Ethical and Religious Directives for Catholic Health Care Services

Seventh Edition

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

Ethical and Religious Directives for Catholic Health Care Services, *Seventh Edition*

This seventh edition of the *Ethical and Religious Directives for Catholic Health Care Services* was developed by the Committee on Doctrine of the United States Conference of Catholic Bishops (USCCB) and approved by the USCCB at its November 2025 Plenary Assembly. This edition of the *Directives* replaces all previous editions, is recommended for implementation by the diocesan bishop, and is authorized for publication by the undersigned.

Rev. Michael J. K. Fuller
General Secretary, USCCB

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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 Services.*

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 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

[1] United States Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops* (1981), https://www.usccb.org/resources/health-and-health-care-pastoral-letter-american-catholic-bishops-november-19-1981.

[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.

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 20:29-34; 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.

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).

In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history. 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. 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. Inspired by the example of Christ and mandated by the Second Vatican Council, lay faithful are invited to a

[3] United States Conference of Catholic Bishops, *Health and Health Care*, p. 5.

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. 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.

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, but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making.

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

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[4] Second Vatican Ecumenical Council, *Apostolicam Actuositatem*, Decree on the Apostolate of the Laity (1965), no. 1, https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decree_19651118_apostolicam-actuositatem_en.html.

[5] Pope John Paul II, *Christifideles Laici*, Post-Synodal Apostolic Exhortation on the Vocation and the Mission of the Lay Faithful in the Church and in the World (1988), no. 29, https://www.vatican.va/content/john-paul-ii/en/apost_exhortations/documents/hf_jp-ii_exh_30121988_christifideles-laici.html.

[6] As examples, see Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion* (1974), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19741118_declaration-abortion_en.html; Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_eutanasia_en.html; Congregation for the Doctrine of the Faith, *Donum Vitae*, Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation (1987), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html.

(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.

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 based on the moral norms for proper health care.

PART ONE

The Social Responsibility of Catholic Health Care Services

Introduction

Their embrace of Christ's healing mission has led 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.

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity, an inherent and inviolable dignity that every person possesses as "inalienably grounded in his or her very being."[7] Human dignity is the foundation the Catholic Church's 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.[8]

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 access to health care for those who are poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured.[9]

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.[10]

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—

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[7] Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, Declaration on Human Dignity (2024), no. 1, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_ddf_doc_20240402_dignitas-infinita_en.html.

[8] Pope John XXIII, *Pacem in Terris*, Encyclical Letter on Establishing Universal Peace in Truth, Justice, Charity, and Liberty (1963), no. 11, https://www.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii_enc_11041963_pacem.html; United States Conference of Catholic Bishops, *Health and Health Care*, pp. 5, 17-18; *Catechism of the Catholic Church* (Vatican City: Libreria Editrice Vaticana, 1993), no. 2211, https://www.vatican.va/archive/ENG0015/__P7T.HTM.

[9] Pope John Paul II, *Sollicitudo Rei Socialis*, Encyclical Letter for the Twentieth Anniversary of *Populorum Progressio* (1987), no. 43, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_30121987_sollicitudo-rei-socialis.html.

[10] United States Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* 1986), no. 80, https://www.usccb.org/resources/economic-justice-all-pastoral-letter-catholic-social-teaching-and-us-economy.

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.

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 maintains its integrity as a ministry carrying on the work of Jesus Christ, in fidelity to his Gospel, by providing high-quality health care in conformity with Catholic teaching and by refusing to provide or permit medical interventions that are judged morally wrong by the teaching authority of the Church. The institutional conscience of a Catholic health care service is rooted in its identity as a ministry and formed by the authoritative teaching 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 care for and treat 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; pregnant women 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.

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.

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.

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.[11]

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.

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.

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.

[11] The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic 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 sponsors, governing boards, and other appropriate senior leaders of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.

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 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."[12] 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. 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.

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, including an understanding of these Directives.

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[12] United States Conference of Catholic Bishops, *Health and Health Care*, p. 5.

11. Pastoral care personnel should work in close collaboration with local parishes and community clergy. 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.

