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At their annual meeting in November, 1971, the Catholic Bishops of the United States approved the Ethical and Religious Directives for Catholic Health Facilities as the National Code. The promulgation and implementation of these Directives on the local level was subject to the approval of the Bishops of the individual dioceses. This study is an attempt to survey what has happened to these Directives since their approval in November, 1971. The study reflects the results of a questionnaire sent to the Catholic Health Representative of each diocese requesting information: (1) regarding the promulgation of the Directives in the diocese, (2) regarding any educational program connected with their promulgation, (3) regarding any new policies or procedures that may have resulted from the Directives, and (4) regarding the establishment of Medico-Moral Committees to implement these Directives. Approximately 50 dioceses out of 156 responded to the questionnaire and, though the survey is in that sense incomplete, it does indicate some of the general patterns and trends occurring across the country. It should be noted that among the respondents to the survey are most of the major dioceses in which Catholic health facilities are found. A probable reason for the number of dioceses not responding is simply that they may not have any significant number of Catholic health facilities. It is hoped that the sharing of these results will enable all of those involved in any way with the Directives to be enriched and profit from the experience of others.

Promulgation

In view of the overwhelmingly

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affirmative vote (232 to 7) that the Directives received from the Bishops on the national level, one would expect that the Directives would be immediately approved and promulgated by the local Bishops in their individual dioceses. Although this has been generally the case, it is interesting to note that nine of the dioceses reporting did not follow through with any formal promulgation on the local level. In most instances, no reason was given for the failure to promulgate the Directives. In a few instances, however, there was an intentional withholding of promulgation because the Directives were seen as unsatisfactory. Even where the Directives were promulgated, the letters of promulgation often contained a cautious reserve indicating that the Directives needed further study, development and updating and suggesting recourse to the Bishop or Diocesan Review Committee when such inadequacies with the Directives were encountered. This lends some credence to the view explaining the overwhelmingly favorable vote of the Bishops not as a resounding approval of the Directives but rather as a necessary response to various groups in the health care apostolate clamoring for an updated medical code. The fact that the preamble provides a procedure that calls for continuing study, review and updating of the Directives enabled a number of Bishops to vote favorably for the Directives even though they may have entertained serious reservations regarding certain aspects of the document.

Most of the letters of promulgation from local Bishops simply in dicated that the Directives were ap proved as official policy for the di ocese, but a number recommende that local hospitals incorporate th Directives as part of their by-law and one diocese requested that th Chancery be informed regardin the day of the adoption of these Di rectives as official policy for th hospital.

The most elaborate promulgatio included, not only an official le ter from the Ordinary of the dioces , but a detailed recommendation: (that the Ethical and Moral Guid - lines for Catholic Health Faciliti s be incorporated into and made pa t of the by-laws of the medical sta , (2) that, at the time of original a - pointment and at the time of regul r annual reappointment, each memb r of the medical staff by signing n approved form indicate his willin - ness to assume the obligation a d responsibility of subscribing to t e Directives and agree to conduct i s practice in accordance with the n, and (3) that each patient be advis d that the Catholic hospital is oper t- ing by official hospital policy in accordance with the Ethical a d Religious Directives. It was furt er advised that this latter be acco n- plished by posting such a notice in a conspicuous place in the admitt ng office, by asking each patient at he time of admission to sign an p- proved form whereby there is ec- ognition of this policy and, fina ly, by posting notices to this effec in conspicuous locations throughout the hospital.

Adoption

In addition to the recommenda- tion of some local Bishops that hospitals formally adopt the Ethical and Religious Directives as part of the by-laws constituting the official policy of the hospital, the Catholic Hospital Association strongly urged its membership to do likewise.

It is not known how many of the 734 Catholic hospitals in the United States have formally adopted by resolution of the Board "The Ethical and Religious Directives" as official hospital policy, but a study of the situation is currently underway by Father Kevin O'Rourke, recently appointed Director of Medical-Moral Affairs of the Catholic Hospital Association, and the results should be forthcoming in the near future.

Education

The survey indicates that in most of the dioceses the Directives were simply promulgated without any serious attempt through an educational program to prepare those who would be implementing the Directives. In many instances, the hospital administrator was expected to see that the Directives were properly explained and observed. In some instances, the Bishop or his representative arranged for a meeting on the diocesan level to discuss and explain the Directives. Several state-wide conferences (Michigan, Ohio, Massachusetts, Minnesota, Wisconsin) open to various representatives from the health care field, were held to explore the meaning of the Directives.

