Physician Orientation Guide
Partnering in a Catholic Health Care Ministry
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Our Mission

As people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.

Our Core Values

Respect

All people have been created in the image of God. – Genesis 1:27

We welcome the uniqueness and honor the dignity of every person.

We communicate openly and we act with integrity.

We develop the talents and abilities of one another.

Compassion

Jesus taught and healed with compassion for all. – Matthew 4:24

We reach out to people in need and give comfort as Jesus did.

We nurture the spiritual, physical and emotional well-being of one another and those we serve.

We embrace those who are suffering.

Justice

This is what the Lord requires of you: act with justice, love with kindness and walk humbly with your God. – Micah 6:8

We believe everyone has a right to the basic goods of the earth.

We strive to remove the causes of oppression.

We join with others to work for the common good and to advocate for social justice.

Excellence

Much will be expected of those who are entrusted with much. – Luke 12:48

We set the highest standards for ourselves and for our ministry.

We strive to transform conditions for a better tomorrow while serving the needs of today.

We celebrate and encourage the contributions of one another.

Stewardship

The earth is the Lord’s and all that is in it. – Psalm 24:1

We believe that everything entrusted to us is for the common good.

We strive to care wisely for our people, our resources and our earth.

We seek simplicity in our lives and in our work.

A Message from Sister Colleen Settles, OP
Chief Mission Integration Officer, Providence Health & Services
California Region

Thank you for joining us in our important and sacred work of “revealing God’s love for all, especially the poor and vulnerable, through our compassionate service”. This is our mission and our passion and it is not possible without a strong partnership with our physicians. As a Catholic health care ministry, we have enjoyed a great deal of success in the area of patient care – all due to the talent, skill and dedication of our clinical team, but most importantly due to the high quality of the physicians who choose to practice with us. We are very glad to have you on our team.

This guide is a way of introducing you to our Mission, our history, our community outreach and to the considerations that must be made when delivering care in our ministries. We are tremendously proud of our Catholic heritage and traditions and you will find that our people are driven and inspired by the history of our founders, the Sisters of Providence and the Sisters of the Little Company of Mary. My hope is that you will be as inspired by the history of the Sisters and that as a person of Providence you will take pride in upholding the traditions that we hold dear. We understand there is a lot to learn and we hope this guide will help you in that process.

Thank you again for joining our team. Our Mission comes alive through the thousands of interactions that occur between our caregivers and those we serve each day. There is no doubt in my mind that your contributions to our Mission will make a sacred difference in the lives of our patients and the communities we serve each day.

Welcome to Providence Health & Services.
Welcome to Providence

As a new provider and person of Providence, we are honored that you have chosen to share your skill, talent and expertise in medicine with us. As you begin your work at Providence, it is essential that you understand our journey and history along with our deep commitment to our Mission and Core Values. Your role as a partner in caring for those in our communities who have the greatest need is part of an amazing shared legacy that began more than 150 years ago.

Here are some key facts that will help introduce you to our ministry:

- Providence is a faith-based organization that is founded on the principles of the Catholic tradition. Our organization identifies our work as a ministry, something bigger than just one person.

- The Sisters of Providence have their roots in the works of Emilie Gamelin, a widow in Montreal, Quebec, who became a friend of the aged, the poor, the handicapped, the mentally ill, the orphaned and the prisoners of her city. In 1843, six women were working with Madame Gamelin in a small home they had established to care for the elderly and sick. That same year, at the request of Bishop Ignace Bourget of Montreal, this group of women agreed to form a religious community – the Sisters of Providence. In 1856, five years after Blessed Emilie Gamelin’s death, five sisters of Providence led by Mother Joseph of the Sacred Heart, traveled to Fort Vancouver in Washington. Their goal was to establish schools, orphanages, homes for the aged and shelters for the mentally ill.

- The Sisters of Little Company of Mary were founded by Mary Potter, a woman born in England four years before the death of Emilie Gamelin. The youngest of five children, Mary was raised by her mother, a single parent. Mary’s spiritual calling did not develop until late in her teenage years when she was influenced, ironically, by the man to whom she was engaged. Mary entered the Sisters of Mercy but illness forced her to return home. During her lengthy convalescence, she was devoted to Our Blessed Lady. It was at this time that Mary realized that her mission (and that of her followers) would be in the “company of Mary” at the foot of the cross caring for the sick and the dying. Despite her illness and many setbacks, Mary and her companions began their ministry at the Hyson Green, Nottingham, England in 1877. In 1893 the Sisters brought their mission to the United States. Today the vision of Mary Potter is carried out in twelve countries.

- We continue the living legacy of Emilie Gamelin and Mother Joseph in our ministry and this is demonstrated each day in our deep commitment to serving the poor and vulnerable and those unable to pay for services.

- A continued commitment to serving the poor and the vulnerable is a priority – as it was for our Founding Sisters. In 2009, Providence Health & Services provided over $119 million in community benefit and charity care programs. These not-for-profit Providence hospitals at comprise the California region offer a wide range of outreach programs with the goal of inspiring a healthier community. From school children to the elderly, our communities are served by programs that promote good health for the body, mind and spirit. Special programs include our Latino Health Promoters programs, Tattoo Removal, Health Kids Van, Faith Community Health Partnership, School Nurse Outreach, Sexual Assault Response Team, Senior Outreach and many more.

- We have concern for our global family through our international mission programs and we encourage and support our employees, physicians and leaders in finding ways to extend their expertise and service by participating in medical mission programs in other countries. These efforts keep us connected to those who are poor and vulnerable around the world and help us share the gifts of our ministry with others in need.
About Providence Health & Services

Providence Health & Services is a not-for-profit health system committed to providing a comprehensive array of services to meet the needs of communities across five states, including Alaska, Washington, Montana, Oregon and California. This ministry includes 27 hospitals, more than 35 non-acute facilities, physician clinics, a health plan, a liberal arts university, a high school, approximately 49,000 employees and numerous other health, housing and educational services. The system office is located in Renton, Washington.

About the California Region

The California Region of Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities we serve – especially the poor and vulnerable. The region operates five, award-winning Medical Centers in Southern California. In addition, Providence operates several non-acute facilities and physician clinics, as well as a high school. With more than 10,000 employees, physicians and volunteers, we remain committed to our core values of respect, compassion, justice, excellence and stewardship. These values, defined by our founding sisters more than 150 years ago, feed philosophies that result in high-quality care for our patients, a broad spectrum of outreach programs for our community, and a focus on recruiting and retaining dedicated physicians and employees.

