

The Ethical and Religious Directives Looking Back To Move Forward

RON HAMEL, PhD

In its 1920 inaugural issue, *Hospital Progress* stated as its mission: “to become the medium through which the best thought and practice in hospital service to the sick will be worked into the lives of those who are consecrated to this service.” Despite an ever-changing health care environment over the past 100 years, the journal now named *Health Progress* has indeed communicated some of the best thought and practice on numerous facets of health care delivery in Catholic facilities. One of the ongoing areas of focus has been health care ethics. In fact, one of the earliest issues published the “Surgical Code for Catholic Hospitals for the Diocese of Detroit” which outlined acceptable and unacceptable surgical procedures from a Catholic ethical perspective. Since then, there have been hundreds if not thousands of articles and columns devoted to a vast range of ethical issues encountered in Catholic health care. To name just a few, these have included euthanasia and assisted-suicide, end-of-life care, reproductive matters, genetics, transplantation, environmental responsibility, organizational ethics issues, and the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), the ethical code that provides moral guidance on aspects of health care delivery for Catholic health care facilities.

Any one of these areas is worthy of exploration because the articles that addressed them helped shape the practice in Catholic health care facilities, generated theological-ethical dialogue and debate, and even influenced the various iterations of Catholic health care’s ethical code, especially earlier versions. But if there is one theme that runs through a century of *Health Progress*, explicitly and implicitly, it is the ERDs. There are a good number of articles dealing explicitly with the code and numerous other articles that are indirectly tied to the ERDs in that they explain, elaborate upon, attempt to clarify or even propose alternative approaches to particular directives.

In a 1947 issue of *Hospital Progress*, Rev. Lawrence Skelly wrote: “Whatever else may be said, certainly there is a need, a crying need, of a certain, definite, concise, clear cut Catholic Code for our Catholic hospitals. . . . Certainly if there should be one distinguishing mark of a Catholic hospital, it should be its code of ethics—else why do we exist?”¹ While one might not totally agree with Fr. Skelly’s claims, there is no doubt that it underscores the importance of “the code” for Catholic health care. And this journal, along with the Catholic Health Association itself, has played a critical role in the various iterations of the ERDs.²

Perhaps this is most true with regard to the 1971 revision and the development of its successor published in 1995, the majority of which still constitutes the current edition of the ERDs. The 1971 revision, *Ethical and Religious Directives for Catholic Health Facilities*, generated a “storm of violent criticism.” Moral theologian Rev. Thomas J. O’Donnell, SJ, described the reaction in a 1972 issue of *Hospital Progress*:

A storm of violent criticism has broken on the American health and hospital scene on the occasion of the U.S. Bishops’ approval, last November, of the new *Ethical and Religious Directives for Catholic Health Facilities*. The *Directives* are criticized as being meaningless for our modern day, as hopelessly ill-suited to the ecumenical dimension of our pluralistic society, of being irrelevant regarding what the Catholic hospital should or should not do, and beyond the scope of what the American hierarchy should or should not teach.³

Between August 1972 and March 1973, *Hospital Progress* published seven articles concerning the 1971 revision, pro and con, including a highly critical report from a commission of the Catholic Theological Society of America titled “Catholic Hospital Ethics.”⁴ *Hospital Progress* documented both sides of the heated debate and spurred further dialogue and debate across Catholic health care about what the *Directives* should be.⁵ In doing so, it is plausible, if not likely, that *Hospital Progress* contributed at least indirectly to the substantial revision in 1995. Since this was such a pivotal turning point in the conceptualization of the *Directives*, it is worth explor-

ing in greater detail. The current ERDs remain substantially the same as the 1995 version, despite three subsequent revisions in 2001, 2009 and 2018. Although the 1995 version was generally very well-received and has served Catholic health care effectively, it is 24 years old. Much has happened in American society and the church, in health care generally and in Catholic health care in particular, as well as in the life sciences, medicine and technology since its publication. Perhaps the *Directives* are due for a thorough update. If so, what are some of the areas to which a revision might need to attend?

