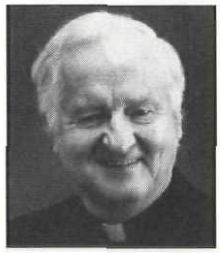
INTRODUCING THE REVISED DIRECTIVES

What Do They Mean for Catholic Healthcare?

BY SR. JEAN DEBLOIS, CSJ, PhD, & REV. KEVIN D. O'ROURKE, OP, JCD



The Catholic Health Association and the Center for Health Care Ethics at the St. Louis University Health Sciences Center are collaborating to publish a series of articles on the Ethical and Religious Directives for Catholic Health Care Services. *This article is the first in the series, written by Sr. deBlois, CHA's senior associate for ethics, and Fr. O'Rourke, director of the Center for Health Care Ethics.*

In November 1994, the Bishops of the United States approved a revised version of the *Ethical and Religious Directives for Catholic Health Care Services* (*ERD*) and recommended their implemention by diocesan bishops. The acceptance of the *ERD* brings to completion a consultative process that spanned seven years and included input from hundreds of persons involved in the Church's health ministry.

The *ERD* are a set of principles that inform the provision of health services under Catholic sponsorship. These standards are not a set of a priori rules. Rather, they are conclusions drawn from a faith-inspired vision of the human person and the experience gained from providing holistic healthcare. Moreover, the *ERD* are not to be followed blindly. They must be applied to individual cases. For example, the directives regarding ordinary and extraordinary means to prolong life (Directives 56, 57) may not be applied until the physiological condition of the patient and the potential for recovering human function (i.e., the diagnosis and prognosis) are known. The value of the *ERD* is expressed in the statement of purpose contained in the preamble: "first, to reaffirm the ethical standards of behavior in health care which flow from the church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues which face Catholic health care today." Finally, the preamble notes that the *ERD* are subject to periodical review by the National Conference of Bishops (NCCB) "in order to address new insights from theological and medical research or new requirements of public policy."

It should be noted as well that, while the newly revised *ERD* are greatly expanded over previous versions, they remain only a part of the much broader moral tradition of the Church. Moreover, the *ERD* focus on just a fraction of the issues that arise in the provision of health services today. Thus, when seeking to ensure the ethical integrity of Catholic-sponsored healthcare, it is not sufficient to rely solely on the *ERD* for guidance. Other sources of moral wisdom must be consulted as well (for example, the social teaching of the Church on matters of justice and the common good and the preferential option for the poor, and other sources).

The goal of the *ERD*, then, is to promote consistency between what is done under the auspices of Catholic sponsorship and Church teaching on moral matters as these relate to the provision of health services. Appropriate regard for the significance of the *ERD* in pursuing this goal depends on an adequate understanding of the foundational reality that both grounds and gives rise to the Church's health ministry.

MISSION AND CATHOLIC HEALTH MINISTRY

Ministry in the Church is a means toward an end, a vehicle for achieving God's purposes in creation. The theological theme that expresses most adequately the content of those purposes, and thus the content of and manner in which ministry must be done, is MISSION ("MISSION" in capital letters connotes the ontological reality that gives meaning to all the ministry's activities. It is distinct from "mission," which refers to how services are provided.) Further, since all ministry in the Christian tradition begins with Jesus,[1] any consideration of ministry must begin with an exploration of Jesus' own ministry.

Jesus is the one sent by God, the *Missio Dei*, who came to reestablish God's reign among all peoples. In Luke's account of the Gospel Jesus outlined what being God's MISSION in the world required of him by applying the words of the prophet Isaiah to himself: "The spirit of the

Lord has anointed me and has sent me to proclaim good news to the poor, release to the captives, recovery of sight to the blind, liberty to the oppressed, to announce the year of the Lord's favor" (Lk 4:18-19).

Everything that Jesus did, that is, his ministry, was done as a means of making the substance of this declaration reality. While his actions focused often on the physical needs of persons, the effects of his activities in response to these needs had an impact and importance beyond mere intervention in the physical realm. When Jesus cured the woman suffering from hemorrhage, for example, he did more than restore an individual to physical health. Through his interaction with the woman and the manner in which he healed her, Jesus declared to the community which had cast her out because of her affliction that the reign of God is inclusive of all persons without distinction.

> Jesus' healing had an impact and importance beyond the physical realm.

