

# A Short Walk Through The ERDs: A Practical Approach

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## Purpose of *ERDs*

p.2

- To reaffirm ethical standards that flow from Church's teaching
- To provide authoritative guidance on certain moral issues facing Catholic Health Care

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## Expectations regarding the ERDs

pp. 10-11 Directives 5,6

5. Catholic health care services **must** adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.
9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

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## Situating Catholic Health Care

General introduction pp. 4-7

- **The Church** has always sought to embody our Savior's Concern for the sick,
- **Christian love as animating principle of health care,**
- **healing and compassion as a continuation of Christ's mission**

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## Situating.....

p6.

- 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.

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## Format of *ERDs*

- **Preamble**
- **General Introduction**

The six parts which each include:

1. Exposition which provides context, and
2. Prescriptive forms bearing on concrete issues.

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## Theological Foundation of the ERDs

pp. 1-3

- Medical/Moral Tradition of the Church
- Flowing principally from Natural Law understood in the revelation of Christ
- “Presuppose” Bishops Statement Health and Health Care

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## Natural Law

A Process of Reasoning Based upon Natural Inclinations

- Preserve human life
- Generate and educate offspring
- Form community
- Seek truth

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## The ERDs Contain Six Parts

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|---|--|
| 1. <b>Social Responsibility</b>                   | 4. <b>Care for the Beginning of Life</b> |
| 2. <b>Pastoral &amp; Spiritual Responsibility</b> | 5. <b>Care for the Dying</b>             |
| 3. <b>Professional-Patient Relationship</b>       | 6. <b>Forming New Partnerships</b>       |

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**PART 1: THE SOCIAL RESPONSIBILITY OF CATHOLIC HEALTH CARE SERVICES (intro)**

**pp. 8-9 Four (or Five) Normative Principles**

- 1. Human dignity**
- 2. Care for the poor**
- 3. Common Good**
- 4. Responsible stewardship of resources**
- **“Catholic health care does not offend the rights of individual conscience by refusing to provide medical procedures judged morally wrong by teaching authority of Church.”**

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**PART 1: THE SOCIAL RESPONSIBILITY OF CATHOLIC HEALTH CARE SERVICES**

**PART 1 Workplace Considerations**

- #1 & #2 &7:
  - “A Catholic institutional health care service is a *community* that provides health care...[and] should be marked by a spirit of *mutual respect*...”
  - Catholic health care institution must treat its employees respectfully and justly...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.

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**PART 1: THE SOCIAL RESPONSIBILITY OF CATHOLIC HEALTH CARE SERVICES**

**PART 1 Workplace Considerations**

- #5,#9 :
  - require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.
  - Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives.

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**PART 1: THE SOCIAL RESPONSIBILITY OF CATHOLIC HEALTH CARE SERVICES**

PART: 1 Care for the Poor:

- #6 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.

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Part 1: Practical Considerations

Three principles regarding work life required by the ERDs:

1. Create an environment for workers to be in community with one another: regardless of position, title etc.
2. Workers must find meaning/purpose in their work.
3. Workers must have a voice in matters that affect them.

Responsibilities regarding adherence/training of the directives.

- Basic knowledge for all co-workers.
- Deeper/more specific knowledge for medical staff, clinical co-workers
- Greater understanding for leaders depending upon their position.

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Part 1: Practical Considerations cont.

Responsibilities flowing from Directive 3:

- How do we reach out to the groups in Directive Three?
- How does our community benefit program reflect the priorities of the poor? Metrics: % care for the poor v. broader community.
- How do our organizational decisions reflect a preferential option for the poor?

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**PART 2: THE PASTORAL AND SPIRITUAL RESPONSIBILITY OF CATHOLIC HEALTH CARE**

Intro:

“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.”

*"Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."*

- PART 2 includes:  
Directives # 10 through #22.  
Several specific prescriptions regarding spiritual care of the sick:

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**PART 2: THE PASTORAL AND SPIRITUAL RESPONSIBILITY OF CATHOLIC HEALTH CARE**

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, including an understanding of these Directives.
11. Pastoral care personnel should work in close collaboration with local parishes and community clergy.
- 12-17 Importance of availability and provision of the sacraments esp. Eucharist, penance, baptism, confirmation.
- 21,22 Relationship with Diocesan Bishop regarding clergy appointments to pastoral staff and non-Catholic pastoral staff members.

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**PART 2: Practical Considerations**

- Spiritual care not the domain of pastoral care department alone.
- Duty to involve all staff in spiritual care of the patient
- Having said that, a minimum duty to maintain sufficient pastoral staff.
- How much emphasis placed on holistic care vs. technology?
- Directive 11 does not mandate ecumenical departments but I think implicitly argues that pastoral staff should be able to meet the needs of ecumenical inter-religious population being served.
- Critical nature of the sacraments.
- Work with Bishop, local pastors for provision of the sacraments.
- Collaboration with Bishop regarding clergy appointments.
- Director of pastoral care appointment in consultation with Bishop. Typically Catholic, although Bishop can approve otherwise.

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**PART 3: THE PROFESSIONAL-PATIENT RELATIONSHIP**

**Intro:**

- *“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.”*
- *“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. “*

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**PART 3: THE PROFESSIONAL-PATIENT RELATIONSHIP**

#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.