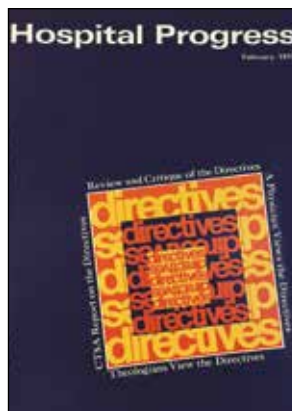
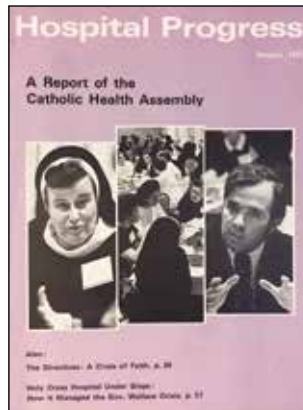
THE 1971 CODE AND ITS CRITICS

Apparently, due to varied and liberal applications of the *Directives* in some dioceses across the country during the 1960s, especially with regard to contraception and sterilization, the executive committee of the Catholic Health Association board of trustees asked the National Conference of Catholic Bishops (the former name of the United States Conference of Catholic Bishops) to draft and promulgate a set of *Directives* that would apply to the entire country.⁶ The hope was that such an authoritative document would resolve the problem of what some perceived as “geographical morality.” Instead, the November 1971 publication of the new *Directives* resulted almost immediately in severe attacks.

Two of the strongest critics were Rev. Richard McCormick, SJ, STD, and Warren Reich, PhD. Though their critiques were not published in *Hospital Progress*, the journal did publish an exchange of views with Eugene Diamond, MD, who was critical of their assessments.⁷ The

first of Diamond’s opinion pieces in December 1972 appeared along with responses to Diamond from Reich and McCormick.⁸ The second set of exchanges appeared in February 1973.⁹

In the same February 1973 issue of *Hospital*



Progress was the Catholic Theological Society of America Commission's Report on "Catholic Hospital Ethics." The commission began the study in June 1971. It was accepted by the Board of Directors on September 1, 1972, and was first published in *The Linacre Quarterly* in November 1972.¹⁰ Reich was a member of the commission and McCormick a consultant. Their critiques of the 1971 Directives are clearly reflected in the report that centers its critiques on four areas: the pluralistic context in which Catholic health care operates, the Catholic presence in health care, the code and ethical decision-making, and the role of conscience and dissent. The Catholic presence in health care is a less important critique and will not be considered here.

First, the theological society commission observes that the preamble to the 1971 edition presented a defensive response to the fact that the church's healing ministry was operating in a highly pluralistic society and was serving people of many different faith traditions and moral beliefs. The preamble's lack of a recognition of pluralism was especially troubling given Vatican II's acknowledgement of and engagement with pluralism in its *Declaration on Religious Freedom* and in *Gaudium et Spes/the Pastoral Constitution on the Church in the Modern World* (report paragraphs 11-15). And what were judged to be the implications of pluralism for Catholic health care? The commission asks whether "Catholic hospitals, on religious and ethical grounds, [can] continue to justify the refusal of certain health services which are legally permitted, commonly accepted in the medical world, and, at least in some cases, not morally harmful according to the judgment of many prudent men?" (paragraph 17). The concern here was that "in trying to retain a Catholic identity through institutional ethical policies we may violate the rights of others, neglect or harm the social good, and force an abdication of Catholic institutional presence in the hospital world" (paragraph 19). Striking a balance between maintaining Catholic identity and addressing the situation of pluralism was acknowledged as a challenge.

Second, the commission critiqued the Directives for their approach to ethical decision-making. Four major themes emerged here.

■ The preamble was found to be not only defensive, but also legalistic. The commission observed that "a number of important elements

which constitute a Christian theology of moral law are unfortunately lacking in the Preamble of the U.S. bishops' Directives, which offers a predominantly legalistic dimension to the Directives" (paragraph 39). In particular, they had in mind the absence of any influence of significant magisterial and theological developments in the areas of law, conscience and freedom that began to emerge in the mid-1950s (paragraph 42). This resulted in the new Directives containing many more moral prescriptions (norms prohibiting or commanding specific behavior) than ethical principles (general statements of moral values that provide guidance) and a greater insistence on their certitude and binding power than in the previous Directives, without acknowledging that these moral norms are not infallible and do not all enjoy the same degree of certitude and binding power (paragraph 41). The new code essentially was a listing of what could not be done in a Catholic health care facility.

