

The Roman Catholic Tradition

Religious Beliefs and Healthcare Decisions

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The Roman Catholic church is one of the largest religious bodies worldwide, numbering over 750 million members, and is the largest single church in the United States. It identifies its origins with Jesus of Nazareth. Although Jesus himself did not found a church, his followers in Jerusalem organized around the Twelve Apostles after his death (ca. 30 C.E.) and carried on his mission of preaching and teaching the reign of God and the “good news of salvation.” The latter was the belief among Jesus’ followers that faith in Jesus, whom they believed to have been raised by God from the dead, would lead to salvation.

Initially, the disciples of Jesus sought converts among fellow Jews throughout Palestine and did not view themselves as distinct from Judaism. The apostle Paul (d. ca. 67 C.E.) made the first significant attempt to convert Gentiles to Christianity. After his own conversion from Judaism, Paul made several missionary journeys throughout the Roman Empire. By about 60 C.E., he and others had preached the faith in most of the eastern Mediterranean and as far west as Rome. A century later, Christian communities existed in most if not all of the cities of the Roman Empire.

The early Christian communities structured themselves in diverse ways and comprised a variety of

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ministries and ministers, including deacons, elders, presbyters, and bishops. Despite their diversity, these communities did hold some elements in common: “faith in Jesus as Messiah and Lord; the practice of Baptism and the celebration of the Eucharist; the apostolic preaching and instruction; the high regard for communal love; and the expectation of the coming Kingdom of God” (McBrien 1980, 2: 583). The apostle Peter, one of the original twelve, held a position of prominence among the other apostles and within the local churches.

During the second and third centuries, Christians were heavily persecuted by the Roman government. But this persecution ceased in the fourth century, and Christianity spread. In 313, the recently converted emperor Constantine not only legalized Christianity, thus ending the persecution, but also showed great favor to Christians in the laws and policies he instituted. This trend was continued by all but one subsequent emperor and culminated in 391 when the emperor Theodosius declared Christianity the official religion of the Roman Empire. Thus began an intimate relationship between church and state that continued in Western Christianity for the next thousand years. This relationship was founded on the belief that the emperor was divinely appointed and was charged with protecting the church as well as ruling the empire.

Constantine contributed in yet another way to the shaping of the Christian church. In 330, he transferred the capital of the empire from Rome to Byzantium in the East, renaming it Constantinople. This action had profound consequences, among them, a gradual increase in papal power. The transfer of power to the East left a political vacuum in the ancient capital of Rome, a vacuum increasingly filled by the pope. The papacy began to view itself as having absolute spiritual and temporal power within the church and established Rome as the spiritual capital of Christianity. Some popes even saw themselves as the Western counterpart to the emperor in the East and as having ultimate power within western Europe.

By the end of the fourth century, Christianity had made significant strides. Most of the urban population in Italy, Spain, Gaul, and Africa had been converted. Much missionary work remained to be done, however, among the peasant populations and throughout the rest of Europe.

Both the spread of Christianity and papal power increased during the early Middle Ages (500-1050), largely because of the 600-year “invasion” of the Germanic tribes into western Europe. Pope Gregory the Great (elected in 590) took great interest in converting the “barbarians” to Christianity for both religious and political reasons. He saw, on the one hand, an opportunity to spread the faith to larger regions of Europe, and on the other, an occasion to gain the support of the Germanic peoples in order to strengthen his own position, given the virtual absence of support for him from the emperor of the East. In fact, the collapse of the Roman Empire and the leadership void it created afforded the papacy even more temporal power. The new converts to Christianity and the nations to which they belonged looked to Rome for leadership. And they in turn were for the pope a source of temporal power and wealth. These trends were reinforced in the early ninth century when Charlemagne became ruler of the Holy Roman Empire. He was a great supporter of the papacy, and under his rule any lines that still separated the church and the Western empire quickly dissolved.

By the time Gregory VII was elected pope in 1073, the Holy Roman Empire had shrunk in size and had become fragmented into feudal municipalities. Christianity was no longer coextensive with the Western empire and, in fact, transcended its boundaries. Given all of this, it seemed only fitting to Gregory that the pope should enjoy political as well as spiritual supremacy, and he acted accordingly. Popes during the remainder of the High Middle Ages continued the tradition of a strong papal monarchy.

This changed during the late Middle Ages (1300-1545) with the rise of nation-states of

nationalistic populations headed by powerful rulers. These forces ultimately led to the collapse of papal supremacy and the power of Western Christianity. The Great Schism (1378-1417), during which there were two, and at one point three, popes reigning simultaneously, further eroded the status and authority of the papacy.

The final blow to the unity, influence, and power of Christianity and to the authority of the pope came with the reform efforts of Luther, Zwingli, and Calvin, the leaders of the Protestant Reformation. Initiatives by several popes and a number of monastic orders to reform abuses had limited success. The Protestant reformers took more radical steps, challenging not only moral laxity and particular abuses within the church but also some of its theology. By the middle of the sixteenth century, the British Isles, Scandinavia, and much of France, Germany, and Austria had broken with Rome. The Reformation “brought to an end the medieval Catholic Church, a structure that had exercised nearly exclusive authority in religion in western Europe for a millennium” (Amundsen 1986: 68).

The Counter Reformation was launched with the election of Pope Paul III in 1534 and the Council of Trent, which met from 1545 until 1563. The council corrected some abuses and was extraordinarily influential in clarifying matters of faith and in issuing disciplinary decrees, but it was not able to reunify Western Christianity.

Catholicism first came to North America with the early Spanish explorers, beginning with Columbus in 1492. By 1565, the first permanent parish in America was founded in St. Augustine, Florida. Subsequently, other missions were founded in Florida, Alabama, California, and the Southwest by Spanish clergy, many of whom were Franciscans. The French explorers also brought missionary clergy with them, and some of the explorers—Cartier, Joliet, Marquette, and Serra—were themselves clergy. These missionaries spread the faith throughout the vast province of France that extended down the Mississippi Valley to Louisiana.

With the founding of the colonies, Roman Catholicism in the United States grew slowly. Most of the colonists were Protestant, and in 1652 legal restrictions were placed on Catholics in Maryland, the colony they had founded in 1634, as well as throughout the other colonies. The Revolution, however, brought Catholics religious and political freedom. With the adoption of the Constitution in 1787, religious equality was legally guaranteed.

Shortly after the Revolution, just over 18,000 Catholics lived in the U.S., concentrated mostly in Maryland, Pennsylvania, Virginia, and New York. They had no clergy and were essentially unorganized. After considerable conflict, John Carroll was named the “prefect apostolic” of the 13 original states; the vicar apostolic of London refused to continue to exercise jurisdiction over the “rebels.” By the early 1800s around 150,000 Catholics had organized about 80 churches. By 1890, the number had grown to 6,231,417, largely because of the flood of immigrants from Catholic countries on the Continent. Today the over 51 million Roman Catholics in the United States belong to about 18,250 churches and make up roughly 22 percent of the population.

