HEALTH CARE *and* CATHOLIC MORALITY (*ThM 580*)

Instructor: Fr. Luke Dysinger, O.S.B.

CLASS NOTES

Theological History of Catholic Teaching on Prolonging Life

Gary M. Atkinson, Ph.D

Chapter 7 of *Moral Responsibility in Prolonging Life Decisions* ed. by McCarthy & Moraczewski
(Pope John Center, St. Louis, 1981, distr. by Franciscan Herald Press Chicago);

Introduction

On November 24, 1957, Pope Pius XII delivered to an international congress of anesthesiologists an address known as "The Prolongation of Life".[1] That address, in a sense, represents a culmination of the theological development of the Church's official teaching regarding the prolongation of life, and at the same time provides an indispensable basis for understanding the contemporary situation. The purpose of this chapter is to present a brief description of the historical development of theologians' answers to questions regarding the duty to preserve life.

In looking at the historical development of an idea or concept, one is frequently faced with the difficulty of deciding just how far back to trace that development. Concerning the question of the prolongation of life, one is inclined to say that any starting point is bound to be somewhat arbitrary. But there are at least two reasons for beginning here with the writings of the Angelic Doctor. First, his assimilation of human reason and divine revelation is held to be without parallel, and the impact of his thinking on his successors down to the present day has been immense. Second, as a practical matter, the history of the development of the idea from Aquinas to the present is a topic of manageable proportions for a chapter of this length.

St. Thomas Aquinas (1224-1274)

Aquinas sees life as a gift from God, so that a person who takes his own life sins against God and violates God's mastery over life and death. Thus, we have a negative duty owed God not to kill ourselves. But do we possess a corresponding positive duty to take steps to keep ourselves alive? Aquinas answers this question in the affirmative. In his lectures on the Epistles of St. Paul, Aquinas writes:

> A man has the obligation to sustain his body, otherwise he would be a killer of himself . . . by precept, therefore, he is bound to nourish his body and likewise we are bound to all the other items without which the body can nor live.[2]

Now it would seem reasonable to draw from this quotation the inference that Aquinas believes we have an absolutely binding obligation to take every step necessary for the preservation of one's life. But there is a basis within the *Summa* for denying such an inference. In the *Secunda Secundae,* Aquinas takes up a discussion of fearlessness, and his first question is whether fearlessness ought to be considered a sin. Aquinas' answer is that it can be:

> It is inbred for a man to love his own life and those things which contribute to it, but in due measure *(tamen debito proprio);* that is, to love things of this kind not as though his goal were set in them, but inasmuch as they are to be used for his final end. So if a man falls below the due measure of love of temporal goods this is against the basic tendency of his nature and consequently a sin ....
>
> So it is possible for someone to fear death and other temporal evils less than he should, because he loves life and its goods less than he should ....[3]
>
> Temporal goods ought to be despised in so far as they hinder us from love and fear of God. And in this sense they ought not to be a cause of fear; so *Ecclesiasticus* says (34:16), *He who fears God will not tremple.* But temporal goods are not to be despised in so far as they are helpful means of attaining things which promote fear and love of God.[4]

It is important here to note two things: *first*, that by man's "final end" Aquinas means here the happiness of eternal life with God and, *second,* that by "temporal goods" Aquinas means to include life on this earth. Thus, Aquinas is saying that there are temporal goods and evils and that they ought to be sought or avoided, but in *due measure* as this pursuit or avoidance is conducive or appropriate to the person's final end who is God. To seek a temporal good or avoid a temporal evil, *not* in due measure, is to act in such a way that God, the final end, is lost sight of. Now Aquinas in this article is concerned with a lack in seeking temporal goods *(aliquis deficiat a debito modo).* But one can also conceive the possibility of an *excess,* of too much of a love for temporal goods. Just as one can sin by a lack of love for one's life, so one can sin by an excess of such love. In either case, the test is whether the pursuit or

avoidance is useful in serving to obtain the final end of knowing, loving, and serving God *(secundum quod eis utendum est propter ultimum finem).*

Francisco De Vitoria (1486-1546)

Aquinas set the parameters for the discussion regarding the prolongation of life: (1) suicide is ruled out, (2) as is the intended killing of the innocent; (3) mutilation is recognized as a legitimate means of saving life; (4) an obligation to preserve life is admitted, but (5) this obligation is seen to be somewhat circumscribed by considerations relating to the proper pursuit of one's final end.[5] The task of the successors of Aquinas became that of elaborating on and specifying the implications of these basic points.

The moral theologians who immediately succeeded Aquinas were content to restate his arguments opposing suicide, and we find in them little discussion regarding the obligation to preserve one's life. This neglect is abruptly altered by the great sixteenth century Dominican moralist, Vitoria. In his *Relectiones Theologicae* he discusses the virtue of temperance and the eating of food. It is in connection with food, and its usefulness in preserving life, that Vitoria raises some points of special interest .Following Aquinas, Vitoria argues that a person has an obligation to preserve his life, based on the natural inclination toward self-preservation. Furthermore, the malice of suicide would arise from the non-preservation of oneself. But if this is so, then it would seem that a sick person who does not eat because of some disgust of food would be guilty of a sin equivalent to suicide. Vitoria denies this inference, and, in response, makes eight important points:

(1) A sick person is required to take food if there exists some hope of life (*cum aliqua spe vitae).*

(2) But, if the patient is so depressed or has lost his appetite so that it is only with the greatest effort that he can eat food, this right away ought to reckoned as creating a kind of impossibility and the patient is excused *(jam reputatur quaedam impossibilitas et ideo excusatur),* at least from mortal sin, especially if there is little or no hope of life.

(3) Furthermore, the obligation to take drugs is even less serious. This is because food *is* "*per se* a means ordered to the life of the animal" *(per se medium ordinatum ad vitam animalis)* and is natural, whereas drugs are not. A person is not obliged to employ every possible means of preserving his life, but only those that are *per se* intended for that purpose *(media per se ad hoc ordinata).*

(4) Nevertheless, if one had a moral certitude that the use of a drug would return him to health, and that he would die otherwise, then the use of the drug would be obligatory . If he did not give the drug to a sick neighbor, he would sin mortally, so it seems he would have the same responsibility to save his life. Medicine is also *per se* intended by nature for health *(medicina per se etiam ordinata est ad salutem a natura).*

(5) On the other hand, it is rarely certain that drugs will have this effect, so it is not mortally sinful to declare abstinence from all drugs, though this is not a praiseworthy attitude to take since God has created medicine because of its usefulness.[6]

(6) It is one thing not to protect or prolong life; it is quite another thing to destroy it. A person is not always held to the first.

(7) To fulfill the obligation to protect life, it is sufficient that a person perform "that by which regularly a man can live" *(satis est, quod det operam, per quam homo regulariter potest vivere).* Again, if a person "uses foods which men commonly use and in the quantity which customarily suffices for the conservation of strength" *(quibus homines communiter utuntur et in quantitate),* then the person does not sin even if his life is notably shortened thereby, and this is recognized.

(8) Thus, a sick person would not be required to use a drug he could not obtain except by giving over his whole means of subsistence .[7] Nor would an individual be required to use the best, most delicate, most expensive foods, even though they be the most healthful. Indeed, the use of such foods would be "blameworthy" *(reprehensibile).* Nor would one be obliged to live in the most healthful location.[8] In another work *(Comentarios a la Secunda Secgndae de Santo Tomás),* Vitoria cites as examples of "delicate foods" hens and chickens. He says that if the doctor were to advise the person to eat chickens and partridges, the individual could still choose to eat eggs and other common items instead, even though he knew for certain he could live another twenty years by eating such special foods.[9]

In a later *Relectio* on the question of homicide, Vitoria summarizes his position as follows: "One is not held, as I said, to employ all the means to conserve his life, but it is sufficient to employ the means which are of themselves intended for this purpose and

congruent" *(ad hoc de se ordinata et congruentia).l°* This makes clear the point also made by Aquinas: that one is not obliged to use any and every means for the preservation of life.

Furthermore, Vitoria is inclined to view the obligation to use certain means not in the abstract but in the concrete. As the second point on the above list shows, what produces a "kind of impossibility" (and no one is obliged to do the impossible) need not be the means themselves but the impact of their use on the individual patient. Thus, the obligation to preserve life is neither absolute nor invariant, but rather can depend on the peculiar circumstances of the individual.

Vitoria raises the question of the relevance of the distinction between natural means (e.g., foods and drink) versus artificial means (e.g., drugs). It should not be surprising that Vitoria himself displays some ambivalence on the subject. On the one hand, (Point 3), the obligation to use drugs is less stringent than the obligation to use food because food is a means *per se* ordered to the life of the animal, and is natural, whereas drugs are neither. But on the other hand, (Point 4), medicine is also intended by nature for health. It would seem, then, that medicine is also natural.

Daniel Cronin offers the following as a possible explanation for Vitoria's distinction between artificial and natural means:

> Food is primarily intended by nature for the basic sustenance of animal life. Food for man is basically and fundamentally necessary from the very beginning of his temporal existence. It is basically required by his human life and nature intends food for this purpose. That is why man has the right to grow food and kill animals. Furthermore, because it is a law of nature that man sustain himself by food, it is a duty for man to nourish himself by food. In the case of drugs and medicines, the same is not true. Drugs and medicines are intended *per se* by nature to help man conserve his life. However, this is by way of exception. Drugs and medicines are not the basic way by which man is to nourish his life. They are intended by nature to aid man in the conservation of his life when he is sick or in pain or unable to sustain himself by natural means. These artificial means are not natural means but they are intended by nature to help man protect, sustain, and conserve his life. If man were never to be sick, he would never need medicines. If he is sick, however, it is quite *natural* for him to make use of *artificial* means of *conserving life*.[11]

Thus, natural means are intended by nature for the preservation of life, whereas artificial means are likewise intended, but only as means supplementing the natural, when this becomes necessary. Such a distinction may be able to explain some moral difference regarding the obligation to employ them, but it would also seem to permit calling artificial means obligatory under certain conditions.

Juan Cardinal De Lugo (1583-1660)

A period of a hundred years stretches between the work of Vitoria and de Lugo. During this time a number of prominent theologians were writing on the topic of obligatory means of preserving life: Soto, Molina, Sayrus, Banez, Sanchez, Suarez. These are important writers, but their work did not advance much beyond Vitoria. This is not to say that their work is inconsequential or insignificant, for it does **serve** to demonstrate a rough consensus with only the relatively minor details to be worked out. By and large, we find few new basic principles being enunciated. The writers seem mostly content to elaborate on old themes.

By paying special attention to de Lugo, then, we may convey the false impression that his ideas are radically new. In fact, many of the topics discussed by de Lugo were thoroughly covered by his predecessors. Both Aquinas and Vitoria admit that there are restrictions on the duty to preserve life, that there can be conditions under which one is not morally obliged to preserve life. It must follow, then, that there are conditions under which not-saving is morally different from killing. De Lugo follows his predecessors in this. What he has to say is not always new, but some of the examples he employs are historically important.

De Lugo deals with one topic not yet discussed in any great detail but of great interest for his predecessors and contemporaries, the question of mutilation. Agreeing with Aquinas, de Lugo held that, just as a person does not possess full dominion over his own life, so he does not possess complete dominion over the parts of his body. Thus, arguing as Aquinas had argued, mutilations of the body are wrong if they are not necessary for the body's health. The question at issue here is whether certain mutilations can become *obligatory,* as being necessary for life or health. De Lugo holds that such a mutilation is *obligatory, provided* that it can be accomplished without intense pain:

> He must permit this cure when the doctors judge it necessary, and when it can happen without intense pain; not, if It is accompanied by very bitter pain; because a man is nor bound to employ extraordinary and difficult means to conserve his life *(media extraordinaria et difficillima).*[12]

Vitoria had insisted, (see the seventh point in summary above), that in most cases one is obliged to use only those means that are regularly *(reguariter)* and customarily *(communiter)* employed for the preservation of life. Here de Lugo seems to be making basically the same point, but he chooses to phrase his position in the negative, that one is not obliged to employ extraordinary or out-of-the-ordinary means for the preservation of life. Thus, de Lugo is saying that the difference between not-saving and overt killing is morally important if the means being refused are either difficult to employ or out of the ordinary. He uses, as an example of means difficult to employ, a mutilation causing intense or bitter pain *(intenso acerbissimo dolore)*. Indeed, a means may be out of the ordinary precisely *because* it is painful to employ.

Nevertheless, it is important to recognize that there may be a number of reasons why a means may be out of the ordinary, other than that it is difficult to employ. Thus de Lugo considers many of the examples of optional means earlier mentioned by Vitoria: the use of choice and costly medicine, or even the drinking of or abstaining from wine.[13] Indeed, one senses in de Lugo a striking attempt to be most liberal in judging a means to be optional. Any reason that would make a means out of the ordinary suffices for de Lugo as a justification for calling it optional. And he is quite willing to relativize this element of the extraordinary (as Vitoria was with the element of the burdensome) to the particular circumstances of the individual. Thus de Lugo argues that a novice in a religious order is not bound to return to the secular world in order to eat better food to preserve his life, since such food, even though ordinary and common for the secular world, is not ordinary for those in the religious life. De Lugo holds that the failure to employ available means necessary for preserving one's life or the failure to avoid a potentially death-dealing natural cause can be morally equivalent to the positive taking of one's own life. But this is true only where the means are ordinarily employed and not difficult to use, or where the death-dealing natural cause can easily be avoided.

In the previous discussion the opinion of Vitoria argued that a sick person is required to take food to preserve his life, at least if the food can be employed without great difficulty. But Vitoria adds a further qualification: for the taking of food to be obligatory, there must exist "some hope of life." The implication there is that a person is not obliged to employ means if there is no hope of their being useful in preserving life.

De Lugo is in agreement with Vitoria on this point and employs an example which will be discussed by later moralists and will be seen to have considerable theoretical and practical significance for the present day. De Lugo considers the case of a man facing certain death in a burning building. The man notices that he has water to extinguish part of the fire, but not all of it, and that he can only delay his death by the water's use. Is the man under an obligation to use the water? De Lugo answers in the negative, "because the obligation of conserving life by ordinary means is not an obligation of using means for such a brief conservation -- which is morally considered nothing at all" *(quae moraliter pro nihilo reputatur)*.[14]

On the other hand, de Lugo holds that if the person could put out the fire completely, he would be obliged to use it. In this latter case, the use of water would be analogous to eating ordinary foods. Certainly the use of water is an ordinary means of putting out a fire (and so saving a life). And, in the example, the means can be easily employed. Thus, de Lugo wished to admit the possibility that an ordinary means need not be obligatory because the benefit to the person is too slight to carry moral weight.

Alphonsus Liguori (1696-1787)

The next author in this survey, St. Alphonsus Liguori, lived about a hundred years after Cardinal de Lugo. Alphonsus adds little to the work of his predecessor. His *Theologia Moralis* has been of great historical importance, but he covers no new ground in his treatment of the duty to preserve life, being content to make a number of well-covered points: (1) that there is no obligation to use costly or uncommon medicines; (2) that one need not move to a more healthful climate; (3) that one is not required to use difficult or extraordinary means of preserving life, such as the amputation of a leg; (4) that one might have an obligation to use ordinary medication if there were good hope for recovery.

Alphonsus does raise a point not yet discussed, though it is not new with him, that a person's subjective repugnance toward the use of a means might make that means nonobligatory for that individual. Alphonsus mentions the case of a woman (particularly a maiden) who might find examination by a male physician greatly abhorrent. This element of subjectivity in the assessment of the obligatoriness of means is firmly in the tradition of Vitoria and de Lugo.

Daniel Cronin, whose work on the history of the ordinary / extraordinary distinction is the most thorough to date, sees little of novelty in the writers of this period. He finds moralists using the very same phrases and examples already well-worn by their predecessors. Cronin offers as one hypothesis for this lack of originality the fact that

> progress in the medical field had not actually reached such a degree as to initiate any speculation on whether a particular remedy should be considered obligatory or not. Evidently an amputation, at this period in history, was the perfect example of a terrible torture which no one ordinarily could be held to undergo....Had doctors and other scientists created doubts or difficulties by advancing new and secure methods of health and cure, no doubt these very moralists would have settled them, as they did in so many other instances. The absence of speculation therefore seems due to the fact that difficulties in the matter were not presented to the moralists, rather than any want of appreciation of the problem irself.[15]

Alphonsus' *Theologia Moralis* shares this general lack of originality. Furthermore, the writers between the time of Alphonsus and the twentieth century have little new to say. To be sure, there are differences in emphases and disagreements on some points. For example, Vincent Patuzzi, an eighteenth century theologian, takes issue with de Lugo, and maintains that a maiden does possess an obligation to accept treatment from a male physician even at the cost of great embarrassment and shame.[16] But it is the scarcity of such differences that is the most striking feature of this period. Daniel Cronin writes:

> After St. Alphonsus and in the nineteenth century, the characteristics of the treatments given this problem of the ordinary and extraordinary means of conserving life were fairly well standardized. St. Alphonsus had emerged as a recognized authority and leader in the field of Moral Theology. What he had learned from the previous theologians was now to be passed down by the authors who followed him. This is particularly true regarding the problem of the ordinary and extraordinary means of conserving life. Here and there different speculation is discovered, but for the most part, the authors are content to paraphrase Alphonsus.[17]

And since there is little new in Alphonsus himself, the basic positions can be traced back to de Lugo, Vitoria and Aquinas.

One last point will be noted before closing this section. In their work Vitoria and de Lugo insisted that in assessing the obligatoriness of a given means, the issue must be relativized to take into account the particular condition of the patient. Thus, if the eating of food produces intense repugnance, that means could become non-obligatory for that patient even though the means would remain obligatory for most patients. But one may turn the question around and ask whether there are some *non-obligatory* means that remain optional *regardless* of the condition of the patient? A surprising number of theologians in the nineteenth and twentieth centuries answer this question in the affirmative. Noldin and Schmitt hold that not even a rich person would be required to seek the services of very skilled doctors or to leave home for a more healthful climate. What is required of the sick is only what can be required of anyone else: the use of means ordinarily employed.[18] This judgment is echoed by Genicot and Salsmans[19] and by Herbert Jone and Urban Adelman.[20] Edwin Healy goes further in his work *Moral Guidance.* In that work, published in 1942, Healy sets as an *absolute* norm the sum of $2,000 beyond which *no one is* obliged to go in saving his life.[21] This position would hold that although the judgment of a means as ordinary and therefore obligatory must *always* be made *relative* to the condition of the individual patient, the judgment *of some* means as extraordinary and optional can be made *absolutely* and

independently of the patient's particular circumstances.

Gerald Kelly (1902-1964)

Kelly is an important figure for this study. As a moral theologian he was intrigued by the history of the concept of ordinary and extraordinary means. He published two key articles in *Theological Studies*, "The Duty of Using Artificial Means of Preserving Life" (1950, hereafter "Artificial")[22] and "The Duty to Preserve Life" (1951, hereafter "Preserve").[23] The earlier article, "Artificial," is the lengthier of the two. In it Kelly presented a resumé of the traditional position and requested help from his readers in resolving a few of the more difficult questions raised. The shorter, "Preserve," appeared eighteen months later and contains Kelly's further reflections on the topic in response to suggestions from his readers.

In the first article, Kelly summarized a descriptive approach to the distinction of ordinary and extraordinary means of prolonging life:

> Speaking of the means of preserving life and of preventing or curing disease, moralists commonly distinguish between *ordinary* and *extraordinary* means. They do nor always define these terms, but a careful examination of their words and examples reveals substantial agreement on the concepts. By *ordinary* they mean such things as can be obtained and used without great difficulty. By *extraordinary* they mean everything which involves excessive difficulty by reason of physical pain, repugnance, expense, and so forth. In other words, an extraordinary means is one which prudent men would consider at least morally impossible with reference to the duty of preserving one's life.[24]

Kelly also notes the uncertain status of major operations in these days of anesthesia and antibiotics. He finds a tendency among modern authors to consider most operations today as ordinary means, though there is also a common willingness to admit the possibility that a strong subjective repugnance on the part of the patient could render those operations extraordinary means for some people.

Kelly raises the question of whether the concept of the "extraordinary" should be treated as relative or absolute, a question raised already in this chapter. Kelly writes that his "general impression" is that "there is common agreement that a relative estimate *suffices.* In other words, if any individual would experience the inconvenience sufficient to constitute a moral impossibility in the use of any means, that means would be extraordinary for him."[25] On the other hand, Kelly cites a number of authors who believe that there is an absolute standard of an extraordinary means beyond which no one, regardless of his condition, need go.

Kelly makes two other points that should be mentioned here. First, he notes that the standard moralists he has consulted are concerned solely with the responsibility of the individual patient and say nothing about the duties of the family or of the medical profession. Second, Kelly points out that the moralists are in agreement that although a patient *is per se* not obliged to use extraordinary means in preserving his life, the use of such means is permissible and usually admirable. Furthermore, a patient *per accidens* may even be obliged to use extraordinary means "if the preservation of his life is required for some greater good such as his own spiritual welfare or the common good." As traditionally cited examples, one might consider the obligation of a person to take extraordinary steps to preserve his life until he can receive the sacraments, or the obligation of a government leader to keep himself alive if his leadership is necessary for the welfare of the community.

The foregoing is relatively unproblematical, at least on a theoretical level. But Kelly continues in a way that will produce terminological difficulty. This occurs when Kelly raises the question whether a patient can be obliged to employ *useless ordinary* means. Kelly cites several authors including Alphonsus. Ballerini-Palmieri and Noldin-Schmitt, as seeming to espouse the view

> that no *remedy is* obligatory unless it offers a reasonable hope of checking or curing a disease. I would not call this a common opinion because many authors do not refer to it, but I know of no one who opposes it, and it seems to have intrinsic merit as an application of the axiom, *nemo ad inutile tenetur [i.*e., No one can be obliged to do what is useless]. Moreover, it squares with the rule commonly applied to the analogous case of helping one's neighbor: one is not obliged to offer help unless there is a reasonable assurance that it will be efficacious.[26]

Kelly is thus willing in "Artificial" to countenance the possibility of some means being ordinary and yet optional and non-obligatory. At the close of that article, Kelly admitted that many of the points he had raised call for further discussion. Two in particular, he said, were of "special import," and one of these was the possibility "that even ordinary, artificial means are not obligatory when relatively useless." His original article can be seen, then, as a call for further discussion on certain controversial issues.

In his second article, Kelly presents some of the reactions his earlier paper had elicited from theologians and offers further reflections of his own. He writes in "Preserve":

> Theologians have responded favorably to the suggestion that even an ordinary artificial means need not be considered obligatory for a patient when it is relatively useless. It was proposed, however,--and I agree with this--that, to avoid complications, it would be well to include the notion of usefulness in the definitions of ordinary and extraordinary means. This would mean that, in terms of the patient's duty to submit to various kinds of therapeutic measures, ordinary and extraordinary means would be defined as follows:
>
> *Ordinary* means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.
>
> *Extraordinary)* means are all medicines, treatments, and operations, which cannot be obtained and used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.
>
> With these definitions in mind, we could say without qualification that the patient is always obliged to use ordinary means. On the other hand, insofar as the precept of caring for his health is concerned, he is never obliged to use extraordinary means; but he might have an extrinsic obligation *to* use such means, e.g., when his life is necessary for the common good or when a prolongation of life is necessary for eternal salvation.[27]

It will be helpful to compare these definitions of ordinary and extraordinary means with the descriptions cited from the first article above. There we see the term *ordinary* as encompassing only those means "as can be obtained and used without great difficulty." The new definition of *ordinary) is* changed in two ways, one obvious and other more subtle. First, Kelly quite obviously adds the concept of usefulness to the definition of *ordinary*. But, secondly, there is a more radical change in the way in which the term *ordinary is* treated. In the earlier definition, the term is treated as *descriptive* term, as simply referring to how easily the means may be obtained and employed. In the latter definition, and the quotation makes this clear, Kelly treats the term as an *essentially normative or evaluative e one.* It is no longer used simply to *describe* ease of use; it is now used to make a judgment regarding *obligatoriness* of use. For the earlier definition, it made quite good sense to suggest as a theoretical possibility that some ordinary means might not be obligatory. But in the second definition, it makes no sense (at least in Kelly's mind) to suggest an ordinary means (as newly defined) might not be obligatory: "without qualification the patient is always obliged to use ordinary means." In other words, to call a means non-obligatory one *must,* using Kelly's new definitions, call the means extraordinary. *Ordinary = obligatory*. *extraordinary = per se optional,* and these two equations are justified by reducing the obligatoriness of means to their being easily obtained and employed and their offering reasonable hope of benefit.

