The Ethical and Religious Directives:
Annotations by the Catholic Health Association of the United States

First Edition

Catholic Health Association of the United States
*We Will Empower Bold Change to Elevate Human Flourishing.*SM

ABOUT CHA

The mission of Catholic Health Association of the United States (CHA) is to advance the Catholic health ministry of the United States in caring for people and communities.

Catholic health care is a ministry of the Catholic Church continuing Jesus' mission of love and healing in the world today. Composed of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. At the national level, these organizations join together in the Catholic Health Association of the United States.
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Introduction

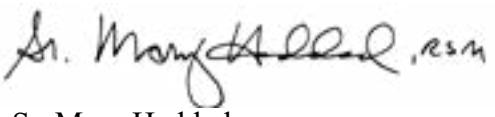
Dear Colleague,

I am honored to introduce this new resource for the good of the Catholic health care ministry.

Catholic moral theology and medical practice in Catholic health care facilities are joined hand in hand. Catholic ethicists, physicians and caregivers work for the good of our patients, but at times from different areas of expertise. A solid understanding and clear interpretation of the Ethical and Religious Directives requires the contribution of all who work in Catholic health care.

The purpose of this resource is to place information in the hands of those who serve our patients. This guide links articles and other resources to particular parts of the ERDs, so that those who serve our patients, and their loved ones can understand the medical and ethical conversations about particular issues.

My hope is that this information will serve you in your own work for Catholic health care.



Sr. Mary Haddad

President and CEO

Catholic Health Association of the United States

Background

The Ethical and Religious Directives have their origin in Detroit, Michigan, when Fr. Michael Bourke, a diocesan priest, wrote the "Surgical Code for Catholic Hospitals" for the Diocese of Detroit in 1921.[1] Those guidelines influenced a discussion in American Catholic health care about how to best accomplish the work that we do, in light of our mission and ethics. There were other Codes, in individual places, that also attempted to capture the ethics and culture of Catholic health care.

In 1947, Fr. Gerald Kelly, S.J., the Catholic Hospital Association's consulting moral theologian, used this "Surgical Code," and the others, to foster a conversation between theologians and health professionals that produced the first edition of what was then called the Ethical and Religious Directives for Catholic Hospitals. It was printed in the Linacre Quarterly in July-October 1948.[2]

Since, under Canon Law, the directives would not be an obligation in any diocese, unless the local Ordinary (Bishop) agreed, the Catholic Hospital Association, which has now become the Catholic Health Association, consulted with the National Conference of Catholic Bishops, which is now the United States Conference of Catholic Bishops, and asked the Conference to assume responsibility for the Ethical and Religious Directives. There have now been six revisions of the original document, with the latest version being published in 2018.[3]

These annotations are to the 6th edition of The Ethical and Religious Directives for Catholic Health Care Services. The original text appears at the top of the succeeding pages, and the CHA annotations appear at the bottom of the page. The original notes of The Ethical and Religious Directives for Catholic Health Care Services are included beginning on page 37.

1 Fr. Michael Bourke, "Surgical Code for Catholic Hospitals" HCEUSA (Fall 2021). Rev. Michael Patrick Bourke was born in 1878 and died in 1928 at the age of 49. His obituary lists the cause of death as a long, severe illness. He practiced as a lawyer before his ordination in 1914. As a lawyer, he received an honorary LL.D., worked for a well-known law firm, and served as assistant attorney general in Michigan. After his ordination in 1914, he served as a chaplain at St. Joseph's Mercy Hospital as well as the Chapel of St. Mary's of the Immaculate Conception on the University of Michigan, Ann Arbor campus. He was particularly instrumental in shaping campus life for young Catholics at the University of Michigan, since he established the campus chapel and also raised funds for an all-male, Catholic dormitory. He also led efforts to improve health care throughout Michigan by serving as president of the Michigan Hospital Association. He served as Director of Catholic Hospitals and Charities, and as editor of Hospital Progress, and authored the Surgical Code for Catholic Hospital throughout his fourteen-year tenure as a priest.

2 "Ethical and Religious Directives for Catholic Hospitals." *The Linacre Quarterly* 15, no. 3. (Summer 1948), 1-9.

3 *Ethical and Religious Directives for Catholic Health Care Services*

Preamble

Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well. At the same time, there are a number of developments within the Catholic Church affecting the ecclesial mission of health care. Among these are significant changes in religious orders and congregations, the increased involvement of lay men and women, a heightened awareness of the Church's social role in the world, and developments in moral theology since the Second Vatican Council. A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the Church and in American society.

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 and has proven to be pertinent and applicable to the ever-changing circumstances of health care and its delivery. In response to today's challenges, these same moral principles of Catholic teaching provide the rationale and direction for this revision of the *Ethical and Religious Directives for Catholic Health Care Service.*[a]

These Directives presuppose our statement *Health and Health Care* published in 1981.[1] There we presented the theological principles that guide the Church's vision of health care, called for all Catholics to share in the healing mission of the Church, expressed our full commitment to the health care ministry, and offered encouragement to all those who are involved in it. Now, with American health care facing even more dramatic changes, we reaffirm the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services.[2] The purpose of these *Ethical and Religious Directives* then is twofold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that

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[a] The *Ethical and Religious Directives for Catholic Health Care Services* are the result of a long process of development in the 20th and 21st centuries. There were early attempts to provide guidelines for ethical health care, like the "Surgical Code for Catholic Hospitals for the Diocese of Detroit," written by Fr. Michael Burke, in 1921. In 1947, Fr. Gerald Kelly, S.J., the Catholic Health Association's consulting moral theologian, convened a committee of theologians and health professionals to produce the first edition of what was then the *Ethical and Religious Directives for Catholic Hospitals*. It was printed in the *Linacre Quarterly* in July-October 1948.

Please see:
Rev. Kevin O'Rourke, OP, JCD, Rev. Thomas Kopfensteiner and Ron Hamel, "A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Services," *Health Progress* (Nov./Dec. 2001) 18-21.

Ron Hamel, "100th Anniversary- The Ethical and Religious Directives: Looking Back to Move Forward," *Health Progress* (Nov/December 2019) 64-71.

"Surgical Code for Catholic Hospitals" *HCEUSA* (Fall 2021)

face Catholic health care today.

The *Ethical and Religious Directives* are concerned primarily 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 also will be helpful to Catholic professionals engaged in health care services in other settings. The moral teachings that we profess here flow principally 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.

The Directives have been refined through an extensive process of consultation with bishops, theologians, sponsors, administrators, physicians, and other health care providers. While providing standards and guidance, the Directives do not cover in detail all of the complex issues that confront Catholic health care today. Moreover, the Directives will be reviewed periodically by the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops), in the light of authoritative church teaching, in order to address new insights from theological and medical research or new requirements of public policy.

The Directives begin with a general introduction that presents a theological basis for the Catholic health care ministry. Each of the six parts that follow is divided into two sections. The first section is in expository form; it serves as an introduction and provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is in prescriptive form; the directives promote and protect the truths of the Catholic faith as those truths are brought to bear on concrete issues in health care.

General Introduction

The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing: he cleansed a man with leprosy (Mt 8:1-4; Mk 1:40-42); he gave sight to two people who were blind (Mt 20:2934; Mk 10:46-52); he enabled one who was mute to speak (Lk 11:14); he cured a woman who was hemorrhaging (Mt 9:20-22; Mk 5:25-34); and he brought a young girl back to life (Mt 9:18, 23-25; Mk 5:35-42). Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9:35). In the account of Matthew, Jesus' mission fulfilled the prophecy of Isaiah: "He took away our infirmities and bore our diseases" (Mt 8:17; cf. Is 53:4).

Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing (Jn 6:35, 11:25-27). He "came so that they might have life and have it more abundantly" (Jn 10:10).

The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.[b]

For the Christian, our encounter with suffering and death can take on a positive and distinctive meaning through the redemptive power of Jesus' suffering and death. As St. Paul says, we are "always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body" (2 Cor 4:10). This truth does not lessen the pain and fear, but gives confidence and grace for bearing suffering rather than being overwhelmed by it. Catholic health care ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. "God himself will always be with them [as their God]. He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, [for] the old order has passed away" (Rev 21:3-4).[c]

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[b] See Fr. Sean Charles Martin, S.T.D., "Interpretations of Healing Narratives in the Bible," *Incarnate Grace: Perspectives on the Ministry of Health Care*, Edited by Fr. Charles Bouchard, OP, STD, (St. Louis: The Catholic Health Association of the United States, 2017); 57-81.