INSTITUTIONAL AUTHORITY AND INDIVIDUAL CONSCIENCE

The Roman Catholic church is probably the most centralized of religious bodies. Authority ultimately resides in the first among the bishops and the spiritual leader of the church, the bishop of Rome or the pope. His authority is believed to derive from Jesus himself, who entrusted to St. Peter, chief among the Twelve Apostles, the authority to govern the church: “I for my part declare to you, you are ‘Rock,’ and on this rock I will build my church, and the jaws of death shall not prevail against it. I will entrust to you the keys of the kingdom of heaven. Whatever you declare bound on earth shall be bound in heaven; whatever you declare loosed on earth shall be loosed in heaven” (Matthew 16:18-19). As successor to St. Peter, the pope is

entrusted with the same authority. Authority resides at the next level in the individual bishops who also are successors of the Twelve Apostles and have inherited the mission and authority bestowed upon them by Jesus Christ. Most bishops are responsible for the Catholic churches and institutions in specified geographical areas (dioceses) in countries where the church is present. As leader of the church, it is the pope's responsibility to ensure the integrity of doctrine and morals. Decisions about these matters or about church organization and practice either are made by him or must receive his approval. Individual bishops have teaching authority within their respective dioceses, and national conferences of bishops have authority over the dioceses in their country, but that authority is always subject to the pope. The teaching authority of the church is often referred to as the *magisterium* of the church. This structure has a direct bearing on moral decision making and the role of conscience within Catholicism.

Catholicism combines a profound respect for conscience and for the authoritative teaching of the church. This teaching comes from the pope himself, from particular offices in the papal administration in Rome, from bishops individually or collectively, or from the pope together with the bishops of the world. Authoritative church teaching seeks to maintain the integrity of the faith and, in the area of morality, to guide Catholics in discerning what behaviors are consistent with that faith. It is meant to communicate moral truth arrived at through the accumulated experience and wisdom of the community of faith and interpreted by its spiritual leaders. It seeks to overcome some of the limitations of individual experience, perspective, and understanding.

What then is the relationship of individual conscience to ordinary, authoritative church teaching on matters of faith and morals? The church requires a "religious assent of soul," a "religious submission of will and mind" to authoritative teaching. This has been interpreted

to mean several things. First, Catholics should presume that church teaching is correct unless and until there is clear and overwhelming evidence to the contrary. The presumption is always in favor of church teaching. Second, if they happen to disagree with the teaching, Catholics must make every effort to reach intellectual agreement with it. And, third, they must strive to appropriate that teaching as their own so that in performing or avoiding the behavior, they do it out of personal conviction. The reason behind this should be a religious one, namely, that Jesus commissioned the church to teach and that the Holy Spirit guides the church in truth.

The Catholic tradition insists on the proper formation of personal conscience over time as well as prior to a particular judgment. The authoritative teaching of the church is a necessary but not a sufficient component of this process of conscience formation. Church teaching is not the sole basis for a moral judgment, but it is an indispensable ingredient. In addition, Catholics should attend to Scripture, to moral values, principles, and rules, to their own and others' experience, to the particularities of the situation, and to the insights of their hearts and minds. After carefully considering these, the individual must discern the right action in response to the situation and consistent with his or her faith (see *Catechism of the Catholic Church* [subsequently referred to as CCC] 1997: nos. 1776-1802 on conscience and nos. 2030-51 for a discussion of the teaching authority of the church).

Catholics are expected by church authorities to follow the church's teachings on moral matters. In reality, however, many Catholics find themselves at variance with some teachings, particularly those having to do with procreation and sexuality. Even a significant number of theologians over the past 30 years have proposed positions at variance with some church teaching and have recommended revisions of that teaching. Hence, it is quite likely that in the healthcare arena (as well as in others), not all Catholics will

follow all of official church teaching. In the search for moral truth, however, it should still be true that the guidance of church authority will play a significant role.

The force and binding nature of church teaching varies depending on its source (pope, Vatican offices, bishops, or pope and bishops together), on what form it takes (a papal encyclical, declaration, instruction, apostolic letter, or sermon; constitutions, decrees or declarations of ecumenical councils, episcopal pastoral letters, and so on), the frequency with which the teaching has been repeated throughout the church's history, and the manner in which it is proposed (as infallible or as binding but not infallible). For example, the pope, either alone or together with the bishops of the world, is said to speak infallibly (that is, without error) when he speaks formally and officially (*ex cathedra*) to the entire church on matters of faith and morals. Such pronouncements are to be considered as revealed truth and as definitive.

This variable "authoritativeness" of church teaching is reflected in the pages that follow. Various sources have been employed in an attempt to present a quasi-"official" Catholic perspective on issues in healthcare ethics. Although all the sources are ecclesiastical documents—from popes, bishops, or Vatican commissions—there is some variance among them regarding the weight they carry and the extent to which they represent an official Catholic position. A pope's reflections in an address on genetic research, for example, are not as authoritative as a Vatican declaration on euthanasia or an instruction on the dignity of life that condemns various reproductive technologies.

FUNDAMENTAL BELIEFS ABOUT ETHICS

Roman Catholic thinking on moral issues is determined primarily by the Hebrew and Christian Scriptures and by what is referred to as *natural law*. Most generally, natural law simply means the use of human reason to discover

moral truth. A particular understanding of natural law, however, has informed virtually all of official Catholic teaching on sexual and medical moral issues. It maintains that God has created all of reality, including human beings and all their abilities, for particular purposes. In order for a human action to be moral, it must be consistent with or fulfill those purposes that are written into the very structure and functioning of human capabilities. The act of sexual intercourse, for example, is considered to have been created by God to be procreative. Any interference with the procreative purpose of the sex act (for example, contraception or sterilization) violates its God-given nature and is therefore immoral. Actions that contradict God's purposes for a particular human faculty are often said to be intrinsically evil—that is, by their very nature, they are evil. Such actions are always prohibited. Over the past three decades, a less biological and more person-centered approach to natural law has shaped some ecclesiastical statements on moral matters. This has not, however, altered conclusions. Some present-day theologians (and many lay members of the church) do not espouse a natural-law approach and sometimes arrive at different conclusions on moral issues. These cannot be considered as the official position of the church, however. Catholics are expected to follow the teaching of the magisterium and not the teaching of individual theologians.

Several convictions guide Roman Catholic teaching on moral issues in medicine:

- *Because human beings are made in the image and likeness of God, every human being has an inherent and inviolable dignity. It is this dignity that is the basis of every individual's inalienable rights. This dignity is not conferred by human beings, cannot be measured in degrees, and cannot be taken away. Assessments of a person's worth on the basis of social utility, the quality of a person's life, or any other characteristic (such as race, gender, social class) or denials of basic human rights are violations of human dignity.*

• *Human beings are social by nature.* Relationships with others and with the community are essential to their survival and flourishing; any exercise of autonomy must therefore consider the individual's relationships and responsibilities to others and to the larger community. In addition to having specific responsibilities to others, individuals have a responsibility to contribute to the common good of society.

• *Human life is considered to be sacred and inviolable from the moment of conception, regardless of its quality.* It is a gift of God and the most basic of all human goods. For this reason, it is immoral to end it directly or unjustly. Human life, however, is not considered to be an absolute. Therefore, not everything must be done to preserve or prolong it. Biological existence must always be subordinated to the total good of the person, particularly to the person's spiritual good. This might mean, in some instances, allowing someone to die.