Kelly's two articles mark, as it were, a kind of watershed between the descriptive and normative senses of *ordinary* and *extraordinary*. Writing in his first article and surveying the past history, Kelly could provide a *descriptive* analysis of *ordinary*. Writing in his second, in response to suggestions, he provides a *normative* analysis. Of course, this descriptive / normative distinction can be pushed too far, for even in the first definition the feature of "without great difficulty" has normative elements. And in the second, the elements of being without excessive burden and offering reasonable hope of benefit are somewhat descriptive. Nevertheless, the differences between the two definitions are sufficiently great to warrant calling them definitions of *different types* of concepts. Thus, the possibility of serious confusion is created when the same word is used to bear such fundamentally different meanings .

In his first article, in discussing the case of a dying patient whose life can be extended for a few weeks by intravenous feeding, Kelly holds that the issue comes down to the usefulness of the means. "To me, the mere prolonging of life in the given circumstances seems to be relatively useless, and I see no sound reason for saying that the patient is obliged to submit to it."[28] A conscious patient should be allowed to decide for himself. If unconscious, Kelly still says, "I see no reason why even the most delicate professional standard should call for their use. In fact, it seems to me that, apart from very special circumstances, the artificial means not only need not, but should not, be used, once the coma is reasonably diagnosed as terminal."[29]

Kelly cites the positions of two earlier commentators on the case. The original commentator, Joseph P. Donovan, had held that the IV feeding itself involves no moral impossibility and hence should be considered an ordinary means. Stopping IV would, according to Donovan, be a form of mercy killing. [30] On the other hand, Joseph V. Sullivan had held the position that extraordinary means are relative to the patient's condition, and, because IV feeding is an artificial means of prolonging life, one may be more liberal in application of principle.[31] Therefore,

Sullivan considers the means to be extraordinary and the physician to be justified in discontinuing the IV. Kelly's position is to offer a distinction. He is in agreement with Donovan in calling IV an ordinary means, but he says that "one may not immediately conclude that it is obligatory." Rather, Kelly wishes to consider such means ordinary, but useless, artificial means of preserving life and so optional. Thus, Kelly is in practical agreement with Sullivan over the discontinuance of the means, but sides with Donovan on designating the means as ordinary. The strong impression conveyed is that both Sullivan and Donovan are using the concept of *ordinary* which Kelly *later* adopted in his second article. Under his revised conception, Kelly would have agreed with Sullivan *in toto,* calling the means useless, and therefore extraordinary, and therefore optional. Kelly says that using oxygen or IV feeding merely to sustain life for a while in "hopeless" cases can be called *remedies* "only in the very wide sense that they delay the hour of death." Because they sustain life, they in a sense offer a hope of success. But their expense quickly can mount up. For a combination of reasons, then, the use of artificial means of preserving life for a few days or weeks is optional. Kelly notes that his principles embody a great deal of imprecision: There are degrees of "success." It is one thing to use oxygen to bring a person through a crisis; it is another thing to use it merely to prolong life when hope of recovery is practically negligible. There are also degrees of "hope," even when it concerns complete recovery. For example, in one case the use of oxygen to bring a

> patient through a pneumonia crisis may offer very high hope, whereas in another case the physical condition of the patient may be such that there is only a slim chance of bringing him through the crisis. Finally, there are degrees of difficulty in obtaining and using ordinary means. Some are inexpensive and very easy to obtain and use; others may involve much more difficulty, though not moral impossibility.[32]

All of these features add considerably to the practical difficulties encountered in deciding about concrete cases. But they do not necessarily create theoretical problems of understanding.

Daniel A. Cronin (1927-)

The most complete work on the history of the ordinary / extraordinary means distinction is Daniel A. Cronin's doctoral dissertation (1958) from the Gregorian Pontifical University in Rome: *The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life.* The author, now the Most Reverend Daniel A. Cronin, S.T.D., Bishop of Fall River, Massachusetts, presents a study of the views of fifty or more moral theologians from Thomas Aquinas to the early 1950's, followed by his own recommendations. His position is presented here in two sections.

A. The Ordinary / Extraordinary Means Distinction

Following his discussion of the views of individual authors, Cronin attempts to summarize and categorize their positions by listing various features commonly cited as grounding the distinction between obligatory and optional means.[33] None of these features is employed by every author Cronin cites, but each of the features is employed by enough of the authors to justify calling it an important aspect of the distinction as it has been drawn historically. Concerning the concept of *ordinary* (obligatory) means, Cronin mentions four commonly cited features:

(1) hope of a beneficial result (spes salutis): even natural means, such as the taking of food or drink, can become optional if this element is not present. Cronin sees this feature as relative to the condition of the patient, so that no means can be said to be absolutely obligatory regardless of the patient's own status;

(2) commonly used (media communia): Cronin sees this notion of what is in common use as basic. "For the moralists, the duty of conserving one's life does not demand a diligence or a solicitude that exceeds the usual care that most men normally give their lives."[34]

(3) comparison with one's social position (secundum proportionem status): This feature serves to emphasize even further the relative feature of what is obligatory. Cronin sees this idea as connected with the idea of commonly used means and also with the feature of cost;

(4) not difficult to obtain and employ (medicina non difficilia): this feature is alternatively phrased positively as "convenient" means, though Cronin notes that most moralists prefer using the negative expression. The difficulty in question must be *excessive,* and, once again, this can be determined only as relative to the patient's own condition.

In addition to characterizing ordinary means, the moralists have also used terms to refer to means held to be extraordinary and therefore as optional. Cronin lists five of these commonly used phrases:

(1) impossibility (quaedam impossibilitas): this feature refers to the element of *moral* as opposed *to physical* impossibility. We may characterize the morally impossible as what one cannot be reasonably expected to do. Again, this feature is relative to the condition of the patient;

(2) great effort (summus labor, media nimis dura): such a quality can encompass even the taking of food;

(3) pain (quidam cruciatus, ingens dolor): Cronin maintains that this should also be understood as relative to the patient's.condition;

(4) expense (sumptus extraordinarius, media pretiosa, media exquisita): again, relative to the condition of the patient, though some authors, as we have noted, would permit some appeal to an absolute standard of expense beyond which no one need go;

(5) *intense emotion (vehemens horror):* fear and repugnance are the two emotions commonly appealed to. This feature is closely related to the first as creating a moral impossibility, and, like the first, is also a relative norm.

Turning from the more historical dimensions of his study, Cronin examines the views of Gerald Kelly. Cronin is generally favorable toward Kelly's definitions of *ordinary* and *extraordinary* quoted above. Cronin's definitions may be understood simply as clarifications of Kelly's:

> *Ordinary means of conserving life* are those means commonly used in given circumstances, which this individual in his present physical, psychological and economic condition can reasonably employ with definite hope of proportionate benefit.
>
> *Extraordinary means of conserving life* are those means not commonly used in given circumstances, or those means in common use which this individual in his present physical, psychological condition cannot reasonably employ, or if he can, will not give him definite hope of proportionate benefit.[35]

Cronin's definitions provide *two* standards, one absolute and one relative. If a means is not ordinarily or customarily used, then *no one* has an obligation to employ it (in the absence of exceptional features). This is an absolute standard. The relative standard enters when a means is customarily employed, but would be unreasonable for that particular

B SPECIAL OBLIGATIONS OF PHYSICIANS

With regard to the special obligations of physicians, Cronin maintains that the physician has the obligation of using ordinary means of conserving life when treating the patient, and that, If the patient chooses to employ extraordinary means the doctor has no choice but to follow his wishes. "In the last analysis, it is the patient who has the right to say whether or not he intends to use the extraordinary means of conserving life."[36] This position, like Kelly's, skirts the question of what the physician ought to do if the patient refuses ordinary (morally obligatory) means.

Cronin discusses a number of specific cases which permit him to illustrate principles regarding the special responsibilities of the physician . Cronin's views are consistently patient-centered . A few of the rules he proposes as guides for the physician are:

(1) if it is unknown what means a patient would wish employed, the doctor's duty does not extend to the use of extraordinary means, even if these would benefit the patient. "We are not bound in charity to force a neighbor to save his life by means which he, personally, is not bound to use to save his own life. [37]

(2) if the patient's actual wishes cannot be ascertained, the physician should make a reasonable effort to determine what the patient *would wish, were* he able to respond;

(3) if relatives are present when the patient's wishes cannot be ascertained, then they should try to make the decision for the patient and the doctor should follow their wishes;

(4) if no relatives or friends or guardians are present, then the doctor should decide on the basis of what he believes to be the greater good of the patient;

(5) the physician's prime duty is to the patient and not the medical profession. The doctor should never judge that an unconscious or mentally incompetent patient or a patient receiving charity should be given extraordinary means merely for the advancement of scientific knowledge or because he believes that the professional ideal requires fighting death to the bitter end. Surreptitious experimentation carried on without informed consent by the use of extraordinary means is wrong. If the common good does not oblige the patient to use extraordinary means, that good cannot oblige the physician either.[38]

Cronin writes:

> In practice, therefore, a doctor should take his norm from the obligation of the patient himself. The doctor must employ the ordinary means of conserving life and then those extraordinary means which, *per accidens,* are obligatory for the patient or which the patient wants to use. He must never practice euthanasia and he must conscientiously strive never to give the impression of using euthanasia. Furthermore, he must strive to find a remedy for the disease. However, when the time comes that he can conserve his patient's life only by extraordinary means, he must consider the patient's wishes, expressed or reasonably interpreted, and abide by them. If the patient *is* incurable and even ordinary means, according to the *general norm,* have become extraordinary for this patient, again the wishes of the patient expressed or reasonably interpreted must be considered and obeyed.[39]

The foregoing represents not only a summary of Cronin's views but a remarkable recapitulation of the ideas that derive from a study of the historical development of the concept of obligatory and optional means of preserving life. That development, given its history of some five hundred years, is surprisingly consistent.40 There are indeed differing emphases, and individual authors may disagree on *specific* points. But the overall appearance is one of uniformity and at times almost one of tedious repetition. No doubt changing circumstances require applications in novel areas, but the basic principles have been firmly laid in a coherent development stretching back at least to the time of Aquinas.

Notes

1. *The Pope Speaks* 4 (1958), 393-98.
2. St. Thomas Aquinas, *Super Epistolas* S. *Pauli (Taurini-Romae,* Marietti, 1953), II Thess., Lec. II, n. 77. Translation in: Cronin, Daniel, *The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life* (Dissertatio ad Lauream in Facultate Theologica Pontificiae Universitatis Gregorianae, Romae, 1958) p. 48.
3. *Summa Theologica,* Blackfriars Translation, Anthony Ross, O.P., and P.G.Walsh. (New York, McGraw-Hlll Book Co., 1966), II, II, q. 126, a. 1.
4. *ibid.* ad. 3.
5. For example, for the teaching of Thomas Aquinas on suicide, see II,II, q. 64, a. 5; for his teaching on killing the innocent: II,II, q. 64, a. 6; on self-detense: II,II, q. 64, a. 7 and 8; on mutilation: II,II, q. 65, a. 1.
6. F. Vitoria, *Relectiones Theologicae,* (Lugduni, 1587), Relectio IX, de Temp. n. 1, (Transl. as in Cronin, op. *cit., pp.* 48-49).
7. *ibid.,* n. 9 (Cronin, p. 49).
8. *ibid.,* n. 12 (Cronin, p. 49).
9. F. Vitoria, *Comentarios a la Secunda Secundae de Santo Tomcis* (Salamanca, ed. de Heredia, O.P., 195 2) in 11,11, q. 147, a. 1 (Transl. as in Cronin, p. 50).
10. F. Vitoria, *Relectiones,* Relectio X, de Homicidio, n. 35, (Transl. as in C ronin,
11. Cronin, op. *cit., p.* 90.
12. J. de Lugo, *Disputationes Scholasticae et Morales* (ed. nova, Parisiis, Vivès,1868-69), *Vol. VI, De iustitia et iure,* Disp. X, Sec. 1, n. 21, (Transl. as in Cronin, p. 59).
13. *Ibid.,* n. 32, 36.
14. *Ibid.,* n. 30, (Transl. as in Cronin, p. 64).
15. Cronin, op. *cit., p.* 70.
16. V. Patuzzi, *Ethica Christiana sive Theologia Moralis,* (Bassani, 1770), Tom. III, Tract. V, Pars. V, Cap. X, Consect. sept.
17. Cronin, op. *cit., p.* 77.
18. H . Noldin and A. Schmitt, *Summa Theologiae Moralis,* 3 Vols., (Oeniponte, Rauch, 1940-41), Vol. 2, p. 308.
19. E. Genicot and J. Salsmans, *Inutitutiones Theologiae Moralis,* 2 Vols., (Bruxelles, L'Edition Universelle, S.A., ed. 17, 19 5 1), Vol. 1, n. 364.
20. H. Jone and U. Adelman, *Moral Theology* (Westminster: Newman Press, 1948), n. 210.
21. E. Healy, *Moral Guidance,* (Chicago: Loyola University Press, 1942), p. 162.22. G. Kelly, "The Duty of Using Artificial Means of Preserving Life," *Theological Studies,* XI (1950), pp. 203-220.
23. G. Kelly, "The Duty to Preserve Life," *Theological Studies,* XII (19 5 1), pp.550-556.
24. Kelly, "Artificial," p. 204.
25. *ibid., p.* 206.
26. *ibid., p.* 207-08.
27. Kelly, "Preserve," p. 55 0.
28. Kelly, "Artificial," p.219.
29. *ibid,, p.* 220.
30. *Homiletic and Pastoral Review,* XLIX,(1949), p. 904.
31. J. Sullivan, *Catholic Teaching on the Morality of Euthanasia,* (The Catholic University of America Studies in Sacred Theology, Second Series, No. 22, Washington, D.C.: The Catholic University of America Press, 1949) p. 72.
32. Kelly, "Artificial," p. 2 14.
33. Cronin, op. *cit., pp.* 98-126.
34. *ibid, p.* 105.
35. *ibid., pp.* 127-28.
36. *ibid, p.* 143.
37. *ibid. pp.* 145-46.
38. *ibid., pp.* 155-56.
39. *ibid., p.* 157.
40. This chapter concludes with the work of Gerald Kelly and Daniel Cronin which preceded the allocution of Pope Pius XII mentioned above in note 1. A helpful

CATHOLIC SOCIAL AND SEXUAL ETHICS: INCONSISTENT OR ORGANIC ?

(*The Thomist:* October, 1993; v.57 n.4 pp. 555-578)

JOHN S. GRABOWSKI
Catholic University of America
Washington, D.C

MICHAEL J. NAUGHTON
University of St. Thomas
St. Paul, Minnesota

p. 555

This article evaluates Charles Curran's proposal that there is an unjustifiable methodological split between recent official Catholic social and sexual teaching.[1] Specifically, this study will argue that the dichotomy between recent Catholic social and sexual teaching is not so sharp as Curran and others suppose, and that the real differences which do exist between these two strands are neither arbitrary nor unjustifiable in light of a Thomistic view of the human good. This study will proceed by first
p. 556 providing an overview of Curran's thesis concerning the divergent methodologies employed in Catholic social and sexual teaching as he and other moral theologians have presented it. It will then offer a critique of this position by considering the unjustifiable dichotomies it creates between reason and nature, the physical and the personal, and historical consciousness and classicism. We conclude that while tensions exist between these two kinds of teaching, the social and sexual teachings of the church are held together organically rather than juxtaposed inconsistently.

I. CURRAN'S POSITION ON THE CHURCH'S MORAL METHODOLOGY

Two Interpretations of Natural Law

Throughout much of his work, Curran calls attention to two divergent understandings of natural law articulated in the history of Western thought and adopted by the Church.[2] Similar observations have been made by other moral theologians.[3]According to this view, Cicero (43 B.C.) exemplifies one strand of the natural law tradition when he speaks of "true law which is right reason in accord with
557 nature."[4] The focus of this "order of reason" approach to natural law is on the rationality and prudential judgment of the agent in his or her own concrete situation.[5] Ulpian (228 A.D.), who describes natural law as "that which nature has taught all animals,"exemplifies a very different approach.[6] This strand of natural law, the "order of nature" approach, inclines toward physicalism because of its emphasis on conformity to biological properties or finalities and because it focuses on the commonality between humans and animals.7

For Curran and other moral theologians these differing strands of natural law have led, especially in recent thought, to markedly different worldviews, anthropologies, and moral methodologies. The focus on the "order of reason" has proved to be more in harmony with modern understandings of the world, with their awareness of growth, process, and historical consciousness.[8] It likewise has proven receptive to an inductive and experiential approach to moral reasoning, and thereby emphasizes the particular and contextual character of moral choice over deductively derived absolute norms.[9] The result is a greater emphasis on the open-ended character of the moral enterprise. As one's apprehension of reality changes, so should one's understanding of moral norms and reasoning.
558 Echoing Curran in this regard, Gula points out that "insofar as reason's grasp of reality is always partial and limited, moral norms are necessarily tentative."[10] These developments also encourage a greater focus on the person as moral agent. According to Curran, this type of "personalism" is characterized by a relationality-responsibility model that understands "the human person in terms of one's multiple relationships with God, neighbor, world, and self and the call to live responsibly in the midst of these relationships."[11]

In contrast, the "order of nature" strand of natural law sees reality as composed of static and immutable essences, from which one can deduce absolute moral norms. Insofar as it sees the physical qualities of actions or the natural finalities of biological processes as morally determinative, this strand is characterized by a kind of "physicalism."[12] Physicalism, as opposed to "personalism," refers

to the tendency in moral discourse to focus on the biological dimensions of the person or of human action in the process of moral judgment.

Application to Church Teaching

Curran and other moral theologians maintain that elements of both the "order of reason" and the "order of nature" approaches can be found in the thought of Aquinas which has proved influential in
559 the formulation of magisterial moral teaching.[13] The "order of nature" with its inherently physicalist preoccupation with biological finality continues to inform the Church's prohibitions in the matters of sexual ethics, particularly in the encyclicals *Casti Conubii* (1930) and *Humanae Vitae* (1968).[14] This understanding of the "order of nature" with its ahistorical and deductive orientation has also informed social encyclicals such as *Rerum Novarum (*1891), *Quadragesimo Anno* (1931), and to a lesser extent *Laborem Exercens* (1981).[15] The church's social teaching after 1960, however, demonstrates an increasing dependence upon the "order of reason" approach to natural law.[16] The decisive moment of this process is said to have been reached in Vatican II's Pastoral Constitution on the Church *Gaudium et Spes* which repudiated the classicist world view in favor of experience, personalism, induction,
560 process, and historical consciousness--a shift evidenced in its appeals to read the "signs of the times." [17] This new approach has been carried forward in most subsequent social teaching However, this shift in the social teachings from the "order of nature" to the "order of reason" has not been paralleled in the church's teaching in sexual matters.

Curran recognizes some development in recent official church teaching on sexuality. He points to the replacement of the language about the procreative end of intercourse as primary and the unitize end as secondary by an affirmation of their equal importance in *Gaudium et Spes.*[18] Even though *Humanae Vitae* reaffirmed this position, Curran and many moral theologians uniformly reject its teaching that spouses must preserve the inseparable unity of these ends in each conjugal act.[l9] In its continued focus on particular acts, and in its understanding that the conjugal act has a natural finality toward procreation, the encyclical reflects the physicalism of the older "order of nature" strand of natural law.[20] Curran and others argue that the logic of personalism would allow the subordination of the physical end of procreation to the more personal demands of love and relationship.[21] The
561 procreative dimension of a couple's sexual relationship need not be realized in particular acts, but can be spread over the duration of their lives together.[22] Sexuality, and particularly fertility,while important, are neither exhaustive nor determinative of the person.[23] As a result these realities can be subordinated to other goods at stake in relationships.[24] While commending the use of personalist language in recent church teaching, most notably in the thought of Pope John Paul II, some accuse the present pope of inconsistencies in his utilization of personalist ideas. In this view John Paul's advocacy of marital experience and personalism is at odds with a continued focus on particular acts, and hence his emphasis on the "dignity of the person" is in conflict with other aspects of his teaching.[25]

Unlike the sexual teachings, Curran maintains that the church's social teaching has gone through a
562 significant development from the order of nature (1891-1958) to the order of reason (1961-present) with John Paul II vacillating between the two orders.[26] For Curran, this development can be seen by contrasting Pius XI's *Quadragesimo Anno* (1931) and Paul VI's apostolic letter *Octogesima Adveniens (*1971) . Pius's plan for social reconstruction was a particular plan proposed for all peoples and all times. Curran sees such a plan as flawed from the start since it was Euro-centric and failed to consider its own historical situation. In essence, according to Curran, Pius's corporatist plan was deductive and classicist. This approach, according to Curran, began to be abandoned in Catholic social thought with John XXIII. It was completely dismissed with Paul VI who demonstrated a historically conscious and inductive approach in his social teachings.[27]

Thus in *Octogesima Adveniens,* he writes:

In the face of such widely varying situations, it is difficult for us to utter a unified message and to put forward a solution which has universal validity. Such is not our ambition nor is it our mission. It is up to the Christian communities to analyze with objectivity the situation which is proper to their own country, to shed on it the light of the gospel's unalterable word, and to draw principles of reflection norms of judgment, and directives from the social teaching of the church.[28]

Curran goes on to explain that John Paul II fails to continue the sensitivity to the historical particularities of social problems, returning to a more static and classicist approach, by proposing official Catholic social "doctrine" for the whole church.[29]

In summary, the thesis advanced by Curran and echoed by others is that there are basic methodological differences between Catholic magisterial teaching on sexual and social morality:" Whereas the official social teaching has evolved so that it now employs historical consciousness,
563 personalism, and a relationality-responsibility ethical model, the sexual teaching still emphasizes classicism, human nature, and faculties, and a law model of ethics."[30] Additionally, attention is also sometimes drawn to the apparent inconsistency between the highly specific nature of the church's sexual teaching which condemns particular acts and the more general principles and analysis contained in the social tradition.[3l]

Are the charges of an unwarranted dichotomy between the church's recent social and sexual teachings accurate ? While Curran and others considered thus far are undoubtedly correct in noting a divergence in tone and method between the two forms of teaching, it remains to be seen whether this divergence is as great and as unjustified as they suppose.

II. CRITIQUE OF CURRAN'S ARGUMENT

Our response to Curran is limited to two basic observations: first, the divergence between the social and sexual teachings of the church is not as great as Curran might suppose; and second, Curran overlooks significant differences between sexual and social issues that account for the differences in method which do exist. Curran's position arises from three dichotomies that underlie his arguments: reason versus nature, the person versus the physical, and historical consciousness versus classicism. In each, Curran exaggerates the differences and advocates one over the other. Considering those three in turn, we propose instead that an organic unity and interconnectedness exist for each of these pairs, while at the same time we recognize reasons for their difference and utilize them accordingly.

