A BRIEF HISTORY

A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services

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Catholics engaged in health care throughout the centuries have always sought to minister in the spirit of Christ and in accord with the teaching of the church as they carried on their ministry of healing. In the 16th century, theologians began to treat issues arising in the practice of medicine more frequently. Thus, such questions as how to determine that death had occurred and which medical methods to prolong life were mandatory and which methods were optional were discussed. Professionals engaged in Catholic health care applied treatment norms agreed upon by theologians as well as general norms for compassionate health care. No formal set of directives was issued for any country in the centuries immediately following, but a common teaching in the Catholic Church concerned the ethical practice of medicine and patient care. In the United States and Canada, the ministry of Catholic health care grew and flourished during the late 19th and early 20th centuries. Hospitals and long-term care facilities multiplied, usually under the sponsorship of religious communities, but always under the jurisdiction of the diocesan bishop.

The Catholic Hospital Association (the former name of the Catholic Health Association [CHA]) was founded in 1915 to improve the effectiveness of patient care and to protect the rights of Catholic health care facilities. One of the expressed needs of the various health care facilities, the sponsors, and administrators—as well as the physicians and nurses more directly involved in patient care—was a written statement of ethical directives that concerned serious moral issues.

The first written set of medical ethical norms seems to have been compiled by Rev. Michael Burke in 1921 for health care facilities in the Archdiocese of Detroit. Most of the norms concerned surgical procedures, prohibiting anything that resulted in the destruction of fetal life or the sterilization of men or women. Exceptions to the latter situation were instances in which the sterilizing effect followed as the indirect and undesired result of necessary interference for the removal of diseased structures. Burke's one-page set of directives, accepted verbatim by many dioceses and slightly modified by others, hung on the operating room walls of many Catholic hospitals in the United States and Canada.

These first regulations concerning ethical medical practices in the Catholic tradition did not consider the scriptural and theological teaching underlying the ministry of healing, but rather listed "dos and don'ts" that were considered most significant at the time. As time went on, however, and as the ministry of health care became more complicated and extensive, a new and more complete document was needed.

Work on a uniform set of directives was begun in 1947 by a committee of theologians and health care professionals from the United States and Canada. This document, under the title Ethical and Religious Directives for Catholic Hospitals, was first published in the July-October 1948 issue of Linacre Quarterly. A brochure version was published in 1949, and a French translation for use in Eastern Canada was published in 1950. This set of directives was explicitly understood to not be an official code for any diocese unless adopted by the bishop. Rev. Gerald Kelly, SJ, CHA's consulting theologian at the time, remarked: "It seems that it was so adopted by a majority of dioceses, but by no means all." Of course, not all dioceses had Catholic hospitals, and some had only one. Hence, every diocese did not need to promulgate the Directives.

After World War II, the government of Canada adopted a system of universal health care, financed
and organized by their federal government and the various provinces. This system, so different from that of the United States, prompted Canadian hospitals to form their own association. In October 1954, the Canadian hierarchy officially adopted a Code of Ethical Directives for the hospitals under its jurisdiction. About the same time, CHA decided that a more succinct expression of the 1949 Directives was needed for convenient printing on charts placed in the surgical suites of Catholic hospitals. To satisfy this form of promulgation, the Code of Medical Ethics for Catholic Hospitals was published in 1954 and was referred to as "the Code" to distinguish it from the more extensive "Directives." The Code did not contain anything different from the Directives, but it could be hung on the operating room wall or in prominent places in the health care facility, replacing the documents that had been used in various dioceses since the 1920s. Thus, it became known as the "U.S. Code." The U.S. Code was also published in booklet form.

In an effort to make the church teachings in regard to health care even more accessible and useful, Fr. Kelly and CHA published a second, revised edition of the 1949 Directives in 1956. However, the 1956 edition did contain new material on professional secrecy, ghost surgery, psychotherapy, and spiritual care for non-Catholics as well as an index, reference material, and consecutive numbering of the paragraphs. Fr. Kelly, the main author of the 1949 and 1956 Directives, commented on them in various articles in Hospital Progress (the former title of Health Progress) in the 1950s. These articles were later published, along with additional chapters, in book form.

The various editions of the Directives were published with the intention that all Catholic hospitals in the United States would follow the same regulations with the same interpretations. They did not become official, however, for a particular hospital or locale until they were approved by the diocesan bishop. The local ordinary also had the right to officially interpret the Directives for his diocese. In the 1950s and early 1960s, the interpretation of the Directives was fairly uniform; no apparent difficulties regarding uniformity existed.

