

Changes in the Seventh Edition of the Ethical and Religious Directives

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Overview

At their annual meeting in Baltimore, the U.S. Bishops approved the Seventh Edition of the *Ethical and Religious Directives for Catholic Health Care Services* on November 12, 2025. This updates the Sixth Edition, approved in November, 2018.

Key changes in Sixth Edition were in Part Six, about collaboration between Catholic and other-than-Catholic providers. The most substantive area of guidance added in the Seventh Edition comes in Part III, relating to gender medicine and what a Catholic institution may and may not offer under its auspices.

A second additional development is in Part V, where the bishops clarify that the Catholic institution may not actively participate in supporting the practice of VSED, or voluntary stopping of eating and drinking by individuals who intend to end their life prematurely in this way. Additionally, this section expands upon the importance of the range of services encompassed in “the full range of multi-disciplinary palliative care.”

The text also includes more, and more recent, citations in its footnotes to Magisterial teaching, particularly from *Samaritanus Bonus* (Congregation for the Doctrine of the Faith, July 14, 2020) and *Dignitas Infinita* (Dicastery for the Doctrine of the Faith, April 2, 2024). These do not introduce new doctrine but expand the grounding the ERD in the broader teaching of the Church. The footnotes increase in number from 49 to 77.

Other changes are minor refinements in language to align with more contemporary terminology in health care (for instance, from “physician” to “provider” to acknowledge the greater range of licensed specialties today; and from “persistent vegetative state” to “unresponsive wakefulness syndrome” to reflect more nuanced advances in neurology). In several places, elements from different past directives are combined for a more consistent and coherent statement. Thus even with some additions, there are 77 Directives in both the Sixth and Seventh Editions, divided into the same six Parts after a Preamble and 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: Collaborative Arrangements with Other Health Care Providers

Significant Changes in the Seventh Edition

Part One

Prior editions of the ERD included a somewhat awkward statement that “Catholic health care does not offend 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.” This could be misunderstood to imply that Catholic health care would comply with any wishes that arose from individual conscience, which is exactly opposite the intended meaning.

This ambiguity is now addressed by new language:

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

Part Two

There are no changes.

Part Three

Directive 26, on free and informed consent, is expanded with some new text (in italics below) and combines elements from directives 26-28 in the Sixth Edition.

26. The free and informed consent of the person or the person’s surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment. This obligation to obtain consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its expected benefits; its risks, side-effects, consequences, and cost; and the same information about any reasonable and morally legitimate alternatives, including no treatment at all. *Each person or the person’s surrogate should also have access to morally sound resources and guidance, including pastoral counsel and ethics consultations, so as to be able to form his or her conscience.* The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic teaching (including that specified in these Directives).

Directives 27, 28, and 29, primarily on genetic engineering and forms of gender medicine, are new. [Footnotes are omitted to focus on the text.]

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

28. Since “creation is prior to us and must be received as a gift,” we have a duty “to protect our humanity,” which means first of all, “accepting it and respecting it as it was created.” In order to respect the nature of the human person as a unity of body and soul, Catholic health care services must not provide or permit medical interventions, whether surgical, hormonal, or genetic, that aim not to restore but rather to alter the fundamental order of the human body in its form or function. This includes, for example, some forms of genetic engineering whose purpose is not medical treatment, as well as interventions that aim to transform sexual characteristics of a human body into those of the opposite sex (or to nullify sexual characteristics of a human body).

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

Of note, the specific interventions proscribed by these Directives, especially Directive 27, are left open. Some may be inferred from the references, in particular to the USCCB’s own “Doctrinal Note on the Moral Limits to Technical Manipulation of the Human Body,” n. 18, which states:

Catholic health care services must not perform interventions, whether surgical or chemical, that aim to transform the sexual characteristics of a human body into those of the opposite sex or take part in the development of such procedures. They must employ all appropriate resources to mitigate the suffering of those who struggle with gender incongruence, but the means used must respect the fundamental order of the human body.

This lack of specificity is likely also intended to allow the Directive to apply to new and unforeseen interventions.

Directive 30 expands on the principle of totality and the functional integrity of the human body. It specifies the conditions under which the anatomical integrity of the body may be sacrificed for the sake of the good of the whole person.

Part Four

Directive 39 is new, directly addressing cryopreservation and destruction of human embryos involved in techniques of assisted reproduction. It adds that “post-mortem gamete retrieval is not permitted.” This concern for such techniques is also added to Directives 40 and 41.

Directive 44 adds for the first time the need to provide “appropriate care and accompaniment during and after miscarriage” to other perinatal services.

Directive 45 specifically adds the term “procured” to its definition of abortion, and explicitly notes that abortion can be done as either a surgical or a chemical intervention. It also expands on the risk of scandal that can arise in association with abortion providers. The new text reads:

45. Procured abortion (that is, the “deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth”) is never permitted, whether chosen for its own sake or for a further end. Every intervention, whether surgical or chemical, whose sole immediate effect is the destruction of a living human embryo or fetus or the removal of a living embryo or fetus from the uterus before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo; removal after viability with the intent for it to result in the death of a living fetus is also an abortion. Catholic health care institutions need to evaluate carefully the risk of scandal in any association with abortion providers, even when the association is limited and does not of itself constitute immoral cooperation with wrongdoing.

Part Five

Directive 56 combines elements of the Sixth Editions Directives 56 and 57 to augment how the distinction between ordinary/proportionate and extraordinary/disproportionate means are assessed. New text is shown in italics.

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

As noted above, Directive 58 updates the terminology around neurological injury and thereby also somewhat expands it beyond the former category of “persistent vegetative state.”

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., a range of neurological conditions including unresponsive wakefulness syndrome, i.e., “persistent vegetative state”) who can reasonably be expected to live an indeterminate amount of time if given such care. 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.” 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.

Directive 59 slightly qualifies the definition of euthanasia. It now reads (new text in italics):

59. Euthanasia is any action or omission that of itself or by intention causes death *in order to bring all suffering to an end. ...*

The Sixth Edition had simply stated “... causes death in order to alleviate suffering.”

Directive 60 prohibits Catholic health care services from facilitating VSED (Voluntarily Stopping Eating and Drinking). The footnote to this Directive clearly distinguishes the natural loss of appetite and thirst in the final stages of illness from the intention to bring about death by refusing food and water. There is some ambiguity remaining on what it would mean to “facilitate” VSED.

60. If a patient expresses an intention to commit suicide by Voluntarily Stopping Eating and Drinking (VSED), he or she should be informed that the Catholic health care service will not facilitate this course of action. Rather, health care professionals should do what they can, in a way that respects the patient’s freedom, to dissuade the patient from this course of action. They should continue to provide appropriate pain management while avoiding immorality with suicide by VSED. When appropriate, psychiatric care can be recommended. The pastoral care team should be consulted. Appropriate steps should be taken to avoid giving scandal.

Directives 61 and 62 are mostly new, and expand on the concepts of palliative care and the importance of human relationships in life-limiting illness.

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

valorizing pain and suffering, should be available to help them to appreciate the Christian understanding of redemptive suffering.

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

Part Six

As Part Six had been substantially reworked for the Sixth Edition, there are no changes to this section in the Seventh Edition.