• *Human beings are stewards of life.* Human life is a gift of the Creator over which human beings are stewards or caretakers. Hence, we have a fundamental responsibility to care for life and health. As created entities, we have only limited power or control over our lives; they are not ours to do with as we will. Only God has full dominion over life.

Stewardship also applies to the goods of creation. Because these are gifts of the Creator for our use, we are called to use them prudently, justly, and in a caring manner.

• *It is legitimate under certain conditions to sacrifice a part for the good of the whole.* This is generally known as the "principle of totality." Traditionally, it has meant that a part of the body can be sacrificed for the good of the whole body (for example, a cancerous uterus can justifiably be removed for the overall good of the woman's body). More recent theology has broadened this principle somewhat by focusing not only on the good of the body but also on the good of the per-

son considered as a whole. This is the principle normally employed to justify surgery.

• *An action having both a good and a bad effect may be justifiable under certain conditions.* This is known as the principle of double effect. Such an action is justifiable when (1) the action considered by itself and independent of its effects is not morally evil; (2) the evil effect is not the means for producing the good effect; (3) the evil effect is not intended but only tolerated; (4) there is a proportionate reason for performing the action and allowing the evil effect to occur. An example would be the removal of a cancerous uterus, which has the good effect of saving the woman's life but the bad effect of making her sterile.

• *The unitive and the procreative aspects of marriage are inseparable.* This principle is based on an understanding of the God-intended purposes of human sexuality, namely, lovemaking and procreation. It holds that God intended these purposes to be inseparable. Any lovemaking apart from an openness to procreation or procreation apart from lovemaking is inherently immoral.

FUNDAMENTAL BELIEFS CONCERNING HEALTH CARE

The Roman Catholic church has a very long tradition in medical ethics. It could actually be said to date back to the early church and has evolved over the centuries as more and more behaviors were included and assessed, blossoming into a separate discipline in the seventeenth century. It continued to flourish in the nineteenth and twentieth centuries.

During much of this time, and particularly in the modern period, several fundamental theological convictions have served to guide ethical reflection about specific medical procedures and interventions.

• *Every person has dignity.* The Catholic/Christian view of the person is grounded in the biblical teaching that all human beings are made in the image and likeness of God, particularly in possessing intelligence and free will (Genesis 1:26-31). Every person is unique and irreplaceable and is called both to human fulfillment and to eternal life. All human beings are equal (Romans 2:11; Galatians 4:38; Ephesians 6:9); and all human life, because it originates in God, is sacred.

• *Health is to be understood holistically.* The Catholic/Christian tradition understands health holistically; it encompasses physiological, psychological, social, and spiritual dimensions of the person. Human health can never be reduced only to physiological or psychological functioning. These aspects of the person should always be subordinated to the social and spiritual well-being of the individual.

• *Suffering can possess meaning.* While the Catholic tradition affirms the pursuit of health, it also recognizes that all human beings are wounded in various ways and to various degrees. Woundedness and the suffering it produces are part of the human condition. They are elements of human finitude and are, in part, the result of human sinfulness. Although suffering and pain are

not considered to be goods in their own right, they can have meaning. They are opportunities for spiritual growth. For some believers they can have a purifying effect, while for others they can be viewed as enabling one to share in the redemptive suffering of Christ and in his resurrection. The church recognizes that people's capacity for suffering varies and that this difference must always be taken into account. Furthermore, it recognizes the legitimacy of trying to eliminate or reduce pain and suffering. The patient is not required to endure pain and suffering at any price (Pontifical Council Cor Unum [hereafter cited as Pontifical Council] 1981; Pius XII, 1944; Congregation for the Doctrine of the Faith [hereafter cited as CDF] 1980).

• *Death is natural and is a transitional stage to life with God.* Death is to be approached with awe and respect and accepted with responsibility and dignity. It marks the end of earthly existence and thus is a decisive summing up of a person's moral and religious life, but it opens up to a new mode of existence—personal life with God. Catholics, with most Christians, believe that Jesus Christ, in being raised up by God, has given a new meaning to suffering and death. Through faith in Jesus Christ, believers overcome the negativities associated with human suffering and death; they have hope in the reality of resurrection and eternal life.

THE INDIVIDUAL AND THE PATIENT-CAREGIVER RELATIONSHIP

The Catholic church does not hold an official position on the patient-caregiver relationship, but it does communicate a certain perspective in its many documents related to health care. As one might expect, that perspective is shaped by Catholicism's staunch belief in the dignity of the human person and in the individual's inherent relatedness to others, especially to the family and to society. The current emphasis

in medical ethics on autonomy, understood individualistically and almost as an absolute, is not compatible with a Catholic understanding of the person and of professional relationships generally. Nor is paternalism compatible because it violates aspects of human dignity. In the patient-caregiver relationship, the Catholic tradition tries to maintain a balance between respect for the individual and awareness of the individual's

relationships and responsibilities toward others. Overall, the church does support the primacy of the patient in decision making, though not to the exclusion of the patient's family and others who might be important to the decision.

Pope Pius XII speaks of the patient's role in decision making in two addresses. The patient, he maintains, is clearly the primary decision maker: "The doctor . . . cannot take any measure or try an intervention without the consent of the patient. The doctor has only that power over the patient which the latter gives him, be it explicitly, or implicitly and tacitly" (Pius XII, 1952). In the other document he writes: "The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission" (Pius XII, 1957).

A more comprehensive statement can be found in the *Ethical and Religious Directives for Catholic Health Care Services* published by the United States Conference of Catholic Bishops in 2001. In the introduction to the section on the professional-patient relationship, the bishops state:

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process. (United States Conference of Catholic Bishops 2001 [hereafter cited as ERD]: 13)

More specifically, the *Directives* state that

informed consent is required prior to the performance of any medical procedure or treatment. It involves communicating to the patient or surrogate reasonable information about the nature of the proposed treatment, its risks, benefits, costs, and legitimate alternatives, including no treatment at all (D. 26, 27). Finally, the *Directives* state that "the free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles" (D. 28).

CLINICAL ISSUES

Self-determination and informed consent

The Catholic church is very supportive of developments in science and technology. Advances in human knowledge, the search for truth, and the use of human creative abilities for the good of human beings are an expression of human dominion over the created world. God created human beings in his own image and likeness (Genesis 1:27), entrusting them with the responsibility of "dominion over the earth" (Genesis 1:28). "Basic scientific research and applied research constitute a significant expression of this dominion of man over creation. Science and technology are valuable resources for man when placed at his service and when they promote his integral development for the benefit of all" (CDF 1987: introduction, no. 2; Pius XII, 1952).

Not everything in scientific research and in the development of various technologies is permitted, however. Science and technology cannot themselves be the source of moral norms, of the meaning of human progress, or of human existence. Usefulness, efficacy, and efficiency are not moral criteria. Rather science and technology are subject to and limited by moral values derived from the human person. In the words of the Congregation for the Doctrine of the Faith, the Vatican office responsible for maintaining orthodoxy in matters of faith and morals: "They [science and technology] draw from the person and his moral values the indication of their purpose and the awareness of their limits. . . .