In all that Jesus did, then, he announced and described the characteristics of God's reign and worked tirelessly to break down any impediments to its full realization. In its ministry today, the Church is charged to do the same. Thus we read in the *Decree on the Apostolate of the Laity* of the twofold activity of the Church in MISSION: proclaiming the message of Christ and penetrating and perfecting the temporal sphere with the spirit of the Gospel.[2]

The significance of the *ERD* can be understood only in light of what MISSION is and requires. Thus, in setting forth the norms for behavior with regard to the way Catholic health services are provided, the *ERD* seek to proclaim in contemporary terms those attitudes and behaviors which are most consistent with furthering God's reign of love and justice (e.g., regard for the dignity of the person and the inviolability of innocent human life; respect for the meaning of human sexuality and of the transmission of new life; appropriate care of the dying and attention to the spiritual dimension of all persons).

In addition, the revised *ERD* acknowledge that current changes in the broader healthcare system necessarily locate the Catholic health ministry within a social context where many persons and structures either do not or cannot accept the validity of that proclamation. Because the ministry, like Jesus, must engage those persons and structures on behalf of the reign of God, the *ERD* offer guidance in this regard as well. Thus the *ERD* offer an opportunity to explore in greater depth the meaning and goals of the Church's health ministry in today's environment. To take advantage of this opportunity, persons associated with the Catholic health ministry should read, study, and discuss not only the specific directives but also the broader theological context that gives rise to the directives.

Historical Development of the *ERD*

Ethical norms for Catholic healthcare facilities in the United States were originally developed in the 1940s and 1950s as an unauthorized collection offering guidance in "sound Catholic teaching" in regard to the practice of medicine in Catholic hospitals.[3] Rev. Gerald Kelly, SJ, one of the pioneers in the field of medical ethics in the United States, wrote the first comprehensive set of *ERD* at the request of the Catholic Hospital Association (CHA) in the early 1950s. CHA published these directives, which, however, had no canonical force until they were approved by a bishop for his diocese.[4] Many dioceses with several Catholic hospitals did in fact approve the CHA directives.

Because the original *ERD* of the CHA were not an authorized version, and because they were subject to various interpretations, they resulted in a situation called "geographical morality," meaning that something allowed in one diocese might be prohibited in another. The main issue leading to geographical morality was the definition of contraceptive sterilization. Specifically, there was disagreement among theologians concerning the nature of sterilizations designed to avoid pathologies that might result from future pregnancies.[5] For example, was a tubal ligation performed to avoid predictable renal malfunction if the woman should become pregnant a contraceptive procedure? Or was it reasonable medical therapy? Some dioceses followed the theological opinion that such surgical procedures were not direct sterilizations and therefore permitted them; others did not.

Because of geographical morality, the CHA

asked the NCCB to compose one set of directives for the entire country. In 1971 a new set of directives was approved by the NCCB.[6] Minor additions were added in 1975. Ironically, the *ERD* of 1971 did not settle clearly the ethical issue concerning sterilization to avoid the physiological pathologies predictable because of pregnancy. In 1975, the question was referred to the Vatican by the NCCB, and the Congregation for the Doctrine of the Faith (CDF) offered the theological opinion that sterilizations of this type were contraceptive and therefore prohibited in Catholic healthcare facilities.[7]

Medical, social, and legal changes have presented challenges to Catholic healthcare.

Reasons for Revision

Many changes in the provision of healthcare have occurred since 1971—changes that predate the recent efforts of the federal government to revise the manner of providing and paying for healthcare. For example, there have been significant changes in the practice of medicine. When the most recent *ERD* were written in 1971, *in vitro* fertilization and reproductive technologies had not been developed; and mechanical devices to prolong life, such as artificial hydration and nutrition and respirators, were not as advanced as they are now.

At the same time, a number of developments within the Catholic Church have affected the ecclesial mission of healthcare. For example, there are fewer members of the religious congregations that sponsor and staff Catholic healthcare facilities. The laity have a more dominant role in all phases of the healthcare ministry, and Catholic healthcare facilities have a greater need to cooperate with non-Catholic facilities.

Other changes that prompt the concern of the Catholic Church are social or legal in nature. Some examples: the number of people who do not have adequate access to healthcare; the increasing expense of healthcare; public health issues such as AIDS; the development of advance directives; and the desire on the part of some to legalize euthanasia. These medical, social, and legal changes present challenges for which Catholic healthcare must make practical provisions. The Catholic bishops addressed some of these contemporary ethical issues in healthcare in a 1981 pastoral letter, *Health and Health Care*, which presented "the theological principles which guide the Church's vision of healthcare and expressed once again the full commitment of the Church in the United States to the health care ministry."[8] This document is still operative and explains the general vision of healthcare offered in the name of Christ, but it does not contain specifics implementing this vision for healthcare facilities.