Reason/Nature: On Intrinsic Connection

564 Curran's separation of human reason from human nature rests upon a misunderstanding of Thomas Aquinas's analysis of human inclinations within the framework of natural law. Curran attempts to separate "physical" from "rational" inclinations in Aquinas's analysis, assigning the former to the influence of Ulpian and the latter to the influence of Cicero.[32] Such a separation overlooks the fundamental unity and integration of these inclinations already worked out by Aquinas. In his discussion of natural law Aquinas considers how there can be several precepts of natural law and several kinds of human inclinations all of which are known and unified through the exercise of reason.[33] Human beings share with all created things an inclination to self-preservation. With the animals, human beings share an inclination to reproduce and to raise and educate offspring. Finally, insofar as people are rational, they have a peculiarly human inclination to live together in society and to know the truth about God. As expressions of various facets of human nature, these
565 inclinations are designated by Aquinas as "good," and are all unified in the exercise of human reason.[34] As Jean Porter points out, these inclinations are an outline of what a "human life should properly look like, what goods it will incorporate, and what relation those goods should have to one another." [35] An understanding of this properly ordered life requires an understanding of the hierarchical order of the inclinations. Porter points out that this hierarchy works in both an ascending

order of excellence and a descending order of fundamentality. In the order of excellence, the inclinations are pursued in a way in which the lower inclinations are subordinated to the pursuit of the higher inclinations; namely, the pursuit of self-preservation and procreation is subordinated to the more excellent pursuit of society and God. But at the same time there is an order of fundamentality that prevents the lower inclinations from being destroyed by the higher inclinations, since it is on the basis of the lower inclinations that the higher inclinations are built. Hence, as the goods involved with the inclinations move from first to third in an order of increasing excellence, they also move in the same direction in an order of decreasing fundamentality. The lower levels are the necessary preconditions for the higher levels.[36]

Thus in Aquinas's understanding of human nature, various inclinations (toward being, reproduction, society, and God) are integrated rather than opposed. In this light, the attempt to depict Aquinas as a "physicalist" is based on a fundamental misreading.[37] Both reason and bodiliness (including sexuality) are integral components of human nature. Thus the order of nature and the
566 order of reason are not two conflicting orders as Curran presents them, but two sides of the same coin. In other words, Curran only views the hierarchy of inclinations in one way, namely, in the direction of excellence, and fails to consider adequately the direction of fundamentality which reason also recognizes. This false dichotomy of nature and reason in turn underlies the dichotomies of personalism / physicalism and historical consciousness / classicism according to which Curran evaluates Catholic social and sexual teachings. While the reading proposed here does not preclude a certain fruitful tension between the various inclinations, it does reject Curran's depiction of them as polar opposites.

Personalism/Physicalism: Unifying the Physical and the Relational

In considering whether the official church's teaching concerning sexuality can rightly be accused of physicalism, a number of observations are in order. To a degree Curran's claim is correct, insofar as the church takes seriously the physical nature of the human body. Sexuality necessarily involves the human body. But like Aquinas the church does not base its teachings merely upon the animal nature of the body. It is noteworthy that the term which church teaching employs in describing marital intercourse is the "conjugal act" or "marital act" which means the marital love that informs sexual
567 intercourse between husband and wife[38]. It is not merely a sex act - that would be physicalism. The conjugal act is a human act. Animals cannot engage in conjugal acts (which carry out reasoned choices).[39] They are incapable of human love and reason. But should the love and reason expressed in the conjugal act subvert its procreative dimension? Can one view the person as free from the constraints of human nature, including its embodied (and hence biological) aspects? Or is not human nature a condition of possibility for all that we do?

While Curran accuses official church teachings of physicalism, his separation of body and spirit forces him to advocate a kind of spiritualism. Curran tends to an ethic for human sexuality which does not account for its concrete embodiedness--in short, its physical character. Can we violate the physical laws of our bodies and still achieve authentic human development ? The church's teaching of the inseparability of the unitive and procreative ends of human sexuality recognizes both the dynamic role of sexuality in human relationships *and* the creative and physical dimension of procreation.

Influenced by modern phenomenology in the 1920s and 30s, Catholic moral theologians such as Herbert Doms and Dietrich von Hildebrand began to develop a sexual ethic from the philosophy of
568 personalism.[40] They criticized the exclusive treatment of marriage in terms of ends, specifically the over-emphasis on the procreative end.[41] These theologians maintained that an exclusive focus on the "ends" of marital intercourse failed to do justice to the profundity of human relationships. They affirmed the centrality of the couple's love in marriage without denying the integral value of procreation in conjugal love.[42] The work of these theologians prepared for the affirmation of the

equal importance of the unitize and procreative dimensions of intercourse at the Second Vatican Council.[43]

When Curran and some other moralists speak of personalism, however, they see the "personal values "of love, freedom, and reason as central to human life and "biological values" such as procreation as secondary and subordinate. In other words the logic of personalism, in this perspective, demands not the elimination of the older language of primary and secondary ends of conjugal love, but its inversion and a corresponding lessening of interest in particular acts.

Such a view is problematic on two counts. First, the argument that personalism necessarily entails a focus on relationships rather than specific acts neglects the existential or reflexive character of
569 human acts. That is, in making particular decisions or choices one shapes one's own character as a moral agent.[44] Even though the person does not summarize or express himself or herself completely in particular actions, particular acts are nonetheless integral in shaping one's disposition and character. That one ought not be deeply concerned about whether particular acts express the procreative dimension of human sexuality but only whether this value is expressed over the course of a relationship begs an important question. Does not the failure to respect the value of procreation in particular acts of contraceptive intercourse lessen one's ability to respect this value and live it out in general? If contraceptive intercourse is a bad act, does it not create a disposition toward other bad acts in those who engage in it? [45]

A second problem with this particular version of personalism can be found in its presuppositions concerning human sexuality, nature, and personhood. Central to this account of the person is an
570 interpretation of rationality, freedom, and various relationships that leaves the place of sexuality in this anthropology undeveloped or minimized.[46] The implication is therefore that sexuality is to be equated with "the physical" or with "nature" and both ought to be viewed as extrinsic to the core of the person. Such an approach is beset by problems. This account of personalism reintroduces the false opposition between reason (here equated with the person) and nature (here equated with the body) criticized above. It also creates a further dichotomy between human nature and personhood. Such a dichotomy is unnecessary if nature is understood as a set of organically united inclinations that are possessed by individual persons as the very ground of their humanity.[47] Finally, this account of personalism restricts sexuality to a physical or biological phenomenon. This ignores the growing awareness of the interpenetration of soul and body within the person and the resulting conclusion that sexuality is not merely a biological reality but also one that affects all areas of human personality and relationship.[48] Hence the version of personalism advocated by Curran and others is rooted in an anthropology which appears unworkable.

Curran maintains that, whereas the church's sexual teaching is plagued with the problem of
571 physicalism, the church's social teaching is far more personalistic, escaping this problem. While he argues that this personalism is achieved through an emphasis on freedom, equality and participation, he does not examine the relationship of the physical nature of the person in the social teachings. This absence points to a failure to understand the importance of the physical in the socioeconomic area of morality and thereby appreciate the organic role of the physical in the moral teachings of the church.

There is little disagreement that sexuality is necessarily more physical and bodily than economic concerns. However, economic concerns cannot be understood outside physical and bodily boundaries. In the church's social teachings on wage justice, for example, the popes have emphasized the "necessary" or physical characteristic of wages. Wages are means to one's physical survival, that is, wages have a necessary and physical characteristic. Because work is necessary for the preservation of one's life and the procreation and education of offspring, any wage theory must envisage a wage commensurate with the necessary or physical character of human work. The proper object of justice is not the strict economic exchange of what is "due," but the person. One's due in reference to wages must be a living wage. The wage contract is not merely two parties bargaining for the best price, each attempting to maximize his or her self-interest. The wage contract is a means to further the perfection of the human person, which Leo XIII always sees in terms of providing the necessities of human

existence to sustain workers and their families in a relatively comfortable life that includes adequate shelter, medical care, food, pension, etc.

This necessary or physical characteristic of remuneration demands that justice guide the relationship between the worker and the firm as well as the state.[49] Precisely because wages are necessary, they cannot be calculated by economics alone. Since people are physical beings, the
572 physical dimensions of all their activities need to be taken into consideration. All physical or material goods have a "universal destination." The very "nature of creation" is directed toward the common use of all people. People do not have absolute control over their property, by the very fact that it is created by God. As John Paul II has pointed out, property has a "social mortgage" and people have the duty of stewardship to see that it is distributed to meet the needs of all people.[50] In other words, wages are an important factor in fulfilling the inclinations toward self-preservation, procreation, and education of offspring.

It should be pointed out that, just as Catholic sexual teaching has undergone development in changing its description of conjugal goods from primary and secondary to an affirmation of their mutual importance, so has Catholic social teaching altered its emphasis on wages and ownership from emphasizing the necessary, physical, or need aspect to a more personalistic criterion. This is particularly evident in John Paul's writings concerning worker ownership, although it is also found in John XXIII's *Mater et Magistra.* While worker ownership serves as a good means by which to distribute the goods of the earth for the needs of people, it serves other ends as well. Worker ownership also has a personal rationale which John Paul II refers to as the "personalist argument." The rule of ownership ought to be at the service of "personalistic values." Workers are not only concerned with what they receive from their labor (extrinsic benefits); they also want to work for themselves (intrinsic benefits). For John Paul II, it is difficult for workers to have a personal
573 connection to what is not their own. He maintains that worker ownership contributes to the personal development of the individual worker--that is, to the formative dimension of work. Another aspect of this personalist component of worker ownership is that it creates stronger social relationships between employees and employers.[5l] Worker ownership is advocated by John Paul II not only because it distributes wealth and fulfills human needs, but because it serves well as a means to personalization by affecting positively the formative dimension of the person and creating stronger social relationships between worker and employer.[52] In other words, the church has come to a fuller expression of the meaning of remuneration by stressing both the order of funda-***[text missing in original article]***

Thus in developments of both the sexual and social teachings of the church, the emphasis has been on uniting and integrating the personal or relational and the physical, not on polarizing them. In the case of John Paul II, this continuity between his teachings in the sexual and social spheres is particularly evident since he employs the language of "the dignity of the person" (drawn from *Gaudium et Spes)* in each. Both contraception and unfair remuneration obscure the dignity of the person because both regard the person as a means rather than as an end in himself or herself. In the case of contraception, the spouses falsify the language of total self-giving which conjugal love is
574 meant to express by withholding an essential aspect of themselves, namely their fertility, from one another. Therefore the person is neither given nor received in the totality which love demands.[53] In the case of unfair remuneration, the person created in God's image and called to transform the world through work is subordinated to things or denied basic needs.[54]

While Curran does not deny the physical dimensions of moral teachings outright, his polarization of the physical and the personal prevents an integration that Aquinas's theory of inclinations demands. Curran's approach stands in marked contrast with the effort to integrate the physical and the personal evident in both the sexual and social teachings of the church.

Historical Consciousness/Classicism: Different Structures, Same Person

Although Curran will remark in passing that there are differences between personal and social ethics, he nonetheless assumes that sexual and social ethics should use the same methodology.[55] The focus of both social and sexual ethics in Catholic teaching concerns two fundamental elements-the structures and the person. Regarding its sexual teachings, the church's primary structural focus is the family with sacramental marriage at its center. The church has regarded sexual activity as limited to marriage between a man and a woman through whose umon in the conjugal act a family begins. The church understands the family as a foundational unit of society, with the sacrament of marriage uniting the fancily as a set institution throughout time.

On the side of Catholic social ethics, the church's primary structural focus has been the state, the market, associations, unions, and productive organizations. Since the Industrial Revolution and Leo XIII's *Rerum Novarum*, the church has focused upon social structures and the effects they have on people. Unlike the familial structure, the church has never ordained one particular social structure as the right one for all times. At times the church has come close to baptizing one economic structure over another (corporatism over capitalism or free market over socialism), but never as the last word
575 on the issue. The emphasis of the church in the social sphere has been on the principles on which structures of different ideologies can rest.[56]

The structural concerns of Catholic social and sexual ethics are different in many ways. The familial structure of the church's sexual teaching is foundational and consequently unchanging. Imitating the love of Christ and His church, a man and a woman unite in the sacrament of God's love. For this reason the church contends that the family was "from the beginning" and is still today God's original plan for humanity.[57] In contrast, particular social structures are not specified in the church's social teaching; rather, the church condemns or condones socioeconomic and political structures from the principles developed in its social tradition. The moral evaluation of social structures is contingent upon such principles and is provisional. Although there are developments in the understanding of the family in church teachings, they are minor in nature (reflecting social shifts such as that from extended to nuclear families) in comparison to developments or shifts in socioeconomic structures (agricultural to industrial to informational). With this said, Curran is correct that the church's social teachings are more historically conscious than its sexual teachings. However, to have it any other way, the church would either have to relativize the family or baptize a particular social structure or system.

The point here is not to separate the family from the socio-economic concerns of society. On the contrary, the family serves as the fundamental structure of any society. But it is precisely in this
576 fundamental role that the family has a more permanent position than other institutions in society. In other words, the social area has a flexibility that the sexual area cannot provide, because to procreate and educate offspring is more fundamental than the social (although not more excellent), and issues concerning life and death are even more fundamental and therefore provide even more permanence. This is not to say that the only role of the family is to procreate and educate offspring. This was treated above in discussing the importance of the unitize end of conjugal love. But to procreate and educate offspring is certainly a fundamental purpose for the family which demands more permanency in any given situation than social institutions such as the state, productive organizations, and other intermediary groups.

On the personal level, one can also notice reasons for the different approaches in these two forms of teachings. In the realm of social ethics, the church has focused on general issues such as whether the person could participate within the structure and whether his or her dignity is respected. Thus, while recognizing a moral dimension to the problem of underdevelopment, for example, the church does not attempt to offer technical solutions to it.[58] As Pius XI noted, the church's moral authority does not reside "in technical matters, for which she has neither the equipment nor the mission, but in

577

all those [matters] that have a bearing on moral conduct." [59] While the social teachings of the popes are ultimately aimed at people, they are also aimed at structures. An organization is subject to political, economic, social, and technological changes which needs room for development. Because of the complexity of these variables, the popes have been reluctant to recommend specific programs, unlike the more determinate nature of sexual and familial teachings. What the church attempts, as a part of its mission of evangelization, is to exercise a prophetic role by speaking out on behalf of the person in defense of human rights and condemning evils and injustices embedded within social structures as well as facilitating particular projects that promote the dignity of peoples.[60]

In regard to the personal component of sexual ethics, the church is much more specific in proscribing certain acts as morally evil. The primary reason for this difference in tone and specificity has already been alluded to above. That is, the church sees a fundamental integration of the person with his or her concrete sexual specificity and human nature. Because the church holds that this nature and its meaning have been revealed by Christ, the individual person and his or her sexuality also stand illumined.[61] As the one to whom this revelation is entrusted, the Church regards herself as an "expert in humanity" and is qualified to speak accordingly.[62]

This is not to imply that the social nature of the person is secondary or peripheral to what it means to be a person. Indeed, John Paul II frequently quotes the teaching of *Gaudiun1 et Spes* in this regard: "man, who is the only creature on earth which God willed for itself, cannot fully find himself except through a sincere gift of himself." [63] We are only fulfilled in communion and community with others. However, as noted above, with the exception of the sexual community of man and woman in the family, this social dimension of human nature does not demand one specific form and the church has seen no reason to impose one.[64]

III. CONCLUSION

This study has sought to examine critically the proposal of Charles Curran and others that the Catholic church has arbitrarily applied two differing moral methodologies in its recent sexual and social teachings. While the point concerning the differing approaches is well taken and undoubtedly correct in certain respects, the idea that this difference is unjustifiable or arbitrary is open to question. We have argued that the differences between the two forms of church teaching are not as great as these thinkers suppose and that the attempt to portray them as such betrays questionable presuppositions concerning moral methodology, natural law, and personalism. We have also argued that there are reasons for the difference in tone and specificity between these two forms of teaching which have not been adequately considered by those offering this critique. For these reasons, this proposal is in need of further examination and perhaps revision.

NOTES

1. We know of no writing that explicitly challenges this thesis. When this idea is mentioned it is only supported. Among the studies which mention or develop this idea see: Kenneth R. Overberg, *An Inconsistent Ethic? Teachings of the American Catholic Bishops* (Lanham: University Press of America, 1980); Richard Gula, *What Are They Saying about Moral NormsF* (New York: Paulist, 1982), pp. 34-48; *Reason Informed by Faith* (New York: Paulist, 1989), pp. 34-35 and chap. 16; Christopher Mooney, *Public Virtue* (Notre Dame: University of Notre Dame Press, 1986), pp. 146-50; Richard McCormick, "The Consistent Life Ethic: Is There An Historical Soft Underbelly?", delivered for the Symposium "A Consistent Ethic of Life" at Loyola University of Chicago, November 7, 1987, pp. 10-13; and *idea, "*Human Sexuality: Toward a Consistent Ethical Method," in *One Ho Fred Years of Catholic Social Teachings*, ad. John A. Coleman, S.J. (Maryknoll: Orbis Books, 1991), pp. 189-97; Russell B. Connors, "Justice and Sex: Differing Ethical Methodologies," *Chicago Studies* 27 (1988): 181-190 ; Thomas F. Schindler, *Ethics: The Social Dtmeitsion* (Wilmington: Michael Glazier, 1989), pp. 70-75; Patrick T. McCormick, C.M., "Abortion: Retooling for a New Frontier," *Ne?v Theology RctSiow* 5 (1992): 48-61.

2.See, for example, Charles Curran, "Absolute Norms in Moral Theology," in X *New Look at Christian Morality* (Notre Dame: Fides, 1968), pp. 74-89; "Dialogue with Social Ethics: Roman Catholic Social Ethics--Past, Present, and Future," in *Catholic Moral Theology in Dialogue* (Notre Dame: Fides, 1972), pp. 116-3i; "Natural Law," in *Directions in Fundanzental Moral Theology (Notre* Dame: University of

Notre Dame, 1985), pp. 119-72; "The Changing Anthropological Bases of Catholic Social Ethics," in *Moral Theology: =4 Contimxing Journey (Notre* Dame: University of Notre Dame, 1982), pp. 173-208.

3.See, for example, Timothy O'Connell, *Principles for a Catholic Morality,* 2nd edition (San Francisco: Harper, 1990), pp. 149-60; John Mahoney, *The Making of Moral Theology* (Oxford: Clarendon Press, 1987), p. 110; Gula, *What Are They Saying,* pp. 34-35 and *Reason Informed,* pp. 222-223.

4De Republica, lib. iii, c. xxii: "*Est. quidem very lea recta ratio, natural congruent."* The citation is from M. Tullii, ad. (Rome, 1852), pp. 405-406.

5.See T. O'Connell, *Principles,* pp. 150-51, and Gula, *What Are They Saying,* p. 35.

6.*Imperatoris Iustiniani Institutionum,* lib. 1, t. 2. pr: "Izts *naherale est. quad nature omnia animilia docuit."* The citation is from the edition by J. B. Moule (Oxford: Clarendon, 1923), p. 100. Ulpian makes this remark with reference to human procreation, but goes on to add that human beings obey this law through the use of reason and out of a sense of duty.

7.Curran, "Natural Law," pp. 127-32, and Gula, *What Are They Saying,* p. 35. For background, see Michael Crowe, "St. Thomas and Ulpian's Natural Law," in *St. Thomas Aquinas 12Z4-19Z4: C0minemorative Studies,* vol. 1, ed. Armand A. Maurer (Toronto: Pontificial Institute of Mediaeval Studies 1974), pp. 261-82.

8.Curran, "Natural Law," pp. 137-40; Gula, *What Are They Saying,* pp. 18-22, and *Reason Infowned,* pp. 30-36.

9.Curran, "Natural Law," pp. 140-41; Gula, *What Are They Saying,* pp. 22-25.

10 Gula, *What Alre They Saying, p.* 42.

11.Curran, "Official Social and Sexual Teaching," in *Tensions in Moral Theology* (Notre Dame: University of Notre Dame Press, 1988), p. 96. See also his "Methodological Overview of Fundamental Moral Theology," in D*irections* pp. 3-27. According to Gula, this brand of "personalism" is "characterized by placing emphasis on dimensions of the human person and human actions which extend beyond the physical and biological to include the social, spiritual, and psychological dimensions as well." See Gula, *What Are They Saying p.* 35. For a more extended consideration of this personalism, see Louis Janssens, "Personalism in Moral Theology," in *Moral Theology: Challenges for the f?ettere,* ad. Charles Curran (New York: Paulist Press, 1990), pp. 94-107.

12.Curran, "Natural Law," p. 127. Cf. Gula, *What Are They Saying* pp. 35-36. For a brief historical survey of this emphasis on the physical nature of acts in moral theology, see B. V. Johnstone, "From Physicalism to Personalism," *Studio Moralia* 30 (1992): 76-78.

13See Curran, "Absolute Norms," pp. 77-84; "Natural Law," pp. 127-31; Gula, pp. 35-37; Timothy O'Colmell, pp. 153-55. Lisa Sowle Cahill also describes Aquinas's understanding of natural law as having physicalist tendencies without citing the influence of Ulpian; see her *Between the Sexes: Founda-tions for a Christian Ethics of Sexuality* (Philadelphia: Fortress, 1985), pp. 108-9.

14.*Cf.* Gula, *What Are They Saying* pp. 36-9. For a more extended critique *of* the teaching *of Hunta7tae Fitae* see Curran "Natural Law," pp. 119-72. For a similar critique *of* the more recent document of the Sacred Congregation for the Doctrine of the Faith, *Declaratio de quibusdam questionibus ad sexualem ethicant spectantibus* (1976), see Curran, "Sexual Ethics: A Critique," in *Issues in Sexual astd Medical Ethics (* Notre Dame: University *of* Notre Dame Press, 1978), pp. 30-52.

15.For Curran's critique *of* pre-conciliar Catholic social thought as well as his critique of the teaching of Pope John Paul II, see "Changing Anthropological Bases" and "Dialogue with Social Ethics," in *Contemporary Moral Theology in Dialogue* (Notre Dame: Fides Publishers, 1972), pp. 132ff. See also Peter J. Henriot, et al., *Catholic Social Teaching* (New York: Orbis Books, 1988), pp. 18-19; J. W. O'Malley, "Reform, Historical Consciousness, Aggiornamento," *Theological Studies* 32 (1971): 573-601 ; Susan L. Secker, "Human Experience and Women's Experience," *The Annual of the Society of Christian Ethics* (1991), p. 135; Leslie Griffin, "The Integration *of* Spiritual and Temporal: Contemporary Roman Catholic Church-State Theory," *Theological Studies* 48 (1987): 250ff.; and *eadem '* Moral Criticism as Moral Teaching: Pope John Paul II's *Sollicitudo Rei Socialis* delivered at the Symposium on Recent Catholic Social Teachings at Notre Dame University, April 24-26, 1989.

16.Curran is dependent here on M. D. Chenu, "The Church's Social Doctrine," *ConciliunZ* 140 (1980): 71-75. Curran himself is somewhat more critical *of* the earlier social tradition and the discontinuity between it and more recent developments. See Curran, "Changing Anthropological Bases," pp. 173-208; "Official Catholic Social and Sexual Teachings," pp. 88-100. In this latter work Curran describes the recent social teaching as not **only more per**sonalist and historically conscious, but also as adopting a "relational responsibility" approach to ethics. See also Gula, *What A~re They Saying* pp. 42-45.

17.See Curran, "Natural Law," pp. 141-43; "Dialogue with Social Ethics," pp. 125-30; and "Changing Anthropological Bases," pp. 183-6.

18.*Gaudium et Spes,* no. 50. Cf. Curran, "Natural Law," pp. 131-32.

19.Paul VI, *Humallae Yitae,* nos. 11-12. Cf. Curran, "Sexuality and Sin: A Current Appraisal" in *Contemporary Problems in Moral Theology* (Notre Dame: Fides, 1970), p. 174.