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 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. 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.[13]

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.[14] In case of emergency, if a priest or a deacon is not available, anyone can validly baptize.[15] 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.[16]

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[13] Cf. *Code of Canon Law*, cc. 921-923, https://www.vatican.va/archive/cod-iuris-canonici/eng/documents/cic_lib4-cann879-958_en.html#Art._2.

[14] Cf. *Code of Canon Law*, c. 867, § 2, and c. 871.

[15] 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."

[16] Cf. *Code of Canon Law*, c. 883, 3°.

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 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.

PART THREE
The Professional-Patient Relationship

Introduction

A person in need of health care and the health care professional treating 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 professional 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.

Today, a patient often receives care from a team of health care professionals, 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 professionals 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.[17] 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 professional 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.[18] 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 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.

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[17] Technology, including Artificial Intelligence, can never replace the human relationship between the health care professional and the patient. Human beings are by nature meant to be in relationships with persons. On the intrinsically relational character of human beings, see Dicastery for the Doctrine of the Faith and Dicastery for Culture and Education, *Antiqua et Nova*, Note on the Relationship between Artificial Intelligence and Human Intelligence (2025), nos. 18-20, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_ddf_doc_20250128_antiqua-et-nova_en.html. On the use of Artificial Intelligence in health care, see nos. 71-76.

[18] See Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, no. 7 and nos. 17-22.

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 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 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.

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. This obligation to obtain consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its expected benefits; its risks, side-effects, consequences, and cost; and the same information about any reasonable and morally legitimate alternatives, including no treatment at all. Each person or the person's surrogate should also have access to morally sound resources and guidance, including pastoral counsel and ethics consultations, 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 teaching (including that specified in these Directives).

27. If a patient or a patient's surrogate requests a medical intervention that is not in accord with Catholic teaching, health care professionals may not refer the patient to another professional for the purpose of obtaining that intervention. If a patient or a patient's surrogate requests a transfer of care to another health care professional or facility that he or she has independently chosen, health care professionals should facilitate a safe transfer of care in compliance with legal and professional requirements while avoiding immoral cooperation.[19]

28. Since "creation is prior to us and must be received as a gift," we have a duty "to protect our humanity," which means first of all, "accepting it and respecting it as it was created."[20] In order

[19] See Part Six, Collaborative Arrangements with Other Health Care Organizations and Providers.

[20] Pope Francis, *Amoris Laetitia,* Post-Synodal Exhortation on Love in the Family, no. 56, https://www.vatican.va/content/dam/francesco/pdf/apost_exhortations/documents/papa-francesco_esortazione-

to respect the nature of the human person as a unity of body and soul, Catholic health care services must not provide or permit medical interventions, whether surgical, hormonal, or genetic, that aim not to restore but rather to alter the fundamental order of the human body in its form or function.[21] This includes, for example, some forms of genetic engineering whose purpose is not medical treatment,[22] as well as interventions that aim to transform sexual characteristics of a human body into those of the opposite sex (or to nullify sexual characteristics of a human body).[23]

29. In accord with the mission of Catholic health care, which includes serving those who are vulnerable, Catholic health care services and providers "must employ all appropriate resources to mitigate the suffering of those who experience gender incongruence or gender dysphoria" and to provide for the full range of their health care needs, employing only those means that respect the fundamental order of the human body.[24]

30. Since the human person is a unity of body and soul, Catholic health care professionals and their patients have the duty and the right to preserve the integrity of the human body. It can be morally permissible, however, to remove or to suppress the function of one part of the body for the sake of the body as a whole under the following conditions: There must be no other reasonable means of addressing the pathological condition, the efficacy of the procedure must be reasonably well assured, and the benefits expected from the procedure must be proportionate to the burdens it imposes, including suffering, cost, and damage to the body. These conditions apply when the body part itself is diseased and presents a risk to the life or the well-ordered functioning of the body as a whole. They also apply when a healthy body part presents a risk to the life or the well-ordered functioning of the body as a whole because its presence or its functioning contributes to a serious pathology in another part of the body.[25]

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ap_20160319_amoris-laetitia_en.pdf; see also, Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, Declaration on Human Dignity, no. 60.

[21] See USCCB Committee on Doctrine, "Doctrinal Note on the Moral Limits to Technological Manipulation of the Human Body" (2023), nos. 13-18, https://www.usccb.org/resources/Doctrinal%20Note%202023-03-20.pdf.