As the result of various changes mentioned above, several people in Catholic healthcare suggested that it was time for a total revision of the *ERD*. In July 1988 a subcommittee of the Committee on Doctrine of the NCCB solicited the help of five agencies capable of assisting in the project: CHA, the Pope John XXIII Center, the Center for Health Care Ethics/Saint Louis University Health Sciences Center, the Medical-Moral Board of the Archdiocese of San Francisco, and the Kennedy Institute of Ethics at Georgetown University.[9] As a result of extensive consultation, in May 1990 the subcommittee published a "Rationale for Revision," began the process of revision, and launched the rewriting of the *ERD* in earnest.

The subcommittee charged with doing the groundwork for the revised *ERD* worked its way through five drafts. After each draft, the document was sent to the aforementioned five agencies for observations and suggested corrections. The subcommittee's work was assumed by the full Committee on Doctrine in 1993. The committee edited at least five more drafts, each one being submitted for observations to competent consultants.

Finally, in fall 1994 the final revision of the directives was submitted to the NCCB after having been sent to the CDF for review. The *ERD* of 1994 sums up the revision process by stating: "During the process of revision, the *Directives* were refined through an extensive process of consultation with bishops, theologians, sponsors, administrators, physicians and other health care providers."[10] It goes on to say: "Because of the continued change in the health care field the document promises that the *Directives* will be reviewed periodically by

the NCCB to address new insights from the theological and medical research or new requirements of public policy."

Audience of the Revised *ERD*

The general introduction to the document says:

> The *ERD* are primarily concerned with institutionally-based Catholic health care services. They address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services. Since they express the Church's moral teaching, these Directives will also be helpful to Catholic professionals engaged in health care services in other settings.[11]

The writing team of the *ERD*, and the bishops who approved the final document, were aware that many of the people serving as trustees, administrators, or healthcare professionals in Catholic facilities are not Catholic. But they call on non-Catholics, as well as Catholics, to manage and administer Catholic healthcare facilities in accord with the norms contained in this document. This is not an unreasonable request. First, non-Catholic administrative personnel and healthcare professionals associated with a Catholic facility have freely chosen that association. They are always free to disaffiliate from the Catholic institution if they think their consciences would be violated.

Second, though the *ERD* seek to apply Christ's teaching to contemporary healthcare, they are also in accord with the goals of human life as discerned by reason, and they seek to promote the dignity of every person. Seeking to explain this viewpoint, the bishops state:

> Throughout the centuries, with the aid of other sciences, a body of moral principles has emerged that expresses the Church's teaching on medical and moral matters. The moral teaching we profess here flows from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From this source, the Church has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity.[12]

> The *ERD* are in accord with the goals of human life.

The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes no contradiction between science and faith. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a conscience based on the moral norms for proper healthcare.[13]

The *ERD* and Accountability

While it is a fine point of Church law, documents such as the *ERD* do not have the force of Church law simply because they are approved by the NCCB.[14] Because of the decentralized nature of the Catholic Church, such documents do not become law for a particular diocese until they are promulgated by the local bishop.

Hence the *ERD* become fully operative only when approved and promulgated by a resident bishop. Given the needs of the healthcare apostolates in the United States, the new *ERD* certainly will be promulgated in each diocese. If they were not promulgated in each diocese, it would open the door for litigation. Litigants could assert that Catholic hospitals cannot refuse to perform abortions and contraceptive sterilizations because "there is no law in this diocese against it." For practical purposes, then, we can say that the *ERD* will be promulgated and will be the discipline for all healthcare facilities in the United States that are affiliated with the Catholic Church.

Taken whole, therefore, the revised *ERD* have their binding force because of their approval by the NCCB and through promulgation by a local bishop. It is worthwhile noting, however, that some of the individual directives are more important than others. Indeed, some of them would be mandatory even if they were not contained in the *ERD*, because they are contained in the teaching of the universal Church.[15] For example, because it reflects a more important teaching of the universal Church, the directive that prohibits performing abortions in Catholic health facilities (Directive 45) is more significant than the directive concerned with appointing people to the pastoral care staff (Directive 21). Moreover, some directives will be more difficult to apply than others. It is much easier to determine which surgical proce-

dures constitute direct abortions, and thus follow Directive 45, than it is to determine what amount of money constitutes "just compensation and benefits for employees" in following Directive 7. The application of the *ERD* in difficult cases will ultimately be the responsibility of the local bishop. He will, however, be guided in such circumstances by healthcare professionals, moral theologians, ethicists, and ethics committees.