20 Cf. Curran, "Natural Law," pp. 156-57; Gula, *What Are They Saying,* pp. 38-9; and Richard McCormick S.J., *Notes on Moral Theologv 1965-1980* (Lanham: University Press of America, 1981), pp. 218-21.

21.Cf. Curran, "Sexuality and Sin," pp. 173-74. This is also a repeated theme in a recent study by Lisa Sowle Cahill, "Catholic Sexual Ethics and the Dignity of the Person: A Double Message," *Theological Studies* 50 (1989): 120-50.

22See Curran, "Sexuality and Sin," p. 174; "The Development of Sexual Ethics in Contemporary Roman Catholicism," in *Tensions in Moral Theology,* p. 76; and McCormick, *Notes 1965-1980* pp. 218-21.

23.McCormick, *Notes 1965-1980,* pp. 219-20; Cahill, "Catholic Sexual Ethics," pp. 139-43.

24.Thus Curran, contrasting his own view with the older and more physicalist approach which saw an inherent teleology in the sexual faculty, states: "A more relational approach sees the sexual faculty related to the human person, and the human person related to others, especially to the marriage partner. For the good of the marriage relationship contraception or sterilization **can be** justified." See "A Methodological Overview," p. 14.

25.Cahill in particular objects to John Paul's affirmations of the importance of the vocation of motherhood as a form of gender role stereotyping which results in women bearing the brunt of the procreative end of marital sexuality and also what she sees as the romanticization of sexual commitment in his descriptions of love as a form of self-giving. See "Catholic Sexual Ethics," pp. 145-6. Similar criticisms are made even more sharply by Christine Gudorf, "Encountering the Other:

the Modern Papacy on Women," *Social Compass* 36 (1989): 298-302. Yet other theologians question whether John Paul II's emphasis on the "dignity of the person" is at all relevant to determining the morality of concrete actions. See Bruno Schuller, "Die Personwurde des Menschen als Beweisgrund in der normativen Ethik," *Theologie und Glaube* 53.(1978): 538-55 and Richard McCormick, *Notes 1965-1980, pp.* 801-7.

26.For Curran, John Paul's social teaching is tainted by a return to aspects of a classicist worldview. See "Official Catholic Social and Sexual Teachings," pp. 92-3. For support of Curran's view, see Joseph A. Selling, "The Theological Presuppositions of *Centesimus A1mus," Louvain Studies* 17 (1992): 35-47, and James O'Connell, "Is There a Catholic Social Doctrine? The Problem of Content and the Ambivalence of History, Analysis and Authority," *Heythrop Jourfital* 32 (1991): 511-538.

*27.*Curran, "Official Catholic Social and Sexual Teachings," p. 92.

*28.*No. 4, as cited in Curran, "Official Catholic Social and Sexual Teachings," p. 91.

*29.*Ibid.; see also Charles Curran, "A Century of Catholic Social Teaching," *Theology Today* 48 (1991/92): 161, 167-169.

30 Curran, "Official Catholic Social and Sexual Teachings," p. 107. Cf. Gula, *What Are They Saying,* pp. 37-45.

*31.*Cf. Richard McCormick, *Notes on Moral Theology 1981 through 1984* (Lanham, MD: University Press of America, 1984), p. 74; and Curran, "Official Catholic Social and Sexual Teachings," p. 106. For an application of the same objection to the teaching of the American bishops see Overberg,

An *~}le(1'15;5teXlt Ftlt*

32.Curran, "Natural Law," pp. 127-31. See also Gula's interpretation of Aquinas's theory of inclination in *Reason Infonned,* p. 225. Influenced by Curran, Gula polarizes Thomas's understanding of the inclinations by maintaining that the inclination to procreate and educate offspring stems from Ulpian's "order of nature" or physicalist approach, while the inclination to know and do the good derives from Cicero's "order of reason" or personalist approach. See also O'Connell, *Principles,* pp. 154-5, for a similar interpretation, although his discussion of Richard Westley's understanding of Aquinas presents an alternative and somewhat more unified view of the interaction of body and spirit in the individual.

33.Cf. *sum1)?a Theologiae (ST)* I-II, q. 94, a. 2.

345T I-II, q. 94. a. 2, ad 2: "Ad *secundu1n dicendut1l quod om1tes ht{jusmodi inclielatioetes quarutncnntque partiuin nnturae huma1zae, puts concupiscibilis et irascibilis, secundusot quod regulaXztzfr ratione, pertinent ad legem naturalem, et reducuxttur ad unuan primuen praeceptum, ut dictum est. et secundum hoc sunt multa praecepta legis naturae in seipsis, quae tamen communica1~t in una radice."* The citation is from the Blackfriars edition, vol. 28 (New York: McGraw-Hill, 1966), p. 82.

33Jean Porter, *Recovery of Virtue* (Louisville: Westminster, 1990), p. 90.

36.Ibid, pp- 89-90

37.William E. May has argued that Curran and O'Connell exaggerate the influence of Ulpian on Aquinas's discussions of natural law. While it is true that human beings share certain inclinations with the animals, they are regulative for human beings only as they are grasped as goods in the light of practical reason. See May, "The Natural Law and Objective Morality: A Thomistic Perspective," in *Principles of Catholic Moral Life* (Chicago: Franciscan Herald Press, 1980), pp. 160-5. Cf. D. O'Donoghue, "The Thomist Concept of Natural Law," *Irish Theological Quarterly 22* (1955) 91. For a further critique of Curran's claim of physicalism in Aquinas and recent official Catholic sexual teachings see William E. May, "The Moral Methodology of Vatican Council II and the Teaching of *Huma)lae Vitae* and *Persona Huntana," =*4n*thropotes 5/I (* 1989): 30-45.

38.*Gaudium et Spes, no. 49; Huenanse Vitae,* nos. 11-13.

39."The sexual characteristics of man and the human faculty of reproduction wonderfully exceed the dispositions of the lower forms of life. Hence the acts themselves which are proper to conjugal love and which are exercised in accord with genuine human dignity must be honored with great reverence." *Gaudium et Spes,* no. 51. The citation is from *The Documents of Vatican II* Walter Abbott, ad. (Piscataway, NJ: New Century, 1966), p. 256. Cf. Johnstone, "From Physicalism to Personalism," p. 73; see n. 6 on the same page where Johnstone states that "in official documents, such as Pius XI's *Casti Connxbii* (1930), that marriage, as a contract by which reason and free will determine the expression of human sexualitv cannot he nut *an* the Rnme leve s ..ion *of*:

40 Good discussions of this development can be found in John C. Ford and Gerald Kelly, *Contemporary Moral Theology, vol.* 2: *Marriage Questions* (Westminster, MD: Newman, 1964), pp. 18-35; William Shannon, *The Lively Debate: Response to Humanae Vitae* (New York: Sheed and Ward, 1970), pp. 12-23; and Theodore Mackin, *What is Marriage?* (New York: Paulist, 1982), pp. 225-35.

41.Here Curran and others are correct in their assertion that the tradition has had elements of physicalism. See Johnstone, "From Physicalism to Personalism "on the origins of physicalism. On the legacy of Augustine in the development of the Church's view of sexuality, see the generally excellent historical study of John T. Noonan, *Contraception:* X *History of Its Treatment by Catholic Theologia~ls and Canonists,* 2nd edition (Cambridge: Harvard University, 1986). Even though there was an over-emphasis on the procreative good, theologians also demonstrated a growing attention to what came to be designated as the unitive good. Hence Augustine will speak of the relationship of husband and wife in terms of friendship (see *De Bono Conjugale,* 1). Aquinas understands marriage as the greatest form of human friendship to which sexual intercourse is not unrelated, even while it does not express its totality (see *Stsmma Contra Gentiles* III, c. 123, 125; cf. *ST* II-II, q. 26, a. 11) . Bonaventure speaks of intercourse 25 an expression of the unique love which exists betwe1+ husband and wife (see In IV *Se7ttentianf7n,* 33, 1).

42.On the precise relationship of this love to the procreative dimension of marital sexuality, there were important differences between them. While both defended the church's prohibition of artificial contraception, for Doms it was the couple's shared life of "two-in-oneship" that gave marriage its primary meaning. It was this same two-in-oneship that Doms saw as "the one immediate purpose" of intercourse rather than procreation, although this was not excluded since a child constituted the "natural fruit" of a couple's love. See Herbert Doms, *The Meaning of Marriage (* New York: Sheed and Ward, 1939), pp. 77-78, 84-85, 94-95. Hence his ideas provide something of an anticipation of the personalism presently advocated by Curran and others.

43. Doms ln particular Urged thtlY badvdocated by Curran and others and "secondary" ends, arguing that "it would be better if we just spoke of the procreative and personal purposes immanent in marriage and distinguished them from its meaning "(ibid., p. 88).

44. Curran is aware of this reflectlveia . ,~ Individual acts are not the most

fundamental ethical category because they are both expressive of the moral subject and constitutive of the moral being of the subject." See "A Methodological Overview," p. 15.

45. A parallel case might be worth considering. Would Curran and others agree that the relation of the unitize dimension of human sexuality to specific sexual acts is equally unimportant? If a particular conjugal act for whatever reason was devoid of love or other personal values, it would not be a good act, but rather an act of sexual manipulation, coercion, or violence. Cf. Cahill, *Between the Sexes, p.* 149. If this is the case, then why should the procreative dimension of human sexuality not also be respected in particular acts?

46.Hence, when discussing the person as moral agent, Curran will describe the importance of certain dispositions or virtues and also one's fundamental relationships with God, neighbor, world, and self. Little is said about the place of sexuality in such an anthropology except to urge that it be subordinated to the overall context of one's relationships. See, for example, "A Methodological Overview," pp. 14-18. When discussing sexuality itself, Curran describes it as a means of personal relationship, but leaves unclear its relation to the person as embodied-except to reject what he believes to be the physicalist preoccupation with procreation characteristic of past Catholic theology and teaching. See "Sexuality and Sin," pp. 168-70. Others will affirm the corporeality of the person as subject, but do not explicitly develop the implications of this with regard to sexuality. See Louis Janssens, "Artificial Insemination: Ethical Considerations," *Louvain Studies* 8 (1980): 2-29. Still others, such as Cahill, want to affirm the sexual as an "important but not all-encompassing" dimension of human experience, but do not specify how this ought to be understood (see "Catholic Sexual Ethics," p. 143). On the Church's view of the difficulties inherent in the opposition of freedom to human nature and embodiment, see John Paul II, Encyclical Letter, *Veritatis Splendor,* nos. 46-50.

47.For a good exposition of the meaning of "person" and "nature" in both classical and contemporary thought, see Ambrose McNicholl, "Person, Sex Marriage and Actual Trends of Thought," in *Human Sexuality and Personhood,* Proceedings of the Workshop for the Hierarchies of the United States and Canada, February 2-6, 1981 (St. Louis: Pope John XXIII Medical Moral Center, 1981), pp. 138-65. It should be noted that the attempt to oppose the categories of person and nature renders unintelligible the Church's classic Christological confession of Christ as one Person in two natures as well as the anthropology of Vatican II with its emphasis on Christ's assumption and revelation of human nature. See *Gaudium et Spes,* nos. 20, 29; *Lumen Gentixm* no. 13.

48.On this point one can find surprising agreement between moralists who hold otherwise sharply different views. Hence Philip Keane, S.S. states: "the gift of sexuality is a gift that touches persons on all levels of their existence . . . thus becoming a basic ontological determinant of human existence or personality." See *Sexual Morality: A Catholic Perspective* (New York: Paulist, 1977), p. 4. Ronald Lawler, O.F.M. Cap., Joseph Boyle, and William May will assert in a similar vein that "sexuality is a modality which affects our entire being as persons." See *Catholic Sexual Ethics. A Summary Explanation and Defense* (Huntington, IN: Our Sunday Visitor, 1985), p. 129.

47.For a good exposition of the meaning of "person" and "nature" in both classical and contemporary thought, see Ambrose McNicholl, "Person, Sex, Marriage and Actual Trends of Thought," in *Human Sexuality and Personhood,* Proceedings of the Workshop for the Hierarchies of the United States and Canada, February 2-6, 1981 (St. Louis: Pope John XXIII Medical Moral Center, 1981), pp. 138-65. It should be noted that the attempt to oppose the categories of person and nature renders unintelligible the Church's classic Christological confession of Christ as one Person in two natures as well as the anthropology of Vatican II with its emphasis on Christ's assumption and revelation of human nature. See *Gaudium et Spes,* nos. 20, 29; *Lumen Gentium,* no. 13.

48.On this point one can find surprising agreement between moralists who hold otherwise sharply different views. Hence Philip Keane, S.S. states: "the gift of sexuality is a gift that touches persons on all levels of their existence . . . thus becoming a basic ontological determinant of human existence or personality." See *Sexual Morality: A Catholic Perspective* (New York: Paulist, 1977), p. 4. Ronald Lawler, O.F.M. Cap., Joseph Boyle, and William May will assert in a similar vein that "sexuality is a modality which affects our entire being as persons." See *Catholic Sexual Ethics: A Summary Explanation and Defense* (Huntington, IN: Our Sunday Visitor, 1985), p. 129.

49.See Leo XIII, *Rerum Novarum* (1891), no. 62.

50 See John Paul's talk to the Indians at Oaxaca, Mexico entitled "Importance and Dignity of Farm Workers," *Tlte Pope Speaks* 24 (Fall 1979):

51.John Paul II, *Laborem Exerce7es,* nos. 14-15. The "personalist argument" is set in the larger context of private property and more specifically in the ownership of the means of production, although it is also applied to the participation of workers in the production process. See Lothar Roos, "On a Theology anal Fthics of Work," *C0111.Ilol)liO* 17 (19S4) 117.

52.Some may want to accuse Leo and Pius of not developing a more personalistic view of remuneration. One clear reason why Leo XIII did not explicate this area is that if societies were not meeting their basic physical needs, it is hardly possible to speak of meeting more personalistic functions. This reality is similar to Maslow's hierarchy of needs. If a person does not have nutrition and shelter, it is useless to speak of one's self-esteem. See also Porter's chapter on justice where she briefly discusses the relationship between the inclinations. She states "The more basic such an inclination is, the more stringent the claims that it generates, over against both the community as a whole and other members of that community, presumably because one who is frustrated in pursuing one of the more basic inclinations will have much less, or no, opportunity to pursue the more distinctively human inclinations" (p. 136) .

53.See Karol Wojtyla, *Love and Restonsibilit,e,* trans. H. T. Willets (New York: Farrar, Strauss, and Giroux, 1981), p. 234. The same understanding is reflected in John Paul II's papal teaching. See his Apostolic Exhortation, *Familiaris Consortio,* no. 32, and the partial collection of his general audiences on his "theology of the body" published in book form as *Rehteefions on Humanae Zitae* (Boston: St. Paul Editions, 1984), pp. 33-34.

54.See Laborem Exercens, nos. 9 and 12.

55.Curran, "A Century of Catholic Social Teaching," *Theology Today (July* 991): 169.

56.While Curran is not unaware of these ideas, he draws different conclusions See his discussion of John C. Murray and the Church/State question in *American Catholic Social Ethics* (Notre Dame: University of Notre Dame, 1982), pp. 225-32.

57.Thus John Paul II writes that, "polygamy . . . in fact, directly negates the plan of God which was revealed from the beginning, because it is contrary to the equal personal dignity of men and women who in matrimony give themselves with a love that is total and therefore unique and exclusive" *(Familiaris Consortia,* no. 19. The citation is from *The Pope Speaks* 27 (1982): 15-16.

58.Cf. John Paul II, *Sollicihado Rei Socialis,* nos. 34 and 41.

59.Pius *XI, Ql(adragesimo Juno* (1931), no. 41. The eitatiort is from the N.C.W.C. translation (Boston: Daughters of St. Paul, nod.).

60 See John Paul II, *Sollicitgdo Rei Socialis,* no. 41. The popes, however, do not stay away from particular programs altogether. As John XXIII writes: "It is not enough merely to formulate a social doctrine. It must be translated into reality" (see John XXIII, *Mater et Magistra* (1961), no. 224; the citation is from *The Pope Speaks 7* (1961): 337). Otherwise, the social doctrine becomes meaningless, and the role of faith is restricted to the realm of one's private life. This is why, for example, Pius XI, Pius XII, John XXIII and John Paul II have encouraged proposals such as worker ownership, profit sharing, and worker participation, which they see as logical, although not necessary in all cases, outcomes of the church's social principles. See John Paul II, *Laborem Exercers,* no 14. For a critique of John Paul's specificity, see James O'Connell, 527. Many people including Curran have been critical of Pius's proposal on vocational groups. See Curran, "Changing Anthropological Bases," pp. 187-88. For a different interpretation of the importance of these groups, see John Cort, "If Not Communism or Capitalism, What?," *New Oxford Review* (September 1990), pp. 18-25 and Jonathan Boswell, *Community and the Ecoutont^) 4 Theory of Public Cooperation* (New York: Routledge, 1990).

6lCf. *Gaudium et Spes* nos. 22 and 29; *Lumest Gentium* no. 18; John Paul II, *Redentptor Hominis* no 8. Perhaps the clearest effort to **understand the** person and sexuality in the light of revelation can be found in Pope John Paul II's "theology of the body" alluded to above which derives especially from his analysis of the first three chapters of Genesis.

62.Cf. John Paul II, *Sollicitzzdo Rei Socialis* no. 41.

63.*Gaudium et Spes,* no. 24, Abbott, ed., p. 223. Cf. John Paul II, Apostolie Letter, *Mulieris Dig7titatem,* no. 7.

fi4Another point of critique that can be explored is the observation that the supposedly radically different worldviews which the historically conscious and the classicist approaches embody in fact share a number of the same presuppositions in their individualistic and reason-centered orientation toward facts and information. The markedly "left-brain" approach betrayed by both world-views shows a definite inability to integrate more holistic, participatory, and communal forms of knowing yielded by story, symbol, and grace. See the discussion of these matters in David Bohr, *Catholic Moral Tradition: In Christ, a New Creation* (Huntington, IN: Our Sunday Visitor Press, 1990), pp. 67-74. See also Joseph Pieper's distinction between *ratio* and *intellectus* in *Leisure as the Basis of Culturer (New* York: New American Library.]95v). pp. 26ff.

Pope John Paul II *on Life- Sustaining Treatment and the Vegetative State*

[http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_it.html]

Address of John Paul II to the Participants in the International Conference on

"Life-Sustaining Treatment and the Vegetative State: Scientific Progress and Ethical Dilemmas"

March 17-20, Augustinianum: Saturday, 20 March 2004

1. DISTINGUISHED Ladies and Gentlemen!

1. I cordially greet all of you who took part in the International Congress: *"Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas"*. I wish to extend a special greeting to Bishop Elio Sgreccia, Vice-President of the Pontifical Academy for Life, and to Prof. Gian Luigi Gigli, President of the International Federation of Catholic Medical Associations and selfless champion of the fundamental value of life, who has kindly expressed your shared feelings.

This important Congress, organized jointly by the Pontifical Academy for Life and the International Federation of Catholic Medical Associations, is dealing with a very significant issue: *the clinical condition called the "vegetative state"*. The complex scientific, ethical, social and pastoral implications of such a condition require in-depth reflections and a fruitful interdisciplinary dialogue, as evidenced by the intense and carefully structured programme of your work sessions

2. WITH deep esteem and sincere hope, the Church encourages the efforts of men and women of science who, sometimes at great sacrifice, daily dedicate their task of study and research to the improvement of the diagnostic, therapeutic, prognostic and rehabilitative possibilities confronting those patients who rely completely on those who care for and assist them. The person in a vegetative state, in fact, shows no evident sign of self-awareness or of awareness of the environment, and seems unable to interact with others or to react to specific stimuli.

Scientists and researchers realize that [1] one must, first of all, arrive at a correct diagnosis, [2] which usually requires prolonged and careful observation in specialized centres, [3] given also the high number of diagnostic errors reported in the literature. Moreover, not a few of these persons, with appropriate treatment and with specific rehabilitation programmes, have been able to emerge from a vegetative state. On the contrary, many others unfortunately remain prisoners of their condition even for long stretches of time and without needing technological support.

Discorso di Giovanni Paolo II
ai Partecipanti al Congresso Internazionale su "I Trattamenti di Sostegno Vitale e lo Stato Vegetativo. Progressi scientifici e dilemmi etici"

(17-20 marzo 2004, augustinianum) Sabato, 20 marzo 2004

Illustri Signore e Signori!

1. Saluto molto cordialmente tutti voi partecipanti al Congresso Internazionale *"Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas"*. Un saluto particolare desidero rivolgere a Mons. Elio Sgreccia, Vice-Presidente della Pontificia Accademia per la Vita, ed al Professor Gian Luigi Gigli, Presidente della Federazione Internazionale delle Associazioni dei Medici Cattolici e generoso paladino del fondamentale valore della vita, il quale s'è fatto amabilmente interprete dei comuni sentimenti.
Questo importante Congresso, organizzato insieme dalla Pontificia Accademia per la Vita e dalla Federazione Internazionale delle Associazioni dei Medici Cattolici, sta affrontando un tema di grande rilevanza: *la condizione clinica denominata "stato vegetativo"*. I complessi risvolti scientifici, etici, sociali e pastorali di tale condizione necessitano di una profonda riflessione e di un proficuo dialogo interdisciplinare, così come dimostra il denso ed articolato programma dei vostri lavori.

2. La Chiesa con viva stima e sincera speranza incoraggia gli sforzi degli uomini di scienza che dedicano quotidianamente, talvolta con grandi sacrifici, il loro impegno di studio e di ricerca per il miglioramento delle possibilità diagnostiche, terapeutiche, prognostiche e riabilitative nei confronti di questi pazienti totalmente affidati a chi li cura e li assiste. La persona in stato vegetativo, infatti, non dà alcun segno evidente di coscienza di sé o di consapevolezza dell'ambiente e sembra incapace di interagire con gli altri o di reagire a stimoli adeguati.

Gli studiosi avvertono che è necessario anzitutto pervenire ad una corretta diagnosi, che normalmente richiede una lunga ed attenta osservazione in centri specializzati, tenuto conto anche dell'alto numero di errori diagnostici riportati in letteratura. Non poche di queste persone, poi, con cure appropriate e con programmi di riabilitazione mirati, sono in grado di uscire dal coma. Molti altri, al contrario, restano purtroppo prigionieri del loro stato anche per tempi molto lunghi e senza necessitare di supporti tecnologici.

In particular, the term *permanent vegetative state* has been coined to indicate the condition of those patients whose "vegetative state" continues for over a year. Actually, there is no different diagnosis that corresponds to such a definition, but only a conventional prognostic judgment, relative to the fact that the recovery of patients, statistically speaking, is ever more difficult as the condition of vegetative state is prolonged in time.

However, we must neither forget nor underestimate that there are well-documented cases of at least partial recovery even after many years; we can thus state that medical science, up until now, is still unable to predict with certainty who among patients in this condition will recover and who will not.

In particolare, per indicare la condizione di coloro il cui "stato vegetativo" si prolunga per oltre un anno, è stato coniato il termine di *stato vegetativo permanente*. In realtà, a tale definizione non corrisponde una diversa diagnosi, ma solo un giudizio di previsione convenzionale, relativo al fatto che la ripresa del paziente è, statisticamente parlando, sempre più difficile quanto più la condizione di stato vegetativo si prolunga nel tempo.

Tuttavia, non va dimenticato o sottovalutato come siano ben documentati casi di recupero almeno parziale, anche a distanza di molti anni, tanto da far affermare che la scienza medica, fino ad oggi, non è ancora in grado di predire con sicurezza chi tra i pazienti in queste condizioni potrà riprendersi e chi no.

3. Faced with patients in similar clinical conditions, there are some who cast doubt on the persistence of the "human quality" itself, almost as if the adjective "vegetative" (whose use is now solidly established), which symbolically describes a clinical state, could or should be instead applied to the sick as such, actually demeaning their value and personal dignity. In this sense, it must be noted that this term, even when confined to the clinical context, is certainly not the most felicitous when applied to human beings.

