and the patient consenting to either of these procedures deliberately intends to suppress the basic good of fertility, and since directly suppressing a basic good diminishes essential human fulfillment, a tubal ligation or vasectomy is a bad act, that is, against the patient's fulfillment. ✓

If a tubal ligation were a double-effect action, as some mistakenly claim, the twin effects—one good (therapeutic), one bad (sterility)—would have to follow simultaneously from the single act of ligation. But no current cure of any pathology, tubal or otherwise, immediately follows from a tubal ligation. In fact, a physician recommends the ligation procedure precisely because the woman's fallopian tubes are healthy, i.e., functioning normally. A curative or preventative effect occurs only as a mediate possibility in the sense of preventing a future pregnancy and then, perhaps, avoiding a particular pathology that might be caused or exacerbated by that pregnancy.¹⁵ The fact that tubal ligations do not cure any current pathology also means that, in terms of a risk/benefit analysis, tubal ligations have only risks (surgical, medical, and psychosocial).

But are there any surgical or medical interventions that could be classified as indirect sterilization? The answer is yes, under certain circumstances. For example:

- 1) A female patient who experiences uncontrolled hemorrhaging at the time of a c-section from an atonic uterus (uterus fails to contract) or abnormal placentation (abnormal placental attachment of the fetus to the uterus) could have her uterus removed to save her life, even though she is rendered sterile as a result of the hysterectomy.¹⁶
- 2) A female patient who has uterine cancer could have her diseased uterus removed as a cure for her cancer, even though she is rendered sterile in the process.

- 3) A female patient with bilateral hydrosalpinx could have a therapeutic bilateral salpingectomy, even though this surgery renders her sterile as an unintended effect.
- 4) A female patient with ovarian cancer could undergo hysterectomy/oophorectomy/salpingectomy for therapeutic purposes, even though the respective intervention would render her sterile as a result.
- 5) A male patient with testicular cancer could have his testicles removed for curative purposes, even though he is sterile as a result.
- 6) A female patient who has any type of cancer and requires chemotherapy or radiation of the pelvis could receive such curative treatment, even though sterility follows.
- 7) A female carrier of the BRCA-1 or BRCA-2 gene could undergo a prophylactic oophorectomy/hysterectomy, even though she is left sterile as a result.
- 8) A woman with an ectopic pregnancy in one fallopian tube followed by an ectopic in the remaining tube could have the second (medically necessary) salpingectomy, even though this last procedure will render her sterile.

Each of the above medical (chemotherapy, radiation) or surgical (hysterectomy, oophorectomy, salpingectomy, and surgical excision of testicles) interventions is morally acceptable because in choosing it, the physician and the patient would be directly intending the good of therapy and only tolerating, that is, indirectly intending, the evil of sterility.

I. Clarify the Distinction Between Direct and Indirect Sterilizations

To correctly understand directive 53 and its prohibition of direct sterilization, we need to carefully consider the distinction it makes between direct and indirect sterilization:

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.

The first sentence of directive 53 defines direct sterilization as a morally unacceptable procedure since, in choosing it, the physician/patient have the sole intent of sterility or the direct suppression of the basic human good

of fertility. Its second sentence defines *indirect* sterilization: a procedure whose direct, that is, intended effect is to cure or alleviate a present and serious pathology and whose indirect, only tolerated, effect is sterility. Thus, an indirect sterilization is morally acceptable since the physician/patient who chooses it directly intends the therapy or cure—a moral good—and only tolerates the bad effect of sterility.

When an indirect sterilization is done for a proportionately grave reason and no simpler therapy is available, it is morally licit. In other words, the Catholic teaching on sterilization explains that, when a surgical, medical, or other intervention cures or remedies a present pathology in the patient but results in sterility, and when a simpler therapy having only good effects is unavailable, the intervention is morally permitted. Although indirectly willed, sterility is still an evil: it is, after all, no small matter for the person to lose the gift of his or her fertility.