■ Along similar lines, the commission was critical of the bishops for deleting a principle from the 1955 code having to do with the resolution of doubt regarding the application of a particular norm to a concrete situation (paragraph 42). This further reinforced the legalism, the binding force of the norms and the insistence on certitude. The report maintained that the principle should still be in effect, not only for clinicians, but also for the patient "who has the first and most basic responsibility to make decisions on his own behalf" (paragraph 42). They further suggested that "today's situation of pluralism in particular should prod us to more openness and candor, both in acknowledging what can be permitted on occasion even in the face of a general prohibition which the Catholic community is reluctant to abandon, and in firmly supporting the prohibitions of which we are deeply convinced and which seem to strike more deeply to the roots of our faith identity" (paragraph 41).

■ In contrast to the legalistic tone of the preamble to the 1971 Directives, the commission noted the very different tone of the Preamble to the Canadian Catholic *Medico-Moral Guide*:

"The Guidelines ... should be read and understood not as commands composed from without, but as demands of the inner dynamism of the human and Christian life Their application to a particular situation will usually

entail a great deal of prudence and wisdom.... The Guidelines should serve to enlighten the judgment of conscience. They cannot replace it” (paragraph 39, italics in the original).

The commission suggested that this approach is far more reflective of a true Christian approach to law and morality. “For the Christian, the moral law is not conceived primarily as a restrictive force but as a liberating force, its function is to guide and inform Christian love and hence Christian compassion, care and healing; and to aid conscientious judgments in an atmosphere of freedom” (paragraph 38). And this is due to the fact that the law of the Christian is Christ Himself. He is the law of our lives. For this reason, “the moral law is not held principally to be a legal enactment, codified and promulgated with penalties imposed” (paragraph 38). This understanding of law, the drafters of the report believed, should influence the approach to the moral standards for Catholic hospitals.

■ Finally, the commission was highly critical of the new Directives’ approach to decision-making, which they believed should be a shared responsibility. They strongly disagreed with the preamble’s claim that the local bishop has ultimate authority when it comes to evaluating the morality of new scientific developments and debated questions. They did not question the importance of the bishop’s role in hospital policy and practice, but rather his competence to be the sole arbiter, “the sole ultimate authority” (preamble to the 1971 Directives). The majority of bishops simply are not moral theologians and do not have expertise in the life sciences or in medical ethics. “This unqualified statement of the local bishop’s competence in medical ethics,” the commission stated, “has been questioned on theological grounds, on legal-medical grounds, and for reasons of common sense” (paragraph 46). Instead, the commission called for broad consultation, especially at the local level, so that “all who have a stake are permitted and encouraged” to share in the decision-making process, especially the patient.



The central moral agency of the patient must be acknowledged and his freedom should be maximized, though not to the exclusion of other considerations. The patient has the right to the fullest amount of information (medical and ethical) necessary for informed and responsible consent, and often he has the right to determine medical practice in his regard on the basis of his consent or dissent—but this latter right is not without limit (paragraph 49).

Third, and finally, the commission turned to conscience, cooperation and dissent. The fundamental issue here was patients’ (Catholic and non-Catholic) and clinicians’ exercise of a sincere and well-formed conscience which the commission believed they have the right to do, within limits, on the basis of the right to religious liberty and the nature of conscience. The challenge for the Catholic hospital was whether it would allow patients, or patients and their physicians, to follow a course of action dictated by conscience, but contrary to some portion of the Directives. The commission proposed that these types of situations should be addressed using the principles of a theology of cooperation (paragraph 54). They went on to explain:

Today a theology of cooperation must be formulated and interpreted in light of the Church’s affirmation of the right of religious liberty, its acceptance of pluralism in principle, and its teaching of ethical norms with varying degrees of affirmation according to a scale of moral values. ... Norms, no matter how detailed, cannot supply the answers. To arrive at decisions concerning cooperation requires a good ethical

sense, consultation with those directly involved, and a knowledge of the local situation (paragraph 55).