Science and technology require for their own intrinsic meaning an unconditional respect for the fundamental criteria of the moral law: That is to say, they must be at the service of the human person, of his inalienable rights and his true and integral good according to the design and will of God” (CDF 1987: introduction, no. 2; Pius XII, 1952; CCC 1997: nos. 2292-95).

The Congregation for the Doctrine of the Faith goes on to elaborate an ethical perspective and a basic principle to guide scientific research and technological developments. Adequate criteria in this area can be derived only from a holistic understanding of the human person, that is, one that takes into account that human beings are a “unified totality,” a unity of the corporal and the spiritual. The corporal dimension of the person is a constitutive element; it is the manner by which the individual expresses himself or herself. Furthermore, because the body is united with a spiritual soul, it cannot be considered a mere assemblage of tissues and organs or nothing more than the bodies of animals. The human body is something more and needs to be treated as such.

This bodily and spiritual nature of the person gives rise to moral norms. The norm that should guide science and technology is articulated this way:

An intervention on the human body affects not only the tissues, the organs, and their functions, but also involves the person himself on different levels. It involves, therefore, perhaps in an implicit but nonetheless real way, a moral significance and responsibility. Pope John Paul II forcefully reaffirmed this to the World Medical Association when he said:

Each human person, in his absolutely unique singularity, is constituted not only by his spirit, but by his body as well. Thus, in the body and through the body, one touches the person himself in his concrete reality. To respect the dignity of man consequently amounts to safeguarding this identity of the man *corpore et anima unus*, as the Second Vatican Council says (*Gaudium et Spes*, 14.1). It is

on the basis of this anthropological vision that one is to find the fundamental criteria for decision making in the case of procedures which are not strictly therapeutic, as, for example, those aimed at the improvement of the human biological condition. (CDF 1987: introduction, no. 3)

The church recognizes that in the process of acquiring new knowledge and developing new technologies, experimentation on human beings may at some point be essential. Furthermore, it recognizes that all risk cannot be eliminated. If only risk-free research were permitted, both scientific research and the well-being of individuals would suffer. Hence, the church accepts experimentation on human beings, even experimentation that involves some risk. However, there are limits and conditions.

The greatest moral threat of experimentation on human beings is turning them into mere objects or violating the “integral well-being” of the person. To some degree, these dangers can be avoided by the free and informed consent of the individual. But there are limits even to informed consent. In the words of Pope Pius XII:

The patient has not the right to involve his physical and psychic integrity in medical experiments or researches, when these interventions entail, either immediately or subsequently, acts of destruction, or of mutilation and wounds, or grave dangers.

Furthermore, in exercising his right to dispose of himself, of his faculties and organs, the individual must observe the hierarchy of the scale of values, and within an identical order of values, the hierarchy of individual goods, to the extent demanded by the laws of morality. So, for example, man cannot perform upon himself or allow medical operations, either physical or somatic, which beyond doubt do remove serious defects or physical or psychic weaknesses, but which entail at the same time permanent destruction of, or a considerable and lasting lessening of freedom, that is to say, of the human personality in its particular and characteristic function. (Pius XII, 1952)

Hence, the individual cannot give consent to any experiment that is likely to harm the core of the person.

Like secular medical ethics, the church distinguishes between therapeutic and nontherapeutic experimentation. Pope John Paul II, for example, observes that for the most part the reason justifying cooperation in an experiment is the improvement of one's own health. However, it can also be the case that an individual may undertake some degree of risk as a "personal contribution to the progress of medicine and thus to the common good." Pope John Paul sees this as a gift of self which "within the limits set by the moral law can . . . be a highly meritorious proof of love and an occasion of spiritual growth of such magnitude as to offset the dangers of a possible physical diminution that is not substantial in kind" (John Paul II, 1980). In both cases, experimentation can be moral only if it does not pose the probability of grave harm to the substantial integrity of the person.

Experimentation on human embryos

The church's position regarding experimentation on human embryos rests on its convictions about the status of embryos. Perhaps the clearest and most recent articulation of this connection is to be found in the CDF's 1987 Instruction:

Thus the fruit of human generation from the first moment of its existence, that is to say, from the moment the zygote has formed, demands the unconditional respect that is morally due to the human being in his bodily and spiritual totality. The human being is to be respected and treated as a person from the moment of conception and therefore from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life. . . . Since the embryo must be treated as a person, it must also be defended in its integrity, tended and cared for, to the extent possible, in the same way as any other human being as far as medical assistance is concerned. (CDF 1987: pt. 1, no. 3)

In formulating its position, the church distinguishes between living and dead embryos and between therapeutic and nontherapeutic experimentation on living embryos. Therapeutic experimentation is permitted, provided appropriate informed consent has been obtained, the proportion of risks to benefits has been weighed, and no other alternatives exist, whereas nontherapeutic experimentation on living embryos is strictly prohibited (pt. 1, no. 4). In the words of the CDF,

No objective, even though noble in itself such as a foreseeable advantage to science, to other human beings, or to society, can in any way justify [nontherapeutic] experimentation on living human embryos or fetuses, whether viable or not, either inside or outside the mother's womb. . . . To use human embryos or fetuses as the object or instrument of experimentation constitutes a crime against their dignity as human beings having a right to the same respect that is due to the child already born and to every human person. (CDF 1987: pt. 1, no. 4; see also John Paul II, 1982)

Dead embryos or fetuses, according to the CDF, must be shown the same respect as the corpses of any other human beings. They should not be mutilated until verification that death has occurred and the consent of the parents, especially the mother, has been obtained. In addition, there must be no complicity in direct abortion in order to obtain dead embryos and fetuses for experimentation, and commercial trafficking in such embryos and fetuses is to be considered illicit and should be prohibited (CDF 1987: pt. 1, no. 4). The *Directives* strongly discourage Catholic hospitals from using tissue obtained by direct abortion for research or even therapeutic purposes (D. 66). It is also immoral, according to the CDF, to produce human embryos in vitro solely for the sake of experimentation, "destined to be exploited as disposable 'biological material'" (no. 5), or to engage in experiments "which damage or impose grave and disproportionate risks" upon embryos (CDF 1987: pt.1, no. 5; see also John Paul II, 1995: no. 63).

Truth-telling and confidentiality

The Catholic church bases its position in regard to truth-telling and confidentiality on respect for persons and on its more general teaching about the moral obligation to communicate truthfully. It supports the current beliefs and practices in medical ethics regarding these issues. Pope Pius XII did address the matter of truth-telling:

The eighth commandment likewise has its place in the morality of medicine. According to the moral law, no one may tell a lie. And yet there are cases when a doctor, even when asked, though he cannot give an answer which is positively untrue, at the same time cannot crudely tell the whole truth, especially when he knows that the patient has not the strength to stand such a revelation. But there are other cases when the doctor has most certainly the duty of speaking out clearly, a duty before which every other medical or humanitarian consideration must give way. It is not lawful to lull the sick person or his relations into a false sense of security when there is the risk of compromising the eternal salvation of the former, or the fulfillment of his duties in justice and charity. It would be wrong to try to justify or excuse such conduct under the pretext that the physician always says what, in his opinion, will best contribute to the patient's well-being. . . . (Pius XII, 1944)

Much of the attention given to the matter of truth-telling has been in the context of informing the terminally ill that they are dying. "The dying, and, more generally, anyone with an incurable disease, have a right to be told the truth" (Pontifical Council 1981). This enables the individual to engage in a personal preparation for death and also to fulfill responsibilities to family and to have an opportunity to put his or her financial matters in order. The responsibility to inform the patient rests with those closest to him or her and should probably be shared among family, the chaplain, and the medical team (Pontifical Council 1981). A similar position is echoed in the 2001 *Directives* (D. 55).