But in the late 1960s, as a result of a new method of moral reasoning known as proportionalism proposed by many influential theologians, the Directives relating to direct sterilizations and the distribution of contraceptives in Catholic hospitals began to be interpreted more liberally in certain dioceses. This led to the phenomenon known as "geographical morality," meaning that a practice that was prohibited in one diocese might be allowed in another. As a result of "geographic morality," the executive committee of the CHA board of trustees requested that the National Conference of Catholic Bishops (NCCB; the former name of the United States Conference of Catholic Bishops) compose and promulgate a set of Directives that would be uniform for the entire country. The executive committee hoped that, if the Directives were composed by a conference of bishops and promulgated by individual bishops, "geographic morality" would disappear.

This request led to the publication of a new set of Directives in November 1971. Although these Directives were overwhelmingly approved by the NCCB, they were not greeted with acclaim by many theologians. Actual promulgation in each diocese was encouraged, however, by the response of the NCCB to the Roe v. Wade decision of the U.S. Supreme Court in 1973, which legalized abortion in the United States, and to an injunction granted by a federal court in Montana against the prohibition of sterilizations in Catholic hospitals. Cardinal John Krol of Philadelphia, then NCCB president, pointed out to the bishops that they might have a difficult time using the federal conscience clause allowing hospitals to prohibit abortions and sterilizations in accord with "religious teaching" unless they were on record as prohibiting such procedures.

The 1971 Directives, however, did not settle all issues of interpretation, especially regarding the practice of sterilizations that might be indicated to avoid a future disease or medical condition arising from pregnancy. Because of questions and doubts surrounding this issue, the NCCB submitted the matter to the Vatican Congre-

**SUMMARY**

The chronology of the various collections of ethical norms published for Catholic health care facilities in the United States is as follows:

1. **Surgical Code for Catholic Hospitals,** Archdiocese of Detroit, 1921.
2. **Ethical and Religious Directives for Catholic Hospitals,** Catholic Hospital Association, St. Louis, 1948 (brochure, 1949).
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gation for the Doctrine of the Faith (CDF). In 1975, the CDF issued a response to the matter entitled Quaecumque Sterilizatio, which indicated that sterilizations performed to avoid pathological medical conditions that might result from future pregnancies were contraceptive sterilizations and could not be performed in Catholic hospitals, no matter what theological opinion might be put forward to justify such procedures.

In 1977, the NCCB issued a commentary on the CDF document of 1975. The commentary agreed with the Vatican document but enlarged upon the interpretation of material cooperation as contained in Quaecumque Sterilizatio. To show that the sterilization issue was not easily settled, the NCCB, at the instigation of the CDF, issued another statement in 1980 offering the traditional interpretation of the principle of totality.

The 1971 Directives were rather legalistic; they did not attempt to explain the reasons for church teaching, but merely stated rules. Moreover, some new ethical issues in health care—such as informed consent for research projects, the use of advance directives, and cooperation with other-than-Catholic health care facilities—had arisen.

In an effort to prepare a more complete, effective, and theologically nuanced set of Directives, the NCCB's Committee on Doctrine was commissioned to prepare a new set of Directives. Over a six-year period, the Committee on Doctrine, working in the initial stages of the project through a subcommittee, enlisted the help of several Catholic organizations and centers, theologians, and ethicists in composing these new Directives. After 11 major drafts, the Revised Ethical and Religious Directives for Catholic Health Care Services were approved by the NCCB in November 1994 with a new title, once again with the understanding that they did not become the law for any particular diocese until promulgated by the diocesan bishop.

The 1994 Directives were composed of six sections, each introduced by a theological basis for the directives in that section. They also contained an appendix that sought to explain the principle of "cooperation in evil," a principle that is significant in the matter of relationships with other-than-Catholic health care facilities (Directive 69). Although the CDF had reviewed the Directives before the bishops' vote, they had not reviewed the appendix. The appendix was still being revised shortly before the vote. Although it was approved by the bishops, the Appendix immediately caused consternation, especially among some theologians. In the spring of 2000, the CDF instructed the NCCB to revisit the appendix as well as their 1977 commentary. Both were viewed by the CDF as sources of misinterpretation and misapplication of the principle of cooperation with other-than-Catholic organizations.

A number of points should be mentioned regarding the 1994 revision. First, the 1994 revision expands the area of medical ethics beyond clinical issues to include issues of social justice. In this way, the Directives were revised in light of the U.S. bishops' Pastoral Letter On Health and Health Care (1981). The issue of access to health care services also became a pressing moral concern. The Directives recognize the social obligations of Catholic health care services to serve the poor, to be responsible stewards of limited resources, and to collaborate with other providers to improve the health of the community.

Second, the Directives moved beyond prescriptions to describe Catholic identity in more positive terms. The Directives were no longer displayed in surgical suites; they now aimed to create a culture in health care that focused on the promotion of human dignity in a way that was animated by the spirit of the Gospel and guided by the teachings of the church. In this way, the 1994 Directives were more than a mere "updating" of earlier editions in light of magisterial teaching.