The confusion comes in when clinicians think that if they perform a tubal ligation on a woman who is obese, suffers from anemia, severe asthma, cardiac diseases, or Rh incompatibility or other blood factors, the act will be good by virtue of its good intention: alleviating the aggravation of these diseases/conditions should she get pregnant in the future. But let us stay with the distinction that directive 53 is making. An *indirect* sterilization cures or mitigates an *existing* disease. Performing a tubal ligation to relieve or avoid conditions exacerbated by a future pregnancy could only be considered indirectly sterilizing if therapy were the procedure's sole *intended (immediate)* effect and if sterility were the *tolerated but unintended (mediate)* effect. To argue this would, of course, be absurd. A tubal ligation, done independently of, or in conjunction with, a c-section, does not cure or mitigate the diabetes, heart disease, anemia, or neurological disorder that a female patient may be currently experiencing. And if one contends that the tubal ligation will prevent exacerbation of said diseases in the future, one demonstrates, first, that the clinician directly intends the sterilization of the woman and, second, that the so-called treated disease does not exist in the present (and, truth to tell, may not exist in the future, even if the woman were to get pregnant), leaving sterilization as the sole immediate effect of the tubal ligation.

The correct interpretation of directive 53 relies on *Quaecumque sterilizatio*, a statement from the Vatican's Congregation for the Doctrine of Faith, which responded to questions posed by U.S. bishops about the legitimacy of performing tubal ligations as therapeutic, i.e., indirect sterilizations:

Any sterilization which of itself, that is, of its own nature and condition, has the sole immediate effect of rendering the generative faculty incapable of procreation is to be considered direct sterilization.... Therefore, *notwithstanding any subjectively right intention of those whose actions*

are prompted by the care or prevention of physical or mental illness which is foreseen or feared as a result of pregnancy, such sterilization remains absolutely forbidden according to the doctrine of the Church. And indeed the sterilization of the faculty itself is forbidden for an even graver reason than the sterilization of individual acts, since it induces a state of sterility in the person which is almost always irreversible.¹⁷

In a commentary on *Quaecumque sterilizatio*, the administrative committee of the National Conference of Catholic Bishops specifically delineated the kinds of conditions to which appeal should *not* be made to justify sterilization of human beings:

As it was stated in the Roman document [*Quaecumque sterilizatio*], the Catholic hospital can in no way approve the performance of a sterilization procedure that is directly contraceptive. *Such contraceptive procedures include sterilizations performed as a means of preventing future pregnancy that one fears might aggravate a serious cardiac, renal, circulatory, or other disorder.* Freely approving direct sterilization constitutes formal cooperation in evil and would be “totally unbecoming to the mission” of the hospital as well as “contrary to the necessary proclamation and defense of the moral order.”¹⁸

Quaecumque sterilizatio is also crystal clear about the formal cooperation in evil that a Catholic health-care facility incurs when it allows the practice of contraception, whether temporary or permanent:

Any cooperation institutionally approved or tolerated in actions which are themselves, that is, by their nature and condition, directed to a contraceptive end, namely, that the natural effects of sexual actions deliberately performed by the sterilized subject be impeded, is absolutely forbidden. For the official approbation of direct sterilization and, *a fortiori*, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil. The Catholic hospital cannot cooperate with this for any reason. Any cooperation so supplied is totally unbecoming the mission entrusted to this type of institution and would be contrary to the necessary proclamation and defense of the moral order.¹⁹

II. Require Compliance with Directive 53

The general introduction to the ERDs summarizes a bishop's responsibilities in respect to maintaining the Catholicity of health-care institutions in his diocese:

Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest. As the center of unity in the diocese and coordinator of ministries in the local church, the diocesan bishop fosters the mission of Catholic health

care in a way that promotes collaboration among health-care leaders, providers, medical professionals, theologians, and other specialists.... As teacher, the diocesan bishop ensures the moral and religious identity of the health-care ministry in whatever setting it is carried out in the diocese.... These responsibilities will require that Catholic health-care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention.²⁰

Given the close working relationship that needs to exist between the bishop and Catholic institutions within his jurisdiction, the general introduction just cited clarifies the moral authority of the local ordinary vis-à-vis the Catholic hospitals in his diocese.²¹ Within that authority and in the context of the ethics audit proposed here, we find the individual bishop's right to require compliance with all of the ERDs, including directives 52 and 53. By collaboration with the hospital's CEO and sponsor institution, the bishop fulfills his duty of mandating ethically appropriate sterilization policies/procedures consistent with the Catholic vision of the healing ministry.