[c] See Fr. Robin Ryan, CP, Ph.D., "God's Presence in Our Suffering," *Incarnate Grace*, 103-121.

In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history.[d] The zealous service of individuals and communities has provided shelter for the traveler; infirmaries for the sick; and homes for children, adults, and the elderly.[3] In the United States, the many religious communities as well as dioceses that sponsor and staff this country's Catholic health care institutions and services have established an effective Catholic presence in health care.[e] Modeling their efforts on the gospel parable of the Good Samaritan, these communities of women and men have exemplified authentic neighborliness to those in need (Lk 10:25-37). The Church seeks to ensure that the service offered in the past will be continued into the future.

While many religious communities continue their commitment to the health care ministry, lay Catholics increasingly have stepped forward to collaborate in this ministry.[f] Inspired by the example of Christ and mandated by the Second Vatican Council, lay faithful are invited to a broader and more intense field of ministries than in the past.[4] By virtue of their Baptism, lay faithful are called to participate actively in the Church's life and mission.[5] Their participation and leadership in the health care ministry, through new forms of sponsorship and governance of institutional Catholic health care, are essential for the Church to continue her ministry of healing and compassion. They are joined in the Church's health care mission by many men and women who are not Catholic.

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. [g]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 pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry of the Church. 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. As priest, the diocesan bishop oversees the sacramental care of the sick. 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.

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[d] See Darrel W. Amundsen, *Medicine, Society and Faith in The Ancient and Medieval Worlds* (Baltimore: Johns Hopkins University Press, 1996): 127-157; and Gary B. Ferngren, *Medicine & Health care in Early Christianity* (Baltimore: Johns Hopkins University Press, 2009).

[e] See Christopher J. Kauffman. *Ministry and Meaning: A Religious History of Catholic Health Care in the United States* (New York: Crossroad, 1995).

[f] See Sr. Doris Gottemoeller, RSM, "Challenges for Sponsorship Today," *Health Progress* 103, no. 3 (Summer 2022)

[g] United States Conference of Catholic Bishops, "The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry," 2nd ed. (Washington, D.C.: USCCB, 2020).

In a time of new medical discoveries, rapid technological developments, and social change, what is new can either be an opportunity for genuine advancement in human culture, or it can lead to policies and actions that are contrary to the true dignity and vocation of the human person. In consultation with medical professionals, church leaders review these developments, judge them according to the principles of right reason and the ultimate standard of revealed truth, and offer authoritative teaching and guidance about the moral and pastoral responsibilities entailed by the Christian faith.[6] While the Church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium,[h] but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making.[i]

Created in God's image and likeness, the human family shares in the dominion that Christ manifested in his healing ministry. This sharing involves a stewardship over all material creation (Gn 1:26) that should neither abuse nor squander nature's resources. Through science the human race comes to understand God's wonderful work; and through technology it must conserve, protect, and perfect nature in harmony with God's purposes. Health care professionals pursue a special vocation to share in carrying forth God's life-giving and healing work.[j]

The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience[k] based on the moral norms for proper health care.

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[h] For those unfamiliar with the term, the Magisterium means the "teaching authority" of the Church. It comes from the Latin word for teacher, magister.

[i] It would be helpful here to distinguish between the work of theologians and the Magisterium. While the final dispositive authority to speak in the name of the Church belongs to the Magisterium, it is important to realize that the final pronouncement on a moral issue is preceded by a learned discussion within the Church. Theologians have a role to play in intellectually exploring various answers to moral questions. Bishops share in the magisterial discernment of truth within their own dioceses. That dialogue between theologians and the episcopacy has been essential in discerning the witness of the faithful, in terms of declaring certain moral decisions to be taught authoritatively. To speak of the Magisterium as a final teaching authority presumes that individual bishops, in communion with the Pope, teach a single knowable truth. That teaching is informed by prior explorations by theologians, and, in this case, those who care for the health of others.

See USCCB, "The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry," 2nd ed. Washington, DC: USCCB, 2020; The Congregation of the Doctrine of the Faith, "Instruction of the Ecclesial Vocation of the Theologian," *Origins* 20 (July 5, 1990) 117-26; Avery Dulles, "The Magisterium, Theology and Dissent," *Origins* 29 (March 28, 1991): 692-96; and Nathaniel Blanton Hibner, "Ethics - A Closer Look at the Authority of Church Teachings," *Health Progress* 102, no. 1 (Winter 2021): 64-65.

[j] The environment greatly impacts health. Pope Francis' encyclical, *Laudato si*, calls for "an integral ecology, one which clearly respects its human and social dimensions." Pope Francis, Laudato Si', (Vatican, 2015.) Since the publication on this encyclical in 2015 greater attention has been given to the connection between stewarding the environment and its impact on health. See Laura Anderko, Ph.D., RN, "Understanding and Addressing Environmental Injustice in Health," *Health Progress*, 102, no. 4 (Fall, 2021)

[k] Health care professionals, as persons, are called to develop their own conscience. Conscience is a practical judgement made through an awareness of moral truth. See St. Thomas Aquinas, *Summa Theologiae*, I.79.13; and *The Catechism of the Catholic Church*, 2nd ed. Vatican: Libreria Editrice Vaticana, 2000. Nos. 1777-78.

Please also see the webinar with Prof. Jason Eberl, of St. Louis University, on "Conscience, Compromise and Complicity," which is part of our series on Emerging Topics in Catholic Health care Ethics, Year 1, Session 3.

PART ONE

The Social Responsibility of Catholic Health Care Services

Introduction

Their embrace of Christ's healing mission has led institutionally based Catholic health care services in the United States to become an integral part of the nation's health care system. Today, this complex health care system confronts a range of economic, technological, social, and moral challenges. The response of Catholic health care institutions and services to these challenges is guided by normative principles that inform the Church's healing ministry.[l]

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.[7][m]

Second, the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured.[8][n]

Third, Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals.[9][o]

Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community. The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons.

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[l]For those interested in a more detailed account of the historical development of Catholic Health care in the United States, please see: Barbra Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace 1865-1925* (Columbus, OH: The Ohio State University Press, 2005); and *American Catholic Hospitals: A Century of Changing Markets and Missions* (New Brunswick, NJ: Rutgers University Press, 2011).

[m]See Michael Naughton, "Catholic Social Tradition-Teaching Thought, Practice," *Health Progress* 87, No. 1 (Jan./Feb. 2006): 44-45; Sr. Jean deBlois and Fr. Kevin O'Rourke, "Health Care and Social Responsibility," *Health Progress* 76, No. 4 (May, 1995) 48-50, 58; and Catholic Health Association, Catholic Social Tradition, St. Louis, CHA, 2011.

Some additional references:
"Human persons are willed by God; they are imprinted with God's image. Their dignity does not come from the work they do, but from the persons they are." (John Paul II, Centesimus Annus, par. 11), and "At the center of all Catholic social teaching are the transcendence of God and the dignity of the human person. The human person is the clearest reflection of God's presence in the world; all of the Church's work in pursuit of both justice and peace is designed to protect and promote the dignity of every person. For each person not only reflects God, but is the expression of God's creative work and the meaning of Christ's redemptive ministry." (United States Conference of Catholic Bishops, The Challenge of Peace, (May 3, 1983), § 15); and, "If you search for just one rather simple, clear reason why Catholic social teaching holds that dignity is a basic characteristic of every human person, you won't find it. Instead, you'll find two reasons, both rather simple and clear: First reason: God is our Creator; we are created in God's image. A reflection of God is found in all those he created … Second reason: In the Incarnation, Jesus Christ becomes one with the human family's members. All human persons are touched by the reality of the Incarnation, and by Christ's redemptive actions. Christ came for all." (United States Conference of Catholic Bishops, *Recognizing Every Person's God Given Dignity*).

