Revising the ERDs for the 21st Century

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For decades the Ethical and Religious Directives for Catholic Health Care Services have served as a unique source of guidance for Catholic health care ministries in the United States. The ERDs cogently distill and apply key elements of the Catholic moral tradition to modern health care delivery. Since 1948, when a document bearing the title Ethical and Religious Directives was first published, the ERDs have undergone major revision only twice, in 1971 and 1995.

Given the historical precedent for major revision roughly every two decades and the significant changes in health care, the Church, and society since the early 1990s, another revision of the ERDs is in order and should be anticipated. While it cannot be predicted when a major revision might be called for or completed, we should prepare to make the most of a once-in-a-generation revision.

This article introduces a series of reflections on the current status of the ERDs and on how they could and should be revised. This initial article will provide an overview of key features of the ERDs as a whole—their history, content and structure, authorship and authority, and functions. Subsequent articles in Ethics & Medics will survey the ERDs part by part to review the guidance that now exists and to discuss what changes are necessary. I hope these reflections stimulate additional thought and discussion on the topic.

History of the ERDs

The first document to bear the title Ethical and Religious Directives for Catholic Hospitals contained fifty-six directives in total—forty-three on issues relating to ethics in medicine and thirteen on the religious care of patients. After minor revisions in 1955, these initial ERDs were endorsed by a resolution of the US bishops and remained in effect until 1971.

The first major revision of the ERDs was published in 1971, occasioned by changes in US health care financing and delivery (following the creation of Medicare and Medicaid in 1965) and in the Church after the Second Vatican Council. This period also was a time of tremendous social and political upheaval in the United States. Apart from authorship, however, the ERDs did not change significantly. The number of directives was consolidated from sixty to forty-three, but their overall structure remained in place. Ethical and religious directives were each given their own sections. Ethical directives were then broken into four parts: general principles, procedures affecting human life, procedures affecting reproductive organs, and other procedures.

Indeed, it was the lack of significant change that disappointed some within Catholic health care and occasioned sharp protests from increasingly dissident theologians, who urged the Church to be more flexible on matters of surgical sterilization and contraception. Appeals to Rome and tussles over the proper interpretation of the ERDs occupied the rest of the 1970s. During this period, the US bishops maintained the 1971 ERDs as written and continued to uphold perennial Church teachings on respect for life and human sexuality. However, the dynamics involved in the 1971 revision influenced the second major revision, which was published in 1995.

The 1995 ERDs represent the most thoroughgoing revision ever conducted. The most distinctive change was a new six-part structure, which provided a broad framework within which to address emerging issues in health care and to supply explanatory context for the Church’s ethical guidance. Although there have been three partial revisions since then—part 6 has been revised twice, and dir. 58 was revised once—everything else in terms of structure and content in the current, sixth edition (2018) dates from 1995.

Structure and Content

The major subject areas covered in the 1995 ERDs include (1) social accountability and organizational ethics, (2) pastoral and spiritual care, (3) the professional–patient relationship and certain clinical issues in health care, (4) issues in care at the beginning of human life and procreation, (5) issues in care for the seriously ill and dying, and (6) an entirely new topic addressing collaborative arrangements and major organizational relationships in the delivery of health care.

Within this broader structure, the number of directives increased from forty-three to seventy (and to seventy-seven in the 2018 ERDs). The new explanatory content in the 1995 ERDs can be found partly in a lengthier preamble and general introduction but mostly in the new introductory sections written for each of the six parts.

Without a doubt, the multi-part structure of the ERDs is here to stay. At issue is whether six parts will remain enough or if more sections should be added to address new issues, such as the migration of much clinical care to outpatient settings, or to provide a greater focus for a range of issues in organizational ethics. While there should be significant continuity in the formulation of key principles (e.g., the wording of dir. 47 has remained practically unchanged since 1948), many areas of health care have changed