BIOETHICAL ISSUES *for* CATHOLICS *at the* END *of* LIFE

USEFUL WEBSITES

VATICAN WEBSITE: http://www.vatican.va (*search for* "vegetative state"; "palliative care")
USCCB Ethical & Relig. Directives (2018): http://www.usccb.org (*search for* "Ethical and Religious Directives")
SEMINARY WEBSITE: http://ldysinger.stjohnsem.edu ("*Palliaive Care vs. Assisted Suicide*")
Email: Fr. Luke Dysinger, OSB: ldysinger@stjohnsem.edu

1, Online Resources; 2, Catholic Magisterium on Palliative and End-of-Life Care, 3. Organ Donation; 4. Physician-Assisted Suicide in California and Euthanasia in Canada

1. ONLINE RESOURCES

- L.A. Archdiocese: "Caring for The Whole Person" https://lacatholics.org/caring-for-the-whole-person/
- *Catechism of the Catholic Church* (Life Issues) §2258-2301 : https://www.usccb.org/sites/default/files/flipbooks/catechism/ ".
- USCCB "*Ethical and Religious Directives,*"6th ed., 2016: https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf
- Pope St. John Paul II, Encyclical "Evangelium Vitae, 1995 https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html
- Congregation for the Doctrine of the Faith "Iura et Bona (Declaration on Euthanasia)," 1980: https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html
- Congregation for the Doctrine of the Faith, "*Donum Vitæ*, on Respect for Human Life in its Origin," 1987: https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html
- Congregation for the Doctrine of the Faith, "*Dignitatis Personae*, On Certain Bioethical Questions," 2008: https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html
- Congregation for the Doctrine of the Faith, "Christ the Good Samaritan," 2020: https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html
- Alexander Raikin, *New Atlantis*, Dec. 16, 2022 "No Other Option" (Detailed discussion of euthanasia in Canada) https://www.thenewatlantis.com/publications/no-other-options
- Ross Douthat, "Will Euthanasia Be Secular or Sacred?" *The New York Times*,Jan. 13, 2023 https://www.nytimes.com/2023/01/13/opinion/euthanasia-canada.html

The ETHICAL and RELIGIOUS DIRECTIVES for CATHOLIC HEALTH CARE SERVICES (ERDs) Sixth Edition, USCCB, 2018

The Church's teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. W e are guided on this issue by Catholic teaching against euthanasia, which is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[38] While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.

Directives

55. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. **Proportionate means are those that in the judgment of the patient**[:]

[1] offer a reasonable hope of benefit and

[2] do not entail an excessive burden

[3] or impose excessive expense on the family or the community.[39]

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

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g. the 'persistent vegetative state') who can reasonably be expected to live indefinitely if given such care.[40]

Medically assisted nutrition and hydration **become morally optional** when[:]

[**1**] they cannot reasonably be expected to prolong life or

[**2**] when they would be "excessively burdensome for the patient

[**3**] or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed."[41] [[41] Cong. Doct..Faith, *Commentary on "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration."*]

For instance, as a patient draws **close to inevitable death** from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

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

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.[42]

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or

suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

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

63.**Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.**

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

65 The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions [43] [413 *Donum Vitae,* Part I, no. 4],

From THE CATECHISM *of the* CATHOLIC CHURCH (1994)

Euthanasia

2276 Those whose lives are diminished or weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible.

2277 Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable.

Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.

2278 Discontinuing medical procedures that are[:]

burdensome
dangerous
extraordinary
or disproportionate to the expected outcome

CAN BE LEGITIMATE;

it is the refusal of "over-zealous" treatment.

Here one **does not will** to cause **death**;

one's **inability to impede it** is merely accepted.

The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.

2279 Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable **Palliative care is a special form of disinterested charity. As such it should be encouraged.**

Euthanasia

2276 Illi, quorum vita impedita est vel infirmata, specialem postulant observantiam. Personae aegrotae vel aliqua incapacitate (*handicap*) laborantes sustineri debent ut vitam degant ita normalem, quantum fieri potest.
2277 Euthanasia directa, quaecumque sunt eius motiva vel media, consistit in fine imponendo vitae personarum aliqua incapacitate (*handicap*) laborantium, aegrotarum vel morientium. Moraliter inacceptabilis est.