III. Promote Directive 52 in Tandem with Directive 53

Directive 52 reads:

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 parenthood²² and in methods of natural family planning.

It would be blatantly unfair if an obstetrician within a Catholic hospital or clinic would fail to offer his patients a moral way of avoiding a future pregnancy that might aggravate a serious disease/condition. How much more just and charitable if that obstetrician were able to direct these women to a natural family planning department within the hospital.²³ With such a resource, the patients and their husbands would be introduced to an effective way of avoiding a pregnancy through a method that both protects the great gift of their fertility and respects their dignity as human persons.

It is imperative for medical staff to understand *why* directive 52 requires hospitals to provide instruction for patients and the hospital staff on responsible parenting. First, the Catholic Church has never insisted that a couple have endless numbers of children or have all the children that they could physically, psychologically, or financially conceive, gestate, and raise. The Church *has* consistently taught that, when there is a serious reason for avoiding a pregnancy (and the medical pathologies discussed above certainly qualify as serious), the couple must achieve their good goal through a good means. Which is to say: the couple must postpone a pregnancy in a truly human way.

Second, previous to the 1930s all mainline churches and even secularists taught that contraception is evil. Pre-1930, these religious traditions understood that contraception (and, *a fortiori*, sterilization) is not appropriate human behavior. It allows men and women, even unmarried persons, to seek sexual intercourse for the sole sake of pleasure, without fully embracing the meaning and consequences of their sexual acts. In other words, the churches and some secular philosophers agreed that contraceptive intercourse—like actions of stealing, lying, or killing—are contrary to human nature, human happiness, and to the good of society.

Third, using natural methods of family planning invites a couple to intelligently reflect on the important truth that the procreative and unitive meanings of their marital love and sexual union are inextricably linked, i.e., they demand, activate, and define one another. The one-flesh union of genuine married loved demands an openness to life; openness to life—procreation—demands the love of their one-flesh union. Hence, a couple who directly suppress their procreative capacity through sterilization or contraception also erode and chip away at their interpersonal union and, ultimately, at their love. This is precisely why it is crucial that a couple avoiding pregnancy for medical reasons do so in a moral way—that is to say, through an intelligent means. The reality of direct sterilization—whether the couple understands it or is conscious of it or not—is that it erodes married love, the glue that holds their marriage together. A woman of reproductive age who has been directly sterilized and no longer retains her procreative capacity is also deprived of intercourse that is truly marital. And the sad reality is that a marriage with this kind of sterilized sex is fragile indeed.

But consider the woman who avoids a pregnancy due to a serious medical condition by confining her acts of intercourse to the infertile times of her cycle. The woman and her husband have recourse to abstinence during fertile times of their cycle and express and deepen their interpersonal union by engaging in intercourse during times of infertility. In doing so, they avoid a pregnancy in a way that does not cripple the complete self-gifting that should mark all their acts of intimacy. In retaining openness to life—never deliberately suppressing the procreative capacity of their acts of sexual union, the woman and her husband are avoiding a pregnancy in a way that neither compromises their marital sexual union nor erodes the love that is its foundation.

For the sake of the health and wellbeing of their married patients, it is incumbent on Catholic hospital administrators, sponsors, and their medical/nursing staff to understand and apply directives 52 and 53 in tandem. By grasping the philosophical vision behind the directives and allowing that vision to guide them in drawing up reproductive policies, Catholic health-care

institutions not only adequately reject the evil of contraception/sterilization but also offer alternatives that are moral, which is to say, truly human and rational. In sum, the goals of a comprehensive sterilization policy within a Catholic hospital (implementing directives 53 and 52) are to respect the dignity of male and female patients, the truth about their sexuality, and the basic human good of their fertility.

IV. Conduct Internal/External Oversight to Insure Durable Compliance

The general introduction to the ERDs advises Catholic health-care providers and the diocesan bishop “to engage in *ongoing* communication on ethical and pastoral matters that require attention.”²⁴ Experience with other kinds of hospital audits dictates that only continuity in oversight guarantees durable compliance. The same axiom applies to conformity of Catholic hospitals to the ERDs, including directives 52 and 53, as discussed above.