Apart from the above indicated educational programs on the hospital, diocesan or state level which were generally limited to one or two-day sessions, the overwhelming majority of those reporting indicated no educational program whatsoever accompanying the issuance of the new Ethical and Religious Directives.

Medico-Moral Committees

One of the surprising results of the study is the number of Medico-Moral Committees that have been established accompanying the promulgation of the new Directives. Perhaps one of the reasons for this was the recommendation coming from the January, 1972, meeting of the Diocesan Coordinators of Health Affairs where the establishment of diocesan Medico-Moral Review Committees was strongly urged. Another possible reason may be the hope that such a committee could undertake the educational task so desperately needed if the Directives are to be made effective. These committees range from special committees on the hospital level through Diocesan Review Committees to state-wide Medico-Moral Committees. The task of such committees appears to be: (1) to address themselves to the problem situations that occur in the practice of health care, (2) to interpret the Directives in particular situations, and (3) to refer unresolved problems either to the Ordinary or to the National Bishops' Committee on Health Affairs.

One of the problems that occurs repeatedly in regard to Medico-Moral Committees is the difficulty in finding adequately prepared and competent theological advisors to serve on them. This is the reason given in several instances why local

hospitals did not institute a committee, and even some individual dioceses preferred to resolve such matters through a state-wide Medico-Moral Committee where competent membership could be ensured. Most of these committees included representation from all areas of the health-care field: theological, official diocesan, legal, medical, hospital administration, Catholic chaplaincy and nursing personnel.

In connection with this, it is important to note that an Advisory Committee has been appointed to the Bishops' Committee on Health Affairs to assist the Bishops in carrying out the recommendation contained in the preamble to the Directives: that "the Committee on Health Affairs of the United States Catholic Conference with the widest consultation possible, should regularly receive suggestions and recommendations from the field, and should periodically discuss any possible need for an updated revision of these Directives." Any revision or updating of the Directives will eventually be processed through this Committee and presented to the U.S. Catholic Conference for approval. In view of this, it would seem that if the Directives are to become instruments for providing effective direction to those involved in the health-care apostolate, the hospital, diocesan and state-wide Medico-Moral Committees must provide the kind of input that would make the members of this Bishops' Committee sensitive to existing problems and able to respond with Directives that are relevant and effective. This appears to be an area of crucial importance in the formation of such committees. Members of these committees should be made aware that their responsibility is not limited to presenting immediate solutions to particular problems but, perhaps of greater importance includes relating their experience to the National Bishops' Committee in order that all involved in the health care apostolate may profit from it.

Problems

The promulgation of the Directives by the American Bishops in November, 1971, met with a sharply critical theological reaction by some highly respected members of the American Catholic theological community. In June, 1971, the Catholic Theological Society of America appointed a study commission to reflect on the matter of Catholic hospital ethics. The report of this CTSA Commission on Ethical and Religious Directives for Catholic Hospitals was completed in September, 1972, and published in the November, 1972, issue of the *Linacre Quarterly*. It is the most detailed and comprehensive evaluation of the Directives available. The principal charges against the Directives are that they are theologically outmoded, inconsistent and insensitive to the changing nature of the Catholic hospital in America today. *The Catholic Mind* of May, 1972, the *Linacre Quarterly* of February, May and August, 1972, plus the November and February issues of *Hospital Progress* and the Fall, 1972, issue of *Chicago Studies* are readily available sources that document this ongoing theological debate. The net result has been a hesitancy on the part of those involved in the health care apostolate to subscribe to the Directives wholeheartedly until further clarification and consensus within the theological community is achieved. Even where the Directives have been adopted there is a gnawing uncertainty on the part of administrators as to how particular Directives are to be interpreted.

The most pressing, immediate problem posed by the Directives concerns the matter of sterilization and the interpretation of Directive 20. The terminology of Directive 20 is ambiguous and subject to widely diverse interpretation among moralists. The precise meaning of such words as "immediately directed," "pathological condition," and "directly contraceptive" are not readily understood by administrators and medical men and are also given varying interpretations by theological experts. The matter is urgent for medical men who insist that concern for the welfare of the total person as well as the practice of responsible medicine requires recourse to sterilization procedures in some instances. Diverse interpretation of this Directive 20 has led to widely divergent practices and applications with regard to sterilization procedures in Catholic hospitals. In one diocese it was indicated that prior to the promulgation of the Directives a policy had been in effect that permitted sterilizations for medical purposes, including psychiatric reasons, under the principle of totality.