Regarding confidentiality, Pope Pius XII affirms the obligation of the physician to preserve professional secrets, but he cautions that this obligation is not absolute. It should not be placed "at the service of crime or injustice" because this would harm the common good, precisely what it is meant to foster (Pius XII, 1944). The *Directives* state quite simply that "health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care" (D. 34).

Proxy decision making and advance directives

In two separate statements, Pope Pius XII recognizes the legitimacy of proxy decision making. In one statement he notes that "the rights and duties of the family depend in general upon the presumed will of the unconscious patient if he is of age and 'sui juris'" (Pius XII, 1957). This would seem to suggest that family members can speak on behalf of the patient and also that the basis of their decision should be what the patient would choose if the patient were able. This is often referred to as "substituted judgment." In the other statement, the pope observes that the rights of proxies in their decision-making capacity are coextensive with those of the patient; that is, proxies have the same rights that the patient has, and to the same extent (Pius XII, 1952).

The *Directives* also affirm the legitimacy of proxy decision making as well as advance directives, provided neither violates Catholic moral principles: "Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions" (D. 25). If a patient has not executed an advance directive and has lost decision-making capacity, those who know the person best—usually family members and loved ones—should participate in making the treatment decision.

FAMILY, SEXUALITY, AND PROCREATION

The Catholic tradition has the highest regard for marriage and family. Both are viewed as created and ordered by God: “Creating the human race in his own image and continually keeping it in being, God inscribed in the humanity of man and woman the vocation, and thus the capacity and responsibility, of love and communion” (John Paul II, 1981: no. 11). One of the two primary ways in which this love is realized is through marriage. Because God created man and woman to unite as husband and wife, to be a community of persons, marriage is seen to be fundamentally good (Second Vatican Council 1965: no. 48; see also CCC 1997: nos. 2201-6).

The same can be said of human sexuality. It too is a creation of God and is therefore good. It is viewed within the Catholic tradition as an essential aspect of human identity and as fundamental to human relations. It is considered one of the principal formative influences in the life of human beings, the “source of the biological, psychological, and spiritual characteristics which make a person male or female and which thus considerably influence each individual’s progress towards maturity and membership of society.” Sexuality is intimately related to human beings’ need to love and be loved, to enter into relationships; it is vital to the creation of families and of the human community (CDF 1975a: no. 1; see also Vatican Congregation for Catholic Education 1983: no. 4; CCC 1997: nos. 2360-79).

Sexual intercourse, as an expression of human sexuality, is considered to be the most profound expression and commitment of one person to another. In the words of John Paul II: “Sexuality, by means of which man and woman give themselves to one another through the acts which are proper and exclusive to spouses, is by no means something purely biological, but concerns the innermost being of the human person as such. It is realized in a truly human way only if it is an integral part of the love by which a man and a woman commit themselves totally to

one another until death. The total physical self-giving would be a lie if it were not the sign and fruit of a total personal self-giving, in which the whole person . . . is present” (John Paul II, 1981: no. 11).

Because it is a sign and an expression of total self-giving, sexual intercourse, as ordered by God, is appropriate only in the context of marriage. This has been the constant teaching of the Catholic church. Furthermore, God has ordered sexual intercourse within marriage not only as an expression and cause of mutual self-giving but also as a means for the procreation of children. “By its very nature the institution of marriage and married love is ordered to the procreation and education of offspring and it is in them that it finds its crowning glory” (Second Vatican Council 1965: no. 48). Children are considered to be the “supreme gift” of marriage and to contribute greatly to the good of the spouses. The procreation of children is, indeed, considered to be cooperation in the creative work of God and God’s building up of the human family.

Until the Second Vatican Council, the Catholic church considered the procreative purpose of conjugal love to be its primary purpose. Since then the unitive dimension has been considered equally important. At no time, however, were these two purposes thought to be separable one from the other. The church has always held them to be inseparable because they were ordained by God as such. The very nature of human acts of sexual intercourse is to be both expressive of love and procreative. To separate these two purposes intentionally is to violate God’s purposes.

Although married couples should regard it as their proper mission to transmit human life and to educate their children, they should exercise this mission responsibly. Spouses are called to responsible stewardship in the exercise of their procreative capacities. The decision to have children must be made conscientiously, taking into

account factors that will have an impact on the future child, the family, and society. Exercising this stewardship involves “consideration of their own good and the good of their children already born or yet to come, an ability to read the signs of the times and of their own situation on the material and spiritual level, and, finally, an estimation of the good of the family, of society, and of the Church. It is the married couple themselves who must in the last analysis arrive at these judgments before God” (Second Vatican Council 1965: no. 50; see also Paul VI, 1968: no. 10).

CLINICAL ISSUES

Contraception

The Catholic church does not permit the use of any medication, instrument, or procedure before, during, or after sexual intercourse that is intended to prevent conception. Any such measures would separate the unitive and procreative aspects of sexual intercourse and thus would violate the divine will. Such measures are considered intrinsically evil. In the words of Pope Pius XI: “Since, therefore, the conjugal act is destined primarily by nature for the begetting of children, those who in exercising it deliberately frustrate its natural power and purpose sin against nature and commit a deed which is shameful and intrinsically vicious” (Pius XI, 1930: no. 4). Pope Paul VI puts it equally forcefully in his famous 1968 encyclical:

This particular doctrine, often expounded by the Magisterium of the Church, is based on the inseparable connection, established by God, which man on his own initiative may not break, between the unitive significance and the procreative significance which are both inherent to the marriage act.

The reason is that the marriage act, because of its fundamental structure, while it unites husband and wife in the closest intimacy, also brings into operation laws written into the actual nature of man and of woman for the generation of new life. . . .

An act of mutual love which impairs the capacity to transmit life which God the Creator, through specific laws, has built into it, frustrates his design which constitutes the norms of marriage, and contradicts the will of the Author of life. Hence, to use this divine gift while depriving it, even if only partially, of its meaning and purpose, is equally repugnant to the nature of man and woman, strikes at the heart of their relationship, and is consequently in opposition to the plan of God and his holy will. (Paul VI, 1968: nos. 12, 13; see also Second Vatican Council 1965: no. 50; John Paul II, 1981: no. 32; CCC 1997: no. 2370)

A further reason noted by Paul VI for condemning artificial contraception is that human beings, just as they do not have full dominion over their bodies, likewise do not have full dominion over their sexual faculties. These capacities by their very nature have to do with the generation of life, of which God is the source (Paul VI, 1968: no. 13). Pope John Paul II adds another reason: the separation of the unitive and procreative aspects of marriage degrades human sexuality by altering its value of total self-giving. “The innate language that expresses the total reciprocal self-giving of husband and wife is overlaid, through contraception, by an objectively contradictory language, namely, that of not giving oneself totally to the other” (John Paul II, 1981: no. 32).