It was the position of the commission that, given church teaching on conscience and the right of legitimate dissent, in some cases and for moral reasons, moral decision-makers might licitly deviate from concrete, non-infallible Directives, provided certain conditions are fulfilled.¹¹

In conclusion, the commission urged a prompt

and thorough revision of the 1971 Directives with input from a wide range of individuals with appropriate competencies. In addition, they made a number of other recommendations, among them less attention to sex and reproduction, and addressing a number of other issues like service to the poor and underserved; end-of-life issues; the necessity of informed consent; transplantation; human experimentation; and genetic counseling.

A REVISED CODE OF ETHICS — 1995

While it took 24 years, the 1971 Directives were revised. Published in 1995 after broad consultation over a six-year period and 11 major drafts, the revised *Ethical and Religious Directives for Catholic Health Care Services*, was dramatically different from the previous version. Many of the critiques levelled against the 1971 code were taken seriously by the drafters and their consultants. As we know, that 1995 edition was more theological/scriptural and less legalistic; provided theological/philosophical rationales for conclusions; began by focusing on core values of Catholic health care and key characteristics of Catholic health care organizations; incorporated social justice considerations; employed human dignity as a central and unifying theme; focused more on the patient as decision-maker; dealt with a broader number of clinical issues; and included a section on partnerships, to name just a few improvements.

LOOKING TO THE FUTURE

It has now been 24 years since such a thoroughgoing revision. As previously noted, in the intervening years, there have been many significant developments on many fronts relevant to Catholic health care. Given this, perhaps it is time for an update of the current edition, one that is not as drastic as the 1995 revision, but one that better reflects and addresses what has transpired over 24 years. As someone who has lectured and written extensively on the ERDs over 17 years and participated in three revisions, I offer a few topics that might be considered in the next revision, recognizing that the ERDs cannot address every relevant topic and issue.

First, Catholic identity has been and continues

to be a major concern for Catholic health care. It cannot be reduced to observance of the ERDs nor to refusing to provide a handful of procedures judged to be immoral, though these are certainly a part of Catholic identity. Rather, a robust description of what constitutes Catholic identity, even though not a comprehensive and definitive description, would be most helpful to the ministry as would a somewhat more detailed explanation of what it means to be a “ministry” and a “ministry of the Church.” As Catholic health care transitions to increasing lay leadership, these are fundamentally important concepts that need to be grasped and lived out if Catholic health care is going to survive and flourish.

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Second, the Catholic Theological Society of America report called for greater attention to conscience. This did not really get developed in the 1995 edition. There are only a couple of passing references to conscience. Yet conscience is a central reality in Catholic moral theology and in the teachings of Vatican II.¹² And each and every day, there are hundreds if not thousands of conscience decisions made in Catholic health care facilities by administrators, clinicians, patients and their families, and many others. Ironically, the 1949 and 1955 editions explicitly address the exercise of conscience in two types of situations: in matters that are legitimately debated by theologians and in cases of doubt when the code does not speak to an issue or where its application is unclear. In these situations, the physician is supported in following his or her conscience and doing what is in conformity with sound medical practice.¹³ Perhaps we have something to learn from our neighbors to the north about addressing the role of con-

science in moral codes for Catholic health care. The 1970 edition of the Canadian Catholic *Medico-Moral Guide* (the Canadian equivalent of the U.S. *Ethical and Religious Directives*) states that the application of the guidelines “to a particular situation will usually entail a great deal of prudence and wisdom. ... The Guidelines should serve to enlighten the judgment of conscience. They cannot replace it.”¹⁴ The current edition of the Canadian Health Ethics Guide contains an appendix devoted to “Making Moral Judgments” with two pages devoted to conscience.¹⁵ An update of the current edition of the ERDs would be providing an important service to all involved in Catholic health care by affirming the role of conscience, what is involved in forming conscience, and the necessary conditions for occasionally departing from a particular directive in the most difficult of cases, while not giving the impression that following conscience means doing what one wants.