The model for a health-care ethics audit proposed here evaluates data garnered from both internal and external oversight. Ideally, the substance of such an audit consists in standardized evaluative criteria—drawn up by an appropriate national Catholic health-care organization²⁵ and approved by the USCCB—that measure institutional compliance with the ERDs. The goal of this ethics investigation is to verify how well the hospital is exercising stewardship over its Catholic identity and ministry by delivering health-care services that are truly Catholic in the areas of 1) social responsibility; 2) pastoral and spiritual responsibility; 3) professional-patient relationship; 4) beginning-of-life issues; 5) care for the dying; and 6) forming new partnerships with health-care organizations and providers.

The system ethicist or mission director facilitates the internal ethics audit. He or she works cooperatively with an ethics audit team in place within the respective hospital comprised of: the CEO, the director of medical informatics, the vice-president for patient care or mission/ethics, the ethics compliance officer,²⁶ the hospital’s legal counsel, and any other hospital manager whose area of responsibility corresponds to those regulated by the ERDs.

The local ordinary and/or his personal health-care liaison representative, relying on the same standardized evaluative criteria approved by the USCCB, directs the external phase of the audit. The diocesan representative meets quarterly with the hospital’s internal ethics-audit team and “audits their audit,” if you like. The external audit not only allows episcopal oversight of the ethical state of the hospital(s) within his jurisdiction but also promotes continuing discussion between the bishop, the hospital team, and the system leadership as to the strength of the hospital’s witness to the gospel of life.

In guaranteeing moral compliance in the area of sterilizations, the local ordinary or his representative would, first, ascertain that the hospital's sterilization policies and practices are in accord with directives 52 and 53. Second, he verifies whether system leadership, administrators, nursing staff, physicians, and members of the ethics team have completed their annual educational training (from the bishop, his ethics liaison representative, and/or from the modules of a USCCB-approved computer-based training for the ERDs).

Finally, if the respective hospital passes muster, it should be commended for, among other things, exercising prudent stewardship over the Catholic mission entrusted to it, protecting the basic human good of fertility and marriage, and promoting the dignity of its patients. If the hospital fails to comply, the CEO should demonstrate clearly—at the next quarterly audit—how the hospital has addressed and corrected any of its contraventions.

Conclusion

The ensuing dialogue about the merits of doing a Catholic hospital ethics audit together with efforts to clarify the directly sterilizing nature of tubal ligations will also help to resolve related debate about sterilizations within Catholic health care, viz., the legitimacy of appealing to the principle of the lesser evil. Should Catholic hospitals in the U.S., based on “duress” in the health-care marketplace, cooperate with the evil of providing tubal ligations for “therapeutic” reasons *in order to preserve the greater good* of a Catholic presence in health care? In respect to the latter, the USCCB either decides that the intrinsic evil of sterilization demands that Catholic hospitals/clinics/outpatient surgical centers refrain from offering the directly sterilizing procedures of tubal ligation and vasectomies, despite opposition. Or the bishops determine that, for the sake of the greater good of maintaining a Catholic presence in health care in the twenty-first century (i.e., for the sake of not alienating ob/gyns and possibly losing obstetrician departments and then entire hospitals), Catholic health-care facilities may tolerate (i.e., provide) tubal ligations for whatever reason. If the U.S. Catholic bishops confirm the conclusion that tolerating tubal ligations is, indeed, a lesser evil than losing Catholic hospitals, then they ought 1) to remove directives 52 and 53 from the ERDs and from the ethics audit of a Catholic hospital as outlined here and ought 2) to clearly and carefully explain the reason for their removal. To continue with policy-as-usual—disparity between the moral theory and practice of sterilization in Catholic health-care facilities—fails to serve the wellbeing of the thousands of women who entrust themselves to Catholic health care every year.