#24-27 Commonly held notions with secular ethics regarding informed consent, advance directives, surrogate decision-making, emergency exception to informed consent etc.

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

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**PART 3: THE PROFESSIONAL-PATIENT RELATIONSHIP**

**#32 & 33: Discussion of benefits vs. risks/burdens.**

- **#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.”

#36: Re treatment of sexual assault victim, “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.”

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**PART 3: THE PROFESSIONAL-PATIENT RELATIONSHIP**

**#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.”**

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**PART 3: THE PROFESSIONAL-PATIENT RELATIONSHIP-  
Practical Considerations**

- Realistic staffing levels for health care providers to enable care for the patient at a quality presupposed by the directives.
- Adequate staffing to assist patients with treatment decisions especially regarding advance directives, treatment decisions.
- Information provided to patients describing when we will not honor advance directives in keeping with #24.
- Protocols surrounding treatment of sexual assault victims (pregnancy approach v. ovulation approach.)
- Ethics committee existence **and** expertise.
- Dialogue with Diocesan Bishop regarding #37.

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**PART 4: ISSUES IN CARE FOR THE BEGINNING OF LIFE**

**Intro: “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.”**

**Two Fundamental Principles Guiding Part IV**  
Sanctity of life  
Dignity of marriage and the marital act.

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**PART 4: ISSUES IN CARE FOR THE BEGINNING OF LIFE**

**#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.”**

**#39-42: Specific prohibitions: IVF, Sperm donation, AI, surrogate motherhood.**

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**PART 4: ISSUES IN CARE FOR THE BEGINNING OF LIFE**

- **#45. Abortion (the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted...**
- **#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.” E.g. chemotherapy, surgery**
- **#48. “In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.”**
- **#49. “For a proportionate reason, labor may be induced after the fetus is viable.”**

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**PART 4: ISSUES IN CARE FOR THE BEGINNING OF LIFE**

- **#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.”**  
**No conflict between #52 and #36**
- **#53. “Direct Sterilization of either men or women, whether permanent or temporary, is not permitted... 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.”**

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**PART 4: ISSUES IN CARE FOR THE BEGINNING OF LIFE:  
Practical Considerations**

- Need for excellent education of medical and clinical staff and policy development around these issues due to their critical nature.
- Assisted reproduction, sperm testing, other fertility testing.
- Rape protocol considerations.
- Tubal Pregnancy Policies: salpingectomy, salpingosomy, methotrexate.
- Treatment of pregnant patients; research on pregnant patients, advance directives.
- Policies related to sterilization: hospital, clinics.
- Policies related to Contraception.

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**PART 5:  
ISSUES IN CARE FOR THE DYING**

**Intro: “Above all... 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 suffering caused by it.”**

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**PART 5: ISSUES IN CARE FOR THE DYING**

Intro: “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... 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.”**

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**PART 5: ISSUES IN CARE FOR THE DYING**

- #55. Person have aright to prepare for death. Medical information, spiritual support, sacraments.
- #56,57, 59. Discussion of Ordinary/extraordinary. Proportionate/Disproportionate. Ordinary means are "morally obligatory." Emphasis on "**patient's judgment.**"
- #58. There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.  
#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.

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**PART 5: ISSUES IN CARE FOR THE DYING**

- #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. 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 suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering."
- #62-65. Concerning organ and tissue donation.
- #66. "Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes."

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**PART 5: ISSUES IN CARE FOR THE DYING: Practical Considerations**

- Catholic health care should be characterized by excellence in in end of life care.
- Careful policies and physician staff education related to DNR, withholding life support, terminal weaning, comfort care.
- Pain control, pain control, pain control.
- Policies related to nutrition/hydration in light of ERDs and recent clarifications.
- Organ donation policies and protocols including DCD.
- ERDs are silent on Futility. Most common reason for ethics consultation.

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**PART 6: FORMING NEW PARTNERSHIPS**

Intro: "On the one hand, new partnerships can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments and so influence the healing profession. For example, new partnerships can help to implement the Church's social teaching. ....On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles."

"The significant challenges that new partnerships may pose, however, do not necessarily preclude their possibility on moral grounds. The potential dangers require that new partnerships undergo systematic and objective moral analysis..."

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**PART 6: FORMING NEW PARTNERSHIPS**

#66. "Decisions that may lead to serious consequences for the identity or reputation of Catholic health care services, or entail the high risk of scandal, should be made in consultation with the diocesan bishop or his health care liaison."

#67 Any partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline. Diocesan bishops and other church authorities should be involved as such partnerships are developed, and the diocesan bishop should give the appropriate authorization before they are completed. The diocesan bishop's approval is required for partnerships sponsored by institutions subject to his governing authority; for partnerships sponsored by religious institutes of pontifical right, his *nihil obstat* should be obtained.

#69-70: Governing material cooperation and the limits to such cooperation.

#71 "The possibility of scandal must be considered when applying the principles governing cooperation.<sup>45</sup> Cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused."

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**PART 6: FORMING NEW PARTNERSHIPS: Practical Considerations**

- Partnerships can be an opportunity to further the mission of Catholic health care.
- Moral analysis should not be an afterthought.
- Compatibility is not simply a matter of observing the directives related to sterilization.
- Explore common vision of health care.
- Explore underlying structures/incentives that are built into partnerships, e.g. physician compensation models.
- Dialogue with diocesan representatives is crucial.

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Case Discussion

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