A chemical agent or procedure that happens to have a contraceptive effect may, however, be used to treat a pathological condition. The contraceptive effect, though it is foreseen, must not be intended and must be unavoidable. The principle of double effect discussed above is operative here (Paul VI, 1968: no. 15).

Sterilization

Sterilization—whether female or male, permanent or temporary—is also condemned by the church for the same reason: it frustrates the procreative aspect of sexual intercourse and of marriage. If, however, the sterilization occurs as the result of a medical procedure intended to cure,

alleviate, or prevent a serious pathological condition when no other reasonable alternatives exist, it is morally permissible on the basis of the principle of double effect. Such sterilizations are called “indirect” because the sterilizing effect is an unintended result of a therapeutic measure. Sterilization is considered to be “direct” and immoral when it intends to prevent procreation (Paul VI, 1968: no. 15; see also ERD, D. 53; Pius XII, 1951; CDF 1975b; NCCB 1980; CCC 1997: nos. 2370, 2399).

NEW REPRODUCTIVE TECHNOLOGIES

Artificial insemination

In its 1987 “Instruction on Respect for Human Life,” the Congregation for the Doctrine of the Faith addresses several reproductive technologies, including artificial insemination. Reflecting its traditional view on procreation, the Vatican condemns artificial insemination between husband and wife (homologous) if it replaces the act of sexual intercourse. As previously noted, the procreation of new life must result from an act of conjugal love; artificial insemination separates the procreation of new life from an act of sexual love. Furthermore, it likely involves masturbation for obtaining sperm, which is also prohibited (CDF 1987: pt. 2.B, no. 6; see also ERD, D. 41; Pius XII, 1949: no. 4; Pius XII, 1951; CCC 1997: no. 2376). If, however, artificial insemination simply assists the act of sexual intercourse or helps it to reach its natural end, namely, fertilization, then it can be considered morally acceptable.

Heterologous artificial insemination, that is, the use of donor sperm or egg, is never morally permissible. Not only does it involve a separation of procreation from sexual intercourse, it also separates procreation from the exclusive union of husband and wife. In the words of Pius XII:

Artificial insemination in matrimony, but produced by means of the active element of a third person, is equally immoral, and as such is to be

condemned without right of appeal.

Only the husband and wife have the reciprocal right on the body of the other for the purpose of generating new life: an exclusive, inalienable, incommunicable right. And that is as it should be, also for the sake of the child. To whoever gives life to the tiny creature, nature imposes, in virtue of that very bond, the duty of protecting and educating the child. But when the child is the fruit of the active elements of a third person—even granting the husband’s consent—between the legitimate husband and the child there is no such bond of origin, nor the moral and juridical bond of conjugal procreation. (Pius XII, 1949: no. 3)

The 1987 CDF document offers a similar condemnation: “Heterologous artificial fertilization is contrary to the unity of marriage, to the dignity of the spouses, to the vocation proper to parents, and to the child’s right to be conceived and brought into the world in marriage and from marriage” (CDF 1987: pt. 2.A, no. 2). Artificial insemination using the gametes of a third party shows disrespect for the unity of marriage and for conjugal fidelity. It violates the “bond existing between husband and wife [which] accords the spouses . . . the exclusive right to become father and mother solely through each other”; it violates the reciprocal commitment of the spouses. It furthermore violates the rights of the child to a filial relationship with his or her parental origins and could conceivably hinder the development of the child’s personal identity. And, finally, it “deprives conjugal fruitfulness of its unity and integrity” by rupturing genetic parenthood, gestational parenthood, and responsibility for the child’s upbringing. The desire to have a child cannot justify heterologous artificial insemination (see also ERD, D. 40).

Gamete intrauterine fallopian transfer (GIFT)

In gamete intrauterine fallopian transfer, the ovaries are hyperstimulated and ova are retrieved. Ova and sperm are placed in a

catheter close to each other and are reinserted into the fallopian tube so that fertilization can occur in the woman's body. The church has not spoken definitively on this matter, but since the procedure assists natural fertilization, there is reason to believe that it would be morally acceptable.

In vitro fertilization (IVF)

In vitro fertilization involves procuring sperm and egg(s) so that fertilization can occur in a laboratory dish, hence outside the body of the woman. Sperm and eggs may be either from the spouses (homologous) or from donors (heterologous). Both types are considered by the church to be immoral because they "involve the separation of procreation from an act of conjugal love, thereby violating the very nature of marriage and the conjugal act" (CDF 1987: pt. 2.B, nos. 4-5). In vitro fertilization also violates the dignity of the child.

In reality, the origin of a human person is the result of an act of giving. The one conceived must be the fruit of his parents' love. He cannot be desired or conceived as the product of an intervention or medical or biological techniques; that would be equivalent to reducing him to an object of scientific technology. No one may subject the coming of a child into the world to conditions of technical efficiency which are to be evaluated according to standards of control and dominion. . . . Such fertilization entrusts the life and identity of the embryo into the power of doctors and biologists and establishes the domination of technology over the origin and destiny of the human person. Such a relationship of domination is in itself contrary to the dignity and equality that must be common to parents and children. (CDF, 1987: pt. 2.B, nos. 4, 5)

A further concern is that this procedure usually, though not necessarily, involves a deliberate destruction of fertilized eggs, constituting abortions in the eyes of the church. The CDF document states: "Such deliberate destruction of

human beings or their utilization for different purposes to the detriment of their integrity and life is contrary to the doctrine on procured abortion" (CDF 1987: pt. 2, Introduction).

Surrogate motherhood

In the same document, the Vatican also condemns surrogate motherhood. It "represents an objective failure to meet the obligations of maternal love, of conjugal fidelity, and of responsible motherhood; it offends the dignity and the right of the child to be conceived, carried in the womb, brought into the world, and brought up by his own parents; it sets up, to the detriment of families, a division between the physical, psychological, and moral elements which constitute those families" (CDF 1987: pt. 2.A, no. 3). The *Directives* add to the reasons for this condemnation a denigration of the dignity of women, especially the poor (D. 42).

ABORTION AND THE STATUS OF THE FETUS

The Catholic church has maintained consistent opposition to all abortion that has as its primary aim the direct termination of fetal life for any reason, whether it be to preserve the life or health of the mother, to avoid serious genetic abnormality, to prevent a birth resulting from rape or incest, or to forgo the burdens of an additional child. Abortions which aim at the termination of fetal life are called direct abortions. Under no circumstances are they permissible (CDF 1974; see also ERD, D. 45; John Paul II, 1995: nos. 57-62; CCC 1997: nos. 2270-72). The primary reason for this condemnation is that the church considers the fertilized ovum to be human life and even a human person. "Thus the fruit of human generation, from the first moment of its existence, that is to say from the moment the zygote has formed, demands the unconditional respect that is morally due to the human being in his bodily and spiritual totality. The human being is to be respected and treated

as a person from the moment of conception; and therefore from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life” (CDF 1987: pt. 1, Introduction; see also CDF 1974: no. 12). The fertilized egg is neither the life of the mother nor the life of the father. It is rather the life of a new human being with its own growth.