In opposition to such trends of thought, I feel the duty to reaffirm strongly that the intrinsic value and personal dignity of every human being do not change, no matter what the concrete circumstances of his or her life. *A man, even if seriously ill or disabled in the exercise of his highest functions, is and always will be a man*, and he will never become a "vegetable" or an "animal".

Even our brothers and sisters who find themselves in the clinical condition of a "vegetative state" retain their human dignity in all its fullness. The loving gaze of God the Father continues to fall upon them, acknowledging them as his sons and daughters, especially in need of help.

3. Di fronte ad un paziente in simili condizioni cliniche, non manca chi giunge a mettere in dubbio il permanere della sua stessa "qualità umana", quasi come se l'aggettivo "vegetale" (il cui uso è ormai consolidato), simbolicamente descrittivo di uno stato clinico, potesse o dovesse essere invece riferito al malato in quanto tale, degradandone di fatto il valore e la dignità personale. In questo senso, va rilevato come il termine in parola, pur confinato nell'ambito clinico, non sia certamente il più felice in riferimento a soggetti umani.

In opposizione a simili tendenze di pensiero, sento il dovere di riaffermare con vigore che il valore intrinseco e la personale dignità di ogni essere umano non mutano, qualunque siano le circostanze concrete della sua vita. *Un uomo, anche se gravemente malato od impedito nell'esercizio delle sue funzioni più alte, è e sarà sempre un uomo*, mai diventerà un "vegetale" o un "animale".

Anche i nostri fratelli e sorelle che si trovano nella condizione clinica dello "stato vegetativo" conservano tutta intera la loro dignità umana. Lo sguardo amorevole di Dio Padre continua a posarsi su di loro, riconoscendoli come figli suoi particolarmente bisognosi di assistenza.

4. MEDICAL doctors and health-care personnel, society and the Church have moral duties toward these persons from which they cannot exempt themselves without lessening the demands both of professional ethics and human and Christian solidarity.

The sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.), and to the prevention of complications related to his confinement to bed. He also has the right to appropriate rehabilitative care and to be monitored for clinical signs of eventual recovery.

I should like particularly to underline how the administration

4. Verso queste persone, medici e operatori sanitari, società e Chiesa hanno doveri morali dai quali non possono esimersi, senza venir meno alle esigenze sia della deontologia professionale che della solidarietà umana e cristiana.

L'ammalato in stato vegetativo, in attesa del recupero o della fine naturale, ha dunque diritto ad una assistenza sanitaria di base (nutrizione, idratazione, igiene, riscaldamento, ecc.), ed alla prevenzione delle complicazioni legate all'allettamento. Egli ha diritto anche ad un intervento riabilitativo mirato ed al monitoraggio dei segni clinici di eventuale ripresa.

In particolare, vorrei sottolineare come la

of water and food, even when provided by artificial means, always represents a ***natural means*** of preserving life, not a ***medical act***.

Its use, furthermore, should be considered, in principle, ***ordinary*** and ***proportionate***, and as such **morally obligatory**,

insofar as and until it is seen to have attained its proper finality,

which in the present case consists in providing nourishment to the patient and alleviation of his suffering.

The obligation to provide the "normal care due to the sick in such cases" (C.D.F., *Iura et Bona* , p. 4) includes, in fact, the use of nutrition and hydration (cf. Pontifical Council "Cor Unum", *Dans le cadre,* 2.4.4; Pontifical Council for Pastoral Assistance to Health Care Workers., *Charter for Health Care Workers,* [1995] n. 120).

The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of *minimal care* for the patient, including nutrition and hydration.

Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal.

In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission.

In this regard, I recall what I wrote in the Encyclical *Evangelium Vitae,* making it clear that "by *euthanasia in the true and proper sense* must be understood an action or omission which by its very nature and intention brings about death, with the purpose of eliminating all pain"; such an act is always "a *serious violation of the law of God,* since it is the deliberate and morally unacceptable killing of a human person" (n. 65).

Besides, the moral principle is well known, according to which even the simple doubt of being in the presence of a living person already imposes the obligation of full respect and of abstaining from any act that aims at anticipating the person's death.

somministrazione di acqua e cibo, anche quando avvenisse per vie artificiali, rappresenti sempre un *mezzo naturale* di conservazione della vita, non un *atto medico*.

Il suo uso pertanto sarà da considerarsi, in linea di principio, *ordinario* e *proporzionato*, e come tale moralmente obbligatorio,
nella misura in cui e fino a quando esso dimostra di raggiungere la sua finalità propria,

che nella fattispecie consiste nel procurare nutrimento al paziente e lenimento delle sofferenze.
L'obbligo di non far mancare "le cure normali dovute all'ammalato in simili casi" (Congr. Dottr. Fede, *Iura et bona*, p. IV) comprende, infatti, anche l'impiego dell'alimentazione e idratazione (cfr Pont. Cons. «Cor Unum », *Dans le cadre*, 2.4.4; Pont. Cons. Past . Operat. Sanit., *Carta degli Operatori Sanitari*, n. 120).
La valutazione delle probabilità, fondata sulle scarse speranze di recupero quando lo stato vegetativo si prolunga oltre un anno, non può giustificare eticamente l'abbandono o l'interruzione delle *cure minimali* al paziente, comprese alimentazione ed idratazione.
La morte per fame e per sete, infatti, è l'unico risultato possibile in seguito alla loro sospensione.
In tal senso essa finisce per configurarsi, se consapevolmente e deliberatamente effettuata, come una vera e propria eutanasia per omissione.
A tal proposito, ricordo quanto ho scritto nell'Enciclica *Evangelium vitae*, chiarendo che "per *eutanasia in senso vero e proprio* si deve intendere un'azione o un'omissione che di natura sua e nelle intenzioni procura la morte, allo scopo di eliminare ogni dolore"; una tale azione rappresenta sempre "una *grave violazione della Legge di Dio*, in quanto uccisione deliberata moralmente inaccettabile di una persona umana" (n. 65).

Del resto, è noto il principio morale secondo cui anche il semplice dubbio di essere in presenza di una persona viva già pone l'obbligo del suo pieno rispetto e dell'astensione da qualunque azione mirante ad anticipare la sua morte.

5. CONSIDEERATIONS about the "quality of life", often actually dictated by psychological, social and economic pressures, cannot take precedence over general principles.

First of all, no evaluation of costs can outweigh the value of the fundamental good which we are trying to protect, that of human life.

Moreover, to admit that decisions regarding man's life can be based on the external acknowledgment of its quality, is the same as acknowledging that increasing and decreasing levels of quality of life, and therefore of human dignity, can be

5. Su tale riferimento generale non possono prevalere considerazioni circa la "qualità della vita", spesso dettate in realtà da pressioni di carattere psicologico, sociale ed economico.

Innanzitutto, nessuna valutazione di costi può prevalere sul valore del fondamentale bene che si cerca di proteggere, la vita umana.

Inoltre, ammettere che si possa decidere della vita dell'uomo sulla base di un riconoscimento dall'esterno della sua qualità, equivale a riconoscere che a qualsiasi soggetto possano essere attribuiti dall'esterno livelli crescenti o

attributed from an external perspective to any subject, thus introducing into social relations a discriminatory and eugenic principle.

Moreover, it is not possible to rule out *a priori* that the withdrawal of nutrition and hydration, as reported by authoritative studies, is the source of considerable suffering for the sick person, even if we can see only the reactions at the level of the autonomic nervous system or of gestures.

Modern clinical neurophysiology and neuro-imaging techniques, in fact, seem to point to the lasting quality in these patients of elementary forms of communication and analysis of stimuli.

decrescenti di qualità della vita e quindi di dignità umana, introducendo un principio discriminatorio ed eugenetico nelle relazioni sociali.

Inoltre, non è possibile escludere *a priori* che la sottrazione dell'alimentazione e idratazione, secondo quanto riportato da seri studi, sia causa di grandi sofferenze per il soggetto malato, anche se noi possiamo vederne solo le reazioni a livello di sistema nervoso autonomo o di mimica.

Le moderne tecniche di neurofisiologia clinica e di diagnosi cerebrale per immagini, infatti, sembrano indicare il perdurare in questi pazienti di forme elementari di comunicazione e di analisi degli stimoli.

6. HOWEVER, it is not enough to reaffirm the general principle according to which the value of a man's life cannot be made subordinate to any judgment of its quality expressed by other men; it is necessary to promote the *taking of positive actions* as a stand against pressures to withdraw hydration and nutrition as a way to put an end to the lives of these patients.

6. Non basta, tuttavia, riaffermare il principio generale secondo cui il valore della vita di un uomo non può essere sottoposto ad un giudizio di qualità espresso da altri uomini; è necessario promuovere *azioni positive* per contrastare le pressioni per la sospensione della idratazione e della nutrizione, come mezzo per porre fine alla vita di questi pazienti.

It is necessary, above all, *to support those families* who have had one of their loved ones struck down by this terrible clinical condition. They cannot be left alone with their heavy human, psychological and financial burden. Although the care for these patients is not, in general, particularly costly, society must allot sufficient resources for the care of this sort of frailty, by way of bringing about appropriate, concrete initiatives such as, for example, the creation of a network of awakening centres with specialized treatment and rehabilitation programmes; financial support and home assistance for families when patients are moved back home at the end of intensive rehabilitation programmes; the establishment of facilities which can accommodate those cases in which there is no family able to deal with the problem or to provide "breaks" for those families who are at risk of psychological and moral burn-out

Occorre innanzitutto *sostenere le famiglie*, che hanno avuto un loro caro colpito da questa terribile condizione clinica. Esse non possono essere lasciate sole col loro pesante carico umano, psicologico ed economico. Benché l'assistenza a questi pazienti non sia in genere particolarmente costosa, la società deve impegnare risorse sufficienti per la cura di questo tipo di fragilità, attraverso la realizzazione di opportune iniziative concrete quali, ad esempio, la creazione di una rete capillare di unità di risveglio, con programmi specifici di assistenza e riabilitazione; il sostegno economico e l'assistenza domiciliare alle famiglie, quando il paziente verrà trasferito a domicilio al termine dei programmi di riabilitazione intensiva; la creazione di strutture di accoglienza per i casi in cui non vi sia una famiglia in grado di fare fronte al problema o per offrire periodi di "pausa" assistenziale alle famiglie a rischio di logoramento psicologico e morale.

Proper care for these patients and their families should, moreover, include the presence and the witness of a medical doctor and an entire team, who are asked to help the family understand that they are there as allies who are in this struggle with them. The participation of volunteers represents a basic support to enable the family to break out of its isolation and to help it to realize that it is a precious and not a forsaken part of the social fabric.

L'assistenza appropriata a questi pazienti e alle loro famiglie dovrebbe, inoltre, prevedere la presenza e la testimonianza del medico e dell'équipe assistenziale, ai quali è chiesto di far comprendere ai familiari che si è loro alleati e che si lotta con loro; anche la partecipazione del volontariato rappresenta un sostegno fondamentale per far uscire la famiglia dall'isolamento ed aiutarla a sentirsi parte preziosa e non abbandonata della trama sociale.

In these situations, then, spiritual counselling and pastoral aid are particularly important as help for recovering the deepest meaning of an apparently desperate condition.

In queste situazioni, poi, riveste particolare importanza la consulenza spirituale e l'aiuto pastorale, come ausilio per recuperare il significato più profondo di una condizione apparentemente disperata.

7. DISTINGUISHED Ladies and Gentlemen, in conclusion I exhort you, as men and women of science responsible for the dignity of the medical profession, to guard jealously the principle according to which the true task of medicine is "to cure if possible, always to care".

As a pledge and support of this, your authentic humanitarian mission to give comfort and support to your suffering brothers and sisters, I remind you of the words of Jesus: "Amen, I say to you, whatever you did for one of these least brothers of mine, you did for me" (Mt 25,40).

In this light, I invoke upon you the assistance of him, whom a meaningful saying of the Church Fathers describes as *Christus medicus*, and in entrusting your work to the protection of Mary, Consoler of the sick and Comforter of the dying, I lovingly bestow on all of you a special Apostolic Blessing.

7. Illustri Signore e Signori, in conclusione vi esorto, come persone di scienza, responsabili della dignità della professione medica, a custodire gelosamente il principio secondo cui vero compito della medicina è di *"guarire se possibile, aver cura sempre"* (*to cure if possibile, always to care*).

A suggello e sostegno di questa vostra autentica missione umanitaria di conforto e di assistenza verso i fratelli sofferenti, vi ricordo le parole di Gesù: "In verità vi dico: ogni volta che avete fatto queste cose a uno solo di questi miei fratelli più piccoli, l'avete fatto a me" (*Mt* 25,40).

In questa luce, invoco su di voi l'assistenza di Colui che una suggestiva formula patristica qualifica come *Christus medicus* e, nell'affidare il vostro lavoro alla protezione di Maria, Consolatrice degli afflitti e conforto dei morenti, a tutti imparto con affetto una speciale Benedizione Apostolica.

PALLIATIVE CARE
An Address by POPE JOHN PAUL II

Address by Pope John Paul II On the Occasion of the International Conference of the Pontifical Council for Pastoral Health Care [on Palliative Care]

Discorso di Giovanni Paolo Ii In Occasione della Conferenza Internazionale Del Pontificio Consiglio per la Pastorale Della Salute

Friday, November 12, 2004

Venerdì, 12 novembre 2004

Venerable Brothers in the Episcopate, Dear Brothers and Sisters,

Signor Cardinale,venerati Fratelli nell'Episcopato,carissimi Fratelli e Sorelle!

1. I am pleased to welcome you on the occasion of the *International Conference of the Pontifical Council for Health Pastoral Care* which is taking place at this time. With your visit, you have wished to reaffirm your scientific and human commitment to those who are suffering.

1. Sono lieto di accogliervi in occasione della *Conferenza Internazionale del Pontificio Consiglio per la Pastorale della Salute*, i cui lavori sono in corso. Con questa vostra visita avete voluto riaffermare il vostro impegno scientifico ed umano a favore di quanti si trovano in uno stato di sofferenza.

I thank Cardinal Javier Lozano Barragán for his courteous words on behalf of you all. My grateful thoughts and appreciation go to everyone who has made a contribution to these sessions, as well as to the doctors and health-care workers throughout the world who dedicate their scientific and human skills and their spirituality to relieving pain and its consequences.

Ringrazio il Signor Cardinale Javier Lozano Barragán per le cortesi espressioni che, a nome di tutti, mi ha testé rivolto. Il mio grato pensiero e il mio apprezzamento vanno a quanti hanno recato il loro contributo a questa assise, come pure ai tanti medici e operatori sanitari che, nel mondo, dedicano le proprie capacità scientifiche, umane e spirituali al sollievo del dolore e delle sue conseguenze.

2. Medicine is always at the service of life. Even when medical treatment is unable to defeat a serious pathology, all its possibilities are directed to the alleviation of suffering. Working enthusiastically to help the patient in every situation means being aware of the inalienable dignity of every human being, even in the extreme conditions of terminal illness. Christians recognize this devotion as a fundamental dimension of their vocation: indeed, in carrying out this task they know that they are caring for Christ himself (cf. Mt 25: 35-40).

2. La medicina si pone sempre al servizio della vita. Anche quando sa di non poter debellare una grave patologia, dedica le proprie capacità a lenirne le sofferenze. Lavorare con passione per aiutare il paziente in ogni situazione significa aver coscienza dell'inalienabile dignità di ogni essere umano, anche nelle estreme condizioni dello stato terminale. In questa dedizione al servizio di chi soffre, il cristiano riconosce una dimensione fondamentale della propria vocazione: nell'adempimento di tale compito, infatti, egli sa di prendersi cura di Cristo stesso (cfr *Mt* 25,35-40).

"It is therefore through Christ, and in Christ, that light is thrown on the riddle of suffering and death which, apart from his Gospel, overwhelms us", the Council recalls (*Gaudium et Spes*, n. 22).Those who open themselves to this light in faith find comfort in their own suffering and acquire the ability to alleviate that of others. Indeed, there is *a directly proportional relationship between the ability to suffer and the ability to help those who are suffering.* Daily experience teaches that the persons most sensitive to the suffering of others and who are the most dedicated to alleviating the suffering of others are also more disposed to accept, with God's help, their own suffering.

"Per Cristo e in Cristo riceve luce quell'enigma del dolore e della morte, che al di fuori del Vangelo ci opprime", ricorda il Concilio (*Gaudium et spes*, 22). Chi nella fede si apre a questa luce, trova conforto nella propria sofferenza ed acquista la capacità di lenire la sofferenza altrui. Di fatto esiste *una relazione direttamente proporzionale tra la capacità di soffrire e la capacità di aiutare chi soffre*. L'esperienza quotidiana insegna che le persone più sensibili al dolore altrui e più dedite a lenire i dolori degli altri sono anche più disposte ad accettare, con l'aiuto di Dio, le proprie sofferenze.

3. Love of neighbour, which Jesus vividly portrayed in the Parable of the Good Samaritan (cf. Lk 10: 2ff.), enables us to *recognize the dignity of every person*, even when illness has become a burden. Suffering, old age, a comatose state or the imminence of death in no way diminish the intrinsic dignity of the person created in God's image.

3. L'amore verso il prossimo, che Gesù ha tratteggiato con efficacia nella parabola del buon samaritano (cfr *Lc* 10, 29ss), rende capaci di *riconoscere la dignità di ogni persona*, anche quando la malattia è venuta a gravare sulla sua esistenza. La sofferenza, l'anzianità, lo stato di incoscienza, l'imminenza della morte non diminuiscono l'intrinseca dignità della persona, creata ad immagine di Dio.

Euthanasia is one of those tragedies caused by an ethic that

Tra i drammi causati da un'etica che pretende di stabilire chi può vivere e chi deve morire, vi è quello

claims to dictate who should live and who should die. Even if it is motivated by sentiments of a misconstrued compassion or of a misunderstood preservation of dignity, euthanasia actually eliminates the person instead of relieving the individual of suffering.

dell'*eutanasia*. Anche se motivata da sentimenti di una mal intesa compassione o di una mal compresa dignità da preservare, l'eutanasia invece che riscattare la persona dalla sofferenza ne realizza la soppressione.

Unless compassion is combined with the desire to tackle suffering and support those who are afflicted, it leads to the cancellation of life in order to eliminate pain, thereby distorting the ethical status of medical science.

La compassione, quando è priva della volontà di affrontare la sofferenza e di accompagnare chi soffre, porta alla cancellazione della vita per annientare il dolore, stravolgendo così lo statuto etico della scienza medica.

4. True compassion, on the contrary, encourages every reasonable effort for the patient's recovery. At the same time, it helps draw the line when it is clear that no further treatment will serve this purpose.

4. La vera compassione, al contrario, promuove ogni ragionevole sforzo per favorire la guarigione del paziente. Al tempo stesso essa aiuta a fermarsi quando nessuna azione risulta ormai utile a tale fine.

The refusal of *aggressive treatment* is neither a rejection of the patient nor of his or her life. Indeed, the object of the decision on whether to begin or to continue a treatment has nothing to do with the value of the patient's life, but rather with whether such medical intervention is **beneficial** for the patient.

Il rifiuto dell' *accanimento terapeutico* non è un rifiuto del paziente e della sua vita. Infatti, l'oggetto della deliberazione sull'opportunità di iniziare o continuare una pratica terapeutica non è il valore della vita del paziente, ma il valore dell'intervento medico sul paziente.

The possible decision either not to start or to halt a treatment will be deemed ethically correct if the treatment is ineffective or obviously disproportionate to the aims of sustaining life or recovering health. Consequently, the decision to forego aggressive treatment is an expression of the respect that is due to the patient at every moment.

L'eventuale decisione di non intraprendere o di interrompere una terapia sarà ritenuta eticamente corretta quando questa risulti inefficace o chiaramente sproporzionata ai fini del sostegno alla vita o del recupero della salute. Il rifiuto dell'accanimento terapeutico, pertanto, è espressione del rispetto che in ogni istante si deve al paziente.

It is precisely this sense of loving respect that will help support patients to the very end. Every possible act and attention should be brought into play to lessen their suffering in the last part of their earthly existence and to encourage a life as peaceful as possible, which will dispose them to prepare their souls for the encounter with the heavenly Father.

Sarà proprio questo senso di amorevole rispetto che aiuterà ad accompagnare il paziente fino alla fine, ponendo in atto tutte le azioni e attenzioni possibili per diminuirne le sofferenze e favorirne nell'ultima parte dell'esistenza terrena un vissuto per quanto possibile sereno, che ne disponga l'animo all'incontro con il Padre celeste.

5. Particularly in the stages of illness when proportionate and effective treatment is no longer possible, while it is necessary to avoid every kind of persistent or aggressive treatment, methods of "palliative care" are required. As the Encyclical *Evangelium Vitae* affirms, they must "seek to make suffering more bearable in the final stages of illness and to ensure that the patient is supported and accompanied in his or her ordeal" (n. 65).

5. Soprattutto nella fase della malattia, in cui non è più possibile praticare terapie proporzionate ed efficaci, mentre, si impone l'obbligo di evitare ogni forma di ostinazione o accanimento terapeutico, si colloca la necessità delle "cure palliative" che, come afferma l'Enciclica *Evangelium vitae*, sono "destinate a rendere più sopportabile la sofferenza nella fase finale della malattia e di assicurare al tempo stesso al paziente un adeguato accompagnamento" (n. 65).

In fact, palliative care aims, especially in the case of patients with terminal diseases, at alleviating a vast gamut of symptoms of physical, psychological and mental suffering; hence, it requires the intervention of a team of specialists with medical, psychological and religious qualifications who will work together to support the patient in critical stages.

Le cure palliative, infatti, mirano a lenire, specialmente nel paziente terminale, una vasta gamma di sintomi di sofferenza di ordine fisico, psichico e mentale, e richiedono perciò l'intervento di un'équipe di specialisti con competenza medica, psicologica e religiosa, tra loro affiatati per sostenere il paziente nella fase critica.

The Encyclical *Evangelium Vitae* in particular sums up the traditional teaching on the licit use of pain killers that are sometimes called for, with respect for the freedom of patients who should be able, as far as possible, "to satisfy their moral and family duties, and above all... to prepare in a fully

In particolare, nell' Enciclica *Evangelium vitae* è stata sintetizzata la dottrina tradizionale sull'uso lecito e talora doveroso degli analgesici nel rispetto della libertà dei pazienti, i quali devono essere posti in grado, nella misura del possibile, "di soddisfare ai loro obblighi morali e familiari e soprattutto devono potersi preparare con piena coscienza all'incontro definitivo con Dio" (n. 65).

conscious way for their definitive meeting with God" (n. 65).

Moreover, while patients in need of pain killers should not be made to forego the relief that they can bring, the dose should be effectively proportionate to the intensity of their pain and its treatment. All forms of euthanasia that would result from the administration of massive doses of a sedative for the purpose of causing death must be avoided.

To provide this help in its different forms, it is necessary to encourage the training of specialists in palliative care at special teaching institutes where psychologists and health-care workers can also be involved.

6. Science and technology, however, will never be able to provide a satisfactory response to the essential questions of the human heart; these are questions that faith alone can answer. The Church intends to continue making her own specific contribution, offering human and spiritual support to sick people who want to open themselves to the message of the love of God, who is ever attentive to the tears of those who turn to him (cf. Ps 39: 13). Here, emphasis is placed on the importance of *health pastoral care* in which hospital chaplaincies have a special role and contribute so much to people's spiritual well-being during their hospital stay.

Then how can we forget the precious contribution of volunteers, who through their service give life to that *creativity in charity* which imbues hope, even in the unpleasant experience of suffering? Moreover, it is through them that Jesus can continue today to exist among men and women, doing good and healing them (cf. Acts 10: 38).