Sic actio vel omissio quae, ex se vel in intentione, mortem causat ad dolorem supprimendum, occisionem constituit dignitati personae humanae et observantiae erga Deum viventem, eius Creatorem, graviter contrariam. Iudicii error, in quem quis bona fide incidere potest, naturam non mutat huius interficientis actus qui semper proscribendus est et excludendus. [193]

2278 Cessatio a mediis medicinalibus,
onerosis,
periculosis,
extraordinariis vel
talibus quae cum effectibus obtentis proportionata non sunt,
legitima esse potest.
Haec est recusatio « saevitiae therapeuticae ».
Hoc modo, non intenditur mortem inferre;
accipitur non posse eam impedire.
Decisiones suscipiendae sunt ab aegroto, si ad id competentiam habeat et capacitatem, secus autem ab illis qui ad id, secundum legem, habent iura, rationabilem aegroti voluntatem et legitimum commodum semper observantes.

2279 Etiamsi mors imminere consideretur, curae, quae ordinario personae aegrotae debentur, nequeunt legitime interrumpi. Analgesicorum medicamentorum usus ad moribundi dolores sublevandos, etiam cum periculo eius dies breviandi, potest esse dignitati humanae moraliter conformis, si mors neque ut finis neque ut medium est volita, sed solummodo praevisa et, tamquam inevitabilis, tolerata. Curae lenientes formam constituunt excellentem caritatis gratuitae. Hac ratione foveri debent.

An Address by POPE JOHN PAUL II:
ON LIFE- SUSTAINING TREATMENT AND THE VEGETATIVE STATE

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"

Saturday, 20 March 2004

[...] **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 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.

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

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 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.

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

Friday, November 12, 2004

[...] 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.

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

Venerdì, 12 novembre 2004

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 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.

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.

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.

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.

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.

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.

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).

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.

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 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.

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

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. 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.

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.

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.

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. 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).

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.

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).

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.

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.

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.

"SAMARITANUS BONUS" ON THE CARE *of* PERSONS *in the* CRITICAL *and* TERMINAL PHASES *of* LIFE
The Dicastery ("Congregation") for the Doctrine of the Faith. September 22, 2020.

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4. *Palliative care*

Continuity of care is part of the enduring responsibility to appreciate the needs of the sick person: care needs, pain relief, and affective and spiritual needs. As demonstrated by vast clinical experience, palliative medicine constitutes a precious and crucial instrument in the care of patients during the most painful, agonizing, chronic and terminal stages of illness. *Palliative care* is an authentic expression of the human and Christian activity of providing care, the tangible symbol of the compassionate "remaining" at the side of the suffering person. Its goal is "to alleviate suffering in the final stages of illness and at the same time to ensure the patient appropriate human accompaniment"[64] improving quality of life and overall well-being as much as possible and in a dignified manner. Experience teaches us that the employment of palliative care reduces considerably the number of persons who request euthanasia. To this end, a resolute commitment is desirable to extend palliative treatments to those who need them, within the limits of what is fiscally possible, and to assist them in the terminal stages of life, but as an *integrated approach to the care* of existing chronic or degenerative pathologies involving a complex prognosis that is unfavorable and painful for the patient and family.[65]

Palliative care should include spiritual assistance for patients and their families. Such assistance inspires faith and hope in God in the terminally ill as well as their families whom it helps to accept the death of their loved one. It is an essential contribution that is offered by pastoral workers and the whole Christian community. According to the model of the Good Samaritan, acceptance overcomes denial, and hope prevails over anguish,[66] particularly when, as the end draws near, suffering is protracted by a worsening pathology. In this phase, the identification of an effective pain relief therapy allows the patient to face the sickness and death without the fear of undergoing intolerable pain. Such care must be accompanied by a fraternal support to reduce the loneliness that patients feel when they are insufficiently supported or understood in their difficulties.

Palliative care cannot provide a fundamental answer to suffering or eradicate it from people's lives.[67] To claim otherwise is to generate a false hope, and cause even greater despair in the midst of suffering. Medical science can understand physical pain better and can deploy the best technical resources to treat it. But terminal illness causes a profound suffering in the sick person, who seeks a level of care beyond the purely technical. *Spe salvi facti sumus*: in hope**,** theological hope, directed toward God, we have been saved, says Saint Paul (*Rm* 8:24).