KEY
- Health Care Campus
- Freestanding Long Term Care Facility
- Housing and Assisted Living
- Owned Primary Care Network
- Educational Facility
- Behavioral Health Services
- Adult and Child Day Care Centers
- Home Health and Hospice Services
- Medical Laboratory Services
- Providence Health Plan
- Providence Infusion and Pharmacy Services
- Freestanding Outpatient Services
- Food Bank
- Community Outreach Center

California
- Oakland: Providence House
- Santa Clarita: Providence Holy Cross Health Center
- Porter Ranch: Providence Holy Cross Health Center
- Mission Hills: Providence Holy Cross Medical Center
- Providence TrinityCare Hospice
- Providence Holy Cross Surgery Center
- Providence Holy Cross Diagnostic Center
- North Hollywood: Providence St. Elizabeth Care Center
- Providence Center for Community Health Improvement
- Tarzana: Providence Tarzana Medical Center
- Providence Tarzana Diabetes Care Center
- Providence Tarzana Women’s Center
- Providence Tarzana Imaging Center
- Providence Tarzana Outpatient/Therapy Center
- Valley Radiation Oncology Center
- Burbank: Providence Saint Joseph Medical Center
- Providence TrinityCare Hospice
- Providence High School
- Providence Saint Joseph Health Center
- Providence Saint Joseph Diagnostic Center
- Roy and Patricia Disney Family Cancer Center
- Providence Home Care

Manhattan Beach: Providence Little Company of Mary Medical Institute
Redondo Beach: Providence Little Company of Mary Medical Institute
Hawthorne: Providence Little Company of Mary Medical Institute
Torrance: Providence Little Company of Mary Medical Center
Torrance: Providence Little Company of Mary Transitional Care Center

California City: Providence Little Company of Mary Medical Center
San Pedro: Providence Sub Acute Center
San Pedro: Providence TrinityCare Hospice
San Pedro: Providence Diagnostic Center
San Pedro: Providence Little Company of Mary Peninsula Recovery Center
Blessed Emilie Gamelin, Foundress of the Sisters of Providence, 1800-1851

Emilie Tavernier was born in Montreal, Quebec, on February 19, 1800, the youngest of 15 children. Left an orphan at an early age, she was brought up under the care of her aunts. Naturally gifted and amiable, Emilie became an accomplished young lady, enjoying the modest pleasures of society, but she was always concerned for the needs of the poor. On June 4, 1823, at the age of 23, she married Jean-Baptiste Gamelin, a wealthy Montreal merchant. In the course of their happy, but brief marriage, they had three sons. Each died at an early age as did Jean-Baptiste on October 1, 1827.

As “the Widow Gamelin,” Emilie dedicated her energy and her financial resources to serving the poor in a spirit of humility, simplicity, and charity. A strong devotion to “Our Mother of Sorrows” gave her comfort and strength. Not content with visiting the poor in their homes, on March 4, 1828, she opened her first refuge for elderly and destitute women. Responding to numerous cholera epidemics and periods of civil unrest, Emilie began nursing the sick and visiting prisoners. These ministries flourished with the assistance of her many friends, and in 1841, Emilie obtained civil incorporation of her work. On February 2, 1842, Emilie took a private vow to serve the poor.

Founding of the Sisters of Providence

With the Most Reverend Ignace Bourget, Bishop of Montreal, Emilie founded the congregation of the Daughters of Charity, Servants of the Poor on March 25, 1843. Although not one of the original seven women chosen for the community, she was admitted to the novitiate on October 8, 1843. After pronouncing her religious vows on March 29, 1844, Emilie was appointed as the first superior of the congregation.

The Daughters of Charity, Servants of the Poor – known to all as the Sisters of Providence – grew rapidly under Mother Gamelin’s direction, serving the poor, mentally ill, aged, orphaned, imprisoned, and handicapped. As “the Widow Gamelin,” Emilie dedicated her energy and her financial resources to serving the poor in a spirit of humility, simplicity, and charity. A strong devotion to “Our Mother of Sorrows” gave her comfort and strength. Not content with visiting the poor in their homes, on March 4, 1828, she opened her first refuge for elderly and destitute women. Responding to numerous cholera epidemics and periods of civil unrest, Emilie began nursing the sick and visiting prisoners. These ministries flourished with the assistance of her many friends, and in 1841, Emilie obtained civil incorporation of her work. On February 2, 1842, Emilie took a private vow to serve the poor.

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Becoming a Saint

Mother Gamelin’s Cause of Beatification was officially opened in 1977, and on December 23, 1993, she was declared a woman of Heroic Virtues worthy of veneration by the Catholic Church. On December 18, 2000, Pope John Paul II declared that the cure of a young boy was a miracle granted by God through Mother Gamelin’s intercession, and authorized her beatification. The ceremony of beatification took place on October 7, 2001, at the Vatican in Rome and her progression toward sainthood continues today.

Mother Joseph of The Sacred Heart (Esther Pariseau), 1823-1902

A Timeless Life

At her 50th anniversary as a Sister of Providence, Mother Joseph’s companions honored her for specific talents for which she had become known: seamstress, carpenter, painter, sculptor, blacksmith, farmer, watchmaker, locksmith, architect and mechanic. But the description they thought fit her best was “builder of services,” for she spent her life seeing to it that the poor were cared for, the homeless sheltered, the sick tended, the hungry fed. All the rest – the building and the sculpting, the sewing and the painting, the farming and the begging – were done to carry out this goal of service.

Mother Joseph of the Sacred Heart was born Esther Pariseau on April 16, 1823 in St. Elzéar, Quebec. In 1856, 13 years after entering the Sisters of Providence, she and four companions traveled 6,000 miles from Montreal to the distant Washington Territory. Compassionate women of Emilie Gamelin, their works were soon directed to service – caring for orphans and the elderly, educating youth, and visiting and healing the sick. During the 46 years Mother Joseph lived in the Northwest, she established, designed, and built institutions of education, health care and social service. Through this work, she employed all her professional and personal skills to meet the ever-present need for finances, persons to share the work and space to expand. As the Sisters’ chief architect, Mother Joseph acquired a reputation for quality craftsmanship. Heavily dependent on donations to support their works of charity, she and other sisters conducted arduous begging tours to mines and lumber camps throughout the West. Somehow she also found time to shower attention on the small orphan children at Providence Academy and throughout her life, many recalled her loving concern.