If a Catholic healthcare facility were to fail to adhere to the *ERD*, it might lose its identification as Catholic. That is, if the *ERD* were not observed, affiliation with the Catholic Church in a particular diocese could be withdrawn by the local bishop.[16] Because some Catholic healthcare facilities are actually owned by a diocese or a religious congregation, the loss of Catholic identification could also result in the closing of the facility. In other cases, when the facility is owned by a board of trustees, the trustees might decide to continue to manage the facility even though it would no longer be affiliated with the Catholic Church.

To date, few Catholic healthcare facilities have been deprived of official Catholic identity because they have not followed the *ERD*. Catholic hospitals have on occasion lost their identity as Catholic through mergers or as the result of being sold to for-profit healthcare corporations. But this is a different basis for yielding Catholic identity than by not following the *ERD*.

Overview of the *ERD*

The *ERD* do not present a complete scriptural and theological explanation of Catholic teaching in regard to all topics mentioned in the document. But the *ERD* are not merely a codex; that is, they contain more than mere behavioral prescriptions. The *ERD*, insofar as possible in a document of this nature, seek to present theological reasons for the behavior they mandate. This is a significant improvement over the *ERD* of 1971. To understand fully the teaching supporting the *ERD*, one would need to study more extensively other documents and books of Catholic theology and healthcare ethics textbooks.[17]

In sum, "the Directives begin with a general introduction that presents a theological basis for the Catholic health care ministry. Each of the parts that follow is divided into two sections. The first section provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is in prescriptive form, stating directives which protect the truths of the Catholic faith as those truths are brought to bear upon concrete issues in health care."[18]

Following a general introduction that presents the various parts and a brief scriptural and theological explanation of the healing mission of Jesus and its implications for contemporary healthcare, the text of the *ERD* is divided into parts:

1. The Social Responsibility of Catholic Health Care Services
2. The Pastoral and Spiritual Responsibility of Catholic Health Care
3. The Professional-Patient Relationship
4. Issues in Care for the Beginning of Life
5. Issues in Care for the Dying
6. Forming New Partnerships with Health Care Organizations and Providers

In forthcoming issues of *Hospital Progress*, we shall consider the content of each section and offer practical observations in regard to the implementation of the various directives. □

NOTES

1. Walter M. Abbott, *The Documents of Vatican II*, New Century Publishers, Piscataway, NJ, 1966, p. 15, n. 3.
2. Abbott, p. 495.
3. Gerald Kelly, *Medical-Moral Problems IV*, Catholic Hospital Association, St. Louis, 1957, p. 7.
4. Gerald Kelly, "Review of Existing Codes, *Hospital Progress*, March 1956, p. 52.
5. Bernard Haring, *Medical Ethics*, Fides Publishers, Notre Dame, IN, 1972, p. 96.
6. *Ethical and Religious Directives for Catholic Health Facilities*, U.S. Catholic Conference, Washington, DC, 1971. The *ERD* were approved by the NCCB in November 1971 as "the national code, subject to the approval of the bishop for use in the diocese." The NCCB and the USCC are comprised of the same members but address different issues. The NCCB is concerned with ecclesiastical affairs, while the USCC is a civil corporation concerned with social issues involving the life of the Catholic Church. For example, the NCCB would be concerned with doctrinal matters such as the content of the *ERD*, while the USCC would be concerned with education and welfare.
7. Congregation for the Doctrine of the Faith, "Sterilizations in Catholic Hospitals," NCCB, September 15, 1977.
8. *Health and Health Care: A Pastoral Letter*, *Origins*, December 3, 1981, pp. 396-402.
9. Letter of Subcommittee, May 1990.
10. *ERD* Preamble.
11. ERD General Introduction.
12. *ERD* Preamble.
13. *ERD* General Introduction.
14. Code of Canon Law, C. 455.
15. *Lumen Gentium*, in "Dogmatic Constitution on the Church," in *Vatican Council II: The Conciliar and Post Conciliar Documents*, Daughters of St. Paul, Boston, 1975, pp. 350-426.
16. Code of Canon Law, C. 391, 394, 681.
17. John Paul II, "Veritatis Splendor," *Origins*, October 14, 1993, p. 334ff; e.g., Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 3d ed., Catholic Health Association, St. Louis, 1989.
18. *ERD* Preamble.