As a result of the Directives, an attempt has been made to restrict the sterilization procedure to those instances clearly stated in the Directives and prohibit even the medically indicated sterilizations that were previously allowed. Very few dioceses have given any specific direction to hospitals regarding the implementation of this Directive. Some hospitals, in an attempt to implement Directive 20, have set up a sterilization committee whose purpose it is to interpret Directive 20 and review particular requests for sterilization that are submitted to it.

Because of the crucial importance of this matter, it might be profitable to share several models of guidelines for implementing Directive 20 that have been proposed. All three have been in operation in Catholic hospitals for nearly a year with no major complications or difficulties.

Model I

POLICY STATEMENT FOR PROCEDURES THAT INDUCE STERILITY

A. In the implementation of the revised Ethical and Religious Directives for Catholic Health Facilities of September, 1971, the following policy has been approved by the Bishop for use by this hospital. The following statement pertains to Number 20 in the Directives relating to procedures that induce sterility which states:

> "Procedures that induce sterility, whether permanent or temporary, are permitted when:
>
> 1. they are immediately directed to the cure, diminution, or prevention of a serious pathological condition and are not directly contraceptive (that is, contraception is not the purpose) and
>
> 2. a simpler treatment is not reasonably available. Hence, for example, oophorectomy or irradia-

tion of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom; and orchidectomy is permitted in the treatment of the prostate."

B. A committee will be appointed by the Board of Directors to aid in the implementation of this policy at this hospital. The committee will consist of representatives of Obstetrics, Gynecology, Internal Medicine, Surgery, Psychiatry, and/or Clinical Psychology, Hospital Administration and a Church Representative — Hospital Chaplain or Diocesan Coordinator of Health Affairs. Each case is to be reviewed by a panel selected from the above committee. A physician is not to review his own case.

C. The following procedure will be used when a physician judges that a tubal ligation seems indicated:

1. The attending physician shall make a written application. This application should be signed by the patient and should contain the following information:
   a) Medical reason for the tubal ligation;
   b) Summary of medical history and pertinent laboratory findings.
2. The physician should also submit an informed consent which is signed by the patient and spouse or legally responsible guardian. It should be duly witnessed.
3. The application and consent form are then submitted to the Hospital Administrator.
4. The Administrator selects the panel as indicated in "B" above and submits a copy of the request to each person.
5. Members of the panel shall review the request and affix their separate reports to the application and return it to the Administrator. A unanimous recommendation of the panel is necessary for approval.
6. The attending physician will then be notified of the decision and he may proceed with scheduling the case.

Model II
STERILIZATION COMMITTEE

Many of our physicians believe th there are a number of medical conditio affecting their female patients whic should the patient become pregnar would be markedly aggravated by t pregnant state or by delivery either p vaginam or by caesarean section. In mar instances such conditions pose a serio threat to the lives of both the mother ar the infant. Under these conditions t physicians advise the patient and h husband of these circumstances and ca tion the patient against further pre nancies.

Frequently the patient and her hu band will request that a tubal ligation other appropriate surgical procedure performed as the preferred method sterilization in such circumstances. Th majority of our obstetrician-gynecologis of all religious faiths, supported by t opinion of some theologians, agree th in certain specific instances these mea ures should be employed.

We believe that a full service cor munity hospital has a clear-cut moral o ligation to provide certain servic which are required for the total good the patient, recognizing the religio pluralism of our patient population ar medical staff.

Accordingly, we will establish a ste ilization committee to review reque for medically indicated sterilization pr cedures from members of our medic staff. Such requests, except in most u usual circumstances, must be received n the office of the Vice President for Me ical Affairs at least 30 days in advance of the proposed operative procedure. Ea h request will be acted upon individua y and must contain the following inform tion:

a) Age;
b) Parity;
c) Brief obstetrical history;
d) Specific indication (s) for the procedure to be performed.

Before such a request can be approved it will require the review of at least three members of the sterilization committee — at least one of whom shall be from the Department of Obstetrics and Gynecology. To avoid potential bias in committee decisions, the name of the physician initiating the request will be deleted from the supporting evidence before the request is reviewed.

Each such request shall be referred to three members of the committee as noted below and the majority decisions of those three members shall be final and binding. From time to time other physicians of the medical staff may be asked to serve the committee as consultants as specific questions requring specialized knowledge arise.

The entire committee shall meet quarterly to review overall policy matters and for mutual guidance as these policies are established.