Mother Joseph was a woman of talent and knowledge who devoted her life to the young, sick and poor until her death in Vancouver in 1902. Her compassion and vision were unlimited. She was many things to different people: intense, motherly, resourceful, prayerful, strong willed, artistic, but above all, a woman of faith in Providence.

A Living Legacy

Mother Joseph’s contributions to the West continue to be recognized today. In 1980, she was named as Washington State’s second representative in National Statuary Hall, in Washington, D.C. In 1999, at the request of a group of Vancouver sixth-grade students, the legislature passed a bill declaring her birthday, April 16, as Mother Joseph Day in Washington State. And on September 19, 2000, she was inducted into the Puget Sound Business Hall of Fame. The corporation Mother Joseph established in 1859 is acknowledged as a “Pioneer Corporation in Washington State” and has developed over the years into Providence Health & Services, which now operates in Alaska, Washington, Oregon, California and Montana.
Venerable Mary Potter, 1847-1913

Mary Potter was born on November 22, 1847, in Bermondsey, London, England. Her compassion for the sick and dying and her vision would change the lives of tens of thousands of people around the world. She had tremendous faith in God and an indomitable spirit.

Mary was the youngest of five and the only daughter. Her mother’s strength of character and deep spirituality helped nurture and inspire Mary’s own unshakable faith.

As a young woman, Mary Potter seriously considered marriage and was, in fact, engaged for a time. She eventually broke off the engagement so that she could devote her life to prayer and good works. She started by teaching at a school for Catholic children for three years. After class, she regularly brought food and comfort to the needy of the parish.

In December of 1868, at the age of 21, Mary Potter was accepted as a postulant by the Sisters of Mercy. However, within the year, Mary became ill and had to return home. During this first of many confinements, she asked other women to join with her in a ministry of care for the sick and dying. Despite many obstacles, Mary’s faith and persistence eventually convinced Bishop Bagshawe of Nottingham to encourage her to find a suitable house with which to begin her mission.

Mary Potter and her initial four companions settled into a warehouse in Hyson Green, a very poor district of Nottingham. After much work remodeling the building Mary Potter had a cross erected atop the high roof on Easter Sunday, 1877. She painted it red to symbolize the blood of the Savior.

The Sisters of the Little Company of Mary were founded on July 2, 1877, the Feast of the Most Precious Blood. Their name and mission were inspired by Mary, the mother of Jesus, and the little company of faithful followers who remained with her at the foot of the cross on Calvary, offering Jesus and Mary their compassionate presence.

Because Mary Potter endured painful and chronic illnesses throughout her life, she intimately understood the emotional and spiritual distress of the sick and dying. She could empathize with their suffering. Serving the sick and poor of the community through compassion, home care and prayerful presence, these Sisters were pioneers in what we now call hospice care. Despite her illnesses, Mary Potter was gifted with the ability to inspire others to carry out her holistic ministry of physical, emotional and spiritual healing.

After years of building her Little Company, and having dedicated her life to the service of the sick and dying, Mary Potter went to her eternal reward on April 9, 1913.

Mary Potter’s legacy, and her wholehearted commitment to God were recognized by Pope John Paul II on February 8, 1988, when he declared Mary Potter “venerable,” the first of three steps toward sainthood. This declaration demonstrated the Church’s validation of Mary Potter’s saintly life and acceptance of her extensive spiritual writings.

Mary’s loving spirit continues to guide the work of her spiritual heirs today. The spiritual heritage of Mary Potter is carried on throughout the world. The Sisters of the Little Company of Mary now provide much-needed services in 14 countries on five continents. Their healing touch can be felt in England, Scotland, Ireland, Northern Ireland, Albania, Wales, Australia, New Zealand, Korea, Zimbabwe, South Africa, Italy, the Kingdom of Tonga and the United States.
In the mid-1950’s, an airplane crash in Pacoima dramatically emphasized the lack of acute-medical care in the Northeast section of the San Fernando Valley. The people of Mission Hills turned to the Sisters of the Holy Cross (from Notre Dame, IN) to build the much needed hospital which opened in 1961. Disaster struck the San Fernando Valley in 1971 in the form of a 6.6 earthquake, then again in 1994 when the Northridge earthquake severely damaged Holy Cross. Each time the hospital came back to serve the acute and trauma needs of the Valley. In 1996, Providence Health System took ownership of the Medical Center. Strategically located near the intersections of the 405, 5, 118 and 210 freeways, the Medical Center serves both the San Fernando Valley as well as the Santa Clarity Valley. A $180 million Leed Certified patient care wing expands Providence Holy Cross Medical Center to 392 beds making it one of the largest hospitals in the San Fernando Valley. It is also one of the very few Medical Centers within the greater Los Angeles area which has achieved the prestigious Magnet designation for excellence for nursing services and is one of only two hospitals in the San Fernando Valley with Level II Trauma Center Designation, verified by the American College of Surgeons.

In 1942, The Sisters of Providence were called by Archbishop Cantwell and the medical community of Burbank to help build the hospital today known as Providence Saint Joseph Medical Center. Located just 12 miles northwest of downtown Los Angeles and in the heart of the media district, Providence Saint Joseph Medical Center opened its doors in 1944 as a 100 bed hospital. Soon the need outgrew the 100 beds and, with the help of the local businesses, mainly Disney and Lockheed, a new 400 bed hospital began development on land donated by the City of Burbank. Today, with 431 licensed patient beds, Providence Saint Joseph is the largest hospital serving the San Fernando and Santa Clarita Valleys and offers state-of-the-art technology and high quality, compassionate care in a variety of medical specialties. The Roy and Patricia Disney Family Cancer Center includes the latest technology and cancer research with a complete integrative therapy program. The Hycy and Howard Hill Neuroscience Institute offers the latest in cutting edge neurology services including deep brain stimulation. Providence Saint Joseph has an active medical staff of more than 650 renowned physicians. The Emergency Department team treated more than 50,000 patients in 2009.
Local History of Southern California Communities (cont’d)

Tarzana

Tarzana Hospital was originally conceived through a limited partnership of 104 physicians and Hyatt Medical Enterprises. While built as a hospital, Hyatt had a backup plan to develop a hotel if the hospital plan failed. After three years in construction, Tarzana Hospital admitted its first patient on October 8, 1973. In 1980 the hospital was sold to American Medical International (AMI). Nearly 11 years after opening, AMI merged with National Medical Enterprises and in 1995 was renamed Tenet. Nine years later, Tenet announced plans to sell Tarzana Regional Medical Center and in September, 2008 Providence Health and Services announced the acquisition of the hospital, changing its name and culture to that of our current Providence Tarzana Medical Center, the fifth acute care facility in our Southern California Region. Today the 245-bed acute care hospital is home to over 900 physicians and offers many quality award winning services to the community. It is currently the only Pediatric and Pediatric ICU program within Providence in the San Fernando Valley with Pediatric ambulance transfer services from our other Providence ministries in the San Fernando and Santa Clarita Valleys.