[n]Some additional references:

"The prime purpose of this special commitment to the poor is to enable them to become active participants in the life of society. It is to enable all persons to share in and contribute to the common good. The 'option for the poor' therefore, is not an adversarial slogan that pits one group or class against another. Rather it states that the deprivation and powerlessness of the poor wounds the whole community. The extent of their suffering is a measure of how far we are from being a true community of persons. These wounds will be healed only by greater solidarity with the poor and among the poor themselves." United States Conference of Catholic Bishops, *Economic Justice for All*, (Nov. 1986), §88; and "Each individual Christian and every community is called to be an instrument of God for the liberation and promotion of the poor, and for enabling them to be fully a part of society. This demands that we be docile and attentive to the cry of the poor and to come to their aid."(Pope Francis, *Evangelii Gaudium*, (Nov. 24, 2013) § 187.

Fifth, within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.

Directives

1. A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.
2. Catholic health care should be marked by a spirit of mutual respect among caregivers that disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need.
3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.[p]
4. A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research must adhere to Catholic moral principles. [q]
5. Catholic health care services must adopt these Directives as policy, require adherence to them within the

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[o] Some additional references:

"Every day human interdependence grows more tightly drawn and spreads by degrees over the whole world. As a result the common good, that is, the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment, today takes on an increasingly universal complexion and consequently involves rights and duties with respect to the whole human race. Every social group must take account of the needs and legitimate aspiration of other groups, and even of the general welfare of the entire human family." Vatican Council II, *Gaudium et Spes*, (Dec. 7, 1965) § 26; and "The common good consists of three essential elements: respect for and promotion of the fundamental rights of the person; prosperity, or the development of the spiritual and temporal goods of society; the peace and security of the group and of its members." Catechism of the Catholic Church, (Vatican City: *Libreria Editrice Vaticana* 1993), § 1925; and "The Bible, from the first page on, teaches us that the whole of creation is for humanity, that it is men and women's responsibility to develop it by intelligent effort and by means of their labor to perfect it, so to speak, for their use. If the world is made to furnish each individual with the means of livelihood and the instruments for growth and progress, all people have therefore the right to find in the world what is necessary for them." Paul VI, *Populorum Progressio*, (March 26, 1967) §22

[p] Please see, "Access to Health care for the Poor: Social Responsibility," with Prof. Claudia Sotomayor, MD, DBe of Georgetown University. This is part of the series, Emerging Issues in Catholic Health care Ethics, Year 1, Session 7. and the webinar, "Health Needs of Vulnerable Populations," with Prof. Tim Guffman, Ph.D. of St. Louis University is also topical here. This is Year one and Session 9 of Emerging Issues in Catholic Health care Ethics.

[q] An institutional review board usually focuses on the ethics of human subject research and an ethics committee usually focuses on the ethics of medical practice. The need for these ethics committees is affirmed by several sources including the Joint Commission, the Department of Health and Human Services (HHS), the Federal Drug Administration (FDA), and the Belmont Report. Joint Commission requires a mechanism be available for clinicians to resolve clinical, ethical dilemmas. The HHS, FDA, and the Belmont Report all require a committee to review the ethics of human subject research.

The lines between clinical practice and human research can be fuzzy at times, and the HHS, FDA, and Belmont Report provide guidance on the difference between practice and research for clinicians and staff. Even though these guidelines focus on protecting human research subjects, their standards also apply to clinical situations. For example, the HHS and FDA standards provide guidelines for informed consent. The Belmont Report affirms principles like respect for human persons, beneficence, and justice. The HHS and FDA also provide guidelines for vulnerable populations like children, women and their fetuses, prisoners, and wards of the state.

Research funded by the HHS and/or FDA must follow their guidelines, but even research not funded by them will find their ethical guidance helpful

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.

6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.[10]

7. A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.[r]

8. Catholic health care institutions have a unique relationship to both the Church and the wider community they serve. Because of the ecclesial nature of this relationship, the relevant requirements of canon law will be observed with regard to the foundation of a new Catholic health care institution; the substantial revision of the mission of an institution; and the sale, sponsorship transfer, or closure of an existing institution.[s]

9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives.[t] They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

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in preventing gross human rights violations as seen in the past with the experiments at Nazi concentration camps and with the Tuskegee Syphilis trial, in which a known syphilis cure was intentionally withheld from study participants. Additionally, the Catholic Church includes its own moral tradition to ensure that the teachings of Christ are carried out at each ministry. Since all of these guidelines do not deal with particularities of each situation, the discernment of the diocesan bishop, the clinical team, and the patient are all necessary. Ethics committees and IRBs, ideally, create a space for all voices to be heard.

See The Belmont Report | HHS.gov; DHHS Title 45, Part 46 - 2018 Requirements (2018 Common Rule) | HHS.gov; FDA Title CFR 50 - eCFR :: 21 CFR Part 50 -- Protection of Human Subjects

[r] Catholic Health Association of the United States, "The Church, Its Social Justice Tradition and the Catholic Health Care Ministry as a Just Workplace," St. Louis: Catholic Health Association of the United States, 2011; Catholic Health Association of the United States, "Always with Us: Justice and Catholic Health Care," St. Louis: Catholic Health Association of the United States, 2011; Michael Naughton, "Distributors of Justice: An Essential Quality of Catholic Health care Leaders," *HCEUSA* 28, no. 2 (Summer 2020); Sr. Doris Gottemoeller, "New Ground Rules Smooth Union Relations," *Health Progress* 92, no. 4 (July-August 2011): 54-55; Jeffrey Hamlin, "A 'Just Wage': More than Dollars," *Health Progress* 83, no. 2 (March-April 2002): 43-45.

Also, see the webinar with Michael Naughton, "Distributors of Justice: Achieving Just Wages in Light of Catholic Social Teaching," which was part of our series, Business Ethics and Catholic Health care.

Due to the declining presence of the founders of American Catholic health care in the institutions that they created, there has been an evolving transformation of the ministry that involves a growing role for the laity. Canon law provides the structure of how this transformation is taking place.

[s] See, "Ministerial Juridic Person: The Growing Role for Laity in Canonical Sponsorship in Catholic Health care," Health Progress Vol. 95, no. 5 (Sept.-Oct. 2014); Brian Smith," "Demystifying Who and What Sponsorship Is," *Health Progress* Vol. 98, no. 3 (May-June 2017): 9-11 . Additional articles may be found this same issue of *Health Progress* (May-June 2017); and Charles Bouchard, OP, "Making Ministry Whole: How MJPS Could Transform the Church," *Commonweal* Vol. 146, no. 17 (Nov. 7, 2019)

[t] CHA offers programs and resources for all associate formation to deepen personal and organizational commitment to human dignity and the common good, and ensure the continuity of the Church's healing ministry of Jesus.

PART TWO

The Pastoral and Spiritual Responsibility of Catholic Health Care

Introduction

The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: "I was ill and you cared for me" (Mt 25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death.

Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For[u] this reason, Catholic health care extends to the spiritual nature of the person. "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[11] Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic health care. Pastoral care encompasses the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace[v]. It should be acknowledged, of course, that technological advances in medicine have reduced the length of hospital stays dramatically. It follows, therefore, that the pastoral care of patients, especially administration of the sacraments, will be provided more often than not at the parish level, both before and after one's hospitalization. For this reason, it is essential that there be very cordial and cooperative relationships between the personnel of pastoral care departments and the local clergy and ministers of care.

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[u] See John Paul II, Salvici Dolores "(On the Christian Meaning of Human Suffering)," (Feb. 11, 1984); Sr. Patricia Talone, RSM, "Ethics - Moral Response in the Face of Suffering," *Health Progress* 99, no. 4 (July-August, 2018): 73-75; Nathaniel Blanton Hibner, "Wipe Every Tear from their Eyes," *Health Progress* 100, no. 6 (November-December, 2019): 5-7; and Nathaniel Blanton Hibner, "Spirit Moves Us to Action." *Health Progress* 100, no. 5 (September-October 2019): 64-65.

[v] See George Fitchett, Peter M. Meyer and Laurel Arthur Burton, "Spiritual Care in the Hospital: Who Requests it? Who Needs it? Journal of Pastoral Care (Summer 2000): 173-186 and David Lichter and Mary Lou Gorman, "Establishing a Chaplain's Value," *Health Progress* 90, no. 3 (May-June 2009): 30-33.

