There are certain procedures which simply are not performed at Catholic health care institutions. These include abortion, surgical sterilization, physician-assisted suicide, euthanasia, and in vitro fertilization. These are not, in fact, “prohibited services.” These procedures are not done not because they have been forbidden by Church authorities; rather, they are not done because Catholic health care institutions do not consider them to be sound medical care. Indeed, each one of these procedures violates human dignity.

Regrettably, many ethicists and representatives of Catholic health care institutions do refer to these procedures as “prohibited services.” There are several problems with the use of this terminology. Consider abortion. Abortion is not a “service” to anyone. It destroys the life of an innocent unborn child and violates the moral, spiritual, and physical integrity of the mother. In a complicated pregnancy there are other ways to render true medical service to both the mother and the child without violating either one of them.

Surgical sterilization is also not sound medical care. There is no pathology or illness which is cured by surgical sterilization. What in fact is done is that a physician renders inoperable an otherwise healthy system of the body. Until recently, health insurance programs did not even cover contraception or contraceptive procedures because they do not address a medical problem. They constitute lifestyle choices by perfectly healthy individuals. For example, a decision is made not to have more children for financial, professional, or other reasons. Why should medical insurance pay for anything other than health care? Granted, sometimes surgical sterilizations are performed because another pregnancy would be a risk for a woman suffering from a disorder such as diabetes or high blood pressure. However, the surgical sterilization itself does nothing to cure the diabetes or the high blood pressure. Fertility is destroyed through surgical sterilization, and fertility itself is not a disease. There are ways to avoid having a child in the future other than such a radical intervention as surgical sterilization.

There are also practical reasons for avoiding using the language of “prohibited services.” It is well known that there are many today who think that any licensed hospital has a duty to perform every procedure which is legal, and they resent the fact that Catholic institutions will not perform certain procedures. First of all, not every medical institution is equipped and able to perform every procedure that is legal, such as, for example, organ transplantation or open-heart surgery. Second, and more important, there are physicians who consider certain procedures to be not only immoral but also medically unsound. This can obviously create problems when Catholic health care professionals work in a broader society which largely accepts these procedures as good medicine.

Collaborative Arrangements

When a Catholic hospital considers entering into a collaborative arrangement with a non-Catholic hospital—sometimes to secure its very survival—the differences of medical and moral opinion can indeed pose difficulties. These potential arrangements are watched very closely and often opposed by those who fear that there will be less access to abortion or contraception because of the merger or joint-venture agreement. They will oppose the arrangement because the Catholic party will insist that certain procedures, such as abortion, be unquestionably forbidden. These negotiations are often followed closely by MergerWatch, NARAL Pro-Choice America, Catholics for Choice, the National Organization for Women, and others. These groups will sometimes mount legal opposition to collaborative arrangements with Catholic institutions, claiming that such arrangements will lead to a diminution of “women’s services” in the community or a reduction of the “full range of reproductive services.”

If the Catholic parties refer to abortion as a “service” which will be “forbidden,” they have played right into the hands of those opposing Catholic health care. They make the claim in the negotiations that there are “services” which they are now forbidden to provide to the community. Those opposing Catholic health care can actually use the very language of the representatives of Catholic health care to undermine the position of the Catholic hospital.

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There Are No “Prohibited Services”
Getting the Language Right
John M. Haas, Ph.D., S.T.L., K.M.

Revising Secular Advance Directives
A Challenge for Catholic Hospitals
Rev. Benedict M. Guevin, O.S.B., Ph.D., S.T.D.
and even obtain judicial relief with the court, thus ending the collaborative arrangement. It is made to appear that Catholic institutions do not provide certain “services” because they are arbitrarily forbidden to do so by Church authorities. Nothing could be further from the truth.

It is the profound commitment to human dignity that drives Catholic health care. As stated in the Ethical and Religious Directives for Catholic Health Care Services (ERDs), written by the U.S. Conference of Catholic Bishops, “Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death.”

1 The above-mentioned procedures are not done in Catholic institutions, once again, not because the bishops have forbidden them but because they are considered not good for patients.

These two approaches to morality were addressed millennia ago by Plato in his work Euthyphro. He asked, “Have the gods forbidden an action because it is wrong or is it wrong because the gods have forbidden it?” The notion that an action is wrong because it is forbidden is known as legal positivism. The term positivism comes from the Latin posit, or “he sets down or puts in place.” A legislature or a court puts in place a law or a ruling against some behavior. The action then becomes wrong in the opinion of the positivist because it has been outlawed—not because there is something wrong with it in and of itself. The other approach says, “No, there should be laws against the direct killing of the innocent (murder/abortion) or the unjust appropriation of someone else’s property (theft) precisely because they are wrong. Such actions bring great injury to innocent people, and the state has a duty to protect the innocent.”