Third, the world of health care involves more than providing medical treatments and procedures. There is an institutional side as well, and this institutional side has as much to do with Catholic identity as does the clinical, if not more. It would be worth considering adding a seventh section or part to the Directives to address some of the more important issues of an organizational nature, for example, the role of ministerial juridic persons and boards in fostering Catholic identity and the mission and values of the organization, formation, hiring for mission fit, executive compensation in a faith-based nonprofit health system, just wages for employees, respecting all forms of diversity, eliminating or reorganizing staff positions, giving employees a voice, conscientious objection, subsidiarity and budgeting as a moral exercise. Such an addition would provide another opportunity for bringing the Catholic social tradition to bear on health care and would help ensure that Catholic identity permeates the organization.



Fourth, several parts of the current edition could be updated. For example, Part One, “The Social Responsibility of Catholic Health Care Services,” would be enhanced by one or more directives relating to care of the environment. It is well-known that health care is one of the worst contributors to environmental degradation. Environmentally responsible health care should be a distinguishing mark of every Catholic health care organization. It is the right thing to do. Also to be included in this section would be directives having to do with preventive health care, addressing the social determinants of health, working in and with communities to address health needs, collaborating with community partners to improve health, and addressing health disparities. These are all important dimensions of the current health care

environment. In Part Five, “Issues in Care of the Seriously Ill and Dying,” one of the most important additions would be an affirmation of palliative care and hospice care, both of which have been supported by our three most recent pontiffs. Guidance on palliative sedation also would be helpful, as well as POLST, or Physician Orders for Life-Sustaining Treatment (medical orders that travel with a patient that can be helpful in end-of-life care). Finally, Part Three, “Issues in Care for the Beginning of Life,” also could use an update.

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There have been developments in genetics, the use of stem cells, uterine ablation, uterine ablation with salpingectomy (the surgical removal of one or both fallopian tubes), salpingectomy for cancer risk reduction. There perhaps also needs to be more clarity about early induction, miscar-

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riage and premature rupture of membranes.

Fifth, and finally, one of the most difficult issues for Catholic health care is the church's prohibition of tubal ligations for serious medical reasons. Such sterilizations are judged to be direct sterilizations and, hence, morally forbidden. This prohibition flies in the face of medical standards of care and common sense. There are several issues here that can only be named, but not discussed. There is a question whether in light of the Vatican's 2018 "Response to a Question on the Liceity of a Hysterectomy in Certain Cases," such tubal ligations might be considered to be indirect sterilizations and, therefore, morally permissible.¹⁶ Others argue "that our rich, moral tradition possesses the pastoral wisdom to enable patients and physicians to remain true to the church's teaching while at the same time making complex medical decisions," decisions that take account of the complexity of some obstetrical cases, circumstances (access to care, availability of specialized obstetric services, newborn intensive care, geographic location, insurance coverage, physician-patient relationship, etc.) and the primary intention, which is to avoid potentially very serious harm to the life or health of the mother and fetus.¹⁷ Also at issue, in addition to the conscientious decision of the patient, is the conscience of the physician and the physician's professional obligation to do no harm and to adhere to standards of care. The reality is there are very difficult cases in which alternatives are not feasible or non-existent. There must be a pastoral approach to these situations. In any case, what is needed is a thorough dialogue at the highest levels that brings together those with the needed competencies for an honest, informed, comprehensive examination.

CONCLUSION

Throughout its 100-year history, *Hospital/Health*

Progress has been true to its original mission of being a vehicle for communicating some of the best thought and practice to the ministry. This is certainly true in the areas of theology and ethics. The journal's contribution to the development of the 1995 revision of the *Ethical and Religious Directives* is but one example, though a most important one. Going forward, it is critical that *Health Progress* continue to be a place where theologians and ethicists can exchange and probe ideas, challenge what needs to be challenged and propose new approaches. In doing so, it can influence practices in our ministries that strengthen Catholic identity, better serve our patients and communities and, quite possibly, help shape future editions of the *Ethical and Religious Directives*, a role it has successfully played in the past.

RON HAMEL is the former senior ethicist at the Catholic Health Association. Currently retired, he serves on SSM Health Ministries and the SSM Health Board of Directors based in St. Louis and the Irving, Texas-based CHRISTUS Health mission integration and human resources committee of the board.