Additional resources can be found on the website of the National Association of Catholic Chaplains.

Priests, deacons, religious, and laity exercise diverse but complementary roles in this pastoral care. Since many areas of pastoral care call upon the creative response of these pastoral caregivers to the particular needs of patients or residents, the following directives address only a limited number of specific pastoral activities.

Directives

10. A Catholic health care organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves. Pastoral care personnel—clergy, religious, and lay alike—should have appropriate professional preparation,[w] including an understanding of these Directives.

11. Pastoral care personnel should work in close collaboration with local parishes and community clergy.[x] Appropriate pastoral services and/or referrals should be available to all in keeping with their religious beliefs or affiliation.

12. For Catholic patients or residents, provision for the sacraments is an especially important part of Catholic health care ministry. Every effort should be made to have priests assigned to hospitals and health care institutions to celebrate the Eucharist and provide the sacraments to patients and staff.[y]

13. Particular care should be taken to provide and to publicize opportunities for patients or residents to receive the sacrament of Penance.

14. Properly prepared lay Catholics can be appointed to serve as extraordinary ministers of Holy Communion, in accordance with canon law and the policies of the local diocese. They should assist pastoral care personnel—clergy, religious, and laity—by providing supportive visits, advising patients regarding the availability of priests for the sacrament of Penance, and distributing Holy Communion to the faithful who request it.

15. Responsive to a patient's desires and condition, all involved in pastoral care should facilitate the availability of priests to provide the sacrament of Anointing of the Sick, recognizing that through this

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[w] Generally speaking, most chaplain positions require a Master's degree in theology or a related field and clinical pastoral education certification from a recognized professional association such as the National Association of Catholic Chaplains.

[x] It is incumbent upon the local health care ministry to ascertain the demographic make up and needs of the community being served. Once determined, the health care ministry should reach out to the local faith leaders and establish a connection in order to help meet the needs of all patients, families and staff.

[y] With the declining number of priest chaplains, there is a challenge to provide this sacramental ministry in health care. See Brian Smith, Michael Kramarack, Thomas Gaunt and David Lichter, "Spiritual Care Survey Reveals Challenges for Ministry," *Health Progress* Vol. 100, no. 5 (Sept-Oct 2019): 59-63.

sacrament Christ provides grace and support to those who are seriously ill or weakened by advanced age. Normally, the sacrament is celebrated when the sick person is fully conscious.[z] It may be conferred upon the sick who have lost consciousness or the use of reason, if there is reason to believe that they would have asked for the sacrament while in control of their faculties.

16. All Catholics who are capable of receiving Communion should receive Viaticum when they are in danger of death, while still in full possession of their faculties.[12]
17. Except in cases of emergency (i.e., danger of death), any request for Baptism made by adults or for infants should be referred to the chaplain of the institution. Newly born infants in danger of death, including those miscarried, should be baptized if this is possible.[13] In case of emergency, if a priest or a deacon is not available, anyone can validly baptize.[14] In the case of emergency Baptism, the chaplain or the director of pastoral care is to be notified.
18. When a Catholic who has been baptized but not yet confirmed is in danger of death, any priest may confirm the person.[15]
19. A record of the conferral of Baptism or Confirmation should be sent to the parish in which the institution is located and posted in its baptism/confirmation registers.
20. Catholic discipline generally reserves the reception of the sacraments to Catholics. In accord with canon 844, §3, Catholic ministers may administer the sacraments of Eucharist, Penance, and Anointing of the Sick to members of the oriental churches that do not have full communion with the Catholic Church, or of other churches that in the judgment of the Holy See are in the same condition as the oriental churches, if such persons ask for the sacraments on their own and are properly disposed.

With regard to other Christians not in full communion with the Catholic Church, when the danger of death or other grave necessity is present, the four conditions of canon 844, §4, also must be present, namely, they cannot approach a minister of their own community; they ask for the sacraments on their own; they manifest Catholic faith in these sacraments; and they are properly disposed. The diocesan

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[z] Whenever possible, pastoral care staff should fully understand the spiritual needs of each patient, preferably from the patient themself. The Sacrament of Anointing of the Sick is ideally administered when the patient is conscious and not only at the time of death. This also allows time to locate a priest and schedule the visit in advance.

bishop has the responsibility to oversee this pastoral practice.

21. The appointment of priests and deacons to the pastoral care staff of a Catholic institution must have the explicit approval or confirmation of the local bishop in collaboration with the administration of the institution. The appointment of the director of the pastoral care staff should be made in consultation with the diocesan bishop.

22. For the sake of appropriate ecumenical and interfaith relations, a diocesan policy should be developed with regard to the appointment of non-Catholic members to the pastoral care staff of a Catholic health care institution. The director of pastoral care at a Catholic institution should be a Catholic; any exception to this norm should be approved by the diocesan bishop.[aa]

[aa] As the number of Catholic chaplains and priests continues to decrease in the United States, the hiring of non-Catholic members of the pastoral care staff is an important areas for the mission and pastoral care leader(s) of the organization to consider and regularly discuss with the local bishop. As the shepherd of the diocese, the local bishop especially needs to know if the sacramental needs of Catholic patients and residents are not being met.

PART THREE

The Professional-Patient Relationship

Introduction

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.[bb]

Today, a patient often receives health care from a team of providers, especially in the setting of the modern acute-care hospital. But the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient. The relationship of the person seeking health care and the professionals providing that care is an important part of the foundation on which diagnosis and care are provided. Diagnosis and care, therefore, entail a series of decisions with ethical as well as medical dimensions. The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health, and the compassionate care of the dying, taking into account the patient's convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identity of the health care

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[bb] See Rev. Thomas Nairn, "Who is the Person in Person Centered Care?" *Health Progress* 93, no. 2 (March-April 2012): 92-94.

institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.[cc]

Directives

23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The[dd] institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.[cc]

26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.[ee]

27. Free and informed consent requires that the person or the person's surrogate receive all reasonable

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[cc] See Francis Cardinal George, "The Dignity and Vocation of the Human Person", *Health Progress* Vol. 82, no. 2(March-April 2001): 60-64 and Sr. Jean de Blois and Rev. Kevin O'Rourke, "Safeguarding Patients' Dignity," *Health Progress* 76, no. 5 (June 1995): 39-43, 48.

[dd] There are several ways in which patients can guide others to respect their choices in medical treatments, especially at the end of one's life. Patients should carefully consider their own decisions prior to a crisis. This website offers resources for how to think about choices and to make them known through advance directives.

[ee] See National Conference of Catholic Bishops Committee on Pro-life Activities, "The Rights of the Terminally Ill," July 2, 1986, *Origins 16* (September 4, 1986): 222-24.

information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.[ff]

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.[gg]

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.[16] The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.[17]

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.[hh]

31. No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent.[ii] In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. Moreover, the greater the person's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.[18][jj]

[ff] Rev. Alfred Cioffi, "Distinguishing Between Assisting and Substituting for Vital Organs," *Ethics and Medics* Vol. 41, No. 9 (September 2016): 1-2.

[gg] See Birgitta Sujdak Mackiewicz, "Essential Goals of Ethics Committees and the Role of Professional Ethicists," *National Catholic Bioethics Quarterly*, Vol. 18, No. 1 (Spring 2018): 49-57.

[hh] See John Paul II, *Evangelium vitae*, (April 6, 1995) § 86. and John Paul II, "Blood and Organ Donors," August 2, 1984, *The Pope Speaks* 30, no. 1 (1985): 1-2.

[ii] See Albert S. Moraczewski, OP, "Human Experimentation and Research," in *Bioethics-The Journey Continues*, edited by Fausto B. Gomex, OP, G. Vincent Rosales and Hanzy Bustamente (Manila: University of Santo Tomas, 1997): 3-18.

[jj] See John Paul II, *Evangelium vitae*, (April 6, 1995) § 65 and Pius XII, "The Prolongation of Life," November 24, 1957, *The Pope Speaks* 4 (Spring 1958): 395-96.