[22] See Congregation for the Doctrine of the Faith, *Dignitas Personae*, Instruction on Certain Bioethical Questions (2008), no. 27, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html.

[23] See Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, Declaration on Human Dignity, no. 59: "All attempts to obscure reference to the ineliminable sexual difference between man and woman are to be rejected." Persons affected by Disorders of Sex Development, however, may exhibit ambiguous or abnormal indicators of sexual difference. An intervention aimed at resolving such abnormalities would not constitute an attempt to alter the fundamental order of the human body (see no. 60).

[24] See USCCB Committee on Doctrine, "Doctrinal Note on the Moral Limits to Technical Manipulation of the Human Body," no. 18.

[25] See Pope Pius XII, "Address to the Participants of the 26th Congress Organized by the Italian Society of Urology," October 8, 1953, I, https://www.vatican.va/content/pius-xii/fr/speeches/1953/documents/hf_p-xii_spe_19531008_congresso-urologia.html. See also Pope Pius XII, "Address to the Participants of the First International Congress on the Histopathology of the Nervous System," 14 September 1952, https://www.vatican.va/content/pius-xii/fr/speeches/1952/documents/hf_p-xii_spe_19520914_istopatologia.html.

31. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any of the donor's essential bodily functions and when 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.[26]

32. 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. 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 those that are nontherapeutic in nature.

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention. Therapeutic interventions that are likely to cause adverse effects can be justified only by a proportionate benefit to the patient. While every person is obliged to use ordinary/proportionate means to preserve his or her health, no person is obliged to submit to a health care intervention whose expected benefits--in the free and informed judgment of the person (or the person's surrogate)--are not proportionate to the risks, burdens, or expense imposed on the person, the family, or the community.[27]

34. Health care professionals are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care.[28]

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.

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care professionals 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 interventions that have as their purpose

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[26] See Pope John Paul II, "Address to Participants of the First International Congress of the Society for Organ Sharing," 20 June 1991 (https://www.vatican.va/content/john-paul-ii/en/speeches/1991/june/documents/hf_jp-ii_spe_19910620_trapianti.html).

[27] See Pope John Paul II, *Evangelium Vitae*, Encyclical Letter on the Value and Inviolability of Human Life, no. 65., https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html, and Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part IV; see also directive 56.

[28] See Dicastery for the Doctrine of the Faith and Dicastery for Culture and Education *Antiqua et Nova*, nos. 90-94.

or direct effect the removal, destruction, or interference with the implantation of a human embryo.[29]

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.

[29] It is recommended that if an abortifacient intervention is requested by a survivor of a sexual assault the provider advise the woman of the ethical standards that prevent Catholic hospitals from providing any abortifacient interventions; see directive 45.

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 for the dignity of marriage and 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."[30] 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 infant and maternal mortality 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 ready will.[31]
>
> 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.[32]

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[30] *Catechism of the Catholic Church*, no. 2319.

[31] Second Vatican Ecumenical Council, *Gaudium et Spes*, Pastoral Constitution on the Church in the Modern World (1965), no. 49, https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.

[32] Second Vatican Ecumenical Council, *Gaudium et Spes*, no. 50.

For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means.[33] 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."[34] Such interventions violate "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning."[35]

With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While it is heartening that many of these technologies have potential for good, one 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.[36]

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.[37]

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.[38]

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[33] See Pope Paul VI, *Humanae Vitae*, Encyclical Letter on the Regulation of Birth, no. 10, https://www.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae.html; *Catechism of the Catholic Church*, no. 2370.

[34] Pope Paul VI, *Humanae Vitae*, Encyclical Letter on the Regulation of Birth, no. 14.

[35] Pope Paul VI, *Humanae Vitae*, Encyclical Letter on the Regulation of Birth, no. 12.

[36] Pope John XXIII, *Mater et Magistra*, Encyclical on Christianity and Social Progress (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, *Donum Vitae*, no. 4.

[37] Pope John Paul II, *Veritatis Splendor*, Encyclical Letter Regarding Certain Fundamental Questions of the Church's Moral Teaching (1993), no. 50, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html.