Principle of Cooperation

The principle of cooperation often guides the thinking of the representatives of the Catholic institution as they attempt to forge a relationship with a non-Catholic institution. This principle acknowledges that we live in a less-than-perfect world and that sometimes we have to cooperate with someone who is doing evil if we are to achieve a great good or even avoid a great evil. For example, St. Mary’s Catholic Hospital would save a lot of money and strengthen its ministry if it could share the expenses of an ambulatory surgery center with Community Hospital. However, Community Hospital is involved in immoral activities such as surgical sterilizations. In the collaborative arrangement, St. Mary’s would have to be certain that it did not cooperate in an immoral way in the surgical sterilizations that were taking place at Community Hospital. This could be done by simply agreeing that no vasectomies or tubal ligations would take place at the ambulatory surgery center. But during the negotiations with Community Hospital, the representatives of St. Mary’s should not refer to the sterilizations as “prohibited services” for all the reasons already given.

Yet the terminology we do use for these procedures can be a delicate matter. St. Mary’s wants to cooperate with Community Hospital in achieving a common good with the new surgery center, and they want to foster good relations with the surgeons at Community Hospital. Consequently, it would probably not be helpful toward the collaboration if the representatives of St. Mary’s Hospital refused to allow vasectomies and tubal ligations because they were “unjustifiable mutilations.” This may indeed be true, but such language would almost certainly offend those with whom St. Mary’s was trying to establish good relations and who, in their own good conscience, believe otherwise. One can therefore imagine the Catholic representatives saying, “We would like to collaborate with you, but vasectomies are prohibited services according to the ERDs and cannot be done at the surgery center.” It is understandable that they would have a tendency to use this kind of language—but it is a tendency that must be resisted.

The Bishops themselves have inadvertently fallen into this mistake. Directive 45 of the ERDs forbids abortion, or even cooperation with abortion, in very clear and uncompromising language. However, the Bishops slipped into the language of “services” in referring to what the Second Vatican Council referred to as an “unspeakable crime.” Directive 45 reads in part, “Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation.” Even though the bishops certainly know that abortion is not a “service,” they inadvertently used this language.

Enumerate the Actions

What language can be used then to promote cooperation with non-Catholics in achieving what is good while avoiding immoral cooperation in evil? Frankly, it is best to enumerate the actions that will not be done so that there can be no doubt among the parties involved in the agreement. The legal documents regulating the collaborative arrangement can simply list them and refer to them by the neutral term “procedures” or “interventions.” The important thing is that these practices not take place in a Catholic institution and that the Catholic institution not cooperate with them in an immoral way. If one would want to use more general terms for these immoral actions without enumerating them every time, one could refer to “those procedures inconsistent with the ERDs.”

Admittedly, at times the Catholic representatives may have to be quite explicit about why the Catholic institution will not cooperate with or perform certain procedures, i.e., because Catholic health care professionals consider them to be immoral acts and bad medicine. It is actually quite good to be afforded the opportunity to clarify the Catholic position and even win over others to our understanding. When and how this is done, however, depends on the prudential judgment of the representatives of Catholic health care involved in the negotiations.

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Revising Secular Advance Directives

In spite of clear magisterial teaching on the obligatory nature of nutrition and hydration—natural or artificial—for patients in a persistent vegetative state (PVS), the issue is far from settled in the minds of some. Two articles recently appeared in Ethics & Medics defending the Vatican’s position on artificial nutrition and hydration (ANH). These articles were a response to the position taken by the Jesuit Consortium in their article in the February 2009 issue of Commonweal, which offered a critique of Church teaching on providing hydration and nutrition to patients in a PVS. Both articles in Ethics & Medics argued that the Jesuit Consortium’s characterization of Vatican teaching, and the position that it adopted, was erroneous and not helpful in providing guidance to those who were responsible for establishing policies and protocols for Catholic health care services.

Church Teaching on ANH

Opinion has long been divided on whether ANH is morally obligatory for patients in a PVS. A pastoral letter published in 1990 by the Texas Conference of Catholic Bishops held that ANH was burdensome and, therefore, not obligatory. The Pennsylvania Conference of Catholic Bishops reached the opposite conclusion in 1992, stating that ANH was generally obligatory. The U.S. Bishops’ Pro-Life Committee reached a conclusion similar to that of the Pennsylvania Conference of Catholic Bishops, although they acknowledged that “legitimate Catholic moral debate continues.”