References

¹ In an *Our Sunday Visitor* interview, Dr. Haas made the point that, given the widespread misinterpretation of directive 53 amongst physicians, patients, and moralists, Catholic sterilization policies need to be audited: “Hospitals already have medical audits and financial audits, and they should have ethics audits, too.” (Ann Carey, “Shocking Lack of Understanding,” *Our Sunday Visitor*, July 13, 2008, 12.)

In a similar vein, the Milwaukee Guild of the Catholic Medical Association has called for Catholic hospitals to conform to a “checklist” of procedures/attitudes/values defining their Catholic identity (Milwaukee Guild, “Checklist for Catholic Hospitals,” *Linacre Quarterly* 74 [2007]: 159–163). Unfortunately, in the list of procedures that ought not be a part of Catholic health-care services, the guild fails to specify the moral difference between *direct* contraception and sterilization, e.g., and their *indirect* forms. Furthermore, the idea of “checking” compliance with all the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) seems to be left up to the honor system—every CEO, if you will, checking his hospital’s compliance on his own initiative and good will. As such, the guild’s seminal idea of doing, what I would call, an informal ethics audit lacks teeth and a reasonable executive plan.

Having said that, it is clear that guild members wrote the article to address what they saw to be a problem: reality on the ground in our Catholic hospitals does not always match the Catholic mission as presented theoretically in the ERDs. (Cf, too, the conclusion of the authors of the Catholic Medical Association’s “Report of the Task Force on Ethical and Religious Directives,” *Linacre Quarterly* 72 [2005], 184: “All were of the opinion that to allow practices such as sterilization on the premises of Catholic hospitals would compromise the legal protection provided by the ERDs in contesting efforts to force Catholic institutions to participate in abortion or other life-terminating procedures.”) Is every Catholic hospital guilty of compromising one or more ethical requirement of the ERDs, particularly directive 53? Certainly not. I know of an entire health system (OSF Healthcare, Peoria, IL) whose member institutions are, according to its ethicist, Joseph Piccione, in compliance with directive 53; they do not offer tubal ligations or vasectomies for any reason. But I also know this: Based on the hundreds of ethics consults on sterilization I have had in the past thirteen years with physicians working in Catholic hospitals across the U.S., OSF Healthcare’s sterilization policy/procedures is the exception, not the rule.

² The audit of sterilization policies described here would be one segment of a comprehensive ethics audit that monitors a Catholic hospital’s compliance with all seventy-two of the ERDs. The entire audit would evaluate how the hospital deals with beginning-of-life and end-of-life questions, merger situations, and the social and spiritual responsibilities of its services.

³ The ERDs also apply to physicians not employed by the Catholic hospital but who

request privileges to practice within in it. As directive 5 states: "Catholic health-care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel."

⁴ Compare the spreadsheet at http://wikileaks.org/wiki/Catholic_hospitals_betray_mission.

⁵ All hospitals in Texas, except for rural institutions, must submit data on all inpatient discharges to the Texas Health Care Information Collection Center for Health Statistics. The Texas legislature requires the Center to collect quarterly utilization data including diagnoses, procedures, and outcome for all patients in order to promote cost-effective, quality health care. Hospitals assign unique patient and physician identifiers so that records may be submitted without violating patient and physician confidentiality. The data is compiled quarterly into public-use data files, in this case, into the Texas Public Use Data File (TPUDF) that may be purchased for research or analytical purposes. When the TPUDF was analyzed to track tubal ligations in Texas Catholic hospitals, it was simple to calculate total numbers in each hospital, since the TPUDF utilize ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) codes where the *diagnosis* of "sterilization for contraceptive purposes" is designated by code V25.2 and the *procedure* of tubal ligation by treatment code 66.32 and variations according to different tubal-ligation methods by treatment codes 66.2x and 66.3x.

⁶ Twenty-three hospitals had explicit violations of the ERDs; nine more had potential violations. seven hospitals did not provide sterilizations, but five of those did not provide ob/gyn services. One hospital was not required to report to the state.