[38] "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" (Congregation for the Doctrine of the Faith, *Donum Vitae*, Part II, B, no. 6; see also Part I, nos. 1, 6).

39. Techniques of assisted reproduction also must not involve the cryopreservation or destruction of human embryos[39] or the cryopreservation of human gametes for the purpose of immoral methods of reproduction.[40] Post-mortem gamete retrieval is not permitted.

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.[41] Furthermore, heterologous fertilization is also prohibited because it typically involves the destruction or cryopreservation of human embryos.

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).[42] Furthermore, homologous artificial fertilization is also prohibited when it involves the destruction or cryopreservation of human embryos.

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.[43] Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.[44]

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

44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children, including appropriate care and accompaniment during and after miscarriage, in a manner consonant with its mission.

45. Procured abortion (that is, the "deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to

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[39] Here, as throughout these Directives, the term "embryo" is used in the broad sense to refer to all the early stages of development beginning upon conception, such as zygote, blastocyst, and embryo.

[40] See Congregation for the Doctrine of the Faith, *Dignitas Personae*, nos. 12, 20.

[41] Congregation for the Doctrine of the Faith, *Donum Vitae*, Part II, A, no. 2; *Catechism of the Catholic Church*, no. 2376.

[42] "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" ' " (Congregation for the Doctrine of the Faith, *Donum Vitae*, Part II, B, no. 6). See also *Donum Vitae*, Part II, B, no. 4(a); *Dignitas Personae*, no. 12; *Catechism of the Catholic Church*, no. 2377.

[43] Congregation for the Doctrine of the Faith, *Dignitas Infinita*, nos. 48-50.

[44] Congregation for the Doctrine of the Faith, *Donum Vitae*, Part II, A, no. 3.

birth"[45]) is never permitted, whether chosen for its own sake or for a further end.[46] Every intervention, whether surgical or chemical, whose sole immediate effect is the destruction of a living human embryo or fetus or the removal of a living embryo or fetus from the uterus before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo;[47] removal after viability with the intent for it to result in the death of a living fetus is also an abortion. Catholic health care institutions need to evaluate carefully the risk of scandal in any association with abortion providers, even when the association is limited and does not of itself constitute immoral cooperation with wrongdoing.

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.

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.

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

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

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 preventive 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 if undertaken with the intention of aborting an unborn child with a serious defect.[49]

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 will not harm the life or physical integrity of an unborn child is permitted with parental consent.[50]

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

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[45] Pope John Paul II, *Evangelium Vitae*, no. 58.

[46] See Pope John Paul II, *Veritatis Splendor*, no. 78.

[47] See Congregation for the Doctrine of the Faith, *Dignitas Personae*, no. 23.

[48] See directive 45.

[49] Congregation for the Doctrine of the Faith, *Donum Vitae*, Part I, no. 2

[50] See Congregation for the Doctrine of the Faith, *Donum Vitae*, Part I, no. 4.

Church's teaching on responsible parenthood and in the various fertility-awareness-based methods of natural family planning.[51]

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.[52]

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.

[51] Pope John Paul II, *Familiaris Consortio*, Apostolic Exhortation on the Role of the Christian Family in the Modern World, no. 35, https://www.vatican.va/content/john-paul-ii/en/apost_exhortations/documents/hf_jp-ii_exh_19811122_familiaris-consortio.html.

[52] See Congregation for the Doctrine of the Faith, "Responses to Questions Posed Concerning 'Uterine Isolation' and Related Matters," (1993), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_31071994_uterine-isolation_en.html.

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.[53] 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.[54]

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. One of the primary purposes of health care for the dying is the relief of pain and suffering. Effective management of pain and other forms of suffering is critical in the appropriate care of the dying. While death itself may incite fear for patients and caregivers, for some it is even more difficult to face the process of dying, especially the dependency, the vulnerability and helplessness, and the sufferings that often accompany terminal illness.