Third, this positive focus on Catholic identity did not diminish the importance of clinical issues. The Directives were expanded to include issues such as advance medical directives, surrogate decision making, reproductive technologies, and the provision of nutrition and hydration to patients in persistent vegetative states. They also offered more nuanced guidance for the treatment of victims of sexual assault. Rather than merely list negative norms, the Directives provided a theological backing for all moral claims made.

Finally, the Directives addressed the issue of partnerships with other-than-Catholic health care providers. The U.S. bishops recognized the growing phenomenon of partnerships as a way of promoting the church's social teaching and influencing the health care profession. The bishops also recognized that such partnerships might prevent Catholic providers from implementing the Directives in a consistent way. To address this dilemma, the bishops detailed the traditional principle of material cooperation in an appendix to the Directives. After consultation with the Vatican, the U.S. bishops unanimously approved the main text in November 1994.

In the spring of 1999, the CDF requested Bishop Joseph A. Fiorenza, president of the Bishops' Conference, to undertake a review of Part Six of the Directives, the appendix, and the NCCB commentary on Quaecumque Sterilizatio. The CDF viewed these texts as contributing to misinterpretation of the principle of cooperation and misapplication of the principle to partnerships with
other-than-Catholic health care organizations.

In response to the request of the CDF, Bishop Florenza asked Archbishop Daniel Pilarczyk of Cincinnati, chair of the Bishops’ Committee on Doctrine, and Bishop Donald Wuerl of Pittsburgh, chair of the Ad Hoc Committee on Health Care Issues and the Church, to serve as leaders of a review of the materials in question. Over a two-year period, the bishops consulted with health care administrators, theologians, other bishops, and CHA staff. In the course of this process, three different drafts were composed. The third draft was sent to the CDF for review. In February 2001, a response was received approving the draft in substance but offering a few comments that were incorporated into the draft sent to the United States Conference of Catholic Bishops for consideration. The new version of the Directives was approved June 15, 2001, by a vote of 209 to 7. Thus, the 2001 version of the Directives, like its predecessors, becomes the official statement of ethical directives for the provision of health care in Catholic facilities, provided the local bishop promulgates the document.

All the revisions to the 1994 Directives occur in Part Six, “Forming New Partnerships with Health Care Organizations and Providers.” There are four significant changes:

- A new directive (Directive 70) forbids Catholic health care organizations from engaging in immediate material cooperation in actions that are intrinsically evil, such as direct sterilization.
- The appendix of the 1994 Directives was deleted; it was judged to be a source of confusion.
- A footnote states that the new directive, Directive 70, is viewed as superceding the 1977 commentary on Quaestiones Super Sterilization.
- The notion of “scandal” is more precisely defined, using the definition contained in the Catechism of the Catholic Church.

The 2001 revision was a two-year process marked by collaboration among the bishops, Catholic health care leaders, theologians and ethicists, and the Holy See. Patience and a commitment to ongoing dialogue, to the teaching of the magisterium, and to the good of the ministry and the people it serves led to a text that addressed the concerns of the CDF while minimizing unintended consequences to Catholic health care.

NOTES

1. Francisco de Vittoria, On Homicide, John P. Doyle, editor, Marquette University, Milwaukee, 1997, p. 95, 103.
2. Almost every manual of moral theology published from the 17th to the 19th century has a section concerned with medical practice.
10. The principal of totality allows excision of a bodily organ if its malfunction may endanger the life of a person, but it prohibits the excision of an organ for other purposes. Thus, a uterus may be removed if it is cancerous, not to prevent conception. Proportionality was popular among many Catholic theologians who proposed that the ultimate purpose of a moral action was more significant than the action performed. The encyclical Veritatis Splendor by Pope John Paul II taught that Catholic moral theology recognizes that some actions are “intrinsically evil,” that is, morally wrong no matter what the motivation that prompts them. Origins, October 14, 1993, vol. 23, p. 18.
12. Catholic Hospital Association, Ethical and Religious Directives for Catholic Health Care Facilities, St. Louis, 1971. Slight revisions were made in 1975, but these revisions were considered a second edition, not a revised edition.
16. Archbishop John Quinn, “Catholic Hospitals and Sterilization; The State of the Question” (private papers of Rev. Kevin O’Rourke, OP). Archbishop Quinn was chair of the NCCB Committee on Doctrine at the time, and it seems that this document sought to explain to the CDF the situation in the United States.
18. Commentaries on the Reply of the CDF on Sterilizations in Catholic Hospitals, National Conference of Catholic Bishops, Washington, D.C., 1977. The reason for the delay in publishing the response of the CDF and the commentary on this response seems to have been the thought that the response was simply a repetition of the traditional theological interpretation of Directive 20.