⁷ The local ordinary could use traditional means of ethics training, viz., through lectures, conferences, panels, etc. In addition, and as a way to guarantee that everyone who should be instructed really understands Catholic values and their application within health care, the bishop could also rely on a computer-based training program developed by an organization such as the Catholic Health Association or the National Catholic Bioethics Center and approved by the United States Conference of Catholic Bishops (USCCB). Included within various modules of the computer-based training for the ethics audit would be the appropriate background on pertinent ethics principles and their application within the areas of health care outlined in the ERDs. The health-care professional attempting to complete a computer-based training program dealing with key ethical values and their applications would be certified only after passing built-in quizzes that test adequate comprehension of the material presented. A good format model for computer-based training for an ethics audit is a program developed by HCS Incorporated to assist health-care providers in understanding the rules and regulations for HIPAA compliance.

⁸ USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, D.C.: USCCB, 2001), is a collection of guidelines drawn up by the United States Conference of Catholic Bishops that explains pertinent Catholic medical-moral principles and values and applies them to clinical practice within

Catholic health-care institutions. Directive 53, for example, applies the principle of double effect and its indirect/direct distinction to sterilization procedures. The description of the ERDs included in the 4th edition is instructive: "This fourth edition of the *Ethical and Religious Directives for Catholic Health Care Services* was developed by the Committee on Doctrine of the National Conference of Catholic Bishops and approved as the national code by the full body of bishops at its June 2001 general meeting. This edition of the *Directives* which replaces all previous editions is recommended for implementation by the diocesan bishop and is authorized for publication by the undersigned." The *Directives* are intended to inform sponsor institutions, administrators, chaplains, health-care personnel, patients, and residents.

⁹ A revision of the second sentence of directive 53 might make the indirect distinction more clear: Procedures are permitted when 1) their direct effect is the cure or alleviation of a present and serious pathology; 2) their indirect effect is sterility; and 3) a simpler treatment is not available.

¹⁰ Since a vasectomy is the only other procedure that is directly sterilizing, it is reasonable to imply that this was also a concern for Bishop Corrada and one that should have been prohibited within the Catholic health-care facilities under his jurisdiction. However, according to data submitted to TPUDF by Trinity Mother Frances and St. Michael hospitals between 2000 and 2003, no vasectomies were provided.

¹¹ From my consultations with physicians working in Catholic health-care facilities across America, I am convinced that the near-universal misunderstanding of directive 53 is not malicious. After some thirty years of acting on a misinterpretation that imposes little restriction on performing tubal ligations, Ob/gyns in Catholic settings were and are only too happy to perform only "medically indicated" sterilizations. Now many of these practitioners embrace and tenaciously defend the notion of so-called therapeutic or indirect sterilizations with a certain righteousness, illustrated in the comments from Trinity Mother Frances hospital representatives: theirs is a "good faith" interpretation of directive 53.

Another way of viewing the issue of whether to allow contraception/sterilization within Catholic hospitals helps to account for the widespread disregard for directives 52 and 53 and, further, why many CEOs and practitioners claim their dissent represents the high moral ground. Father Kevin McMahon summarizes this perspective by identifying fifteen themes articulated by the Catholic Health Association in 2001 when the bishops were discussing revisions to the 1994 *Directives*, revisions that involved discussion of whether allowing direct sterilizations would be unjustifiable cooperation in evil on the part of the health-care institution. The Catholic Health Association made the case for allowing direct sterilizations in Catholic health-care facilities either by appeal to legitimate cooperation in evil or the principle of the lesser evil. Their essential message to the bishops was this: Catholic hospitals should allow contraception and sterilization—practices that are not considered immoral by many inside and outside of the Roman Catholic Church—for the sake of the greater good of preserving Catholic presence in health care and especially in obstetrics and gynecology (both in Catholic sole-provider hospitals and in partnerships of Catholic and non-Catholic health-care institutions). Only this

approach will enable Catholic health-care institutions to resist the greater evil of abortion and to carry on the mission of healing in the name of Jesus so needed in our anti-life society. Commenting on the proposed revisions, McMahon concludes, and I believe, correctly that “the process underway to revise the ERDs ’94 [resulting in the current fourth edition quoted here] is a new opportunity to accomplish this illusive objective [eliminating the unjustifiable cooperation of Catholic entities in direct sterilization]. This author believes that the mistakes of the past which have permitted unjustifiable cooperation to continue are well on the way to correction as the ERDs ’94 are revised.” (McMahon, “Revising the ERDs’94: Goals, Opposition and Resolution,” *Linacre Quarterly* 68 [2001]: 101–123.)