The truth that human life is a sacred gift from God has profound implications for how we exercise stewardship of this gift. 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. We may reject potentially life-prolonging interventions that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia, however, are never morally acceptable options.[55]

A fundamental part of the vocation of every health care professional is to provide care at all times, even when a cure is not possible. 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 various interventions in an attempt to maintain life. The use of life-sustaining interventions in Catholic health care is judged in light of the Christian meaning of life, suffering, death, and resurrection. In this way two extremes are avoided: on the one hand, an insistence on likely ineffective or burdensome interventions even when a patient may legitimately wish to forgo them; and, on the other hand, the withdrawal or application of interventions with the intention of causing death.[56]

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[53] Pope John Paul II, *Salvifici Doloris*, Apostolic Letter on the Christian Meaning of Human Suffering (1984), nos. 25-27, https://www.vatican.va/content/john-paul-ii/en/apost_letters/1984/documents/hf_jp-ii_apl_11021984_salvifici-doloris.html.

[54] United States Conference of Catholic Bishops, *Order of Christian Funerals* (Collegeville, Minn.: The Liturgical Press, 1989), no. 1.

[55] See Congregation for the Doctrine of the Faith, *Samaritanus Bonus*, Letter on the Care of Persons in the Critical and Terminal Phases of Life (2020), V, 1 (https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html).

[56] See Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*.

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."[57] 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 with unresponsive wakefulness syndrome (formerly known as "persistent vegetative state") and other forms of neurologic injury, because even the most severely debilitated patient retains the full dignity of a human person and must receive ordinary and proportionate care.[58]

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.[59]

56. A person has a moral obligation to use ordinary/proportionate means of preserving his or her life. Proportionate means are those that offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the patient, the family, or the community.[60]
A person may forgo extraordinary/disproportionate means of preserving life. Disproportionate means are those that do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the patient, the family, or the community.[61] Such means are not morally obligatory. The final determination as to what constitutes a proportionate benefit and what constitutes an excessive burden belongs to the patient (or the patient's surrogate) and should be informed by professional medical advice.

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[57] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part II.

[58] See Congregation for the Doctrine of the Faith, *Samaritanus Bonus*, V, 8.

[59] This includes those patients awaiting transplants, as they and their caregivers live between the suffering of the terminal illness and the hope, but not guarantee, of extending life.

[60] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part IV; Pope John Paul II, *Evangelium Vitae*, no. 65.

[61] For example, a patient (or his or her surrogate) may request a Do Not Attempt Resuscitation order (DNAR) if, in close consultation with the health care team, he or she determines that resuscitative measures would not offer a reasonable hope of benefit or entail excessive burden. It must be clear to patients, families, and caregivers that a DNAR order does not mean that ongoing care should cease; on the contrary, ordinary/proportionate care should continue.

57. The free and informed judgment made by a competent adult patient or surrogate concerning the use or withdrawal of life-sustaining interventions should always be respected and normally complied with, as long as it is not contrary to Catholic moral teaching.

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.[62] This obligation extends to patients in chronic and presumably irreversible conditions (e.g., a range of neurological conditions including unresponsive wakefulness syndrome, i.e., "persistent vegetative state") who can reasonably be expected to live an indeterminate amount of time if given such care.[63] 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."[64] 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.

59. Euthanasia is any action or omission that of itself or by intention causes death in order to bring all suffering to an end. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should instead be given 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.[65]

60. If a patient expresses an intention to commit suicide by Voluntarily Stopping Eating and Drinking (VSED), he or she should be informed that the Catholic health care service will not facilitate this course of action.[66] Rather, health care professionals should do what they can, in a way that respects the patient's freedom, to dissuade the patient from this course of action. They should continue to provide appropriate pain management while avoiding immoral cooperation

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[62] See Congregation for the Doctrine of the Faith, *Samaritanus Bonus*, V, 3.

[63] See Pope John Paul II, "Address to the Participants in the International Congress on 'Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas'" (March 20, 2004), no. 4, https://www.vatican.va/content/john-paul-ii/en/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc.html, 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), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html.

[64] 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," https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html.

[65] See Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part IV.

[66] Intended suicide by VSED should be distinguished from the natural loss of desire for food and water that often accompanies dying patients in the final stages of their illness.

with suicide by VSED. When appropriate, psychiatric care can be recommended. The pastoral care team should be consulted. Appropriate steps should be taken to avoid giving scandal.