7. Thus, the Church makes her own contribution to this moving mission for the benefit of the suffering. May the Lord deign to enlighten all who are close to the sick and encourage them to persevere in their different roles and various responsibilities.

May Mary, Mother of Christ, accompany everyone in the difficult moments of pain and illness, so that human suffering may be raised to the saving mystery of the Cross of Christ.

I accompany these hopes with my Blessing.

D'altra parte, mentre non si deve far mancare ai pazienti che ne hanno necessità il sollievo proveniente dagli analgesici, la loro somministrazione dovrà essere effettivamente proporzionata all'intensità e alla cura del dolore, evitando ogni forma di eutanasia quale si avrebbe somministrando ingenti dosi di analgesici proprio con lo scopo di provocare la morte.

Ai fini di realizzare questo articolato aiuto occorre incoraggiare la formazione di specialisti delle cure palliative, in particolare strutture didattiche alle quali possono essere interessati anche psicologi e operatori della pastorale.

6. La scienza e la tecnica, tuttavia, non potranno mai dare risposta soddisfacente agli interrogativi essenziali del cuore umano. A queste domande può rispondere solo la fede. La Chiesa intende continuare ad offrire il proprio contributo specifico attraverso l'accompagnamento umano e spirituale degli infermi, che desiderano aprirsi al messaggio dell'amore di Dio, sempre attento alle lacrime di chi si rivolge a lui (cfr *Sal* 39,13). Si evidenzia qui l'importanza della *pastorale sanitaria*, nella quale ricoprono un ruolo di speciale rilievo le cappellanie ospedaliere, che tanto contribuiscono al bene spirituale di quanti soggiornano nelle strutture sanitarie.

Come dimenticare poi il contributo prezioso dei volontari che con il loro servizio danno vita a quella *fantasia della carità* che infonde speranza anche all'amara esperienza della sofferenza? E' anche per loro mezzo che Gesù può continuare oggi a passare tra gli uomini, per beneficarli e sanarli (cfr *At* 10,38).

7. La Chiesa offre così il proprio contributo in questa appassionante missione a favore delle persone che soffrono. Voglia il Signore illuminare quanti sono vicini ai malati, incoraggiandoli a perseverare nei distinti ruoli e nelle diverse responsabilità.

Tutti accompagni Maria, Madre di Cristo, nei momenti difficili del dolore e della malattia, affinché la sofferenza umana possa essere assunta nel mistero salvifico della Croce di Cristo.

Accompagno tali auspici con la mia Benedizione.

SACRED CONGREGATION *for the* DOCTRINE *of the* FAITH

DECLARATION ON EUTHANASIA (*IURA ET* BONA) May 5, 1980

(*Declaratio de Euthanasia deque analgesicorum remediorum usu therapeutico recte ac proporzionate servando*)

AAS 72, 1 (1980) 542-552; DOCUMENTA 38 *OR 27.6.1980, 1.4; CEE 145-163 [Lat./Hisp.]; EV 7, 332-351; LE 4772; Dokumenty, I, 38*

INTRODUCTION

The rights and values pertaining to the human person occupy an important place among the

Iura et bona quae humanae personae inhaerent, magnum obtinent momentum in quaestionibus quae apud nostrae aetatis homines agitantur. Ad rem quod

questions discussed today. In this regard, the Second Vatican Ecumenical Council solemnly reaffirmed the lofty dignity of the human person, and in a special way his or her right to life. The Council therefore condemned crimes against life “such as any type of murder, genocide, abortion, euthanasia, or willful suicide” (Pastoral Constitution *Gaudium et Spes*, no. 27).

attinet, Concilium Oecumenicum Vaticanum II praecellentem personae humanae dignitatem, peculiarique modo ius ipsius ad vitam, sollemniter confirmavit. Quapropter idem Concilium denuntiavit crimina contra vitam, quorum in numero ponuntur « cuiusvis generis homicidia, genocidia, abortus, euthanasia et ipsum voluntarium suicidium » (Constitutio pastoralis *Gaudium et Spes*, n. 27).

More recently, the Sacred Congregation for the Doctrine of the Faith has reminded all the faithful of Catholic teaching on procured abortion.[1] The Congregation now considers it opportune to set forth the Church’s teaching on euthanasia.

Recentiore tempore S. Congregatio pro Doctrina Fidei in omnium Christifidelium mentem doctrinam de abortu procurato revocavit.l Nunc vero eadem S. Congregatio opportunum ducit Ecclesiae doctrinam de euthanasia proponere.

It is indeed true that, in this sphere of teaching, the recent Popes have explained the principles, and these retain their full force [2]; but the progress of medical science in recent years has brought to the fore new aspects of the question of euthanasia, and these aspects call for further elucidation on the ethical level.

Verum quidem est, hoc in doctrines campo, ultimos Ponti. fices ‘- principia exposuisse, quae vim suam integre servant; at rnodicae artis progressus effecerunt ut in quaestione de euthanasia hisce ultimis annis novi aspectus in medium proferrentur; qui quidem aspectus postulant ut novis dilucidationibus proponantur, ad ethicas normas quod attinet.

In modern society, in which even the fundamental values of human life are often called into question, cultural change exercises an influence upon the way of looking at suffering and death; moreover, medicine has increased its capacity to cure and to prolong life in particular circumstances, which sometime give rise to moral problems.

In hominum societate, quae hodie est, cum saepe in discrimen vocentur ipsa fundamentalia vitae humanae bona, fit ut mutatio civilis culturae vim habeat in ipsam rationem mortem et dolorem aestimandi; animadvertendum etiam est auctam esse medicae artis virtutem sanandi vitamque prorogandi quibusdam datis condicionibus, quae quidem interdum nonnullas de re morali quaestiones gignunt.

Thus people living in this situation experience no little anxiety about the meaning of advanced old age and death. They also begin to wonder whether they have the right to obtain for themselves or their fellowmen an “easy death,” which would shorten suffering and which seems to them more in harmony with human dignity.

Itaque homines, qui in tali rerum statu versantur, anxii sibi interrogationes ponunt de extremae senectutis et mortis significatione. Ac proinde consentaneum est, ut iidem quaestionem sibi ponant an ius habeant sibi vel suis procurandi « dulcem mortem », quae bre-viores dolores reddere possit, quaeque ipsis videtur hominis dignitati magis respondere.

A number of Episcopal Conferences have raised questions on this subject with the Sacred Congregation for the Doctrine of the Faith. The Congregation, having sought the opinion of experts on the various aspects of euthanasia, now wishes to respond to the Bishops’ questions with the present Declaration, in order to help them to give correct teaching to the faithful entrusted to their care, and to offer them elements for reflection that they can present to the civil authorities with regard to this very serious matter.

Qua de re plures Conferentiae Episcopales Sacrae Congregationi pro Doctrina Fidei quaestiones proposuerunt. Nunc autem haec Sacra Congregatio, postquam circa varios euthanasiae aspectus peritorum sententiam iam quaesivit, in animo habet hac Declaratione episcoporum petitionibus respondere, quo.ipsi facilius fideles sibi creditos recte docere possint, idque habeant unde ad gravissimam hanc causam publicae rei moderatoribus considerationis elementa praebeant.

The considerations set forth in the present document concern in the first place all those who place their faith and hope in Christ, who, through His life, death and resurrection, has given a new meaning to existence and especially to the death of the Christian, as St. Paul says: “If we live, we live to the

Argumenta hoc in documento proposita ad eos in primis spectant, qui fidem et spem suam reponunt in Christo, e cuius vita, morte et resurrectione christianorum vita ac mors praesertim novam significationem acceperunt, iuxta S. Pauli verba « Sive enim vivimus, Domino vivimus, sive morimur, Domino morimur. Sive ergo vivimus sive morimur,

Lord, and if we die, we die to the Lord" (*Rom*. 14:8; cf. *Phil*. 1:20).

As for those who profess other religions, many will agree with us that faith in God the Creator, Provider and Lord of life - if they share this belief - confers a lofty dignity upon every human person and guarantees respect for him or her.

It is hoped that this Declaration will meet with the approval of many people of good will, who, philosophical or ideological differences notwithstanding, have nevertheless a lively awareness of the rights of the human person. These rights have often, in fact, been proclaimed in recent years through declarations issued by International Congresses[3]; and since it is a question here of fundamental rights inherent in every human person, it is obviously wrong to have recourse to arguments from political pluralism or religious freedom in order to deny the universal value of those rights.

I. THE VALUE OF HUMAN LIFE

Human life is the basis of all goods, and is the necessary source and condition of every human activity and of all society. Most people regard life as something sacred and hold that no one may dispose of it at will, but believers see in life something greater, namely, a gift of God's love, which they are called upon to preserve and make fruitful. And it is this latter consideration that gives rise to the following consequences:

1. No one can make an attempt on the life of an innocent person without opposing God's love for that person, without violating a fundamental right, and therefore without committing a crime of the utmost gravity.[4]
2. Everyone has the duty to lead his or her life in accordance with God's plan. That life is entrusted to the individual as a good that must bear fruit already here on earth, but that finds its full perfection only in eternal life.
3. Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on the part of a person is to be considered as a rejection of God's sovereignty and loving plan. Furthermore, suicide is also often a refusal of love for self, the denial of a natural instinct to live, a flight from the duties of justice and charity owed to one's neighbor, to various communities or to the whole of society - although, as is generally

Domini sumus » *(Rom* 14, 8; cf. *Phil 1, 20).*

Ad eos autem quod attinet, qui alias religiones profitentur, horum plerique nobiscum in id profecto consentient, quod scilicet fides in Deum Creatorem, Providentem et vitae Dominum - si quidem eam ipsi participent - unicuique personae humanae praecellentem dignitatem tribuit, eiusque reverentiam tuetur.

Sperandum est hanc Declarationem consensum adipisci posse etiam hominum bonae voluntatis, qui etsi philosophicae doctrinae vel ideologiae diversitate inter se discrepant, nihilominus de iuribus personae humanae vivam conscientiam ferunt. Haec ipsa iura, alioquin, recentiorum annorum decursu, saepe proclamata sunt per declarationes Conventuum Internationalium; [3] cum autem hic agatur de iuribus fundamentalibus cuiusvis humanae personae propriis, patet fas non esse argumentis inniti ductis a pluralismo politico vel a libertate religiosa, ut eorundem iurium vis universalis denegetur.

I VITAE HUMANAE VALOR

Vita humana est fundamentum omnium bonorum itemque necessarius fons et condicio cuiusvis activitatis humanae necnon consortionis socialis. Quod si maxima pars hominum vitam aestimant rem sacram esse, et fatentur neminem eadem libere uti posse, christifideles tamen in ea quiddam praestantius cernere valent, donum scilicet amoris Dei, quod conservare fructuosumque reddere debent. Qua ex altera consideratione haec consectaria sequuntur

1. Nemini attentare licet vitam alicuius hominis innocentis, quin sese opponat amori Dei erga ipsum, quip fundamentale ius violet, quod nec amitti nec alienari potest, ac proinde quin summae gravitatis crimen committat.°

2. Omnis homo vitam secundum Dei consilium agere debet. Ea ipsi committitur tamquam bonum quod iam hisce in terris fructus facere oportet, sed cuius plena et absoluta perfectio in aeterna vita exspectanda erit.

3. Voluntaria mors igitur, seu suicidium, pariter ac homicidium nefas est; talis enim hominis actio habenda est reiectio supremae Dei potestatis eiusque amoris consilii. Suicidium, praeterea, saepe est etiam recusatio amoris erga seipsum, negatio naturalis instinctus vivendi, fuga a iustitiae et caritatis officiis quae debentur sive proximis, sive variis communitatibus, sive consortioni hominum universae - quamvis interdum, ut omnes norunt, animi status contingant quae culpam minuere aut etiam plene

recognized, at times there are psychological factors present that can diminish responsibility or even completely remove it

However, one must clearly distinguish suicide from that sacrifice of one's life whereby for a higher cause, such as God's glory, the salvation of souls or the service of one's brethren, a person offers his or her own life or puts it in danger (cf. *Jn*. 15:14).

auferre possint.

A suicidio tamen plane distinguendum est illud vitae sacrificium, quo quis ob excelsam causam - cuiusmodi est Dei honor, salus animarum, vel servitium pro fratribus - vitam suam profundit aut in discrimen adducit (cf. *Io* 15, 14).

II. EUTHANASIA

In order that the question of euthanasia can be properly dealt with, it is first necessary to define the words used. Etymologically speaking, in ancient times *Euthanasia* meant an *easy death* without severe suffering. Today one no longer thinks of this original meaning of the word, but rather of some intervention of medicine whereby the suffering of sickness or of the final agony are reduced, sometimes also with the danger of suppressing life prematurely.

Ultimately, the word *Euthanasia* is used in a more particular sense to mean "mercy killing," for the purpose of putting an end to extreme suffering, or having abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years of a miserable life, which could impose too heavy a burden on their families or on society.

It is, therefore, necessary to state clearly in what sense the word is used in the present document. By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.

Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used.

It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a fetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity.

II EUTHANASIA

Ut autem quaestio de euthanasia rite tractetur, expedit in primis vocabulorum significationem accurate explicare.

Etymologia spectata, *euthanasia* apud antiquos *placidam mortem* significabat acerbis doloribus vacuam. Hodie amplius non attenditur ad hanc originariam vocis significationem, sed potius ad quendam medicae artis interventum, quo dolores infirmitatis vel supremi vitae agonis imminuuntur, interdum etiam cum periculo vitam praemature auferendi.

Denique hoc verbum strictiore sensu accipitur, ita ut eius vis et notio sit *mortem inferre miserationis causa*, eo quidem proposito, ut extremi dolores radicitus tollantur, vel ut pueris abnormibus, aegrotis insanabilibus aut mente captis evitetur infelicis vitae prorogatio, fortasse ad plures annos, quae nimium grave onu familiis vel societati imponere possit.

Necessarium igitur est ut plane pateat, quae notio huic voc in praesenti documento tribuatur. Nomine euthanasiae significatur actio vel omissio quae suapto natura vel consilio mentis mortem affert, ut hoc modo omni, ·dolor removeatur.

Euthanasia igitur in voluntatis proposito et in procedendi rationibus, quae adhibentur, continetur.

Iamvero, denuo firmiter declarandum est neminem nihilque ullo modo sinere posse ut vivens humanum innocens occidatur, sive sit fetus vel embryon, sive infans vel adultus, sive senex, sive morbo insanabili affectus, sive in mortis agone constitutus. Praeterea nemini licet mortiferam hanc ,actionem petere sibi aut alii, qui sit ipsius responsabilitati commissus, immo in eadem ne consentire quidem potest expli·cite vel implicite. Nec auctoritas ulla potest eam legitime iniungere vel permittere. Agitur enim de legis divinae violatione, de offensione dignitatis personae humanae, de crimine contra vitam, de facinore in hominum genus.

It may happen that, by reason of prolonged and barely tolerable pain, for deeply personal or other reasons, people may be led to believe that they can legitimately ask for death or obtain it for others. Although in these cases the guilt of the individual may be reduced or completely absent, nevertheless the error of judgment into which the conscience falls, perhaps in good faith, does not change the nature of this act of killing, which will always be in itself something to be rejected. The please of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact, it is almost always a case of an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses.

Fieri potest ut ob diuturnos ac vix tolerandos dolores, ob rationes in animi affectibus innixas, vel ob alterius generis causas, aliqui ad persuasionem adducantur se legitime posse mortem sibi petere aut aliis afferre. Quamquam hisce in casibus hominis culpa imminui aut omnino deesse potest, nihilominus error iudicii in quem conscientia, bona fide fortasse, incidit, naturam huius actus mortiferi non mutat, qui per se repudiandus semper erit. Gravissime aegrotantium implorationes, quandoque mortem invocantium, haud intelligendae sunt quasi veram euthanasiae voluntatem significent; etenim fere semper agitur de anxiis invocationibus auxilii et amoris. Praeter medicas curas, id quo aegrotus indiget, est amor, est fervidus animi affectus humanus et supernaturalis, quo proximi omnes, pa rentes et filii, medici et aegrotorum ministri eum complecti possunt ac debent.

III. THE MEANING OF SUFFERING FOR CHRISTIANS AND THE USE OF PAINKILLERS

Death does not always come in dramatic circumstances after barely tolerable sufferings. Nor do we have to think only of extreme cases. Numerous testimonies which confirm one another lead one to the conclusion that nature itself has made provision to render more bearable at the moment of death separations that would be terribly painful to a person in full health.

Hence it is that a prolonged illness, advanced old age, or a state of loneliness or neglect can bring about psychological conditions that facilitate the acceptance of death.

Nevertheless the fact remains that death, often preceded or accompanied by severe and prolonged suffering, is something which naturally causes people anguish.

Physical suffering is certainly an unavoidable element of the human condition; on the biological level, it constitutes a warning of which no one denies the usefulness; but, since it affects the human psychological makeup, it often exceeds its own biological usefulness and so can become so severe as to cause the desire to remove it at any cost.

According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will. Therefore, one must not be surprised

III DOLORIS SIGNIFICATIO APUD CHRISTIANOS ET ANALGESICORUM REMEDIORUM USUS

Non semper mors advenit in miserabilibus condicionibus post vix tolerandorum dolorum cruciatum. Neque necesse est ut casus omnino singulares prae oculis habeamus. Plura enim eaque concordia testimonia opinari iubent naturam ipsam consuluisse, ut leviores redderentur separationes illae in morte faciendae, quae si homini acciderent optima utenti valetudine, ,acerbae praeter modum ipsi evaderent.

Quo fit ut morbi diuturnitas, provecta senectus, solitudinis ac derelictionis status eiusmodi inducant psychologicas condiciones, quae acceptionem mortis faciliorem efficiant.

Nihilominus fatendum est mortem, quam saepe acerbi diuturnique dolores praecedunt aut comitantur, eventum exstare, qui naturaliter hominis animum angore afficit.

Corporis dolor certe condicionis humanae pars est, quae vitari non potest; ratione biologica spectata, is monitum praebet, cuius utilitas est indubia : at, cum psychologicam hominis vitam attingat, eius vis saepe biologicam utilitatem superat atque adeo augere potest, ut optabilis sit eius amotio, quoquo pacto obtinenda.

Secundum christianam doctrinam, tamen, dolor praesertim in extremis vitae momentis, propriurn obtinet locum in salvifico Dei consilio; is enim est participatio passionis Christi et coniunctio cum redemptionis sacrificio, quod Ipse obtulit voluntati Patris obtemperans. Quare mirum non est si christiani quidam cupiunt modice uti anaestheticis

if some Christians prefer to moderate their use of painkillers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified (cf. *Mt*. 27:34).

Nevertheless it would be imprudent to impose a heroic way of acting as a general rule. On the contrary, human and Christian prudence suggest for the majority of sick people the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semiconsciousness and reduced lucidity. As for those who are not in a state to express themselves, one can reasonably presume that they wish to take these painkillers, and have them administered according to the doctor's advice.

But the intensive use of painkillers is not without difficulties, because the phenomenon of habituation generally makes it necessary to increase their dosage in order to maintain their efficacy.

At this point it is fitting to recall a declaration by Pius XII, which retains its full force; in answer to a group of doctors who had put the question: "Is the suppression of pain and consciousness by the use of narcotics ... permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?"

the Pope said: "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes."[5] In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine.

However, painkillers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. Thus Pius XII warns: "It is not right to deprive the dying person of consciousness without a serious reason." [6]

IV. DUE PROPORTION IN THE USE OF REMEDIES

Today it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against a

medicamentis, ita ut partem saltem dolorum suorum voluntarie assumentes, per cos conscio modo cum doloribus Christi cruci affixi sese coniungere valeant (cf. *Mt 27*, 34).

Nihilominus a prudentia alienum est heroicam quandam agendi rationem tanquam generalem normam imponere. E contrario humana et christiana prudentia pro pluribus aegrotis suadet usum eorum medicamentorum quae apta sint ad leniendum vel auferendum dolorem, etiamsi inde, ut secundarii effectus, torpor et imminuta animi conscientia consequantur.

Quod autem ad eos attinet quibus deest facultas sensa sua exprimendi, recte praesumi potest ipsos velle haec doloris lenimenta sumere, eademque sibi ministrari secundum medicorum consilia.

At intensivus analgesicorum remediorum usus difficultatibus non caret, quia ad eorum efficaciam servandam, ob assuetudinis phaenomenon, communiter portio sumenda augeri de bet.

Iuvat hic commemorare quandam Pii XII declarationem, quae adhnc integram vim suam retinet. Medicorum coetui, qui hanc quaestionem proposuerant : « Doloris et conscientiae sublatio ope narcoticorum medicamentorum [...] iuxta religionem et disciplinae moralis normas potestne permitti medico et aegroto (etiamsi mors immineat atque horum medicamentorum usus praevideatur breviaturus esse vitam) ?)>,

Pontifex respondit : « Si alia subsidia desunt, et si in hisce rerum adiunctis id minime impedit quominus alia religiosa et moralia officia impleantur : licet u.[5] Quo in casu, uti patet, mors nullo modo est animo intenta aut quaesita, etsi rationabili de causa in eius periculum incurritur; id tantummodo in propositis fuit, ut dolores efficaciter lenirentur, adhibitis ad id analgesicis remediis, quae medicae arti praesto sunt.

Attamen analgesica medicamenta, quibus aegroti sui conscientiam amittunt, peculiari considerations digna sunt. Multum interest, enim, homines posse non solum moralibus praeceptis et officiis erga familiares satisfacere, verum etiam ac praesertim plene sibi conscios ad occursum Christi rite animum disponere. Pius XII idcirco admonet « fas non esse morientem sine gravi causa sui conscientia privari » .[6]

IV PROPORTIO SERVANDA IN REMEDIORUM THERAPEUTICORUM USU

Nostris temporibus magni refert, mortis momento, personae humanae dignitatem et christianam vitae significationem servari, cavendo a quadam « technicitate », uti aiunt, quae periculum abusus

technological attitude that threatens to become an abuse. Thus some people speak of a “right to die,” which is an expression that does not mean the right to procure death either by one’s own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity.

secumfert. Ac revera sunt qui loquuntur de « iure ad mortem », qua quidem dictione non intelligitur ius alicuius ad mortem sibi consciscendam per se vel per alium, quemadmodum ipsi placet, sed ius moriendi omni cum tranquillitate, humana et christiana dignitate servata. Si res ita consideretur, artis therapeuticae usus interdum nonnullas quaestiones afferre potest.

From this point of view, the use of therapeutic means can sometimes pose problems. In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person’s name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case.

Pluribus in casibus fieri potest ut rerum status adeo implexus sit, ut dubitationes oriantur de modo, quo doctrinae moralis principia in rem traduci oporteat. Decisiones capiendae ad conscientiae iudicium tandem pertinent sive aegroti vel eorum qui legitime ipsius nomine agunt, sive etiam medicorum qui omnes prae oculis habere debent tum disciplinae moralis praecepta tum multiplices casus aspectus.

Everyone has the duty to care for his or he own health or to seek such care from others. Those whose task it is to care for the sick must do so conscientiously and administer the remedies that seem necessary or useful.

Uniuscuiusque officium est consulere valetudini suae et efficere ut sibi curationes ministrentur. Ii autem quibus infirmorum cura concredita est, omni cum diligentia operam suam praestare debent ac remedia praebere, quae necessaria vel utilia videantur.

However, is it necessary in all circumstances to have recourse to all possible remedies?

Suntne igitur in omnibus rerum adiunctis cuncta prorsus remedia experienda ?