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

34. Health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care.[kk]

35. Health care professionals should be educated to recognize the symptoms of abuse and violence and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.[ll]

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.[19][mm]

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends, there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these Directives.[nn]

[kk] On confidentiality, see Pope Pius XII, "Christian Principles and the Medical Profession," Nov. 12, 1944, in *The Human Body: Papal Teachings*, ed. Monks of Solesmes (Boston: St. Paul Editions, Daughters of St. Paul, 1960), 63 and Pope Pius XII, "The Intangibility of the Human Person," Sept. 13, 1952, in *The Human Body: Papal Teachings*, ed. Monks of Solesmes (Boston: St. Paul Editions, Daughters of St. Paul, 1960), 196-197.

[ll] See tools to identify victims of abuse and human trafficking.

[mm] See Ron Hamel, "Thinking Ethically about Emergency Contraception," *Health Progress* 91, no. 1 (January-February 2010): 62-67; Ron Hamel and Michael Panicola, "Emergency Contraception and Sexual Assault," *Health Progress* 83, no. 5 (September-October 2002): 12-19; and Sandra Reznik, M.D., "'Plan B': How It Works" *Health Progress* 91, no. 1 (January-February 2010):59-61.

[nn] Two types of committees address ethical decisions in medical settings: an institutional review board (IRB) and an ethics committee. Ethics consultation in Catholic health care has developed since Directive 37 was first written. While there are still some facilities that use ethics committees, in general, the practice of ethics consultation is shifting toward professionally trained ethicists, who meet professional criteria for practice. CHA's Striving for Excellence in Ethics demonstrates those qualifications, as does the American Society for Bioethics and Humanities Core Competencies.

Resources

Daniel P. Maher, "The Moral Triangle," *Ethics and Medics* 22, no. 5 (May 1997).

Mark Repenshek, "Examining Quality and Value in Ethics Consultation Services," *The National Catholic Bioethics Quarterly* 18, no. 1 (Spring 2018): 59-68.

Nicholas J. Kockler and Kevin M. Dirksen, "Integrating Ethics Services in a Catholic Health System in Oregon," *The National Catholic Bioethics Quarterly* 18, no. 1 (Spring 2018): 113-34.

Matthew R. Kenney, "A System Approach to Proactive Ethics Integration," *The National Catholic Bioethics Quarterly* 18, no. 1 (Spring 2018): 93-112.

PART FOUR

Issues in Care for the Beginning of Life

Introduction

The Church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life "from the moment of conception until death."[20] The Church's defense of life encompasses the unborn and the care of women and their children during and after pregnancy. The Church's commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to provide adequate health care to mothers and their children before and after birth.

The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being. The Second Vatican Council affirms:

> This love is an eminently human one. . . . It involves the good of the whole person. . . . The actions within marriage by which the couple are united intimately and chastely are noble and worthy ones. Expressed in a manner which is truly human, these actions signify and promote that mutual self-giving by which spouses enrich each other with a joyful and a thankful will.[21]
>
> Marriage and conjugal love are by their nature ordained toward the begetting and educating of children. Children are really the supreme gift of marriage and contribute very substantially to the welfare of their parents. . . . Parents should regard as their proper mission the task of transmitting

> human life and educating those to whom it has been transmitted. . . . They are thereby cooperators with the love of God the Creator, and are, so to speak, the interpreters of that love.[22]

For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. The Church cannot approve contraceptive interventions that "either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible."[23] Such interventions violate "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning."[24]***oo***

With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential for good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity. Just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act. As Pope John XXIII observed:

> The transmission of human life is entrusted by nature to a personal and conscious act and as such is subject to all the holy laws of God: the immutable and inviolable laws which must be recognized and observed. For this reason, one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals.[25]

Because the moral law is rooted in the whole of human nature, human persons, through intelligent reflection on their own spiritual destiny, can discover and cooperate in the plan of the Creator.[26]***pp***

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oo While many Catholics assume that the debate about contraception began with the promulgation of *Humanae Vitae* in 1968, in fact, the discussion has been with the Church for centuries. In opposition to paganism, the Church affirmed the fundamental goodness of procreation, and the prohibition against interfering with the conjugal act. That remained the stance of all Christian churches until the early 20th c. In fact, Martin Luther and John Calvin were vehement about the goodness of procreation.

That changed in 1930, when the Anglican Church approved a resolution at their Lambeth conference, which permitted married couples to use means other than abstinence to control their fertility. In the years following, most of the major Protestant churches followed the Anglicans. In response, Pope Pius XII reaffirmed the Catholic position on the control of fertility in *Casti Connubbii* (Dec. 31, 1930) § 56.

pp For an overview of Part 4 of the ERDs, please see Sr. Jean de Blois and Rev. Kevin O'Rourke, "Care for the Beginning of Life," *Health Progress* 76, no. 6 (September-October 1995): 36-40.

Directives

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.[27]

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.[qq]

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.[28]

41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).[29] [rr]

42. Because of the dignity of the child and of marriage, and because of the uniqueness of the mother-child relationship, participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.[30]

43. A Catholic health care institution that provides treatment for infertility should offer not only technical assistance to infertile couples but also should help couples pursue other solutions (e.g., counseling,[ss] adoption).

44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers

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[qq] See Richard J. Fehring, R.N., "The Catholic Physician and Family Planning: Building a Culture of Life," *National Catholic Bioethics Quarterly* Vol. 9, No. 2 (Spring 2009): 305-323.

[rr] A further application of this directive is the Catholic facilities will not participate in post-mortem sperm collection, even if the couple had been married.

[ss] Please see the Diocese of Arlington's website.

and their children in a manner consonant with its mission.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted.[tt] Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

46. Catholic health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion.[uu]

47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.[vv]

48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.[31][ww]

49. For a proportionate reason, labor may be induced after the fetus is viable.[xx]

50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.[32]

51. Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents or, if the father cannot be contacted, at least of the mother. Medical research that

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[tt] There are three important points for a proper understanding of the definition of abortion in Directive 45. First, the use of "intention" here refers both to the proximate subjective intention of the agent(s) (finis operantis) and the intention of the act itself (finis operis). Second, "termination of pregnancy" in the definition includes every procedure whose sole immediate effect is the cessation of an embryo's or a fetus's life. Third, it needs to be determined in each case whether there is a sole immediate effect of the procedure or if there are two immediate effects (one good and the other bad). For the latter, an appropriate application of the Principle of the Double Effect is required to assess the moral status of the procedure. A procedure that would not violate Directive 45 would be performing a hysterectomy on a woman with uterine cancer, when the sole immediate effect of the procedure is a therapeutic intervention for the cancer (see Directive 47).

See also Brian M. Kane, PhD, "What is Abortion?" *Health Progress* 104, no. 1 (Winter 2023).

[uu] The Project Rachel Ministry is a valuable resource for addressing the grief of a pregnancy loss.

[vv] Similar to the use of "intention" in Directive 45, "direct purpose" here refers both to the proximate subjective intention of the agent(s) (finis operantis) and the intention of the act itself (finis operis).

See, Hamel, Ron, Ph.D. "Early Pregnancy Complications and the ERDs." HCEUSA 48-56 (Winter 2014); Cataldo, Goodwin, and Pierucci. "Early Induction of Labor." *Catholic Health Care Ethics: A Manual for Practitioners, 3rd Edition.*

[ww] For addressing ectopic pregnancies, there are several possible approaches. There has been significant theological discussion on the permissibility of those approaches, especially salpingectomy, salpingostomy, methotrexate, and expectant management. In general, the consensus among theologians has been that it is moral to treat the medical condition, even when it is foreseen that the embryo will die as an indirect result.