61. Catholic health care services should strive to support those who suffer from life-limiting illness, including those awaiting transplants, with the full range of multidisciplinary palliative care in order to address suffering that may be physical, psychological, and spiritual. While such care includes effective pain relief therapy and symptom management, it also includes personal accompaniment, to counteract the isolation and loneliness that they may experience. Spiritual accompaniment, while not valorizing pain and suffering, should be available to help them to appreciate the Christian understanding of redemptive suffering.[67]

62. For patients who are in the final phase of life before death, Catholic health care services have a duty to provide end-of-life care in keeping with Catholic teaching, including the psychological, communal, and spiritual support that patients and their families need.[68] This care should take place in the most suitable environment, whether at home, in a hospital, nursing home, or hospice center, and should facilitate the patient's contact with their family, friends, and parish or faith community as much as possible. Dying persons remain members of the family, members of society, and members of the Church or their faith communities; therefore every effort should be made to maintain their relationships and to counteract the isolation and loneliness that they may experience.

63. 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, especially in view of the necessity for preparation for death, for reception of the sacraments, and for conscious interaction with family and loved ones. If a patient is in the terminal phase of illness and typical pain-management therapies are ineffective, palliative measures that induce a temporary or intermittent loss of consciousness can be permitted provided that the patient or surrogate has given proper consent, a plan of care is in place that addresses degree and length of sedation, and the patient has had the opportunity to perform his or her personal and religious preparations for death (if he or she is capable of this). Medicines directed toward alleviating or suppressing pain and other symptoms may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the dose is therapeutic and the intent is not to hasten death.

64. 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 transplantation and research after death.[69] Such organs may never be removed until it has been medically determined that the patient has died. The determination of death should be made by the physician or competent medical authority in accordance with well-founded medical criteria that establish with moral certitude that death has

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[67] See Congregation for the Doctrine of the Faith, *Samaritanus Bonus*, V, 4.

[68] See Congregation for the Doctrine of the Faith, *Samaritanus Bonus*, V, 5.

[69] The conditions for free and informed consent must also be fulfilled in the case of someone arranging for the donation of their organs and bodily tissue, including the provision of all the relevant information that is reasonably available. See Part Three, Directive no. 26.

occurred.[70] In order to prevent a conflict of interest, the physician who determines death must 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.[71]

[70] Moral certitude is not absolute certitude, such as one finds in mathematical equations, as "it does admit the absolute possibility of the contrary," but it does mean that "well-founded or reasonable doubt" is excluded (Pope Pius XII, Address to the Tribunal of the Sacred Roman Rota [October 1, 1942], as quoted by Pope John Paul II, Address to the Roman Rota [February 4, 1980], no. 6, https://www.vatican.va/content/john-paul-ii/en/speeches/1980/february/documents/hf_jp-ii_spe_19800204_sacra-rota.html). Absolute certitude is not morally obligatory for an action to be ethical.

[71] Congregation for the Doctrine of the Faith, *Donum Vitae*, Part I, no. 4; *Dignitas Personae*, no. 35.

PART SIX
Collaborative Arrangements with Other Health Care Organizations and Providers[72]

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. 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 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.'"[73] 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.

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[72] See: Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with non-Catholic Entities in the Provision of Healthcare Services," published in *The National Catholic Bioethics Quarterly* 14, no. 2 (2014): 337-40.

[73] Pope John Paul II, *Veritatis Splendor*, no. 13.

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."[74] 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."[75] 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 healthcare 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.

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[74] Pope John Paul II, *Evangelium Vitae*, no. 74.

[75] *Catechism of the Catholic Church*, no. 2284.

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.

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, 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.

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.[76]

[76] 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) (27 June 1998) https://www.vatican.va/content/john-paul-ii/en/speeches/1998/june/documents/hf_jp-ii_spe_19980627_ad-limina-usa-ix.html. See also "Reply of the Sacred Congregation for the Doctrine of the Faith

71. When considering opportunities for collaborative arrangements that entail material cooperation in wrongdoing, Catholic institutional leaders must assess whether scandal[77] 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.

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on Sterilization in Catholic Hospitals" (*Quaecumque Sterilizatio*) (13 March 1975), no. 1, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19750313_quaecumque-sterilizatio_en.html: "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.

[77] 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).

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.