Torrance

In 1956, Cardinal McIntyre invited the Sisters of the Little Company of Mary to build a hospital on a 10 acre site in Torrance, deeded to them from the Archdiocese of Los Angeles. After years of fundraising, Little Company of Mary Hospital in Torrance, a cross shaped, 150 bed hospital was opened in 1960 with the sisters living on the 4th floor. Little Company of Mary was known throughout the South Bay for its breakthrough treatment of cardiovascular disease, with the first area implant of a pacemaker and first coronary bypass surgery. Throughout the years, Little Company of Mary continued to expand, leading to the merger with Providence Health System in 1999. Today, Providence Little Company of Mary Medical Center – Torrance features a 317 acute care medical center which provides the latest techniques in invasive and non-invasive cardiac procedures, and comprehensive cardiac rehabilitation services along with the latest in advanced imaging technology. Providence Little Company of Mary in Torrance combines medical care with a healing environment, attuned to the needs of the patient.

San Pedro

In 1924 a group of doctors and local businessmen organized and incorporated the San Pedro General Hospital Association as a private stock corporation. The San Pedro General Hospital opened its doors in 1925 as a 19 bed facility. Throughout the years, the names and owners of this medical center have changed – but the dedication to the people of San Pedro has remained strong. In 1992 San Pedro Peninsula Hospital joined with Little Company of Mary Hospital in Torrance and in 1999 merged with Providence Health and Services to become Providence Little Company of Mary Medical Center – San Pedro. Today, this hospital is a 356 bed facility which is a primary Stroke Center and the sole acute rehabilitation provider in the South Bay and Harbor communities providing patients who have experienced serious disabling conditions such as stroke, brain injuries, neurological illness or major orthopedic conditions with the necessary care. Along with an active OB department, ER and surgical departments, Providence Little Company of Mary Medical Center – San Pedro also provides the Recovery Center, specializing in the care of chemical dependent patients and Bridges Psychiatric Services. Both of these specialty programs have inpatient and outpatient service available.
Providence Health & Services is much more than a network of health care ministries. We are a community partner. We believe in providing for the needs of the communities we serve because it is our responsibility as a not-for-profit health system and it is our Mission. As an actively engaged partner, our regional community benefit efforts are always shaped around the specific needs of each community. As a physician partner with us, we invite you to also become involved in any of these many outreach programs.

**Outreach Into Our Communities**

**Providence Tattoo Removal:** Utilizing trained physicians and the latest in laser technology, the Tattoo Removal Program offers a safe and effective method for removing tattoos. Located in the San Fernando Valley, we have been performing tattoo removal treatments since 1998. Social gang related tattoos are removed for free with the client performing hours of community service in exchange for the treatment. In addition to removing tattoos, the Providence Tattoo Removal Program seeks to reduce violence in the community through its outreach program. The Violence Prevention Outreach program makes informational presentations with current clients (who are typically ex-gang members) to local middle schools, high schools and community organizations. These presentations cover the dangers of getting tattoos, lifestyle choices and peer pressure. If you are interested in volunteering as a physician in this program, please call (818) 847-3860.

**Providence Access to Care:** Working with case managers in the Emergency Rooms, our trained Community Care Coordinators search out the resources needed by our uninsured patients who use the ED due to lack of other known options. The Access to Care staff also work with the local clinics and our own physicians, forging partnerships to care for the uninsured – finding patients a medical home and linking them with available resources in the community. Providence Health & Services partners with our physicians in providing pro-bono diagnostics when physicians provide pro-bono care as well. If you are interested in volunteering as a physician in this program, please call (818) 847-3989.

**Providence Early Detection and Prevention Mobile Van:** In partnership with Dr. Glenn Lopez and Providence Medical Institute, this mobile program provides appointments for low cost medical care and disease management to uninsured and underinsured adults who are dealing with diabetes, hypertension, high cholesterol and other chronic diseases. The van makes regular visits to local churches and community centers within the San Fernando Valley. For more information on this mobile van program call (818) 433-9204.

**Providence Latino Health Promoters Program:** The majority of our Latino Health Promoters are volunteer community members who receive extensive training on health topics, then provide health and referral information to community residents of all ages and backgrounds. These volunteers provide the diverse cultural population of the San Fernando and Santa Clarita Valleys with health screenings and workshops, support groups, health fair sponsorship, health information booths at churches and health information classes on diabetes, nutrition, breast self-exams and natural family planning. Volunteers also aid in linking people with benefits such as insurance, Healthy Families and Medi-Cal. For more information call (818) 847-3983.

**Faith Community Health Partnership:** Faith Community Nurses are experienced registered nurses with spiritual maturity and special training who commit to promoting health and healing in their faith communities. Providing a holistic approach to health, this program focuses on the mind-body-spirit connection by offering health screenings and fairs, personal health counseling, home visitation, health information and education, resources and referrals, on-site consultations, volunteer training and materials. Faith communities establish health ministry teams linked with trained Faith Community Nurses to help promote health and wellness both physically and spiritually. For more information call (818) 847-3980.

**School Health Outreach Program:** The Providence School Nurse works in partnership with local elementary schools to improve the health of children and adolescents. The program provides services and screenings including vision, hearing, dental, scoliosis and other physical assessments, nutritional guidance, training of teachers and staff in CPR, and consultations with parents on health issues. The program services children from kindergarten through eighth grade and is supervised by an RN with a background in pediatrics and public health. For more information call (818) 847-3818.

**Valley Service Area Outreach Programs**

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**School Health Outreach Program:** The Providence School Nurse works in partnership with local elementary schools to improve the health of children and adolescents. The program provides services and screenings including vision, hearing, dental, scoliosis and other physical assessments, nutritional guidance, training of teachers and staff in CPR, and consultations with parents on health issues. The program services children from kindergarten through eighth grade and is supervised by an RN with a background in pediatrics and public health. For more information call (818) 847-3818.
Senior Peer Counseling: Many elderly in our community are dealing with heavy burdens in their lives including loneliness, isolation, grief and depression. The listening ear of someone who cares and understands can be invaluable. This is the role of the Senior Peer Counselor. Senior Volunteers (50 years and older) receive 72 hours of training in topics including communication and listening skills, depression, normal aging, dementia, grief, case management, care giving issues, acute and chronic conditions and their impact upon the elderly, legal and ethical issues, and healthy aging. They meet individually with seniors in need of help, usually referred by case managers, social workers, home health nurses or physicians.