See, Peter, A. Clark, S.J, "Methotrexate and Tubal Pregnancies: Direct or Indirect Abortion?" *Linacre Quarterly* 67: 1 (February 2000): 7–24; Ron Hamel, "Catholic Hospitals and Ectopic Pregnancies," HCEUSA 19, no. 1 (Winter 2011); William E. May, "Methotrexate and Ectopic Pregnancy," *Ethics & Medics* 23: 3 (March 1998): 1-3; William E. May, "The Management of Ectopic Pregnancies: A Moral Analysis," *The Fetal Tissue Issue: Medical and Ethical Aspects*, ed.; Peter J. Cataldo and Albert S. Moraczewski, O.P., (Braintree, Mass.: Pope John Center, 1994), 121-47; Albert S. Moraczewski, O.P., "Ectopic Pregnancy Revisited," *Ethics & Medics* 23: 3 (March 1998): 3-4; Albert S. Moraczewski, O.P., "Tubal Pregnancies: Part I," *Ethics & Medics* 21: 6 (June 1996): 3-4; Albert S. Moraczewski, O.P., "Tubal Pregnancies: Part II," *Ethics & Medics* 21: 8 (August 1996): 3-4; and Jack Healy, "Ectopic Pregnancy and Methotrexate," *Linacre Quarterly* 63: 3 (August 1996): 95-96.

will not harm the life or physical integrity of an unborn child is permitted with parental consent.[33]

52. 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 parenthood and in methods of natural family planning.[yy]

53. 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.[34][zz]

54. Genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects, in accordance with Catholic moral teaching and the intrinsic rights and obligations of married couples regarding the transmission of life.

[xx] It is important to note that the age of viability is a changing standard. Viability is dependent on the medical resources in a particular place. Viability will be different in individual facilities. Level I to level V trauma facilities, for example, will have different resources to manage difficult pregnancies. Also, of course, viability will change in international circumstances.

[yy] Sometimes contraceptive medications and devices (e.g. IUDs) are used directly to treat other medical conditions. When both the object of the act and the intent is to treat a medical condition and not avoid conception, and when there is a moral ceritude that the medication will not be abortifacient, Catholic institutions allow the prescription and provision of these medical interventions.

[zz] See Rev. Kevin O'Rourke, OP , "Catholic Health Care and Sterilization," *Health Progress* 83, no. 6 (November-December 2002): 43-48.

See The Congregation of the Doctrine of the Faith "Responses to Questions Proposed Concerning Uterine Isolation and Related Matters," July 31, 1993; Congregation for the Doctrine of the Faith, "Response to a Question on the Liceity of a Hysterectomy in Certain Cases" December 10, 2018; Sr. Patricia Talone, RSM and Amy Warner, "Ethics and Medical Standards of Care: Hysterectomy, Tubal Ligation or Salpingectomy?" *HCEUSA* 27, no. 1 (Winter 2019); Charles Bouchard, OP and Nathaniel Blanton Hibner, "A New Look at the Liceity of Hysterectomy in Certain Cases," *HCEUSA* 27, No. 1(Winter 2019); and Peter Cataldo, "The CDF's Response to a Question of the Liceity of a Hysterectomy in Certain Cases: A Fundamental Turn," *HCEUSA* 27, No. 2 (Spring 2019).

The 2018 Responsum leaves unresolved the question of how to address future foreseen pregnancies that may be hazardous to the health of the mother where the same justifying moral conditions articulated in the 2018 Responsum exist.

PART FIVE

Issues in Care for the Seriously Ill and Dying

Introduction

Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.[35] The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death—for many, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life.[36]***aaa***

Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying.***bb***

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

The task of medicine is to care even when it cannot cure.***ccc*** Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning

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aaa See The Congregation for the Doctrine of the Faith, "*Samaritanus bonus*," (On the Care of Persons in the Critical and Terminal Phases of Life), September 22, 2020 and Johnny Cox, RN, "Selected Comments of the Congregation of the Doctrine of the Faith's letter, Samaritanus bonus," *HCEUSA* 28, no. 3.

bbb The medical subspeciality that has as its purpose the alleviation of pain is palliative care. For an overview of the field, please see The Catholic Health Association of the U.S., "Special Section: Palliative Care," *Health Progress* 92, no. 1 (January-February 2011): 10-57.

It is also important to distinguish palliative care from hospice. Hospice is comfort care at the end of life that address a person's physical, mental and spiritual needs. Hospice always includes palliative care.

Please see CHA, Living Well with Serious Illness and Caring for People at the End of Life.

ccc The challenges of making decisions for end of life care are even more acute for children. Please see the CHA webinar with Dr Erica Salter of St. Louis University on "When a Child Dies: End of Life Decision Making in Pediatrics," which is part of our series, Emerging Issues in *Catholic Health care Ethics*, Year one, Session Six.

of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.[37]

The Church's teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against euthanasia, which is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[38] While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.[ddd]

Directives

55. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.[eee]
56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.[39]
57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive

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[ddd] See Congregation for the Doctrine of the Faith, "Response to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," (August 1, 2007); Fr. Myles Sheehan, SJ, MD, "Feeding Tubes: Sorting out the Issues," *Health Progress* 82, no. 6 (November-December 2001):22-27; Michael Panicola, "Withdrawing Nutrition and Hydration: The Catholic Tradition Offers Guidance for the Treatment of Patients in a Persistent Vegetative State," *Health Progress* 82, no. 6 (November-December 2001): 28-33; Patrick Guinan, MD, "Is Assisted Nutrition and Hydration always Mandated?" *National Catholic Bioethics Quarterly* 10, no. 3 (Autumn 2010): 481-488; Alan Sanders, "The Clinical Reality of Artificial Nutrition and Hydration for Patients at the End of Life," *National Catholic Bioethics Quarterly* 9, no. 2 (Summer 2009): 293-304.

Also, please see our webinar with Fr. Myles Sheehan, SJ, MD, on the topic of "Medically Assisted Nutrition and Hydration," which is part of our series, Emerging Issues in Catholic Health care Ethics, Year one, Session 4.

[eee] See our webinar with Dr. Allen Roberts of Georgetown University in the CHA series, "Emerging Issues in Catholic Health care Ethics," Year one, Session 10, "End of Life Decision Making in the Intensive Care Unit," and also Alex Fleming, "Two Alternatives to Intensive Care," *Ethics and Medics*, Vol. 42, No. 1 (Jan. 2017): 3-4.

burden, or impose excessive expense on the family or the community.[fff]

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.[40] Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed."[41] For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.[ggg]

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.[42][hhh]

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing

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[fff] See Rev. Kevin O'Rourke, "The Catholic Tradition of Forgoing Life Support," *National Catholic Bioethics Quarterly* 5, no. 3 (Autumn 2005): 537-553.

See Cronin, Daniel A. *Ordinary and Extraordinary Means of Conserving Human Life.* (Philadelphia: The National Catholic Bioethics Center, 2011).

[ggg] See Fr. Myles Sheehan, SJ, MD, "Medically Assisted Nutrition and Hydration," in the CHA series, "Emerging Issues in Catholic Health care Ethics," Year one, Session 4: and Myles Sheehan, SJ, "Feeding Tubes in Advanced Dementia and Ischemic Stroke," *HCEUSA* 24, no. 1 (Winter 2016); and Ron Hamel, and Rev. Thomas Nairn, "The New Directive 58: What Does It Mean?" *Health Progress* 91, no. 1 (January-February 2010): 70-72.

[hhh] See Nathaniel Blanton Hibner, "Ars Moriendi and Society," *HCEUSA* 27, no. 4 (Fall 2019)

suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.[iii]

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.[iii]

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.[43]

[iii] See John Haas, "Catholic Teaching regarding the Legitimacy of Neurological Criteria for the Determination of Death," *National Catholic Bioethics Quarterly* 11, no. 2 (Summer 2011): 279-299 and A.Battro et al., "Why the Concept of Brain Death Is Valid as a Definition of Death: Statement by Neurologists and Others," in *Signs of Death: Proceedings of the Working Group of 11–12 September 2006*, ScriptaVaria110 (Vatican City: Pontifical Academy of Sciences, 2007): XXI-XXIX.

Also see our webinar, with Fr. Myles Sheehan, SJ, MD, and Kevin Donovan, MD, of Georgetown University on the topic, "Brain Death: Are Neurological Criteria Sufficient for Declaring Death?" in our series, Emerging Topics in Catholic Health care Ethics, Year 1, Session 1.

[iii] See Peter A. Clark, S.J., ""A Catholic Perspective on Organ Doanation After Cardiac Death," in Jason T. Eberl, Ed. Contemporary Controversies in Catholic Bioethics (Cham, Switzerland: Springer Press, 2017) 499-513.