Model III
POLICY STATEMENT FOR PROCEDURES THAT INDUCE STERILITY

A. THEOLOGICAL PRINCIPLES:

1. The revised Ethical and Religious Directives for Catholic Health Facilities approved by the National Conference of Catholic Bishops in November, 1971, issued the following Directive regarding selective sterilizations:

   No. 20 "Procedures that induce sterility, whether permanent or temporary, are permitted when: a. They are immediately directed to the cure, diminution, or prevention of a serious pathological condition and are not directly contraceptive (that is, contraception is not the purpose); and b. a simpler treatment is not reasonably available. Hence, for example, oophorectomy or irradiation of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom; and orchidectomy is permitted in the treatment of carcinoma of the prostate."

2. Decisions regarding selective sterilization in Catholic Health Facilities are to be made in the light of this Directive. The Directive is to be understood and implemented in accordance with sound theological interpretation and acceptable medical practice. Where a legitimate diversity of theological opinion exists regarding the interpretation of the Directive, the recommendation of the 1955 edition of the Ethical Religious Directives for Catholic Hospitals is to be observed:

   "In questions legitimately debated by theologians, liberty is left to physicians to follow the opinions which seem to them more in conformity with the principles of sound medicine."

B. COMMITTEE FOR IMPLEMENTATION:

1. To ensure the proper implementation of this Directive, a Selective Sterilization Committee will be appointed by the Board of Directors (or by the Chief of Staff and approved by the Board of Directors.)
2. Adequate theological orientation will be provided Committee members to ensure correct understanding and application of the Directive within acceptable theological limits.
3. The Committee should be composed of the following members: Chief of Obstetrics, Gynecologist, Surgeon, Internist, Psychiatrist, Chaplain or Moral Theologian, Administrator and Nurse.
4. Each member must have an alternate.
5. Each case is to be reviewed by a panel consisting of a minimum of three medical staff members selected from the above Committee. A physician is not to review his own case. The Administrator, Chaplain and Committee Chairman will be standing but nonvoting members of every such panel.
6. A favorable recommendation must be made by the majority of the panel before the procedure can be approved. The Committee Chairman, Administrator and Chaplain may veto a favorable decision by the Committee. In the event of a veto, a written explanation of the reasons for the veto decision must be submitted to the Committee. The interested physician or Committee may then forward the case to the Archdiocesan Medical-Moral Committee or the Bishops' Committee on Health Affairs for further consideration.

C. PROCEDURE:

The following procedure will be used

when a physician judges that a tubal ligation seems indicated:

1. The attending physician shall make a written application. This application should be signed by the patient and should contain the following information:
   a) Medical reason for the tubal ligation.
   b) Summary of medical history and pertinent laboratory findings.
2. The physician should also submit an informed consent which is signed by the patient and spouse or legally responsible guardian. It should be duly witnessed.
3. The application and consent form are then submitted to the Committee Chairman.
4. The Chairman selects the panel as indicated in "B" above and submits a copy of the request to each person as well as to the Administrator and Chaplain.
5. Members of the panel shall review the request and affix their separate reports to the application and return it to the Chairman.
6. The attending physician will then be notified of the decision and he may proceed with scheduling the case.

D. EXCEPTIONAL CASES:

All patients recommended for sterilization shall have their cases reviewed by a panel prior to surgery. Emergencies are recognized whereby time would not permit the appointment and convening of such a panel by the Committee Chairman. In these exceptional cases, a panel will be appointed to review each case retrospectively. Abuse of this protocol may result in the restriction of the physician's privileges.

Diverse Interpretations

The Advisory Committee of the Bishops' Committee on Health Affairs is well aware of the great diversity with which Directive 20 is interpreted and applied. It is attempting to face the problem by formulating an authoritative interpretation of the Directive as it now stands and by considering the possible revision of the Directive i the evidence so indicates. Father Thomas O'Donnell and John Cor nery, both of whom served as ac visors with the original Bishop Committee that drafted this D rective, have indicated that the D rective as it stands would allow fo sterilization in the instance of re peated Caesarean sections that hav resulted in a weakened uterus th would make a future pregnanc precarious. Beyond this instanc and the explicit examples cited the Directive, it simply is not cle at the present time what constitut the pathological condition me tioned in the Directive and to wh other situations permission for s lective sterilization indicated the Directive may be extended.