The church does, however, permit indirect abortion. This occurs when a treatment, operation, or medication is aimed at curing or alleviating a serious pathological condition in the pregnant woman even if it has an abortive effect, if there are no other reasonable alternatives (CDF 1974; ERD, D. 47). The death of the fetus is unintended (though foreseen) and is the unavoidable by-product of the procedure. A classic example is the removal of a cancerous uterus in early pregnancy. The aim is to save the life of the mother. The removal of the pathology simultaneously saves the mother’s life and results in the death of the fetus. The principle of double effect is operative here.

PRENATAL DIAGNOSIS AND TREATMENT

The official teaching of the church supports the use of prenatal diagnosis if it “respects the life and integrity of the embryo and the human fetus and is directed toward its safeguarding or healing as an individual” (CDF 1987: pt. 1, no. 2; see also ERD, D. 50; CCC 1997: no. 2274; John Paul II, 1995, no. 63). In other words, insofar as prenatal testing makes it possible to anticipate earlier and more effectively certain therapeutic, medical, or surgical procedures without subjecting the fetus or the mother to disproportionate risk, it is morally acceptable, if the parents’ informed consent has been obtained.

If prenatal diagnosis is to be done, however, with the deliberate intention of aborting a fetus that is found to be malformed or abnormal, it is considered gravely immoral and is prohibited.

The mother who would seek prenatal diagnosis for this purpose, anyone suggesting or imposing it, and any specialist who in communicating the results suggests a link between prenatal diagnosis and abortion would be acting immorally.

Furthermore, “any directive or program of the civil and health authorities or of scientific organizations which in any way were to favor a link between prenatal diagnosis and abortion, or which were to go as far as directly to induce expectant mothers to submit to prenatal diagnosis planned for the purpose of eliminating fetuses which are affected by malformations or which are carriers of hereditary illness, is to be condemned as a violation of the unborn child’s right to life and as an abuse of the prior rights and duties of the spouses” (CDF 1987: pt. 1, no. 2).

CARE OF SEVERELY HANDICAPPED NEWBORNS

Because of its view of the human person, the Catholic church affirms the dignity and worth of severely handicapped newborns. They cannot be discriminated against on the basis of their limitations. They have the same right to life and to medical care as any “normal” newborn. At the same time, however, parents of handicapped newborns and their caregivers must ask whether medical treatment is appropriate and, if so, which treatments are appropriate. The same steps are taken here as with adult patients, namely, an assessment of the benefits and burdens of treatment to the infant. The handicap itself and burdens upon the family are not in themselves legitimate reasons for withholding or withdrawing treatment from these babies. The early delivery of anencephalic infants, an issue debated by several theologians in the past ten years, was declared unethical by the National Conference of Catholic Bishops in 1996 (NCCB 1996).

GENETICS

The Catholic tradition views genetics positively though cautiously. It is positive in that it affirms genetic medicine's actual and future capability of helping human beings overcome limitations on the normal functioning of their psychophysical selves and its intention to contribute to the good of individuals and of the community. In the words of Pope Pius XII (1953), "The fundamental tendency of genetics and eugenics is to influence the transmission of hereditary factors in order to promote what is good and eliminate what is injurious. This fundamental tendency is irreproachable from the moral viewpoint." He believes that the "practical aims being pursued by genetics are noble and worthy of recognition and encouragement."

At the same time, however, Catholicism is cautious. Certain values must not be violated. The biological nature of every human is inviolable insofar as it constitutes an essential component of the personal identity of the individual. The person is a unity of body and soul. Respecting the dignity of the person means respecting this unity. Pope John Paul II also raises cautions against racially motivated genetic manipulations or manipulations that arise out of a materialist mentality which promotes a reductive view of human happiness. More specifically, he writes: "Genetic manipulation becomes arbitrary and unjust when it reduces life to an object, when it forgets that it has to do with a human subject, capable of intelligence and liberty, and worthy of respect, whatever its limitations; or when genetic manipulation treats the human subject in terms of criteria not founded on the integral reality of the human person, at the risk of doing damage to his dignity. In this case it exposes man to the caprice of others, by depriving him of his autonomy" (John Paul II, 1983).

It would be appropriate to mention here the Catholic view of disability. The Catholic tradition recognizes the fundamental dignity of all persons, including those who may be physically

or mentally disabled. Because of this, the church sees its role as defending the rights of disabled persons, particularly their right to life as well as other rights which enable the handicapped individual to "achieve the fullest measure of personal development of which he or she is capable" (United States Catholic Conference [hereafter cited as USCC] 1978). It is also incumbent upon the church to work for the realization of the rights of the handicapped in society. It must work to sensitize society to the needs of the handicapped and to support their rightful demand for justice. This involves being "informed by a sincere and understanding love that penetrates the wall of strangeness and affirms the common humanity underlying all distinction" (USCC 1978).

CLINICAL ISSUES

Genetic screening and counseling

There is no official church teaching in this area. Given the church's moral stance concerning issues in genetics, the church would approve of genetic screening and counseling if it contributed to more responsible parenthood and to better preparation for the treatment and care of children likely to be born with genetic abnormalities. Screening that is discriminatory, involuntary, or provided without sufficient informed consent from the couple or that violates the couple's right to procreate may be considered morally unacceptable (ERD, D. 54).

Sex selection

In the 1987 "Instruction on Respect for Human Life," the church condemns the use of sex selection of embryos. These nontherapeutic manipulations "are contrary to the personal dignity of the human being and his or her integrity and identity" (CDF 1987).

Selective abortion

The abortion of malformed or abnormal fetuses is condemned (CDF 1974; CDF 1987).

Gene therapy

In principle, therapeutic interventions that seek to correct various abnormalities are considered moral and even desirable as long as they genuinely promote human well-being and do not harm the integrity of the person or worsen the person's life conditions. "The research of modern biology gives hope that the transfer and mutation of genes can ameliorate the condition of those who are affected by chromosomal diseases; in this way the smallest and weakest of

human beings can be cured during their intrauterine life or in the period immediately after birth" (John Paul II, 1982; see also John Paul II, 1983).

Nontherapeutic interventions must also aim at improving the human biological condition; they must not do violence to the dignity of the person and to the common biological nature that all share. They threaten to do this if they treat persons as objects or diminish their autonomy, if they are undertaken with racist motives or aim at a materialist view of happiness, or if they create people who are likely to be socially marginalized (John Paul II, 1983).

ORGAN AND TISSUE TRANSPLANTATION

The Catholic church considers the donation of an organ to those who have need of it a "noble and meritorious act," particularly if it is motivated by human and Christian solidarity—"the love of neighbor, which forms the inspiring motive of the Gospel message, and which has been defined, indeed, as the new commandment" (John Paul II, 1984a).

John Paul II has been very supportive of organ and tissue transplantation. In a 1991 discussion focused on transplantation, he writes: "We should rejoice that medicine, in its service to life, has found in organ transplantation a new way of serving the human family, precisely by safeguarding that fundamental good of the person" (John Paul II, 1991). He frames transplantation in the context of gift:

This form of treatment is inseparable from a human act of donation. In effect, transplantation presupposes a prior, explicit, free and conscious decision on the part of the donor or of someone who legitimately represents the donor, generally the closest relatives. It is a decision to offer, without reward, a part of one's own body for the

health and well-being of another person. In this sense, the medical act of transplantation makes possible the donor's act of self-giving, that sincere gift of self which expresses our constitutive calling to love and communion.