NOTES

1. Rev. Lawrence E. Skelly, "Code of Ethics for Catholic Hospitals," *Hospital Progress* 28, no. 1 (January 1947): 17.
2. The Catholic Hospital Association and *Hospital Progress* played a central role in the development of the 1949 and 1956 editions of the Directives. Rev. Gerald Kelly CHA's consulting ethicist, was the main author of both. In addition, for 10 years beginning in 1947, Kelly published, in virtually every issue of *Hospital Progress*, a column ("Medico-Moral Problems") on some topic related to the Directives. These were eventually collected under one cover and published by CHA as *Medico-Moral Problems* in 1957.
3. Rev. Thomas J. O'Donnell, "The Directives: A Crisis of Faith," *Hospital Progress* 53, no. 8 (August 1972): 34.
4. Commission on Ethical and Religious Directives for Catholic Hospitals, "Catholic Hospital Ethics," *Hospital Progress* 54, no. 2 (February 1973): 44-56.
5. In addition to the articles listed below that were critical of the 1971 Directives, there were several published in *Hospital Progress* that either took a different point of view than the critics or supportive of the code. Besides the one by O'Donnell cited above, Rev. Donald J. Keefe, offered a scathing rebuttal of the Catholic Theological Society of America report (Donald J. Keefe, "A Review

and Critique of the CTSA Report," *Hospital Progress* 54, no. 2, February 1973: 57-69) and two clergy from Minnesota offered a pro and con dialogue on the Directives. (Rev. Mark Dosh and Rev. William Hunt, "Dialogue on the Directives," *Hospital Progress* 54, no. 3 (March 1973): 46-52.)

6. Rev. Kevin O'Rourke, Rev. Thomas Kopfensteiner, and Ron Hamel, "A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services," *Health Progress* 82, no. 6 (November-December 2001), 19.

7. Rev. Richard A. McCormick, "Not What Catholic Hospitals Ordered," *The Linacre Quarterly* 39, no. 1 (February 1972): 16-20; Warren T. Reich, "Policy vs. Ethics," *The Linacre Quarterly* 39, no. 1 (February 1972): 21-29.

8. Eugene Diamond, "A Physician Views the Directives," *Hospital Progress* 53 (November 1972): 57-59; Warren T. Reich and Richard A. McCormick, "Theologians View the Directives," *Hospital Progress* 53 (December 1972), 50-54, 68.

9. Diamond, "A Physician Views the Directives," 70-72; Warren T. Reich and Richard A. McCormick, "Theologians View the Directives," *Hospital Progress* 54 (February 1973), 73, 74, 76.

10. CTSA Commission on *Ethical and Religious Directives for Catholic Hospitals*, "Catholic Hospital Ethics," *The Linacre Quarterly* 39, no. 4 (November 1972), 246-67. It should be noted that the themes in the CTSA Report, as well as in McCormick's and Reich's critiques, were con-

cerns and perspectives that were very much "in the air" at that time in the field of moral theology/ethics.

11. See paragraph 63 for a listing of these conditions.
12. See Vatican II, The Declaration on Religious Freedom, par. 3; *Constitution on the Church in the Modern World*, par. 16.
13. National Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Hospitals, Introduction," *Hospital Progress* 30, no. 3 (March 1949): 67.
14. The Catholic Hospital Association of Canada, *Medico-Moral Guide* (Ottawa: The Catholic Hospital Association of Canada, 1970).
15. Catholic Health Alliance of Canada, *Health Ethics Guide* (Ottawa: Catholic Health Alliance of Canada, 2012), 113-14.
16. See Peter Cataldo, "The CDF's Response to a Question on the Liceity of a Hysterectomy in Certain Cases: A Fundamental Turn," *Health Care Ethics USA* 27 (Spring 2019), 1-7.
17. See Amy Warner and Sr. Patricia Talone, "Ethics and Medical Standards of Care: Hysterectomy, Tubal Ligation, or Salpingectomy?" *Health Care Ethics USA* 27 (Winter 2019): 21-27. See also Rev. Francis G. Morrissey, "Restructuring Systems: A Call for Dialogue," *Health Progress* 94, no. 1 (January-February 2013): 66-67. In this article, Morrissey calls for dialogue within the Catholic community regarding the need for a new approach to the matter of tubal ligations.

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