"The wine of hope" is the specific contribution of the Christian faith in the care of the sick and refers to the way in which God overcomes evil in the world. In times of suffering, the human person should be able to experience a solidarity and a love that takes on the suffering, offering a sense of life that extends beyond death. All of this has a great social importance: "A society unable to accept the suffering of its members and incapable of helping to share their suffering, and to bear it inwardly through 'com-passion' is a cruel and inhuman society".[68]

It should be recognized, however, that the definition of palliative care has in recent years taken on a sometimes equivocal connotation. In some countries, national laws regulating palliative care (*Palliative Care Act*) as well as the laws on the "end of life" (*End-of-Life Law*) provide, along with palliative treatments, something called Medical Assistance to the Dying (MAiD) that can include the possibility of requesting euthanasia and assisted suicide. Such legal provisions are a cause of grave cultural confusion: by including under palliative care the provision of integrated medical assistance for a voluntary death, they imply that it would be morally lawful to request euthanasia or assisted suicide.

In addition, palliative interventions to reduce the suffering of gravely or terminally ill patients in these regulatory contexts can involve the administration of medications that intend to hasten death, as well as the suspension or interruption of hydration and nutrition even when death is not imminent. In fact, such practices are equivalent to a *direct action or omission to bring about death and are therefore unlawful*. The growing diffusion of such legislation and of scientific guidelines of national and international professional societies, constitutes a socially irresponsible threat to many people, including a growing number of vulnerable persons who needed only to be better cared for and comforted but are instead being led to choose euthanasia and suicide.

[64] Francis, *Address to participants in the plenary of the Pontifical Academy for Life* (5 March 2015): *AAS* 107 (2015), 274, with reference to: John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: *AAS* 87 (1995), 476. Cf. *Catechism of the Catholic Church*, 2279.

[65] Cf. Francis, *Address to participants in the plenary of the Pontifical Academy for Life* (5 March 2015): *AAS* 107 (2015), 275.

[66] Cf. Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 147.

[67] Cf. John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 2: *AAS* 76 (1984), 202: "Suffering seems to belong to man's transcendence: it is one of those points in which man in a certain sense 'destined' to go beyond himself, and he is called to this in a mysterious way".

[68] Benedict XVI, Encyclical Letter *Spe salvi* (30 November 2007), 38: *AAS* 99 (2007), 1016.

3. Organ Donation

Evangelium Vitae

Bl. Pope John Paul II, March 25, 1995

86. As part of the spiritual worship acceptable to God (cf. *Rom* 12:1), the *Gospel of life* is to be celebrated above all in *daily living,* which should be filled with self-giving love for others. In this way, our lives will become a genuine and responsible acceptance of the gift of life and a heartfelt song of praise and gratitude to God who has given us this gift. This is already happening in the many different acts of selfless generosity, often humble and hidden, carried out by men and women, children and adults, the young and the old, the healthy and the sick.

It is in this context, so humanly rich and filled with love, that ***heroic actions*** too are born. These are *the most solemn celebration of the Gospel of life,* for they proclaim it ***by the total gift of self.*** They are the radiant manifestation of the highest degree of love, which is to give one's life for the person loved (cf. *Jn* 15:13). They are a sharing in the mystery of the Cross, in which Jesus reveals the value of every person, and how life attains its fullness in the sincere gift of self. Over and above such outstanding moments, there is an everyday heroism, made up of gestures of sharing, big or small, which build up an authentic culture of life.

A **particularly praiseworthy example** of such gestures is the **donation of organs**, performed in an ethically acceptable manner, with a view to **offering a chance of health and even of life itself to the sick** who sometimes have no other hope.

86. In ratione spiritalis cultus Deo grati (Cfr. *Rom.* 12, 1), *Evangelii vitae* celebratio suam postulat effectionem praesertim in *cotidiana exsistentia*, quae in caritate erga alios agitur atque sui ipsius oblatione. Hac ratione tota nostra exsistentia fiet vera et officii conscia acceptio doni vitae atque sincera grataque laus in Deum qui nobis talem tribuit donationem. Quod iam accidit plurimis in signis donationis, modestae saepe et absconditae, quae primos exhibent actores viros et mulieres, parvulos et adultos, iuvenes et seniores, sanos et aegrotos.