PART SIX

Collaborative Arrangements with Other Health Care Organizations and Providers[44]

Introduction

In and through her compassionate care for the sick and suffering members of the human family, the Church extends Jesus' healing mission and serves the fundamental human dignity of every person made in God's image and likeness. Catholic health care, in serving the common good, has historically worked in collaboration with a variety of non-Catholic partners.[kkk] Various factors in the current health care environment in the United States, however, have led to a multiplication of collaborative arrangements among health care institutions, between Catholic institutions as well as between Catholic and non-Catholic institutions.

Collaborative arrangements can be unique and vitally important opportunities for Catholic health care to further its mission of caring for the suffering and sick, in faithful imitation of Christ. For example, collaborative arrangements can provide opportunities for Catholic health care institutions to influence the healing profession through their witness to the Gospel of Jesus Christ. Moreover, they can be opportunities to realign the local delivery system to provide a continuum of health care to the community, to provide a model of a responsible stewardship of limited health care resources, to provide poor and vulnerable persons with more equitable access to basic care, and to provide access to medical technologies and expertise that greatly enhance the quality of care. Collaboration can even, in some instances, ensure the continued presence of a Catholic institution, or the presence of any health care facility at all, in a given area.

When considering a collaboration, Catholic health care administrators should seek first to establish arrangements with Catholic institutions or other institutions that operate in conformity with the Church's moral teaching. It is not uncommon, however, that arrangements with Catholic institutions are not practicable and that, in pursuit of the common good, the only available candidates for collaboration are institutions that do not operate in conformity with the

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[kkk] See St. John XXII on the intersection of the obligations to act charitably and avoid illicit cooperation in wrongdoing: "In their economic and social activities, Catholics often come into contact with others who do not share their view of life. In such circumstances, they must, of course, bear themselves as Catholics and do nothing to compromise religion and morality. Yet at the same time they should show themselves animated by a spirit of understanding and unselfishness, ready to cooperate loyally in achieving objects which are good in themselves, or can be turned to good." (*Mater et Magistra*, n. 239)

Church's moral teaching.

Such collaborative arrangements can pose particular challenges if they would involve institutional connections with activities that conflict with the natural moral law, church teaching, or canon law. Immoral actions are always contrary to "the singular dignity of the human person, 'the only creature that God has wanted for its own sake.'"[45] It is precisely because Catholic health care services are called to respect the inherent dignity of every human being and to contribute to the common good that they should avoid, whenever possible, engaging in collaborative arrangements that would involve them in contributing to the wrongdoing of other providers.

The Catholic moral tradition provides principles for assessing cooperation with the wrongdoing of others to determine the conditions under which cooperation may or may not be morally justified, distinguishing between "formal" and "material" cooperation. *Formal* cooperation "occurs when an action, either by its very nature or by the form it takes in a concrete situation, can be defined as a direct participation in an [immoral] act . . . or a sharing in the immoral intention of the person committing it."[46] Therefore, cooperation is formal not only when the cooperator shares the intention of the wrongdoer, but also when the cooperator directly participates in the immoral act, even if the cooperator does not share the intention of the wrongdoer, but participates as a means to some other end. Formal cooperation may take various forms, such as authorizing wrongdoing, approving it, prescribing it, actively defending it, or giving specific direction about carrying it out. Formal cooperation, in whatever form, is always morally wrong.

The cooperation is *material* if the one cooperating neither shares the wrongdoer's intention in performing the immoral act nor cooperates by directly participating in the act as a means to some other end, but rather contributes to the immoral activity in a way that is causally related but not essential to the immoral act itself. While some instances of material cooperation are morally wrong, others are morally justified. There are many factors to consider when assessing whether or not material cooperation is justified, including: whether the cooperator's act is morally good or neutral in itself, how significant is its causal contribution to the wrongdoer's act, how serious is the immoral act of the wrongdoer, and how important are the goods to be

preserved or the harms to be avoided by cooperating. Assessing material cooperation can be complex, and legitimate disagreements may arise over which factors are most relevant in a given case. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation.

Any moral analysis of a collaborative arrangement must also take into account the danger of scandal, which is "an attitude or behavior which leads another to do evil."[47] The cooperation of a Catholic institution with other health care entities engaged in immoral activities, even when such cooperation is morally justified in all other respects, might, in certain cases, lead people to conclude that those activities are morally acceptable. This could lead people to sin. The danger of scandal, therefore, needs to be carefully evaluated in each case. In some cases, the danger of scandal can be mitigated by certain measures, such as providing an explanation as to why the Catholic institution is cooperating in this way at this time. In any event, prudential judgments that take into account the particular circumstances need to be made about the risk and degree of scandal and about whether they can be effectively addressed.

Even when there are good reasons for establishing collaborative arrangements that involve material cooperation with wrongdoing, leaders of Catholic health care institutions must assess whether becoming associated with the wrongdoing of a collaborator will risk undermining their institution's ability to fulfill its mission of providing health care as a witness to the Catholic faith and an embodiment of Jesus' concern for the sick. They must do everything they can to ensure that the integrity of the Church's witness to Christ and his Gospel is not adversely affected by a collaborative arrangement.

In sum, collaborative arrangements with entities that do not share our Catholic moral tradition present both opportunities and challenges. The opportunities to further the mission of Catholic health care can be significant. The challenges do not necessarily preclude all such arrangements on moral grounds, but they do make it imperative for Catholic leaders to undertake careful analyses to ensure that new collaborative arrangements—as well as those that already exist—abide by the principles governing cooperation, effectively address the risk of scandal, abide by canon law, and sustain the Church's witness to Christ and his saving message.

While the following Directives are offered to assist Catholic health care institutions in analyzing the moral considerations of collaborative arrangements, the ultimate responsibility for interpreting and applying of the Directives rests with the diocesan bishop.[lll]

Directives

67. Each diocesan bishop has the ultimate responsibility to assess whether collaborative arrangements involving Catholic health care providers operating in his local church involve wrongful cooperation, give scandal,[mmm] or undermine the Church's witness. In fulfilling this responsibility, the bishop should consider not only the circumstances in his local diocese but also the regional and national implications of his decision.

68. When there is a possibility that a prospective collaborative arrangement may lead to serious adverse consequences for the identity or reputation of Catholic health care services or entail a risk of scandal, the diocesan bishop is to be consulted in a timely manner. In addition, the diocesan bishop's approval is required for collaborative arrangements involving institutions subject to his governing authority; when they involve institutions not subject to his governing authority but operating in his diocese, such as those involving a juridic person erected by the Holy See, the diocesan bishop's *nihil obstat* is to be obtained.

69. In cases involving health care systems that extend across multiple diocesan jurisdictions, it remains the responsibility of the diocesan bishop of each diocese in which the system's affiliated institutions are located to approve locally the prospective collaborative arrangement or to grant the requisite *nihil obstat*, as the situation may require. At the same time, with such a proposed arrangement, it is the duty of the diocesan bishop of the diocese in which the system's headquarters is located to initiate a collaboration with the diocesan bishops of the dioceses affected by the collaborative arrangement. The bishops involved in this collaboration should make every effort to reach a consensus.

[lll] See CHA Ethicists, "US Bishops Revise Part Six of the Ethical and Religious Directives," *HCEUSA* 26, no.3 (Summer 2018) and John Gallagher, "Reflections on the Revisions to Part Six of the ERDs," *HCEUSA* 26, no. 6 (Fall 2018).

As a general resource, see CHA's web page on The Principle of Cooperation.

[mmm] See Nathaniel Blanton Hibner, "Ethics - Scandal: Delving Into Popular Versus Theological Definitions," *Health Progress* 99, no. 6 (November-December 2018): 71-72.

70. Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.[48]

71. When considering opportunities for collaborative arrangements that entail material cooperation in wrongdoing, Catholic institutional leaders must assess whether scandal[49] might be given and whether the Church's witness might be undermined. In some cases, the risk of scandal can be appropriately mitigated or removed by an explanation of what is in fact being done by the health care organization under Catholic auspices. Nevertheless, a collaborative arrangement that in all other respects is morally licit may need to be refused because of the scandal that might be caused or because the Church's witness might be undermined.

72. The Catholic party in a collaborative arrangement has the responsibility to assess periodically whether the binding agreement is being observed and implemented in a way that is consistent with the natural moral law, Catholic teaching, and canon law.