Volunteers for Seniors: These volunteers provide valuable services for frail, home-bound seniors who have no other resources. Volunteers for seniors provide access to medical care and help to seniors maintain independence in the home, which enhances and maintains the quality of life for seniors. Services include: transportation to medical appointments, shopping for groceries, light housekeeping, cooking a meal and friendly visiting.

Physicians in the San Fernando Valley may make referrals to this program by calling (818) 847-3845.

Promotora Patient Navigation Program: Helping connect uninsured patients with low-cost or free clinics was key. But how? Any solution had to embrace the culture, language and special needs of our Hispanic population. It had to come from the community itself and our Promotoras helped to craft the solution themselves. By pairing promotoras with uninsured ER patients, patients learn how to navigate the complex and confusing healthcare system. They learn how to enroll their children and themselves in low cost insurance programs and learn the importance of medical homes. For more information call (310) 257-3586.

Creating Opportunities for Physical Activity (COPA) addresses childhood obesity by increasing children's daily physical activity and training classroom teachers and after-school program staff to independently lead physical education during and after school. Program evaluation has shown statistically significant increases in the amount of time children participate in physical education as well as teachers' confidence in leading physical education activities. For more information call (310) 257-3586.

Even Start: A family literacy program for parents and young children (birth to 5). Services include ESL classes, child development activities and parent/child interactive learning activities. For more information call (310) 257-3586.

Providence Little Company of Mary Baby Moves: This program, staffed by Promotoras, offers fun and learning for children from birth to age 4. It offers a safe and fun environment for parents to learn how to engage in age-appropriate play with their children. While children play with their caregivers and peers, great things happen! They build cognitive, language and social skills, they develop fine and large motor skills, and they become eager to take part in community activities. For more information call (310) 257-3586.

CAVA/SART: This collaborative, comprised of Providence Little Company of Mary and 3 other South Bay hospitals, provides education for and tracking of domestic violence screenings through the ED's. Forensic nurse exams for sexual assault victims take place in a respectful and confidential setting within our Medical Center. For more information call (310) 241-4353.
Introduction to Spiritual Care and Ethics

Providence Health & Services' interfaith approach to spiritual care allows chaplains to serve the unique needs of patients, family members, physicians and staff of the health care community. The chaplains' focus is on supporting the deeper spiritual meaning and understanding of suffering and sickness, health and wellness.

Our staff is composed of women and men who are professionally trained chaplains. While the chaplains are assigned to an acute care hospital, they are also available to meet with patients and staff from our Providence Medical Institute offices.

Call upon a Providence Chaplain to:
• Empower a patient to draw upon the strengths of their spiritual resources
• Provide spiritual and emotional support in times of crisis or difficult diagnosis
• Serve as a resource for ethical decision-making
• Assist a patient or staff member to reflect about the meaning of a life experience
• Be a spiritual companion on the journey

To reach a chaplain, call the Spiritual Care Department at your affiliated Providence Health and Services Medical Centers.

Ethics Education, Consultation and the Discernment Process

Providence Health & Services strives to provide ethics resources to patients, family members, physicians and staff across the continuum of care, including Providence Medical Institute sites. These resources, including education as well as consultation services, focus on ethical issues in the care of patients of diverse faith, spiritual and cultural traditions as well as palliative and end-of-life care. Consultation may also be requested in issues relating to the application of the Ethical and Religious Directives for Catholic Healthcare Services as well as Organizational Ethics issues.

Providence Health & Services is also committed to using our mission and values when making major decisions within our ministries. This commitment is reflected in our use of the tool found on the following page entitled Providence Ethical Discernment Process. This process should be used when:
• We must weigh significant resources for capital projects
• Adding or eliminating service lines or departments
• Making significant reductions in staff, or
• Entering into joint ventures or similar relationships, especially with partners whose interests or values are different than ours.

If you would like to arrange for ethics education and consultation or facilitation in using the Ethical Discernment Process, contact the Regional Director of Ethics at 818-847-3352.

Introduction to the Providence Ethical Discernment Process

The Providence Ethical Discernment Process should be used when making major decisions in Providence Health & Services. We consider our Mission and Core Values in all we do, but with more difficult decisions we may be uncertain about which option is best or how to weigh values that appear to be in conflict. We use the discernment process in such situations to help us come to a judgment that is consistent with our Mission, Core Values, and Operating Commitments, and that takes into account the decision’s likely effects on others, especially the poor and vulnerable.

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Options</th>
<th>Values</th>
<th>Decision</th>
<th>Implementation</th>
<th>Evaluation</th>
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</thead>
<tbody>
<tr>
<td>What are the presenting issues or questions?</td>
<td>What are the options for action (doing nothing is an option)?</td>
<td>Consider the issues and options in light of our Mission and Core Values</td>
<td>Do we need a “time-out” for reflection or prayer to find a creative space or to access our spiritual resources?</td>
<td>How will we… Communicate the decision to our stakeholders and others?</td>
<td>How well and how timely did we decide, communicate, and implement the decision?</td>
</tr>
<tr>
<td>What are the key facts (who, what, when, where, why, how)?</td>
<td>How do the options: • Address the issues? • Advance our Mission? • Promote our Core Values? • Affect other stakeholders, including the poor and vulnerable? • Affect other ministries within the system?</td>
<td>Which values relate to this issue or appear to be in conflict?</td>
<td>Considering… • Our situational context, • Our options and their effects on stakeholders, • Our Mission, Core Values, and Operating Commitments, • Other important values, What other important values are affected or to access our spiritual resources?</td>
<td>Implement the decision?</td>
<td>Did the decision achieve the desired result?</td>
</tr>
<tr>
<td>How does the situational context affect analysis (market, social, religious, financial, legal, political)?</td>
<td>By when should the decision be made?</td>
<td>What can we learn from experience (our own, others’)?</td>
<td>How might our Mission and Core Values be affected positively or negatively?</td>
<td>What lessons did we learn?</td>
<td>As evidenced by what metrics?</td>
</tr>
<tr>
<td>Who should be involved and how (who is affected, has needed expertise, has responsibility or authority to decide)?</td>
<td>Will a facilitator or an ethicist be helpful?</td>
<td>What is our best judgment on how we should proceed?</td>
<td>Did the decision achieve the desired result?</td>
<td>Why or why not?</td>
<td>Should we revise our decision based on what we have learned?</td>
</tr>
</tbody>
</table>

If so, how?
Introduction to the Catholic Social Teachings

The Catholic Church’s social teachings focus especially on how we are involved in a complex network of relationships within modern societies. The human sciences and philosophy are helpful for interpreting our central place within society and for enabling us to understand ourselves better as social beings. There is no doubt various opinions exist on one’s interpretation of implementation. These discussions should be conducted with respect and understanding. It is the conversation that is important.