(Editor's note. Asked to comme on this point, Father O'Donn replied: "It is perfectly evid that Directive 20 does not per any sterilization that is 'direc contraceptive.' The term 'direc contraceptive' or 'contracepti sterilization' means, in the dir tive (as in its accepted usage moral theology), the suppress of the generative function for purpose of preventing pregnan whether this is done merely a means of birth control or even is supported by considerations clinical expediency. Thus w pregnancy would be expected have a deleterious effect on s serious pathological condition side of the generative system, as cardiac decompensation, chronic kidney disease, etc., a tubal liga tion or any other procedure to sup press fertility is contrary *to Directive 20 and, of course, likewise contrary to the official teaching of the Church.*

If the purpose of the procedure is to prevent pregnancy, it is a contraceptive sterilization, whether or not there is a medical reason for it, and this is contrary to Catholic teaching. This was spelled out in extremely clear detail by Pope Pius XII in his address to the Italian Society of Urologists, Oct. 8, 1953 (Acta Apos. Sedis, 44, 1953, pp. 674-675).

The reference to the uterus so severely damaged by Caesarean sections that it cannot safely support another pregnancy brings up a very difficult point which is often misunderstood. The theological basis of the problem is the solidly probable opinion that the removal of this uterus is permitted precisely because the damage in the uterus itself makes it a functionally dangerously pathological organ — and that, as such, it can be removed even though it is a uterus — and that because of the consideration of the dangerous damage in this organ itself, *its removal need not be viewed as a contraceptive sterilization.*

The next step is the very tenuous opinion (which has nevertheless received recognition by some very reliable theologians) that, in view of the fact that the first step in this clinically justified hysterectomy would be the freeing of the uterus at the tubal adnexa, one could simply do this, by way of isolating the damaged uterus, if the total operation would be contraindicated by the condition of the patient.

The question is — can this procedure be viewed, not as a contraceptive sterilization, but as a legitimate and less drastic substitute for the indicated hysterectomy?

Some physicians would violently disagree with this approach on purely clinical grounds, while others would disagree on moral grounds — saying that they see it as nothing more than a contraceptive tubal ligation. Let me add that those who do see it that way obviously cannot do the procedure in good conscience.

The point here is that the isolation procedure is a very unique situation, and can in no way be extended to justify tubal ligation in the presence of cardiac complications, kidney disease, or any other clinical entity apart from the dangerously damaged uterus.")

Another problem area reported by some of the respondents dealt with the Directives regarding contraception. Doctors, nurses and administrators in Catholic health facilities wrestling with the problem of responsible parenthood and a respect for individual conscience wonder what bearing Directive 19 has, for instance, on teaching family planning values and methods, especially to members of outpatient clinics. The present policy in most Catholic hospitals is felt to be a hindrance to an effective program of responsible family counseling, as well as a disadvantage for medical interns applying for training at Catholic hospitals because of the limited options available within the Catholic hospital context.

A third area that is sure to cause increasing concern in Catholic hospitals in the light of the recent Supreme Court decision is that of abortive procedures. Many Catholic hospitals have formally reaffirmed as hospital policy the position on abortion stated in the Directives, but it is feared that attempts may be made to force Catholic hospitals by court order, especially in those areas where they are the only health facilities serving the community and where they have received community funds, to permit abortive procedures within the guidelines allowed by law.

Other Factors

Other issues which have been raised concern questions regarding the moment of death, euthanasia, organ transplantation, genetic counseling, experimentation guidelines, medical fees and expenses, and the delivery of health care for the poor and needy. From these indications it is quite clear that the present Ethical and Religious Directives for Catholic Health Facilities promulgated by the American Bishops are far from being regarded as a finished product, but rather mark the beginning of what will hopefully be a continuing and cooperative effort among all involved in the health care apostolate to work towards a more adequate and comprehensive summary of guidelines for medical care in Catholic health facilities.

In light of the available evidence, the following recommendations seem to suggest themselves as appropriate regarding the present Directives: (1) that local Bishops promulgate and individual hospitals formally adopt the Directive as official policy even while recognizing the limitations of the document and thereby acknowledging their responsibility to be part of a continuing process of updating and renewal, (2) that serious and continuing education programs be arranged on the hospital, diocesan and state-wide levels for all members involved in the health care apostolate in order that the Christian moral values and theological principles that underlie the Directives and that are crucial to the proper understanding and implementation might be better grasped, (3) that medico-moral committees be established on the hospital, diocesan or state levels comprising representation from all areas of the health care apostolate to create the necessary bridge that will translate the abstract Directives into responsible, concrete decisions, sensitive and responsive to the particular circumstances of the individual case, and (4) finally, that clear channels of communication be established to forward local experience, questions and difficulties to the Bishops' Committee on Health Affairs whose responsibility it is to make the Directives ever more responsive to the realities of the Christian experience. Only when the above elements are more widely and effectively realized at all levels can we expect the Ethical and Religious Directives for Catholic Health Facilities to be revised and to reflect more clearly a Christ-like concern for the sick and suffering. Q