For a good summary of the debate about whether duress in the marketplace counts as justification for a Catholic hospital’s cooperation in the evil of sterilization and contraception, see a series of articles in the *Linacre Quarterly* between James F. Keenan, S.J., and Lawrence J. Welch. (Keenan, “Institutional Cooperation and the Ethical and Religious Directives” *Linacre Quarterly* 64.3 [August 1997]: 53–76; Welch, “An Excessive Claim: Sterilization and Immediate Material Cooperation” *Linacre Quarterly* 66.4 [November 1999]: 4–25; Keenan, “Not an Excessive Claim, Nor a Divisive One, But a Traditional One: A Response to Lawrence Welch on Immediate Material Cooperation,” *Linacre Quarterly* 67.4 [November 2000]: 83–88.) *Health Progress* also dedicated several articles of its November/December 2002 issue (83.6) to the topic of sterilization and cooperation. Kevin O’Rourke, O.P., argues, in “Catholic Health Care and Sterilization” (pp. 43–48, 60), that “the most common and clear-cut method of ensuring that cooperation between Catholic and non-Catholic facilities is ethically acceptable is to have direct sterilization and other prohibited procedures performed by a separate entity.” If possible, these sterilizations should take place “at a facility physically separate from both hospitals.” But under the right circumstances, it would be possible to perform direct sterilizations within a specially designated section of the Catholic hospital campus. In the latter case, though, serious reasons for the situation would need to be present: First, it might not be possible (for financial reasons, say) to construct another hospital. Second, to avoid formal participation, all personnel performing the prohibited procedures would have to be employed and managed by the third party. Third, the diocesan bishop would have to determine that scandal would not arise from the arrangement.” Peter Cataldo and John Haas, in “Institutional Cooperation: The ERDs” (pp. 49–57, 60), caution that “viewing the principle of cooperation as a creative source of morally obligated action reconfigures the principle into a moral mandate to cooperate.” Such an approach could lead to illegitimate institutional cooperation such as “immediate material cooperation by an institution in direct sterilizations for the sake of a collaborative arrangement.”

¹² EWTN News, “Texas Catholic Hospitals Challenge Bishop: Announce Plans to Continue Sterilizations,” December 16, 2008 (Catholic World News Brief), <http://www.ewtn.com/vnews/getstory.asp?number=92682>. Trinity Mother Frances, in a public statement released on April 2, 2009, made it known that no direct sterilizations would be provided through the hospital in the future: “In 2003, Trinity Mother Frances Health System, in good faith, relied upon a misinterpretation of Church

teaching and specifically pertinent elements of the *Ethical and Religious Directives for Catholic Health Services* in the United States (ERDs). In subsequent years as the authentic teaching of the Magisterium was clarified for the Health System, direct sterilizations decreased and have ceased. Trinity Mother Frances Health System regrets any confusion about Catholic teaching on this topic that might have resulted. Measures are in place to ensure that going forward no direct sterilization will occur.”

¹³ Cf. the Catholic Medical Association and the National Catholic Bioethics Center, “A Catholic Guide to Ethical Clinical Research,” *Linacre Quarterly* 75 (2008): 191.

¹⁴ Doctors frequently suggest a tubal ligation at the time of delivery for a woman with a history of repeat c-sections in order to avoid maternal and/or fetal catastrophic complications that could occur should the woman become pregnant in the future. This scenario underscores the point that the disease is not present at the time of the tubal and may not occur at all should the woman become pregnant in the future. The sole effect of the tubal ligation is sterility.

¹⁵ Some of the conditions or pathologies that may be brought on or exacerbated by pregnancy and that comprise the medical reasons for which many Catholic hospital policies justify tubal ligations include: significant risk of uterine rupture or additional anesthesia; Rh incompatibility or other blood factors; psychiatric disorders; neurologic disorders (e.g., partially repaired aneurysm); auto immune disorders; endometriosis; clotting disorder; seizure disorder; neoplastic disease; advanced maternal age; obesity; anemia; asthma; cardiac diseases; diabetes; hypertension.