These principles have been developed over the course of a century from the writings of the Popes and the bishops of the Catholic Church. They have been organized into ten different themes which continue to be considered, reflected upon and written about even today.

As part of understanding Catholic Health Care in general and Providence in particular, you will note that our five values come from scripture and from these teachings.

The Ten Themes of the Catholic Social Teachings

- Human Dignity
  The Catholic Church proclaims that human life is sacred and that the dignity of the person is at the core of a moral vision for society. Our belief in the sanctity of human life and the inherent dignity of the human person is the foundation of all the principles of our social teaching.

- Community and the Common Good
  In a global culture driven by excessive individualism, our tradition proclaims that the person is not only sacred but also social. How we organize our society – in economics and politics, in law and policy – directly affects human dignity and the capacity of individuals to grow within a community. Our Church teaches that the role of government and other institutions is to protect human life and human dignity and promote the common good.

- Rights and Responsibilities
  Catholic tradition teaches that human dignity can be protected and a healthy community can be achieved only if human rights are protected and responsibilities are met. Therefore, every person has a fundamental right to life and a right to those things required for human decency. Corresponding to these rights are duties and responsibilities – to one another, to our families, and to the larger society.

- Option for the Poor and Vulnerable
  Catholic teaching proclaims that a basic moral test is how our most vulnerable members are faring. In a society marred by deepening divisions between rich and poor, our tradition recalls the story of the Last Judgment (Matthew 25) and instructs us to put the needs of the poor and vulnerable first.

Introduction to the Catholic Social Teachings (cont’d)

- Participation
  All people have a right to participate in the economic, political, and cultural life of society. It is a fundamental demand of justice and a requirement for human dignity that all people be assured a minimum level of participation in the community. Conversely, it is wrong for a person or a group to be excluded unfairly or to be unable to participate in society. In the words of the U.S. bishops, “The ultimate injustice is for a person or group to be treated actively or abandoned passively as if they were non-members of the human race. To treat people this way is effectively to say they simply do not count as human beings.”

- Dignity of Work and Rights of Workers
  In a marketplace where too often the quarterly bottom line takes precedence over the rights of workers, we believe that the economy must serve people, not the other way around. If the dignity of work is to be protected, then the basic rights of workers must be respected – the right to productive work, to decent and fair wages, to organize and join unions, to private property and to economic initiative.

- Stewardship of Creation
  Catholic tradition insists that we show our respect for the Creator by our stewardship of creation. We are called to protect people and the planet, living our faith in relationship with all of God’s creation.

- Solidarity
  Catholic social teaching proclaims that we are our brothers’ and sisters’ keepers, wherever they live. We are one human family, whatever our national, racial, ethnic, economic, and ideological differences. Solidarity means that “loving our neighbor” has global dimensions in an interdependent world.

- Role of Government
  Because we are social beings, the state is natural to the person. Therefore, the state has a positive moral function. It is an instrument to promote human dignity, protect human rights, and build the common good. Its purpose is to assist citizens in fulfilling their responsibility to others in society. Since, in a large and complex society these responsibilities cannot adequately be carried out on a one-to-one basis, citizens need the help of government in fulfilling these responsibilities and promoting the common good. According to the principle of subsidiarity, the functions of government should be performed at the lowest level possible, as long as they can be performed adequately. If they cannot, then a higher level of government should intervene to provide help.

- Promotion of Peace
  Catholic teaching promotes peace as a positive, action-oriented concept. In the words of Pope John Paul II, “Peace is not just the absence of war. It involves mutual respect and confidence between peoples and nations. It involves collaboration and binding agreements.” There is a close relationship in Catholic teaching between peace and justice. Peace is the fruit of justice and is dependent upon right order among human beings.
Introduction to the Ethical Religious Directives Summary for Catholic Health Care Services

This section gives an overview of the Ethical and Religious Directives (ERDs) to give you a general understanding of what each section addresses. At the end of this guide, you will see the complete version of the ERDs for more specific information and reference as needed.

There are two aims of the Ethical and Religious Directives for Catholic Health Care Services (ERDs):

1. Reaffirm the ethical standards that flow from the Church’s teaching about human dignity.
2. Provide authoritative guidance on some specific moral issues facing Catholic health care.

Part One
The Social Responsibility of Catholic Health Care Services

- Catholic health care is guided by four normative principles:
  1. commitment to promote human dignity
  2. care for the poor
  3. contributions to the common good
  4. responsible stewardship of available resources.

- Catholic health care is marked by respect among caregivers (e.g., physicians and nurses).

- Catholic health care is distinguished by service to and advocacy for the poor and vulnerable.

- Catholic health care institutions treat employees respectfully and justly.

- Employees respect and uphold the ERDs.

Part Two
The Pastoral and Spiritual Responsibility of Catholic Health Care

- Catholic health care extends to and embraces the spiritual nature of the person.

- Pastoral/spiritual care staff minister to the religious and spiritual needs of all patients, residents and families.

- Pastoral/spiritual care staff work collaboratively with community clergy.

- Sacramental ministry is available to Catholic patients and residents.

- Staff has appropriate professional preparation.

Introduction to the Ethical Religious Directives Summary for Catholic Health Care Services (cont’d)

Part Three
The Professional-Patient Relationship

- Both the patient and the professional participate in the healing process. The professional-patient relationship is built upon the values of respect, trust, honesty and appropriate confidentiality.

- Personal nature of care must not be lost even when a team of caregivers is involved in care.

- Medical staff must not withdraw technology with the intention of causing death.

- The dignity of the person is respected regardless of health problem or social status.

- Advance directives, consistent with moral teaching, are respected and honored.

- Informed consent of persons is required and includes information about benefits, risks, side effects, consequences and cost of treatment alternatives.

- Organ donation is encouraged.