Pope John Paul II, in his March 20, 2004, address to the participants in the International Congress on “Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,” stated that hydration and nutrition were minimal care that could not be interrupted or stopped in patients in a PVS. In 2007, when the U.S. Conference of Catholic Bishops sought clarification of whether the administration of nutrition and hydration by natural or artificial means was morally obligatory for patients in a PVS, the Congregation for the Doctrine of the Faith stated that “the administration of food and water even by artificial means” is obligatory for patients in a PVS.

There is no longer any room for confusion. In the fifth edition of the Ethical and Religious Directives for Catholic Health Care Services (ERDs), the U.S. Conference of Catholic Bishops states, “In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the ‘persistent vegetative state’) who can reasonably be expected to live indefinitely if given such care.”

Confusion in Catholic Hospitals

Unsuspecting patients, however, may still go to a Catholic hospital and be provided with an advance directive that allows them to forgo ANH if they become “permanently unconscious.” I discovered this when I contacted my local Catholic hospital and asked for a copy of the current version of its advance directive. Under the heading “Durable Power of Attorney for Health Care,” I was surprised to read the following:

I realize that situations could arise in which the only way to allow me to die would be to not start or to discontinue medically administered nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

___ (a) medically administered nutrition and hydration not be started, or if started, be discontinued.

-or-

___ (b) even if all forms of life-sustaining treatment have been withdrawn, medically assisted nutrition and hydration continue to be given to me.

If you fail to complete [this item], your agent will not have the power to direct the withholding or withdrawal of medically administered nutrition and hydration.

Under “Living Will,” I found the following:

If . . . my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or [if] I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn. . . . I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:

(Initial beside your choice of (a) or (b).)

___ (a) medically administered nutrition and hydration not be started, or if started, be discontinued.

-or-

___ (b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

In both sections, the patient is given the option to refuse medically administered nutrition and hydration or have it withdrawn in a situation where “the only way to allow me to die” is to discontinue ANH. This option is contrary to Church teaching.

It is important to note that this directive does not mention patients in a PVS as such. Rather, it refers only to those who are in a “permanently unconscious condition,” defined in the document as “a lasting condition, indefinitely without improvement, in which you are not aware of your thought, your self and environment and other indicators of consciousness are absent as determined by a neurological assessment by a doctor in consultation with your doctor or [advanced practice registered nurse].” While a PVS and a permanent unconscious condition are two different states, the Vatican teaching applies to both.
This advance directive, and probably others like it, was issued by legal authorities of the State, not the hospital. The State mandates that the directive be substantially unchanged, meaning that nothing can be omitted from the text if it is to be legally valid. What hospital administrators may not know, however, is that advance directives can be revised by adding text to conform to Church teaching.

While Vatican teaching does not bind non-Catholics, Catholic health care facilities are so bound whether their patients are Catholic or not. Catholic health care facilities, then, should tailor those advance directives generated by secular authorities for use in Catholic facilities so that they reflect Church teaching. Without this guidance, unsuspecting patients may assume that the provisions laid out for them in a secular advance directive, if provided by a Catholic facility, are morally licit.

Patients should also be made aware that they are not legally obligated to use a secular advance directive—and they must not do so if the directive is contrary to their Catholic faith. As a moral alternative, The National Catholic Bioethics Center publishes an advance medical directive, included in A Catholic Guide to End-of-Life Decisions, for use by patients and Catholic health care services. Now that the obligation to provide ANH to patients in a PVS has been more definitively articulated, Catholics should ensure that their provisions for end-of-life care adequately reflect the Church’s clear teaching.

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7Congregation for the Doctrine of the Faith, Commentary on “Responses to Certain Questions of the USCCB concerning Artificial Nutrition and Hydration” (August 2007), response to the first question, reprinted in National Catholic Bioethics Quarterly 8.1 (Spring 2008): 123.


10Ibid. 16.

11Even the revised Directive 58 refers to patients in “chronic and presumably irreversible conditions,” of which they specifically state the PVS as one example.

12For a critique of the advance directive found at the Aging with Dignity Web site, http://www.agingwithdignity.org/forms/5wishes.pdf, see Edward J. Furton, M.A., Ph.D. Contents ©2010 by The National Catholic Bioethics Center. ISSN 1071-3778 (print), ISSN 1938-1638 (online). Reprinting permitted at 50¢ per copy per page (donation). Send inquiries to address above. All rights reserved.