Hoc in rerum contextu, humanitatis caritatisque pleno, *heroicae* oriuntur *res gestae*. Quae sunt *sollemnissima Evangelii vitae celebratio*, utpote quae illud *tota sui ipsius donatione* proclament; sunt clara supremae caritatis significatio, actio scilicet ponendi vitam pro amico dilecto (Cfr. *Io.* 15, 13); sunt mysterii Crucis participatio, qua Iesus patefacit quantum pretium habeat sibi vita cuiusque hominis atque quo modo ea in sincerae sui ipsius donationis plenitudine efficiatur. Praeter facta celebria rerum cotidianarum exstat heroica virtus, quae parvis magnisve constat beneficentiae actibus unde verus alitur vitae cultus.

Quos inter plurimi ducenda est organorum donatio rationibus ethica disciplina probabilibus effecta, ut salutis vel etiam vitae ipsius opportunitas aegris praebeatur omni nonnumquam spe destitutis.

from the Catechism *of the* Catholic Church (1994)

2296 *Organ transplants* are in conformity with the moral law if the physical and psychological dangers and risks to the donor are proportionate to the good sought for the recipient. Organ donation after death is a **noble and meritorious act** and is to be **encouraged as a expression of generous solidarity**. It is not morally acceptable if the donor or his proxy has not given explicit consent. Moreover, it is not morally admissible to bring about the disabling mutilation or death of a human being, even in order to delay the death of other persons.

2296 *Organorum transplantatio* legi morali est conformis, si pericula et discrimina physica atque psychica quae donans subit, bono sunt proportionata quod pro eo quaeritur cui illa destinatur. Donatio organorum post mortem est actus nobilis et meritorius atque alliciendus tamquam generosae solidarietatis manifestatio. Moraliter acceptabilis non est, si donans vel eius propinqui ius ad id habentes suum explicitum non dederint consensum. Praeterea nequit moraliter admitti, mutilationem, quae invalidum reddit, vel mortem directe provocare, etiamsi id fiat pro aliarum personarum retardanda morte.

ADDRESS *of his* HOLINESS BENEDICT XVI
to PARTICIPANTS *at an* INTERNATIONAL CONGRESS
ORGANIZED *by the* PONTIFICAL ACADEMY *for* LIFE
Friday, 7 November 2008

Organ donation is a peculiar form of witness to charity. In a period like ours, often marked by various forms of selfishness, it is ever more urgent to understand how the logic of free giving is vital to a correct conception of life. Indeed, a responsibility of love and charity exist that commits one to make of their own life a gift to others, if one truly wishes to fulfil oneself. As the Lord Jesus has taught us, only whoever gives his own life can save it (cf. Lk 9: 24).

[...] Prescinding from this dimension leads to a perspective incapable of grasping the totality of the mystery present in each one. Therefore, it is necessary to put respect for the dignity of the person and the protection of his/her personal identity in the first place. As regards the practice of organ transplants, it means that someone can give only if he/she is not placing his/her own health and identity in serious danger, and only for a morally valid and proportional reason. The possibility of organ sales, as well as the adoption of discriminatory and utilitarian criteria, would greatly clash with the underlying meaning of the gift that would place it out of consideration, qualifying it as a morally illicit act. However, in these cases the principal criteria of respect for the life of the donator must always prevail so that the extraction of organs be performed only in the case of his/her true death (cf. Compendium of the Catechism of the Catholic Church, n. 476). The act of love which is expressed with the gift on one's vital organs remains a genuine testimony of charity that is able to look beyond death so that life always wins. The recipient of this gesture must be well aware of its value. He is the receiver of a gift that goes far beyond the therapeutic benefit. In fact, what he/she receives, before being an organ, is a witness of love that must raise an equally generous response, so as to increase the culture of gift and free giving.

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4. PHYSICIAN-ASSISTED SUICIDE *in* CALIFORNIA

2015 CALIFORNIA HEALTH AND SAFETY CODE: THE "CALIFORNIA END *of* LIFE OPTION ACT"

(Summary by: *The California Board of Registered Nursing* http://www.rn.ca.gov/endoflife.shtml

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What does the new California law do?

The law authorizes a resident of California

who is **18 years of age** or older,
who has been determined to **be terminally-ill**
and **mentally-competent**, [*sic*: has "capacity"; "competence" is nowhere mentioned in act]
to make a request for a drug prescribed for the purpose of ending his or her life.

What safeguards are included in the law?