- Caregivers, especially physicians, understand and utilize the benefit/burden principle (ordinary/extraordinary means) in the analysis of treatment options for patients and residents.

- An ethics mechanism (e.g., ethics committee) is available to assist with case consultation, education and policy review.

Part Four
Issues in Care for the Beginning of Life

- Catholic health care ministry honors the sanctity of life from conception until death.

- Some specific forms of procreative assistance are permissible.

- Surrogate parenting relationships are precluded.

- Abortion and elective sterilization are not allowed.

- Compassionate care is provided to those who have had an abortion.
Introduction to the Ethical Religious Directives Summary for Catholic Health Care Services (cont’d)

Part Five

Issues in the Care of the Seriously Ill and Dying

• A Catholic health care institution will be a community of respect, love and support to patients and residents and their families as they face the reality of death. The task of medicine is to care even when it cannot cure.
• Catholic health care avoids the use of futile or burdensome technology that offers no reasonable benefit to patient or resident.
• Euthanasia (physician-assisted dying) is not permitted.
• There is the presumption for nutrition and hydration if the benefit outweighs the burden to the patient or resident.
• Patients and residents should be kept as free of pain as possible.
• Pain suppressing or alleviating medicine that may indirectly shorten a person’s life is permitted so long as the intent is not to hasten death.

Part Six

Forming New Partnerships with Health Care Organizations and Providers

• Time of extraordinary change in health care finds Catholic health care organizations and systems increasingly involved with other providers.
• New relationships may offer opportunities to influence the healing profession.
• New relationships may pose serious challenges to Catholic identity.
• Systematic and objective moral analysis is necessary when considering new relationships.
• Reliable theological experts are to be consulted when considering arrangements with other organizations.
• Partnerships that affect the mission or religious and ethical identity of the Catholic health care institution must respect Church teaching and discipline.
• Decisions leading to serious consequences for the identity or reputation of Catholic health care services are made in consultation with local Church leadership.
• Implementation of arrangements with other organizations must be periodically reviewed to ensure alignment with Church teaching.

Note: This is a summary of the Ethical and Religious Directives for Catholic Health Care Services (2001) as prepared by Wheaton Franciscan Services, Inc. It is not an official summary from the National Conference of Catholic Bishops and does not substitute for careful reading of the Ethical and Religious Directives for Catholic Health Care Services. For more information, please contact Mike Douglas, WFSI vice president of ethics, at 630-784-2548 or mdouglas@wfs-inc.org.
Physician Orientation Guide

Introduction to Providence Health International

Providence Health International (PHI) exists to bring assistance to the needy of the world in the areas of medical care and supplies, clinical education support and leadership development. Housed within the Mission Leadership Department of Providence Health & Services, PHI’s areas of focus are varied:

• They offer support through grants for Providence employees wishing to volunteer internationally.
• They operate a warehouse in Lacey, Washington, designated for receiving medical equipment and supplies that are then loaded onto containers and shipped to developing countries.
• They sponsor a leadership immersion trip to El Salvador each fall. The make-up of this delegation of approximately 15 employees rotates each year throughout our Providence regions, i.e., people from our Alaska Region one year, from Washington/Montana Region the next year, from Oregon Region the third year, and from California Region the fourth year; then the rotation begins again.
• They support education exchanges that take place between Providence nurses/residents and health care professionals in developing countries. Current exchange programs involve Providence Portland Medical Center residents practicing in Kenya, Providence St. Vincent Medical Center (PSVMC) residents practicing in Uganda, and a nurse exchange program between PSVMC and nurses from Tanzania.

One of the areas of interest for many physicians is grant process for providing short-term international service, normally as volunteers through other not-for-profit organizations. The grants are intended to help with travel-related expenses and/or the purchase of needed medical supplies for volunteers from one to three weeks.

Rationale for Supporting Volunteers

A commitment to be a healing presence among the poor is a foundational component of the ministries of the Sisters of Providence. Serving those beyond their borders has also been an essential component of their mission since their formation in 1843. It was this spirit of service that first called the Sisters to leave Canada and serve the people of the Pacific Northwest. It was this same spirit that led the Sisters of Little Company of Mary from Europe to the United States. Supporting employees who provide medical care to people in need beyond the borders of the U.S. is a continuation of that same spirit of service.

Providence Health & Services provides grants for multiple reasons. One is to alleviate the unneeded suffering of people wherever they may live. Another is based on the belief that such opportunities provide important opportunities for learning that benefit not only for the person providing the service, but also for the institutions they represent. The intent is to support projects that offer benefit and transformation for both those being served as well as those providing the service. It is hoped that individuals will return with:

• Greater skill and understanding to work with people of diverse cultural and economic backgrounds.
• Increased awareness to be good stewards of the material resources we use.
• New perspectives on health care delivery and meaningful ways to serve the poor.
• A deeper commitment to the Mission and values of Providence Health & Services.
Introduction to Providence Health International (cont’d)

Process for Approval

The amount of funding available on an annual basis is limited. Preference will be given to people volunteering with organizations that reflect the following criteria:

- Are charitable (501c3) organizations committed to serving medical needs.
- Have a mission and value system consistent with Providence Health & Services.
- Have developed ongoing relationships with the local community and have an organizational commitment to continue that relationship.
- Promote self-sufficiency for the people and communities in which they are working.
- Are committed to addressing issues of social justice that strive for systemic solutions to situations of poverty and alienation experienced by the poor.
- Are not actively engaged in proselytizing those being served.

Upon the completion of the volunteer experience the grant recipient is required to complete an individual evaluation of his/her experience within four weeks of returning to the U.S. (Note: in cases where more than one grant recipient is involved in the same project, each participant is still expected to submit his/her own report). Volunteers are asked to include several pictures of their experience with their report; preferably, the pictures would show the volunteer in the service role. Volunteers are also encouraged to find opportunities to share what they have gained from this experience with others in their institutions and local communities.

Southern California Mexican Experience

Providence Health and Services in California also sponsors an annual trip to Tijuana, Mexico for leaders. This 5 day trip includes working with Esperanza, a local group that helps families build concrete homes. We visit Casa Del Migrante and look at the health issues facing our neighbors to the South.

For more information on the annual trip to Mexico contact the Chief Mission Integration Office for S. California at 818-847-3350.