¹⁶ Indirect or therapeutic sterilization brought on by surgical removal of organs always involves excision of pathologically diseased reproductive organs—uterus, fallopian tubes, ovaries. The removal of the uterus from a woman suffering from uterine cancer, for example, is therapeutic because it prevents the woman’s death. Applying the hysterectomy model to tubal ligation, we would have to demonstrate that the fallopian tubes are diseased and that ligation or blocking of the tubes would be a cure for that disease.

¹⁷ Congregation for the Doctrine of the Faith, *Quaecumque sterilizatio*, n. 1, emphasis added.

¹⁸ National Conference of Catholic Bishops, (1977), emphasis added.

¹⁹ Congregation for the Doctrine of the Faith, *Quaecumque sterilizatio*, n. 3a.

²⁰ USCCB, *Ethical and Religious Directives*, 6.

²¹ There is no reference in the 1983 *Code of Canon Law* to health care and its various institutions. However, since Catholic health care is an apostolic activity, canon 394, n. 1, would apply (the diocesan bishop should be involved in its apostolic work) and, more directly, the norms relating to temporal goods would apply (a Catholic hospital would qualify as a public juridic person, and its goods those of a public juridic person). Therefore, Catholic health-care institutions, under the jurisdiction of the diocesan bishop, do not exist per se but to spread the gospel and to nourish the faith of people of good will. If these health-care facilities cannot fulfill their apostolic end, they should be reformed. If they are incapable of reform, or will not reform, or

will not refrain from illegitimate cooperation in evil, the bishop has the authority to strip the institution of its Catholic title.

²² The common teaching of Christians, until contemporary times, was that contraception is immoral. From the teachings of the Talmud to Paul's Letter to the Galatians (5:19–21), from Justin Martyr of the second century to Clement of Alexandria of the third century, from St. Augustine in the fifth century to Pope Pius XI in the nineteenth century, from Pope Paul VI and his teaching in the twentieth-century encyclical *Humanae vitae* to John Paul II and his many reflections on the theology of the body, there is a coherent Catholic teaching concerning the nature of marriage, marital love, and marital intercourse. *Humanae vitae* summed up this teaching when it addressed the kinds of acts that ought to be avoided by a moral person: those of direct sterilization, whether perpetual or temporary, whether of the man or of the woman.

²³ The Creighton Model FertilityCare System is a natural method of family planning designed to be integrated into hospital ob/gyn departments. For more information on setting up such a center, contact the Pope Paul VI Institute, Omaha, Nebraska.

To those who insist that natural methods of avoiding pregnancy do not work, it is wise to remember that no method of contraception is 100 percent effective in avoiding a pregnancy, including tubal ligation. Pregnancy statistics following tubal ligations range from 0.75 percent to 5.4 percent depending on the method employed (Robert D. Hilgers, "Risk of Pregnancy After Tubal Ligation," ACOG review [September/October 1996]: 6). The 5.4 percent risk of pregnancy following one method of doing a tubal ligation or its 94.6 percent effectiveness rate in preventing pregnancy compares favorably with that from a meta-analysis of Creighton Model FertilityCare System involving 1,876 couples over 17,310 couple-months of use. The latter study documents that the Creighton System method effectiveness rates for avoiding pregnancy were 99.5 percent at the twelfth ordinal month and 99.5 percent at the eighteenth ordinal month. The user effectiveness rates for avoiding a pregnancy were 96.8 percent at the twelfth ordinal month and 96.4 percent at the eighteenth ordinal month. (Thomas W. Hilgers and Joseph B. Stanford, "Creighton Model NaProEducation Technology for Avoiding Pregnancy," *Journal of Reproductive Medicine* 43 [1998]: 495–502.)

²⁴ USCCB, *Ethical and Religious Directives*, 4.

²⁵ For example, the National Catholic Bioethics Center, the Catholic Medical Association, or the Catholic Health Association.

²⁶ The position of an ethics compliance officer would assist the system and institutional ethicist to carry out their work, particularly in respect to implementation of the ethics audit.