The Act includes several safeguards, which are aimed at restricting access to patients who are terminally-ill and mentally-competent:

- Two physician assessments are required. The "*attending*" and "*consulting*" physicians must each independently determine that the individual has a terminal disease with a prognosis of six months or less, and is able to provide informed consent. Elements of informed consent, including disclosure of relevant information, assessment of decisional capacity and assurance of voluntariness, are stipulated in the law.
- If either physician is aware of any "*indications of a mental disorder,*" a mental health specialist assessment must be arranged to determine that the individual "*has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.*"
- The attending physician must provide counseling about the importance of the following: "*having another present when he or she ingests the aid-in-dying drug, not ingesting the aid-in-dying drug in a public place, notifying the next-of-kin of his or her request for the aid-in-dying drug, participating in a hospice program and maintaining the aid-in-dying drug in a safe and secure location.*"

- The attending physician must offer the individual the opportunity to withdraw his or her request for the aid-in-dying drug at any time.
- The individual must make two oral requests, separated by a minimum of fifteen days, and one written request for the aid-in-dying drug.
- The written request must be observed by two adult witnesses, who attest that the patient is "*of sound mind and not under duress, fraud or undue influence.*"
- The patient must make a "*final attestation,*" forty-eight hours before he or she intends to ingest the medication.
- Only the person diagnosed with the terminal disease may request a prescription for the aid-in-dying drug (i.e., surrogate requests are not permitted).
- The individual must be able to self-administer the medication.

What are the documentation and reporting requirements?

The law explicitly stipulates a number of requirements for documentation in the patient's medical record, largely corresponding to the safeguards above. In addition, the law creates two reporting obligations:

1. Within 30 days of writing a prescription for an aid-in-dying drug, the attending physician must submit to the California Department of Public Health (CDPH) a copy of the qualifying patient's written request, an attending physician checklist and compliance form, and a consulting physician's compliance form.
2. Within 30 days following the individual's death, the attending physician must submit a follow-up form to CDPH. All forms will be posted on the CDPH and Medical Board websites.

Is participation required?

No. Participation in the law is voluntary for all parties. Individual providers -- and institutions as well -- may make personal, conscience-based decisions about whether or not to participate.

"**sunset clause" and a legislative evaluation in 2026**

Oct, 2021 CHANGES in CALIFORNIA ASSISTED-SUICIDE LEGISLATION

Senate Bill No. 380 CHAPTER 542

An act to amend Sections 443.1, 443.3, 443.4, 443.5, 443.11, 443.14, 443.15, and 443.17 of, and to repeal and add Section 443.215 of, the Health and Safety Code, relating to end of life.

[Approved by Governor October 05, 2021. Filed with Secretary of State October 05, 2021.]

LEGISLATIVE COUNSEL'S DIGEST

SB 380, Eggman. End of life.

This bill would allow for an individual to qualify for aid-in-dying medication by making 2 oral requests a minimum of 48 hours apart. **The bill would eliminate the requirement that an individual who is prescribed and ingests aid-in-dying medication make a final attestation**. The bill would require that the date of all oral and written requests be documented in an individual's medical record and would require that upon a transfer of care, that record be provided to the qualified individual. **The bill would extend the operation of the act until January 1, 2031**, thereby imposing a state-mandated local program by extending the operation of crimes for specified violations of the act.

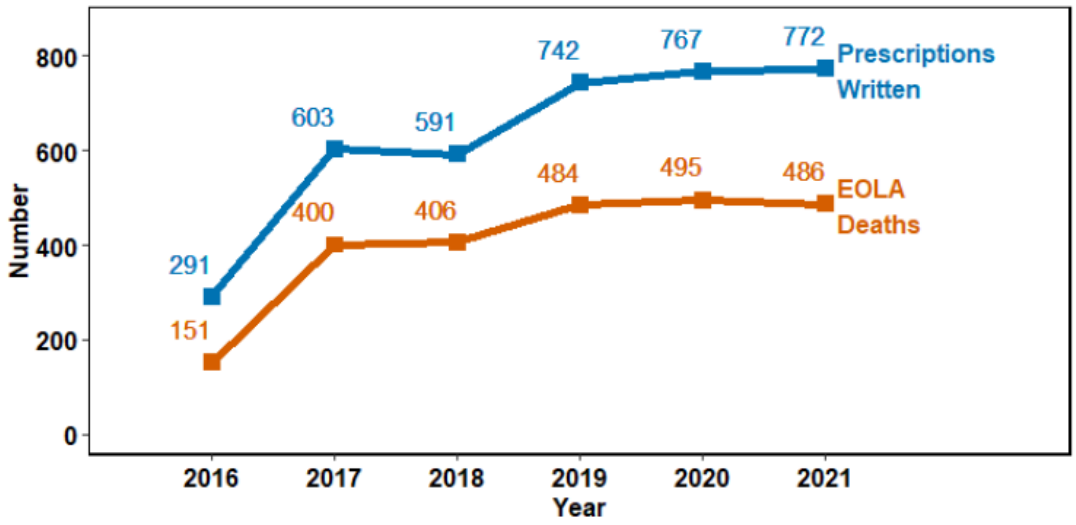
This bill would require a health **care provider who is unable or unwilling to participate under the act to inform the individual seeking an aid-in-dying medication that they do not participate**, document the date of the individual's request and the provider's notice of their objection, **and transfer their relevant medical record upon request.**