Ethical and Religious Directives for Catholic Health Care Services

Fifth Edition

Preamble

General Introduction

Part One
The Social Responsibility of Catholic Health Care Services

Part Two
The Pastoral and Spiritual Responsibility of Catholic Health Care

Part Three
The Professional-Patient Relationship

Part Four
Issues in Care for the Beginning of Life

Part Five
Issues in Care for the Seriously Ill and Dying

Part Six
Forming New Partnerships with Health Care Organizations and Providers

Conclusion
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 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 Savin’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 (Mk 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, the 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 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. 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 (Gen 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 institutionally based 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; this is the foundation of its 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. 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 health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured. 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. 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 – 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 does not offer the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority 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 deal with 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 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 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 these 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.

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.
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.”11 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.

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 lay – 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.11

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.13 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.15

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.
Appendix: Ethical and Religious Directives

Part Three

The Professional-Patient Relationship

Introduction

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. 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 provider 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 health care from a team of providers, especially in the setting of the modern acute care hospital. But the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient. 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. 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 provider 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. 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.

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 Catholic moral principles and 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.

27. Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits, its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person’s surrogate should have access to medical and moral information and counseling 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 principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity. The functional integrity of the person may be sacrificed to maintain the health of the person when no other morally permissible means is available.

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and 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.

31. 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 surrogates 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 nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.

33. The well-being of the whole person must be taken into account in making ethical decisions about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

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

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 providers 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 treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.

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.
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 with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life “from the moment of conception until death.” 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 the high infant mortality rate 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 thankful will.”

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.

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

With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential for good inherent in many of these technologies, we 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.

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. 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.

Appendix: Ethical and Religious 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.22

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

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.23

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).24

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. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.

43. A Catholic health care institution that provides treatment for infertility should offer not only technical assistance to infertile couples 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 in a manner consonant with its mission.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

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 extraneous pregancy, no intervention is morally licit which constitutes a direct abortion.

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 preventative 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 when undertaken with the intention of aborting an unborn child with a serious defect.25

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.26
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 about the Church’s teaching on responsible parenthood and in methods of natural family planning.

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.28

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.

Part Five

Appendix: Ethical and Religious Directives

Physician Orientation Guide

Physician Orientation Guide

Appendix: Ethical and Religious 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.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.30

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

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. 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.49 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.”46 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. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive 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.44

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. 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. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person’s life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. 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 donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should 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.43

Part Six

Forming New Partnerships with Health Care Organizations and Providers

Introduction

Until recently, most health care providers enjoyed a degree of independence from one another. In ever-increasing ways, Catholic health care providers have become involved with other health care organizations and providers. For instance, many Catholic health care systems and institutions share in the joint purchase of technology and services with other local facilities or physicians’ groups. Another phenomenon is the growing number of Catholic health care systems and institutions joining or co-sponsoring integrated delivery networks or managed care organizations in order to contract with insurers and other health care payers. In some instances, Catholic health care systems sponsor a health care plan or health maintenance organization. In many dioceses, new partnerships will result in a decrease in the number of health care providers, at times leaving the Catholic institution as the sole provider of health care services. At whatever level, new partnerships forge a variety of interwoven relationships: between the various institutional partners, between health care providers and the community, between physicians and health care services, and between health care services and payers.

On the one hand, new partnerships can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments and so influence the healing profession. For example, new partnerships can help to implement the Church’s social teaching. New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.

For example, new partnerships can help to implement the Church’s social teaching. New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.

On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles. The risk of scandal cannot be underestimated when partnerships are not built upon common values and moral principles. Partnership opportunities for some Catholic health care providers may even threaten the continued existence of other Catholic institutions and services, particularly when partnerships are driven by financial considerations alone. Because of the potential dangers involved in the new partnerships that are emerging, an increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships.

The significant challenges that new partnerships may pose, however, do not necessarily preclude their possibility on moral grounds. The potential dangers require that new partnerships undergo systematic and objective moral analysis, which takes into account the various factors that often pressure institutions and services into new partnerships that can diminish the autonomy and ministry of the Catholic partner. The following directives are offered to assist institutionally based Catholic health care services in this process of analysis. To this end, the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops) has established the Ad Hoc Committee on Health Care Issues and the Church as a resource for bishops and health care leaders.

This new edition of the Ethical and Religious Directives omits the appendix concerning cooperation, which was contained in the 1995 edition. Experience has shown that the brief articulation of the principles of cooperation that was presented there did not sufficiently forestall certain possible misinterpretations and in practice gave rise to problems in concrete applications of the principles. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation, with the proviso that, as a rule, Catholic partners should avoid entering into partnerships that would involve them in cooperation with the wrongdoing of other providers.

Directives

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

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

69. If a Catholic health care organization is considering entering into an arrangement with another organization that may be involved in activities judged morally wrong by the Church, participation in such activities must be limited to what is in accord with the moral principles governing cooperation.

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.44

71. The possibility of scandal must be considered when applying the principles governing cooperation.45 Cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused. Scandal can sometimes be avoided by an appropriate explanation of what is in fact being done at the health care facility under Catholic auspices. The diocesan bishop has final responsibility for assessing and addressing issues of scandal, considering not only the circumstances in his local diocese but also the regional and national implications of his decision.46

72. The Catholic partner in an arrangement has the responsibility periodically to assess whether the binding agreement is being observed and implemented in a way that is consistent with Catholic teaching.

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 rejoin 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.

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.

3. Health and Health Care, p. 5.


10. The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic institutionally based 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 governing boards of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.


13. Cf. ibid., c. 867, § 2, and c. 871.

14. 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.”

15. Cf. c. 883, 30.

16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.

17. Cf. directive 53.

18. Declaration on Euthanasia, Part IV; cf. also directives 56-57.


22. Ibid., no. 50.


24. Ibid., no. 12.


27. “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” (Donum Vitae, Part II, B, no. 6; cf. also Part I, nos. 1, 6).

28. Ibid., Part II, A, no. 2.

29. “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”’” (Donum Vitae, Part II, B, no. 6).

30. Ibid., Part II, A, no. 3.

31. Cf. directive 45.

32. Donum Vitae, Part I, no. 2.


37. See Declaration on Euthanasia.

38. Ibid., Part II.

40. 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, 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).


42. See Declaration on Euthanasia, Part IV.

43. Donum Vitae, Part I, no. 4.

44. 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), in Origins 28 (1998): 283. See also “Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals” (Quaecumquae Sterilizatio), March 13, 1975, Origins 6 (1976): 33-35: “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.

45. See Catechism of the Catholic Church: “Scandal is an attitude or behavior which leads another to do evil” (no. 2284); “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).