73. Before affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures.

74. In any kind of collaboration, whatever comes under the control of the Catholic institution— whether by acquisition, governance, or management—must be operated in full accord with the moral teaching of the Catholic Church, including these Directives.

75. It is not permitted to establish another entity that would oversee, manage, or perform immoral procedures. Establishing such an entity includes actions such as drawing up the civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity.

76. Representatives of Catholic health care institutions who serve as members of governing boards of non-Catholic health care organizations that do not adhere to the ethical principles regarding health care articulated by the Church should make their opposition to immoral procedures known and not give their

consent to any decisions proximately connected with such procedures. Great care must be exercised to avoid giving scandal or adversely affecting the witness of the Church.

77. If it is discovered that a Catholic health care institution might be wrongly cooperating with immoral procedures, the local diocesan bishop should be informed immediately and the leaders of the institution should resolve the situation as soon as reasonably possible.

Conclusion

Sickness speaks to us of our limitations and human frailty. It can take the form of infirmity resulting from the simple passing of years or injury from the exuberance of youthful energy. It can be temporary or chronic, debilitating, and even terminal. Yet the follower of Jesus faces illness and the consequences of the human condition aware that our Lord always shows compassion toward the infirm.

Jesus not only taught his disciples to be compassionate, but he also told them who should be the special object of their compassion. The parable of the feast with its humble guests was preceded by the instruction: "When you hold a banquet, invite the poor, the crippled, the lame, the blind" (Lk 14:13). These were people whom Jesus healed and loved.

Catholic health care is a response to the challenge of Jesus to go and do likewise. Catholic health care services rejoice in the challenge to be Christ's healing compassion in the world and see their ministry not only as an effort to restore and preserve health but also as a spiritual service and a sign of that final healing that will one day bring about the new creation that is the ultimate fruit of Jesus' ministry and God's love for us.

Notes

1. United States Conference of Catholic Bishops, Health and Health Care: A Pastoral Letter of the American Catholic Bishops (Washington, DC: United States Conference of Catholic Bishops, 1981).
2. Health care services under Catholic auspices are carried out in a variety of institutional settings (e.g., hospitals, clinics, outpatient facilities, urgent care centers, hospices, nursing homes, and parishes). Depending on the context, these Directives will employ the terms "institution" and/or "services" in order to encompass the variety of settings in which Catholic health care is provided.
3. Health and Health Care, p. 5.
4. Second Vatican Ecumenical Council, Decree on the Apostolate of the Laity (Apostolicam Actuositatem) (1965), no. 1.
5. Pope John Paul II, Post-Synodal Apostolic Exhortation On the Vocation and the Mission of the Lay Faithful in the Church and in the World (Christifideles Laici) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 29.
6. As examples, see Congregation for the Doctrine of the Faith, Declaration on Procured Abortion (1974); Congregation for the Doctrine of the Faith, Declaration on Euthanasia (1980); Congregation for the Doctrine of the Faith, Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day (Donum Vitae) (Washington, DC: United States Conference of Catholic Bishops, 1987).
7. Pope John XXIII, Encyclical Letter Peace on Earth (Pacem in Terris) (Washington, DC: United States Conference of Catholic Bishops, 1963), no. 11; Health and Health Care, pp. 5, 17-18; Catechism of the Catholic Church, 2nd ed. (Washington, DC: Libreria Editrice Vaticana–United States Conference of Catholic Bishops, 2000), no. 2211.
8. Pope John Paul II, On Social Concern, Encyclical Letter on the Occasion of the Twentieth Anniversary of "Populorum Progressio" (Sollicitudo Rei Socialis) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.
9. United States Conference of Catholic Bishops, Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy (Washington, DC: United States Conference of Catholic Bishops, 1986), no. 80.
10. The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic institutionally based health care services must be attentive to occasions when the policies and practices of other institutions are not compatible with the Church's authoritative moral teaching. At such times, Catholic health care institutions should determine whether or to what degree collaboration would be morally permissible. To make that judgment, the governing boards of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.
11. Health and Health Care, p. 12.
12. Cf. Code of Canon Law, cc. 921-923.
13. Cf. ibid., c. 867, § 2, and c. 871.
14. To confer Baptism in an emergency, one must have the proper intention (to do what the Church intends by Baptism) and pour water on the head of the person to be baptized, meanwhile pronouncing the words: "I baptize you in the name of the Father, and of the Son, and of the
Holy Spirit." 15. Cf. c. 883, 3º.
16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.
17. Cf. directive 53.
18. Declaration on Euthanasia, Part IV; cf. also directives 56-57.
19. It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," Origins 22 (1993): 810.
20. Pope John Paul II, "Address of October 29, 1983, to the 35th General Assembly of the World Medical

Association," Acta Apostolicae Sedis 76 (1984): 390.
21. Second Vatican Ecumenical Council, Pastoral Constitution on the Church in the Modern World (Gaudium et Spes) (1965), no. 49.
22. Ibid., no. 50.
23. Pope Paul VI, Encyclical Letter On the Regulation of Birth (Humanae Vitae) (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 14.
24. Ibid., no. 12.
25. Pope John XXIII, Encyclical Letter Mater et Magistra (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, Donum Vitae, no. 4.
26. Pope John Paul II, Encyclical Letter The Splendor of Truth (Veritatis Splendor) (Washington, DC: United States Conference of Catholic Bishops, 1993), no. 50.
27. "Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose" (Donum Vitae, Part II, B, no. 6; cf. also Part I, nos. 1, 6).
28. Ibid., Part II, A, no. 2.
29. "Artificial insemination as a substitute for the conjugal act is prohibited by reason of the voluntarily achieved dissociation of the two meanings of the conjugal act. Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: even when it is done for the purpose of procreation, the act remains deprived of its unitive meaning: 'It lacks the sexual relationship called for by the moral order, namely, the relationship which realizes "the full sense of mutual self-giving and human procreation in the context of true love"'" (Donum Vitae, Part II, B, no. 6).
30. Ibid., Part II, A, no. 3.
31. Cf. directive 45.
32. Donum Vitae, Part I, no. 2.
33. Cf. ibid., no. 4. (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.
34. Cf. Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," July 31, 1993, Origins 24 (1994): 211-212.
35. Pope John Paul II, Apostolic Letter On the Christian Meaning of Human Suffering (Salvifici Doloris) (Washington, DC: United States Conference of Catholic Bishops, 1984), nos. 25-27.
36. United States Conference of Catholic Bishops, Order of Christian Funerals (Collegeville, Minn.: The Liturgical Press, 1989), no. 1.
37. See Declaration on Euthanasia.
38. Ibid., Part II.
39. Ibid., Part IV; Pope John Paul II, Encyclical Letter On the Value and Inviolability of Human Life (Evangelium Vitae) (Washington, DC: United States Conference of Catholic Bishops, 1995), no. 65.
40. See Pope John Paul II, Address to the Participants in the International Congress on "LifeSustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), no. 4, where he emphasized that "the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act." See also Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration" (August 1, 2007).
41. Congregation for the Doctrine of the Faith, Commentary on "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration."
42. See Declaration on Euthanasia, Part IV.
43. Donum Vitae, Part I, no. 4.
44. See: Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with nonCatholic Entities in the Provision of Health care Services," published in The National Catholic Bioethics Quarterly (Summer 2014), 337-40.
45. Pope John Paul II, Veritatis Splendor, no. 13.
46. Pope John Paul II, Evangelium Vitae, no. 74.

47. Catechism of the Catholic Church, no. 2284.

48. While there are many acts of varying moral gravity that can be identified as intrinsically evil, in the context of contemporary health care the most pressing concerns are currently abortion, euthanasia, assisted suicide, and direct sterilization. See Pope John Paul II's Ad Limina Address to the bishops of Texas, Oklahoma, and Arkansas (Region X), in Origins 28 (1998): 283. See also "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (Quaecumque Sterilizatio), March 13, 1975, Origins 6 (1976): 33-35: "Any cooperation institutionally approved or tolerated in actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end . . . 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." This directive supersedes the "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" published by the National Conference of Catholic Bishops on September 15, 1977, in Origins 7 (1977): 399-400.

49. See Catechism of the Catholic Church: "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (no. 2287).

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