In the past, moralists replied that one is never obliged to use “extraordinary” means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of “proportionate” and “disproportionate” means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

Haud multo ante moralis disciplinae cultores respondebant usum mediorum « extraordinariorum „ numquam praecipi posse. Huiusmodi responsio, quae, ut principium, semper valet, hodie fortasse minus perspicua apparet sive ob parum definitum dicendi modum, sive etiam ob celeres progressus, qui in re therapeutica facti sunt. Hinc est quod quibusdam potius placet loqui de mediis , proportionatis » et « non proportionatis ». Utcumque res se habet, recta mediorum aestimatio fieri poterit, si artis therapeuticae genus, eiusque difficultatum et periculorum gradus ac sumptus necessarii necnon possibilitas eodem utendi, cum effectibus, quos exspectare licet, comparentur, debita ratione habita tum status aegroti tum ipsius corporis et animi virium.

In order to facilitate the application of these general principles, the following clarifications can be added:

Quo facilius haec generalia principia ad rem deducantur, iuvare poterunt accuratiores explicationes, quae sequuntur

- If there are no other sufficient remedies, it is permitted, with the patient’s consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity.

- Si alia remedia non suppetunt, licet, ex consensu aegroti, media adhibere, quae novissima medicae artis inventa protulerunt, etiamsi haud satis adhuc experimentis probata sint nec aliquo periculo careant. Aegrotus, qui ea accipiat, poterit etiam exemplum generosi animi praebere in bonum generis humani.

- It is also permitted, with the patient’s consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made,

- Pariter licet horum mediorum usum abrumpere, quotiescumque exitus spem in eis repositam fallit. At in hoc capiendo consilio, ratio habeatur iusti desiderii

account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter.

aegroti eiusque familiarium, nec non sententiae medicorum, qui vere periti sint;

The latter may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques.

hi profecto prae ceteris aequam aestimationem facere poterunt, cum sumptus instrumentorum et hominum in id impendendorum non respondet effectibus qui praevidentur, et cum medicae artis adhibita subsidia imponunt aegroto dolores aut incommoda graviora quam utilitates quae inde ei afferri possunt.

- It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

- Semper licet satis habere communia remedia, quae ars medica suppeditare potest. Quapropter nemini obligatio imponenda est genus curationis adhibendi quod, etsi in usu iam est, adhuc tamen non caret periculo vel nimis est onerosum. Quae remedii recusatio comparanda non est cum suicidio verius habenda est vel simplex acceptatio condicionis humanae; vel cura vitandi laboriosum rnedicae artis apparatum cui tamen par sperandorum effectuum utilitas non respondet; vel denique voluntas onus nimis grave familiaee aut communitati non imponendi.

- When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger.

- Imminente morte, quae remediis adhibitis nullo modes impediri potest, licet ex conscientia consilium inire curationibus renuntiandi, quae nonnisi precariam et doloris plenam. vitae dilationem afferre valent, haud intermissis tamen ordinariis curis, quae in similibus casibus aegroto debentur. Tune' causa non est cur medicus animi angore afficiatur, quasi alicui,. qui in periculo versaretur, auxilium negaverit.

CONCLUSION

CONCLUSIO

The norms contained in the present Declaration are inspired by a profound desire to service people in accordance with the plan of the Creator. Life is a gift of God, and on the other hand death is unavoidable; it is necessary, therefore, that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity. It is true that death marks the end of our earthly existence, but at the same time it opens the door to immortal life. Therefore, all must prepare themselves for this event in the light of human values, and Christians even more so in the light of faith.

Normae quae hac Declaratione continentur, proficiscunturab impenso studio opem hominibus ferendi, secundum Creatoris consilium. Si ex una parte vita habenda est Dei donum, ex altera vero mors vitari nequit ; necesse igitur est ut nos, mortis, horam nullo modo properantes, eam excipere valeamus plene• nobis conscii responsabilitatis nostrae et omni cum dignitate. Mors, enim, finem quidem imponit terrestri huic vitae, sed simul ad immortalem vitam aditum patefacit. Quapropter ad hoc eventum omnes homines animum rite disponere debent,. humanorum valorum praefulgente luce, ac multo magis christi-fideles suae fidei lumine ducti.

As for those who work in the medical profession, they ought to neglect no means of making all their skill available to the sick and dying; but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness

Quod attinet ad publicae sanitati tuendae addictos, ii pro-fecto nihil reliqui faciant ut totam artis suae peritiam in bonum infirmorum et morientium impendant; quibus tamen meminerint aliud solacium deberi, idque multo magis necessarium, scilicet immensam bonitatem et ardentem caritatem.

and heartfelt charity. Such service to people is also service to Christ the Lord, who said: "As you did it to one of the least of these my brethren, you did it to me" (*Mt*. 25:40).

Huiusmodi ministerium, quod hominibus praestatur, ipsi Christo Domino etiam praestatur, qui dixit : « Quamdiu fecistis uni de his fra-tribus meis minimis, mihi fecistis » *(Mt* 25, 40).

At the audience granted prefect, His Holiness Pope John Paul II approved this declaration, adopted at the ordinary meeting of the Sacred Congregation for the Doctrine of the Faith, and ordered its publication.

Hanc declarationem in Conventu ordinario huius S. Congregationis deliberatam, Summus Ponti f ex Ioannes Paulus PP. II, in Audientia in frascripto Cardinali Prae fecto concessa, adprobavit et publici iuris fieri iussit.

Rome, the Sacred Congregation for the Doctrine of the Faith, May 5, 1980.

Romae, ex Aedibus S. Congregationis pro Doctrina Fidei, die 5 Maii 1980.

Franjo Cardinal Seper
Prefect

Jerome Hamer, O.P.
Tit. Archbishop of Lorium
Secretary

FOOTNOTES

[1] DECLARATION ON PROCURED ABORTION, November 18, 1974: AAS 66 (1974), pp. 730-747.

[2] Pius XII, ADDRESS TO THOSE ATTENDING THE CONGRESS OF THE INTERNATIONAL UNION OF CATHOLIC WOMEN'S LEAGUES, September 11, 1947: AAS 39 (1947), p. 483; ADDRESS TO THE ITALIAN CATHOLIC UNION OF MIDWIVES, October 29, 1951: AAS 43 (1951), pp. 835-854; SPEECH TO THE MEMBERS OF THE INTERNATIONAL OFFICE OF MILITARY MEDICINE DOCUMENTATION, October 19, 1953: AAS 45 (1953), pp. 744-754; ADDRESS TO THOSE TAKING PART IN THE IXth CONGRESS OF THE ITALIAN ANAESTHESIOLOGICAL SOCIETY, February 24, 1957: AAS 49 (1957), p. 146; cf. also ADDRESS ON "REANIMATION," November 24, 1957: AAS 49 (1957), pp. 1027-1033; Paul VI, ADDRESS TO THE MEMBERS OF THE UNITED NATIONAL SPECIAL COMMITTEE ON APARTHEID, May 22, 1974: AAS 66 (1974), p. 346; John Paul II: ADDRESS TO THE BISHOPS OF THE UNITED STATES OF AMERICA, October 5, 1979: AAS 71 (1979), p. 1225.

[1] *Declaratio de abortu procurato,* die 18 novembris 1974, *AAS* 66 (1974), pp. 730-747.

[2] Pii XII *Allocutio ad Delegatos Unionis Internationalis* Sodalitatum *mulierum catholicarum,* die 11 septembris 1947, AAS 39 (1947), p. 483. *Allocutio ad membra Unionis Catholicae Italicae inter obstetrices,* die 29 octobris 1951, *AAS 43* (1951), pp. 835-854. *Allocutio ad membra Consilii Internationalis inquisitionis de medieina* exercenda *inter milites,* die 19 octobris 1953, *AAS* 45 (1953), pp. 744-754. *Allocutio ad participantes XI Congressum Societatis Italicae de anaesthesiologia,* die 24 februarii 1957, *AAA* 49 (1957), p. 146. Cfr. etiam *Allocutio circa quaestionem de a reanimatione »,* die 24 novembris 1957, AAS 49 (1957), pp. 1027-1033. Pauli VI Allocutio *ad membra Consilii Specialis Nationum Unit arum* versanti8 *in quaestione ((Apartheid)),* die 22 mail 1974, *AAS* 66 (1974), p. 346. Ioannis Pauli II *Allocutio ad Episcopos Statuum Foederatorum* Americae *Septentrionalis,* die 5 octobris 1979, AAS 71 (1979), p. 1225.

[3] One thinks especially of Recommendation 779 (1976) on the rights of the sick and dying, of the Parliamentary Assembly of the Council of Europe at its XXVIIth Ordinary Session; cf. Sipeca, no. 1, March 1977, pp. 14-15.

[3] Attendatur peculiar! modo ad Admonitionem 779 (1976) de iuribus aegrotorum et morientium, quae acceptata fult a Coetu Deputatorum Consili! Europae, In XXVII sessione ordinaria. Cfr. SIPECA, n. 1, mense martio 1977, pp. 14-15.

[4] We leave aside completely the problems of the death penalty and of war, which involve specific considerations that do not concern the present subject.

[4] Hic omnino praetermittuntur quaestiones de poena mortis et de bello, quae postulant ut aliae fiant peculiares considerationes, quae huius Declarationis argumento extraneae aunt.

[5] Pius XII, ADDRESS of February 24, 1957: AAS 49 (1957), p. 147.

[5] Pii XII, *Allocutio* diei 24 februarii 1957, AAS 49 (1957), p. 147.

[6] Pius XII, Ibid., p. 145; cf. ADDRESS of September 9, 1958: AAS 50 (1958), p. 694.

[6] *Ibid., p.* 145; cfr. *Allocutio* dlei 9 septembris 1958, *AAS* 50 (1958), p. 694.

THE SANCTITY *of* LIFE *in the* HIPPOCRATIC OATH *and in* EARLY CHRISTIANITY

CHRISTIAN CONCERN *for the* UNBORN *and* DEFENSELESS

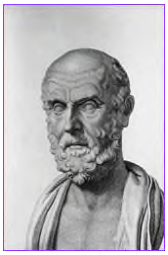
THE LETTER *of* BARNABAS (c. 100) Engl: *Ante-Nicene Fathers: Volume I* (pp. 137-149). Greek: BARNABA EPISTOLH *Épître de Barnabe* (Cerf, Paris 1971).

19) 1) The way of light, then, is {this}: [...]	**19.1α Ἡ οὖν ὁδὸς τοῦ φωτός ἐστιν αὕτη–**
LOVE the One Who created you:	**19.2αἈγαπήσεις τόν σε ποιήσαντα,**
[fear him who formed you]...	**φοβηθήση τόν σε πλάσαντα,**
1) You shall not be of [divided] mind as to whether a thing shall be or not.	**19.5α Οὐ μὴ διψυχήσῃς πότερον ἔσται ἢ οὔ**
2) You shall not take the name of the Lord in vain.	**19.5β Οὐ μὴ λάβῃς ἐπὶ ματαίῳ τὸ ὄνομα κυρίου.**
3) You shall love your neighbor more than your own soul.	**19.5ξἈγαπήσεις τὸν πλησίον σου ὑπὲρ τὴν ψυχήν**
4) YOU SHALL NOT MURDER A CHILD THROUGH ABORTION; NOR AGAIN SHALL YOU DESTROY IT AFTER IT IS BORN.	**19.5δ Οὐ φονεύσεις τέκνον ἐν φθορᾷ, οὐδὲ πάλιν γεννηθὲν ἀνελεῖς.**
5) You shall not withdraw your hand from your son, or from your daughter, but from their infancy you shall teach them the fear of the Lord.	**19.5ε Οὐ μὴ ἄρῃς τὴν χεῖρά σου ἀπὸ τοῦ υἱοῦ σου ἢ ἀπὸ τῆς θυγατρός σου, ἀλλὰ ἀπὸ νεότητος διδάξεις φόβον κυρίου.**

The DIDACHE (*Teaching of the Twelve* [*Apostles*]), ch. 2

AND the second commandment of the Teaching; 2. You shall not commit murder, you shall not commit adultery, you shall not commit paederasty, you shall not commit fornication, you shall not steal, you shall not practise magic, you shall not practise witchcraft,	**2.1 Δευτέρα δὲ ἐντολὴ τῆς διδαχῆς· 2.2 οὐ φονεύσεις, οὐ μοιχεύσεις, οὐ παιδοφθορήσεις, οὐ πορνεύσεις, οὐ κλέψεις, οὐ μαγεύσεις, οὐ φαρμακεύσεις,¨**
YOU SHALL NOT MURDER A CHILD BY ABORTION NOR KILL THAT WHICH IS BEGOTTEN.	**οὐ φονεύσεις τέκνον ἐν φθορᾷ οὐδὲ γεννηθὲν ἀποκτενεῖς,**

THE HIPPOCRATIC OATH



Jusjurandum, ed. by É. Littré *Oeuvres Completes d'Hippocrate*, vols. 4 (Paris: Baillie 1844; Amsterdam: Hakkert, 1962) pp. 628-632. *TLG* canon 627.13.1-27. Engl. *Hippocrates, Works*, trans., Francis Adams (New York; Loeb) vol. I, 299-301

OATH	ΟΡΚΟΣ.
I SWEAR by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation -	Ὄμνυμι Ἀπόλλωνα ἰητρὸν, καὶ Ἀσκληπιὸν, καὶ Ὑγείαν, καὶ Πανάκειαν, καὶ θεοὺς πάντας τε καὶ πάσας, ἵστορας ποιεύμενος, ἐπιτελέα ποιήσειν κατὰ δύναμιν καὶ κρίσιν ἐμὴν ὅρκον τόνδε καὶ ξυγγραφὴν τήνδε·
INDENTURE	
TO REGARD the one who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation;	ἡγήσασθαι μὲν τὸν διδάξαντά με τὴν τέχνην ταύτην ἴσα γενέτῃσιν ἐμοῖσι, καὶ βίου κοινώσασθαι, καὶ χρεῶν χρηΐζοντι μετάδοσιν ποιήσασθαι, καὶ γένος τὸ ἐξ ωὐτέου ἀδελφοῖς ἴσον ἐπικρινέειν ἄῤῥεσι, καὶ διδάξειν τὴν τέχνην ταύτην, ἢν χρηΐζωσι μανθάνειν, ἄνευ μισθοῦ καὶ ξυγγραφῆς,
and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others.	ἡγήσασθαι μὲν τὸν διδάξαντά με τὴν τέχνην ταύτην ἴσα γενέτῃσιν ἐμοῖσι, καὶ βίου κοινώσασθαι, καὶ χρεῶν χρηΐζοντι μετάδοσιν ποιήσασθαι, καὶ γένος τὸ ἐξ ωὐτέου ἀδελφοῖς ἴσον ἐπικρινέειν ἄῤῥεσι, καὶ διδάξειν τὴν τέχνην ταύτην, ἢν χρηΐζωσι μανθάνειν, ἄνευ μισθοῦ καὶ ξυγγραφῆς,
FAVOR LIFE	
I WILL follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion.	Διαιτήμασί τε χρήσομαι ἐπ' ὠφελείῃ καμνόντων κατὰ δύναμιν καὶ κρίσιν ἐμὴν, ἐπὶ δηλήσει δὲ καὶ ἀδικίῃ εἴρξειν. Οὐ δώσω δὲ οὐδὲ φάρμακον οὐδενὶ αἰτηθεὶς θανάσιμον, οὐδὲ ὑφηγήσομαι ξυμβουλίην τοιήνδε· ὁμοίως δὲ οὐδὲ γυναικὶ πεσσὸν φθόριον δώσω.
With purity and with holiness I will pass my life and practice my Art.	Ἁγνῶς δὲ καὶ ὁσίως διατηρήσω βίον τὸν ἐμὸν καὶ τέχνην τὴν ἐμήν.
NO DRASTIC SURGERY	***(if untrained?)***
I WILL not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work.	Οὐ τεμέω δὲ οὐδὲ μὴν λιθιῶντας, ἐκχωρήσω δὲ ἐργάτῃσιν ἀνδράσι πρήξιος τῆσδε.

NO ABUSE of OFFICE	
INTO whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves.	Ἐς οἰκίας δὲ ὁκόσας ἂν ἐσίω, ἐσελεύσομαι ἐπ' ὠφελείῃ καμνόντων, ἐκτὸς ἐὼν πάσης ἀδικίης ἑκουσίης καὶ φθορίης, τῆς τε ἄλλης καὶ ἀφροδισίων ἔργων ἐπί τε γυναικείων σωμάτων καὶ ἀνδρῴων, ἐλευθέρων τε καὶ δούλων.
CONFIDENTIALITY (SECRECY)	
WHATEVER, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.	Ἃ δ' ἂν ἐν θεραπείῃ ἢ ἴδω, ἢ ἀκούσω, ἢ καὶ ἄνευ θεραπηΐης κατὰ βίον ἀνθρώπων, ἃ μὴ χρή ποτε ἐκλαλέεσθαι ἔξω, σιγήσομαι, ἄῤῥητα ἡγεύμενος εἶναι τὰ τοιαῦτα.
OATH - REITERATION	
WHILE I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!	Ὅρκον μὲν οὖν μοι τόνδε ἐπιτελέα ποιέοντι, καὶ μὴ ξυγχέοντι, εἴη ἐπαύρασθαι καὶ βίου καὶ τέχνης δοξαζομένῳ παρὰ πᾶσιν ἀνθρώποις ἐς τὸν αἰεὶ χρόνον· παραβαίνοντι δὲ καὶ ἐπιορκοῦντι, τἀναντία τουτέων.

THE CHRISTIAN FORM *of the* HIPPOCRATIC OATH

(ca. 3rd - 6th cent.) (Urbinus 64 mss) tr. W.H.S. Jones, *the Oath According to Hippocrates In So Far as a Christian May Swear It* : The Doctor's Oath: *An Essay in* the *History of Medicine* (New York: Cambridge University Press, 1924), pp. 23- 25.

BLESSED be God the Father of our Lord Jesus Christ, who is blessed for ever and ever; I lie not.

I will bring no stain upon the learning of the medical art

NEITHER will I give poison to anybody though asked to do so, nor will I suggest such a plan. Similarly I will not give treatment to women to cause abortion, treatment neither from above nor from below.

But I will teach this art, to those who require to learn it, without grudging and without an indenture. I will use treatment to help the sick according to my ability and judgment. And in purity and in holiness I will guard my art'.

Into whatsoever houses I enter, I will do so to help the sick, keeping myself free from all wrongdoing, intentional or unintentional, tending to death or to injury, and from fornication with bond or free, man or woman.

WHATSOEVER in the course of practice I see or hear (or outside my practice in social intercourse) that ought not to he published abroad, I will not divulge, but consider such things to be holy secrets.

NOW if I keep this oath and break it not, may God be my helper in my life and arts and may I be honoured among all men for all time. If I keep faith, well; but if I forswear myself may the opposite befall me.

Ancient Medicine

And if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such.

For where there is love of humankind (*philanthropia*),
there is also love of The Art (*philotechnia*).
For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician.

Ἢν δὲ καιρὸς εἴη χορηγίης ξένῳ τε ἐόντι καὶ ἀπορέοντι, μάλιστα ἐπαρκέειν τοῖσι τοιουτέοισιν·
ἢν γὰρ παρῇ φιλανθρωπίη,
πάρεστι καὶ φιλοτεχνίη.
Ενιοι γὰρ νοσέοντες ἠσθημένοι τὸ περὶ ἑωυτοὺς πάθος μὴ ἐὸν ἐν ἀσφαλείῃ, καὶ τῇ τοῦ ἰητροῦ ἐπιεικείῃ εὐδοκέοντες, μεταλλάσσονται ἐς ὑγιείην.¨

The Hippocratic Corpus: Precepts 6; in *Hippocrates*, vol. I, (Loeb, Harv.U.Pr, 1962) p. 318.

The Seventeenth Century

Lysetta. What will you do, sir, with four physicians? Is not one enough to kill any one person?

Sganarel. Hold your tongue. Four heads are better than one.

Lysetta. Cannot your daughter die well enough without the assistance of these gentlemen?

Sganarel Do you think people die through having physicians?

Lysetta. Undoubtedly; and I knew a man who maintained - and proved it, too, by excellent reasons - that we should never say, "Such a one has died of a fever, or a from an inflammation of the lungs," but "Such a one has died of four doctors and two apothecaries."

Sganarel. Hush! Do not offend these gentlemen.

Lysetta. Upon my word, sir, our cat had a narrow escape from a leap he took a little while ago, from the top of the house into the street; he was three days without eating, and unable to move head or paw; but it is very lucky that there are no cat-doctors, else it would have been all over with him, for they would have purged and bled him.

Sganarel. Will you hold your tongue, I say? What impertinence is this! Here they come.

Lysetta. Take care; you are going to be finely edified. They will tell you in Latin that your daughter is ill.

Molière (1622-1673) *Love is the Best Doctor*; tr. H. Van Laun, *The Dramatic Works of Molière*, vol III (Edinburgh, 1866), p. 211.

[Molière's] four doctors were caricatured from real characters well known in Paris at the time - Guy Patin says they were Guénaut, Brayer, Des Fougerais, and Valot. They attended the fatal illness of Cardinal Mazarin in 1661, wrangled, and did not agree as to the cause of his trouble... At a later time when Guénaut was one day entangled in a crowd of vehicles in the street, a cart driver shouted "Let the Doctor go ahead. He's the one who did us the service to rid us of the Cardinal."

Logan Clendening, *Source Book of Medical History* (Dover, 1942) pp. 221-222

The Nineteenth Century

Physicians ... should minister to the sick with due impressions of the importance of their office ... They should study, also, in their deportment, so to unite *tenderness* with *firmness*, and *condescension* with *authority*, as to inspire the minds of their patients with gratitude, respect, and confidence.

American Medical Association, 1847*: First Code of Medical Ethics*, quoting Thomas Percival (1740-1804); reprinted in *Ethics in Medicine, Historical Perspectives and Contemporary Concerns*, ed. Reiser *et.al.* (M.I.T. Press, 1977) p.29.

THE NUREMBERG CODE

From: *Trials of War Criminals before the Nuernberg Military Tribunals under Control Council Law No. 10*, vol. 2, (Washington D.C.: U.S. Government Priniting Office, 1949) pp. 181-182

The Proof as to War Crimes and Crimes against Humanity

Judged by any standard of proof the record clearly shows the commission of war crimes and crimes against humanity substantially as alleged in counts two and three of the indictment. Beginning with the outbreak of World War II criminal medical experiments on non-German nationals, both prisoners of war and civilians, including Jews and "asocial" persons, were carried out on a large scale in Germany and the occupied countries. These experiments were not the isolated and casual acts of individual doctors and scientists working solely on their own responsibility, but were the product of coordinated policy-making and planning at high governmental, military, and Nazi Party levels, conducted as an integral part of the total war effort. They were ordered, sanctioned, permitted, or approved by persons in positions of authority who under all principles of law were under the duty to know about these things and to take steps to terminate or prevent them.

Permissible Medical Experiments

The great weight of evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably welldefined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted where there is an a *priori* reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of in jury, disability, or death.
8. The experiment should be con ducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject....

LIST OF PATIENT RIGHTS IN CALIFORNIA

(California Administrative Code. Title 22 4/81)

In accordance with Section 70707 of the California Administrative Code, the hospital and medical staff have adopted the following list of Patient Rights:

1. Exercise these rights without regard to sex, cultural, economic, educational, or religious background or the source of payment for care.

2. Considerate and respectful care.

3. Knowledge of the physician who has primary responsibility for coordinating care and the names and professional relationships of other physicians and non-physicians who will see the patient.

4. Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand.

5. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment, or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

6. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.

7. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

8. Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.

9. Reasonable responses to any reasonable requests made for service.

10. Leave the hospital even against the advice of physicians.

11. Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care.