This bill would instead **authorize a health care entity to prohibit employees and contractors, as specified, from participating under the act while on the entity's premises or in the course of their employment**. The bill would

prohibit a health care provider or health care entity from engaging in false, misleading, or deceptive practices relating to their willingness to qualify an individual or provide a prescription for an aid-in-dying medication to a qualified individual. The bill would require a health care entity to post its current policy regarding medical aid in dying on its internet website.

From the California End of Life Option Act 2021 Data Report

Figure 1: Summary of EOLA Prescriptions and Deaths 2016-2021



[In 2021 there were 200 persons prescribed lethal drugs with unknown ingestion status]

Table 1: Demographics of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug, continued

EOLA Individuals	2021	(N=486)	2020	(N=495)	2016-2019	(N=1441)	Total	(N=2422)
Race/Ethnicity	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
White	416	(85.6)	430	(86.9)	1278	(88.7)	2124	(87.7)
Black	4	(0.8)	6	(1.2)	14	(1.0)	24	(1.0)
American Indian/Alaska Native	0	(0.0)	0	(0.0)	1	(0.1)	1	(0.0)
Asian	34	(7.0)	38	(7.7)	81	(5.6)	153	(6.3)
Hawaiian/Pacific Islander	0	(0.0)	1	(0.2)	3	(0.2)	4	(0.2)
Other	0	(0.0)	1	(0.2)	2	(0.1)	3	(0.1)
Multi-race	6	(1.2)	2	(0.4)	12	(0.8)	20	(0.8)
Hispanic	25	(5.1)	17	(3.4)	49	(3.4)	91	(3.8)
Unknown	1	(0.2)	0	(0.0)	1	(0.1)	2	(0.1)

Table 1: Demographics of the EOLA Individuals Who Died Following Ingestion of an Aid-in-Dying Drug

EOLA Individuals	2021	(N=486)	2020	(N=495)	2016-2019	(N=1441)	Total	(N=2422)
Age	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Under 60	56	(11.5)	44	(8.9)	171	(11.9)	271	(11.2)
60-69	91	(18.7)	111	(22.4)	317	(22.0)	519	(21.4)
70-79	159	(32.7)	168	(33.9)	427	(29.6)	754	(31.1)
80-89	113	(23.3)	110	(22.2)	346	(24.0)	569	(23.5)
90 and Over	67	(13.8)	62	(12.5)	180	(12.5)	309	(12.8)
Median Age (Range)	76	(30-105)	75	(27-107)	75	(23-106)	75	(23-107)
Gender	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Female	232	(47.7)	252	(50.9)	710	(49.3)	1194	(49.3)
Male	254	(52.3)	243	(49.1)	731	(50.7)	1228	(50.7)
Education	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
No High School Diploma	15	(3.1)	10	(2.0)	49	(3.4)	74	(3.1)
HS Diploma or GED	92	(18.9)	104	(21.0)	291	(20.2)	487	(20.1)
Some College	68	(14.0)	88	(17.8)	264	(18.3)	420	(17.3)
Associate's Degree	37	(7.6)	49	(9.9)	93	(6.5)	179	(7.4)
Bachelor's Degree	134	(27.6)	131	(26.5)	355	(24.6)	620	(25.6)
Master's Degree	88	(18.1)	64	(12.9)	227	(15.8)	379	(15.6)
Doctorate or Professional Degree	46	(9.5)	46	(9.3)	151	(10.5)	243	(10.0)
Unknown	6	(1.2)	3	(0.6)	11	(0.8)	20	(0.8)