12. Be advised if the hospital / personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.

13. Be informed of continuing health care requirements following discharge from the hospital.

14. Examine and receive an explanation of the bill regardless of the source of payment.

15. Know which hospital rules and policies apply to the patient's conduct while a patient.

16. Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

[*LACMA-LACBA*] *Guidelines for Foregoing Life-Sustaining Treatment for Adult Patients*

February, 1990; Amended March, 1993; Amended June 1996

[From the 1993 Guidelines: *These Guidelines were developed by the committee on biomedical ethics of the Los Angeles County Medical Association and Los Angeles County Bar Association. Adopted by the Council of the Los Angeles County Medical Association on January 8, 1990 and by the Board of Trustees of the Los Angeles County Bar Association on February 28, 1990*]

A. APPLICATION OF GUIDELINES

1. These Guidelines are applicable to all adult persons, whether in health facilities that provide acute care, skilled nursing care, or other levels of health care.

2. It been widely believed that the State Department of Health Services does not permit the foregoing of some types of life-sustaining treatment in certain treatment settings (primarily medically administered nutrition and hydration in skilled nursing facilities). The Department has Issued written guidelines (amended in December of 1988) clarifying that this is not its policy, and that such decisions are to be made by patients or their surrogates and the patient's physician.

3. Once a patient has been pronounced dead, all medical interventions, including ventilatory support, may be withdrawn. For information concerning the Neurological Determination of Death, see Appendix I of these Guidelines.

B. RIGHTS OF PATIENTS

1. An adult person capable of giving informed consent has the right to make his or her own decisions regarding medical care after having been fully informed about the benefits, risks and consequences of treatment alternatives, even when such decisions might result in shortening the individual's life. As the California Court of Appeal has stated, "*(I)f the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospitals and doctors."*[1]

2. For adult persons who are unable to give informed consent, the legal authority to make decisions regarding life-sustaining treatment rests with a surrogate decision-maker.

C. SURROGATE DECISION MAKERS FOR INCOMPETENT PATIENTS [2]

1. The surrogate decision maker for an incompetent patient is the attorney-in-fact appointed persuant to a Durable Power of Attorney for Health Care, or where there is none, the family or significant others.[3] Only in rare cases will it be necessary to seek Court appointment of a conservator to make these decisions. Where there is no attorney-in-fact or conservator, and family members or potential surrogate decision makers disagree among themselves, the physician should generally maintain life-sustaining treatment until either the disagreement is resolved or a conservator is appointed and makes a decision.

2. The surrogate should act in accordance with treatment preferences stated by the patient, if known.

3. If the surrogate does not know of any treatment preferences stated by the patient while competent, the surrogate is to act in the patient's best interest by analyzing the comparative benefits and burdens of continued treatment, as well as the patient's attitudes and beliefs, and such factors as relief of suffering, the preservation or restoration of function, and the quality and the extent of life sustained.

D. ROLE OF THE PHYSICIAN

1. The physician must provide sufficient information to patients or surrogates to enable them to understand the medical condition, the treatment options, and the possible consequences of the various treatment options. Understanding of options by the patient or surrogate will often increase over time. Therefore, decision making should be treated as a process, rather than an event. In order to provide patients and surrogates adequate time to reach a decision, the process of informing patients or surrogates and communicating with them concerning treatment goals should begin at the earliest possible time.

2. Before withdrawing or withholding life-sustaining treatment from a competent patient, it is the responsibility of the physician to assess the patient's mental and emotional status carefully to identify any factors (such as the existence of pain) that may be affecting the patient's refusal of treatment. Any identified factors should be discussed and any options that might cause the patient to continue life-sustaining treatment should be explored with the patient. If after such assessment and discussion, the patient continues to refuse life-sustaining treatment, the patient has a right to forgo treatment even though the physician disagrees.

3. The role of the physician in determining whether or not life-sustaining treatment may be withheld or withdrawn from an incompetent patient is to provide to the surrogate decision maker the same information that would be provided to a competent patient, *i.e.* full and complete information concerning the diagnosis, the prognosis, and the options for treatment. Recommendations from the physician are appropriate, and are often helpful to the surrogate. The decision, however, belongs to the surrogate decision-maker, in light of his or her knowledge of the patient's preferences and beliefs, except in the circumstances discussed in paragraph D.5.

4. Should the patient or patient's surrogates choose a course of action that would violate the ethical or religious beliefs of the physician, the physician may generally decline to participate in that course of action, where another physician who is willing to be guided by the patient's wishes will accept care of the patient.[4] In doing so, however, the physician declining to participate must cooperate in transfer of the care of the patient to the new physician. A decision to transfer the patient should be made only for reasons of conscience and after serious efforts have been made to reconcile the views of the physician and patient or patient's surrogate, and after adequate notice has been given to the patient or surrogate that the physician will have to withdraw from the case.

5. In cases where a surrogate's treatment decisions appear to be inconsistent with the patient's previously expressed preferences or best interests, the treating physician should thoroughly discuss the issue with the surrogate. If at the conclusion of the discussion(s), the physician continues to believe that the surrogate's requested course of treatment is inconsistent with the patient's treatment preferences or best interests, the physician should advise the surrogate that he or she is unwilling to write the orders requested, giving reasons. Consultation with a Bioethics Committee, or other institutional resources, may be of assistance. In extreme cases, if the surrogate is clearly not acting in the patient's best interest, legal remedies exist to replace the surrogate.

E. GENERAL TREATMENT PRINCIPLES

1. Life-sustaining treatment need not be continued solely because it was initiated.

2. Dignity, hygiene and comfort of patients should be preserved in all circumstances, even if specific life-sustaining treatment is withheld or withdrawn.

3. Medication should be given as indicated for pain or discomfort even if it may tend to hasten death, but should not be used with the primary intent to cause or hasten death.

4. Medically administered nutrition and hydration (*i.e.*, including NG tubes, gastrostomies, intravenously administered fluids, and hyperalimentation) should be analyzed in the same way as any other medical treatment. Nutrition and hydration have a powerful symbolic significance to many members of the public, as well as to many caregivers. It is therefore particularly important that those people who take care of the patient fully understand the rationale for any order to forgo medically administered nutrition and hydration.

F. DOCUMENTATION AND INSTITUTIONAL POLICIES

1. In cases in which life-sustaining treatment is withheld or withdrawn, the medical record should include:

a. A clear statement in the physician's progress notes of all relevant data and information concerning the treatment decision, including the treatment plan, the diagnosis and prognosis, and how they have been established, along with documentation of any consulting opinions that have been obtained;

b. A statement in the physician's progress notes of the basis on which the physician concluded that an informed refusal of life-sustaining treatment has occurred. This could include documentation by the physician of discussions with a competent patient, or with an appropriate surrogate of an incompetent patient. This documentation will usually suffice in lieu of written consent forms except when institutional policies require otherwise. The refusal may also be documented by a written treatment directive signed by the patient such as a living will or a Natural Death Act Directive; and

c. A written order directing the withholding or withdrawal of the specific treatment.

2. Decisions to withhold or withdraw life-sustaining treatment should be made in accordance with any applicable institutional policies or procedures.

G. USE OF ETHICS COMMITTEES

1. Many institutions have found a biomedical ethics committee functioning in an advisory capacity to be helpful in dealing with decisions to withhold or withdraw life support.

2. Such committees may be helpful in discussing and exploring alternative approaches to the problem, clarifying legal or ethical issues, facilitating communications, resolving any disputes or questions among members of the healthcare team, or identifying perspectives on the issue not previously considered by the physician or the surrogate. Such committees should not make treatment decisions, however. Such decisions are to be made by the patient or the surrogate and the treating physician, as set forth in these Guidelines.

H. ROLE OF THE COURTS

1. Most cases involving the forgoing of life-sustaining treatment can be, should be, and are, resolved without the involvement of the courts.

2. When necessary, the courts may be approached to resolve legal disputes, such as when healthcare providers cannot determine who the proper surrogate is, or believe that the surrogate is not acting in the patient's best interests.

3. Withholding or withdrawing life-sustaining treatment at the direction of a patient or appropriate surrogate does not legally constitute encouraging or participating in suicide.

4. Physician orders to withhold or withdraw life-sustaining treatment in appropriate circumstances do not create civil or criminal liability for the physician.

I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND DOCUMENTATION OF PATIENT TREATMENT PREFERENCES

1. Physicians should be familiar with the Durable Power of Attorney for Health Care, and should encourage its use because it identifies and appoints a person as surrogate decision maker without the need for court proceedings, offers the opportunity for discussion and reflection concerning treatment issues, and helps to assure that the patient's wishes will be followed. The Durable Power of Attorney for Health Care is generally the most powerful and flexible method available by which a person may attempt to assure future medical treatment in accordance with his/her preferences. See Appendix II.

2. Any communication by a patient concerning treatment preferences, whether written or oral, may provide helpful guidance in determining an appropriate course of treatment. Written communications are often given greater weight by the courts because they reflect that the patient was sufficiently serious about his or her treatment preferences to document them. Patients with clear treatment preferences should be encouraged to state them in writing, with copies provided to the physician for inclusion in the medical record. Any oral statements of the treatment preferences should be documented in the medical record.

3. Various methods for documenting treatment preferences, and the Durable Power of Attorney for Health Care, are discussed in more detail in Appendix II to these Guidelines.

REFERENCES:

[1] *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195 (1984)

[2] The terms *competent* and *incompetent* are used in this document as they are used by physicians, and in the Durable Power of Attorney for Health Care. *Competent* means that the patient has the ability to understand the nature and consequences of the treatment options being discussed, and *incompetent* means that the patient lacks this ability. While the terms also have technical legal meanings which refer to a formal adjudication by a court of a person's competence, the terms are not used with such a meaning here. Such a formal adjudication of competence by a court is not required in making most treatment decisions, or in determining whether the appointed surrogate may act persuant to a Durable Power of Attorney for Health Care.

[3] In seeking to identify the appropriate surrogate of the patient with whom to consult the provider should consider immediate family members who: (a) are "in the best position to know (the patient's) feelings and desires (regarding treatment)," (b) "would be most affected by the treatment decision," (c) "are concerned for (the patient's) comfort and welfare," and (d) have expressed an interest in the patient by visits or inquiries to the patient's physician or hospital staff. *Barber v. Superior Court*, 147 Cal.App. 3d 1006, fn 2 (1983). In addition to family members, it may be appropriate to rely on non-family members who satisfy these criteria.

[4] An ethical or religious objection by another member of the healthcare team should generally be accomodated as well, to the extent possible without interfering with the patient's or surrogate's decision.

LACMA/LACBA GUIDELINES: Forgoing Life-Sustaining Treatment for Adult Patients: Patients Without Decision-Making Capacity Who Lack Surrogates (4/93)

1. PREAMBLE

Health care providers regularly deal with patients who lack capacity to make their own decisions and have no relatives, close friends or other qualified surrogates decision-makers for health care decisions.

In these cases, state law provides no process designed to deal with issues of terminating or withholding care when continued life sustaining treatment is inappropriate or not in the best interests of the patient.

State law precludes health care providers (since they are creditors of the patient) from initiating a proceeding for the appointment of a guardian or conservator of the patient (Probate code § 1820 (c)). Although the Public Guardian's office could initiate such a proceeding and be appointed to make health care decisions for the patient, in may counties the Public Guardian's office is unable or unwilling to become involved due to its limited resources and large case load. In such counties, there is no practical method by which decisions can be made through the courts concerning life support issues for patients lacking capacity without surrogates.

California courts have recognized that all patients are entitled to have appropriate medical decisions made on their behalf. The initiation or continuation of life-sustaining treatment without a decision that such treatment provides a medical benefit or is in the patient's best interests may subject patients to indignity and suffering.

The patient lacking capacity for whom no surrogate can be found and who has executed no advance directives requires special attention and protection when medical decisions are to be made on his or her behalf. Not only are such persons especially vulnerable, but it is not possible to ascertain what their wishes would be with regard to treatment.

This document describes an institutional process designed to achieve reasoned life support decisions for patients who cannot make such decisions for themselves and who have no surrogates, and to assure that the interests of the patient are fully considered.

2. RELEVANT LEGAL AND ETHICAL PRINCIPLES

The process suggested in these Guidelines has been developed in light of the following principles established by the California courts and drawn from the Joint Committee's guidelines for Forgoing Life-Sustaining Treatment for Adult Patients:

(a) Competent adult patients have the right to refuse treatment, including life sustaining treatment, whether or not they are terminally ill.

(b) Patients who lack capacity to make health care decisions retain the right to have appropriate medical decisions made on their behalf, including decisions regarding life-sustaining treatment. An appropriate medical decision is one that is made in the best interests of the patient, not the hospital, the physician, the legal system, or someone else.

(c) A surrogate decision-maker is to make decisions for the patient who lacks capacity to decide based on the expressed wishes of the patient, if known, or based on the best interests of the patient, if the patient's wishes are not known.

(d) A surrogate decision-maker may refuse life support on behalf of a patient who lacks capacity to decide where the burdens of continued treatment are disproportionate to the benefits. Even a treatment course which is only minimally painful or intrusive may be disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in the patient's condition.

(e) The best interests of the patient do not require that life support be continued in all circumstances, such as when the patient is terminally ill and suffering, or where there is no hope of recovery of cognitive function.

(f) Physicians are not required to provide treatment that has proven to be ineffective or will not provide a benefit.

(g) Health care providers are not required to continue life support simply because it has been initiated.

3. INSTITUTIONAL PROCESS.

When the attending physician believes that life-sustaining treatment should be foregone for a patient who lacks decision-making capacity and has neither a surrogate nor known treatment preferences, he or she should refer the matter to an institutional process for review prior to foregoing treatment. Other health care givers can also initiate the process. The goal of the institutional process should be to assure that any decision made is: a) based on medical advice, b) consistent with the patient's best interests, and (c) made in the absence of material conflict of interest. To this end the process should:

- Vest review and approval authority in a formally constituted committee.
    - The committee (which may be the facility's ethics committee) should be interdisciplinary and should have at least one person who is not a health care professional and at least one person from outside the facility involved in the decision (these may be the same person).
    - If the patient is in a long-term care facility, the committee should include an ombudsman or an equivalent advocate for the patient.
- Confirm after a diligent search process that no surrogate decision-maker is available.
- Require that any person with material conflict of interest, real or apparent, with regard to the treatment of the patient in question disclose such conflict.
- Obtain all relevant medical information regarding the patient's medical history, current condition, and prognosis.
    - The committee should make sure it considers all medical information that may be available including that from medical records, private physicians, and other facilities.
    - In addition to the patient's attending physician, at least one other physician should have examined the patient and concur in the prognosis.
    - Consider the views of the nursing staff and other caregivers.
- View burdens and benefits from the point of view of the patient.
    - Search for historical information regarding the patient, including the patient's values and beliefs, which might afford an understanding of how that patient might view the burdens and benefits of continued treatment.
- Caregivers' point of view should not be projected on the patient.
- Exclude from consideration any judgment regarding the "social value" of the patient.
- The benefit of continued life to a disabled patient should not be devalued or underestimated.

4. OUTCOME OF THE INSTITUTIONAL PROCESS

The patient's attending physician is ultimately responsible for making the treatment decision.

- The Committee should review the above factors and any other relevant information. The Committee should either concur in or object to the attending physician's proposal to forego life-sustaining treatment.
- When the Committee concurs with the physician's proposed treatment decision, the physician may so document in the patient's chart and enter appropriate orders in the patient's record.
- In the rare situation where the Committee objects to the physician's proposed treatment decision and it is not possible to resolve the issue throughout the institutional process, the matter should be referred to the courts.

CALIFORNIA PROBATE LAW SUMMARY

(§ 1-8 below are unofficial summaries, followed by the official text of the relevant statute)

Effective July 1, 2000 California has enacted the Health Care Decisions Law: This Law has been incorporated into the California Probate Code. The following summaries and extracts from the Code are of particular relevance to health-care providers:

1) Adults have the right to control decisions relating to their own health care, including the decision to have life-sustaining treatment withheld or withdrawn.

2) Medical treatment that artificially prolongs life "beyond natural limits", thus prolonging the dying process, may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.

3) Decisions regarding withdrawing or withholding life-sustaining treatment should normally (that is, "in the absence of controversy") be made without the assistance of the court.

> **4650**. The Legislature finds the following:
>
> (a) In recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.
>
> (b) Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.
>
> (c) In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.

4) A patient's decision to withdraw or withhold life-sustaining treatment is **NOT** the same as suicide, and the health care provider who carries out the patient's wishes is not guilty of "mercy killing, assisted suicide, or euthanasia".

> **4653**. Nothing in this division shall be construed to condone, authorize, or approve mercy killing, assisted suicide, or euthanasia. This division is not intended to permit any affirmative or deliberate act or omission to end life other than withholding or withdrawing health care pursuant to an advance health care directive, by a surrogate, or as otherwise provided, so as to permit the natural process of dying.
>
> **4656**. Death resulting from withholding or withdrawing health care in accordance with this division does not for any purpose constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

5) Adults may execute a Durable Power of Attorney for Health Care in which they designate an agent to make health-decisions on their behalf: this person then "has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information." The agent is to act in accordance with the patient's wishes and best interests. In making health-care decisions for the patient the agent has priority over all other persons (including the patient's family).

The Durable Power of Attorney for Health Care may also include the patient's health care instructions. This document is valid in California even if it was executed in another state;

and a copy of this document has the same effect as the original, which must normally be signed by the patient and be either signed by two witnesses or notarized. It remains in effect until revoked.

4660. A copy of a written advance health care directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

4670. An adult having capacity may give an individual health care instruction. The individual instruction may be oral or written. The individual instruction may be limited to take effect only if a specified condition arises.

4671. (**a**) An adult having capacity may execute a power of attorney for health care, as provided in Article 2 (commencing with Section 4680). The power of attorney for health care may authorize the agent to make health care decisions and may also include individual health care instructions.

(**b**) The principal in a power of attorney for health care may grant authority to make decisions relating to the personal care of the principal, including, but not limited to, determining where the principal will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment.

4672. (**a**) A written advance health care directive may include the individual's nomination of a conservator of the person or estate or both, or a guardian of the person or estate or both, for consideration by the court if protective proceedings for the individual's person or estate are thereafter commenced.

(**b**) If the protective proceedings are conservatorship proceedings in this state, the nomination has the effect provided in Section 1810 and the court shall give effect to the most recent writing executed in accordance with Section 1810, whether or not the writing is a written advance health care directive.

4673. A written advance health care directive is legally sufficient if all of the following requirements are satisfied:

(a) The advance directive contains the date of its execution.

(b) The advance directive is signed either (1) by the patient or (2) in the patient's name by another adult in the patient's presence and at the patient's direction.

(c) The advance directive is either (1) acknowledged before a notary public or (2) signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675.

4676. (**a**) A written advance health care directive or similar instrument executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of this state, is valid and enforceable in this state to the same extent as a written advance directive validly executed in this state.

(**b**) In the absence of knowledge to the contrary, a physician or other health care provider may presume that a written advance health care directive or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.

4678. Unless otherwise specified in an advance health care directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

4684. An agent shall make a health care decision in accordance with the principal's individual health care instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

4685. Unless the power of attorney for health care provides otherwise, the agent designated in the power of attorney who is known to the health care provider to be reasonably available and willing to make health care decisions has priority over any other person in making health care decisions for the principal.

4686. Unless the power of attorney for health care provides a time of termination, the authority of the agent is exercisable notwithstanding any lapse of time since execution of the power of attorney.

6) Unless they are related to the patient, health-care providers involved in the patient's care may **NOT** serve as the patient's surrogate decision-maker.

> **4659**. (**a**) Except as provided in subdivision (b), none of the following persons may make health care decisions as an agent under a power of attorney for health care or a surrogate under this division:
>
> (1) The supervising health care provider or an employee of the health care institution where the patient is receiving care.
>
> (2) An operator or employee of a community care facility or residential care facility where the patient is receiving care.
>
> (**b**) The prohibition in subdivision (a) does not apply to the following persons:
>
> (1) An employee who is related to the patient by blood, marriage, or adoption.
>
> (2) An employee who is employed by the same health care institution, community care facility, or residential care facility for the elderly as the patient.
>
> (**c**) A conservator under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code) may not be designated as an agent or surrogate to make health care decisions by the conservatee, unless all of the following are satisfied:
>
> (1) The advance health care directive is otherwise valid.
>
> (2) The conservatee is represented by legal counsel.
>
> (3) The lawyer representing the conservatee signs a certificate stating in substance: "I am a lawyer authorized to practice law in the state where this advance health care directive was executed, and the principal or patient was my client at the time this advance directive was executed. I have advised my client concerning his or her rights in connection with this advance directive and the applicable law and the consequences of signing or not signing this advance directive, and my client, after being so advised, has executed this advance directive."

7) Patients are presumed to have the capacity to make health-care decisions and to appoint or disqualify surrogate decision-makers: the determination that they lack or have recovered capacity is normally made by their physician.

> **4657**. A patient is presumed to have the capacity to make a health care decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate. This presumption is a presumption affecting the burden of proof.
>
> **4658**. Unless otherwise specified in a written advance health care directive, for the purposes of this division, a determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual health care instruction or the authority of an agent or surrogate, shall be made by the primary physician.

8) Patients cannot oblige health-care providers to offer treatment "contrary to generally accepted health care standards".

> **4654**. This division does not authorize or require a health care provider or health care institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or health care institution.

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form. Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains. Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form. Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death. Part 4 of this form lets you designate a physician to have primary responsibility for your health care. After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility. You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER *of* ATTORNEY *for* HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(name of individual you choose as agent)

_____

(address) (city) (state) (Zip Code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my **first alternate agent**:

_____

(name of individual you choose as first alternate agent)

_____

(address) (city) (state) (Zip Code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my **second alternate agent**:

_____

(name of individual you choose as second alternate agent)

_____

(address) (city) (state) (Zip Code)

_____

(home phone) (work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS *for* HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: _ |_| (a) Choice Not To Prolong Life I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR _ |_| (b) Choice To Prolong Life I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed.)

PART 3
DONATION *of* ORGANS *at* DEATH (OPTIONAL)

(3.1) Upon my death (mark applicable box):

☒ (a) I give any needed organs, tissues, or parts, OR

☒ (b) I give the following organs, tissues, or parts only.

_____

☒ (c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant (2) Therapy (3) Research (4) Education

PART 4
PRIMARY PHYSICIAN (OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (Zip Code)

_____

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (Zip Code)

_____

(phone)

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

_____

(date) (sign your name)

_____

(address) (print your name)

_____

(city) (state)

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS	SECOND WITNESS
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city) (state)	(city) (state)
_____	_____
(signature of witness)	(signature of witness)
_____	_____
(date)	(date)

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____	_____
(signature of witness)	(signature of witness)

PART 6
SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

_____

(date) (sign your name)

_____

(address) (print your name)

_____

(city) (state)

---

[1] *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195 (1984)

[2] The terms *competent* and *incompetent* are used in this document as they are used by physicians, and in the Durable Power of Attorney for Health Care. *Competent* means that the patient has the ability to understand the nature and consequences of the treatment options being discussed, and *incompetent* means that the patient lacks this ability. While the terms also have technical legal meanings which refer to a formal adjudication by a court of a person's competence, the terms are not used with such a meaning here. Such a formal adjudication of competence by a court is not required in making most treatment decisions, or in determining whether the appointed surrogate may act persuant to a Durable Power of Attorney for Health Care.

[3] In seeking to identify the appropriate surrogate of the patient with whom to consult the provider should consider immediate family members who: (a) are "in the best position to know (the patient's) feelings and desires (regarding treatment)," (b) "would be most affected by the treatment decision," (c) "are concerned for (the patient's) comfort and welfare," and (d) have expressed an interest in the patient by visits or inquiries to the patient's physician or hospital staff. *Barber v. Superior Court*, 147 Cal.App. 3d 1006, fn 2 (1983). In addition to family members, it may be appropriate to rely on non-family members who satisfy these criteria.

[4] An ethical or religious objection by another member of the healthcare team should generally be accomodated as well, to the extent possible without interfering with the patient's or surrogate's decision.