Love, communion, solidarity, and absolute respect for the dignity of the human person constitute the only legitimate context of organ transplantation. It is essential not to ignore the moral and spiritual values which come into play when individuals, while observing the ethical norms which guarantee the dignity of the human person and bring it to perfection, freely and consciously decide to give a part of themselves, a part of their own body, in order to save the life of another human being . . .

For Christians, Jesus' offering of himself is the essential point of reference and inspiration of the love underlying the willingness to donate an organ, which is a manifestation of generous solidarity, all the more eloquent in a society which has become excessively utilitarian and less sensitive to unselfish giving. (John Paul II, 1991; ERD, D. 63)

CLINICAL ISSUES

Issues concerning recipients

Recipients of organs should not forget that they are receiving a gift of self offered by the donor. This is a profound act of human solidarity (John Paul II, 1991).

Issues concerning donors

Organ and tissue donation from live donors is considered to be morally acceptable if it is done with the free and informed consent of the donor, if it does not deprive the donor of life or the integrity of an organ system, and if there is an acceptable proportion between the good to be experienced by the recipient and the harm done to the donor (John Paul II, 1984a; CCC 1997: no. 2296).

Procurement of organs from corpses is also morally acceptable if respect is shown for the body and the rights of the next of kin. It should not normally occur without the consent of the next of kin or over the previous objections of the potential donor (Pius XII, 1956).

While a statement has been made by the NCCB concerning the early delivery of anencephalic infants (NCCB 1996), no official

church statement regarding the procurement of tissue or organs from anencephalic newborns has been made. However, one can infer a position from church teaching on the dignity of the human person and on organ transplantation generally. Procurement of organs from anencephalic newborns who have died would be treated like procurement from any other corpse. But the removal of organs while the infant is still living (breathing spontaneously) which results in the death of the infant would be a form of homicide. The church does not permit the removal of organs if removal would cause the individual's death. Nor would it permit the use of anencephalics merely as a source of organs.

Much the same would be true of human fetuses. (See also "Experimentation on human embryos," above.)

The sale of organs is condemned. "Such a reductive materialist conception would lead to a merely instrumental use of the body, and therefore of the person. In such a perspective, organ transplantation and the grafting of tissue would no longer correspond to an act of donation but would amount to the dispossession or plundering of a body" (John Paul II, 1991).

MENTAL HEALTH

Not much attention has been given to the topic of mental health in official church teaching. One of the few to address it was Pope Pius XII, who was concerned primarily about the compatibility of psychotherapy and clinical psychology with a Christian understanding of the person (Pius XII, 1952). It would be safe to say, in view of the principles enunciated earlier, that no form of psychotherapy or chemical or surgical manipulation of human behavior would be justifiable if it eliminated or severely limited human freedom or severely damaged the human personality. Short of this, if the behavior modifi-

cation is undertaken for the well-being of the patient, achieves a suitable proportion between benefits and risks or harms, and is attempted with the informed consent of the patient or guardian, it would be considered ethical. Behavior control that is nontherapeutic and that is undertaken for the benefit of others is considerably more difficult to justify, especially if it results in harm to the patient. Respect for human dignity and the integrity of the person are essential.

Several moral principles provide further guidance in this area:

1. The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available (ERD, D. 29).
2. Therapeutic procedures that are likely to cause harm or undesirable side effects can be justified only by a proportionate benefit to the patient (ERD, D. 33).
3. The greater the person's incompetency and vulnerability, the more compelling the reasons must be to perform any medical experimentation, especially nontherapeutic procedures (ERD, D. 31).

CLINICAL ISSUES

Involuntary commitment

There is no official Catholic teaching on this issue. But since involuntary commitment is a deprivation of human freedom, it could be justified only for a serious reason.

Psychotherapy, behavior modification, and psychopharmacology

Psychotherapy, behavior modification, and psychopharmacology can be morally justified when they are employed for the well-being of the patient and have the effect of enhancing the patient's freedom. The principles noted above would guide these decisions.

Electroshock

There is no official Catholic teaching on electroshock. The treatment would seem, however, to be justifiable on the basis of the principle of totality. It involves manipulating (and possibly damaging) a part of the body for the good of the whole person. As with other interventions, the church insists on the free and informed consent of the individual (to the degree possible) or the proxy. The full exploration of any less radical alternatives, and an acceptable proportion between harms and benefits, must also be reckoned.

DEATH AND DYING

Catholicism views death as a natural event, part of the human condition. It is a fact of life, inextricably bound up with human finitude. Insofar as it ends an individual's existence, ruptures relationships, disrupts lives, and creates profound losses, it is viewed as tragic and negative. But Catholics also believe that Christ, through his death and resurrection, has overcome the "sting of death." Death is not the final word. Catholic Christians live in the hope of their own resurrection. They face death with the confidence of faith. Death, then, makes possible a new and better existence, one that constitutes the ultimate fulfillment of the human person and of human existence: union with God.

The dying process can also be a most important time, a time of preparation for the moment of death. This preparation can include a deepening of relationships and even a healing of relationships with God, family, and friends. It can

also be a time of personal transformation and growth before the final summing up of one's life in death. The process of dying can provide extraordinary opportunities for good to occur.

Catholicism's beliefs about the sacredness of human life should also be kept in mind when one is considering ethical issues in the care of the dying. Life is a sacred gift of the Creator and a fundamental good. It is a good over which we do not have complete power. As stewards, we have a duty to preserve life and use it for the purposes for which it was intended. But this duty to prolong life is not absolute. Not everything must be done to preserve life, though nothing can be done intentionally and directly to end innocent human life (CDF, 1980).

Finally, Catholicism's approach to the care of the dying is shaped by a profound respect for the dignity and total well-being of the person. These convictions have enabled Catholicism to

avoid two extremes: maintaining life at all costs and directly hastening death.

CLINICAL ISSUES

Determining death

The Catholic church recognizes total brain death as a criterion for determining that a person has died. The Pontifical Academy of Sciences has stated: “A person is dead when he has irreversibly lost all capacity to integrate and coordinate the physical and mental functions of the body. Death has occurred when: A. The spontaneous cardiac and respiratory functions have definitively ceased; or B. An irreversible cessation of every brain function is verified” (Pontifical Academy of Sciences 1985). The ERD state that physicians should determine death on the basis of “commonly accepted scientific criteria” (D. 62). In cases of total brain death, the church also supports the use of mechanical ventilation to prolong respiratory and cardiac function so that organs may be removed for transplantation (Pontifical Academy of Sciences 1985; see also United States Catholic Conference Advisory Committee on Ethical and Religious Directives for Catholic Health Facilities 1975).

Pain control and palliative care

As previously noted, Catholicism upholds the belief that pain and suffering can be beneficial, but it does not see them as good in themselves or as conditions to be endured without relief. The church not only supports but recommends the relief of pain and suffering—with some qualifications, however. A major concern that surfaces in various ecclesiastical documents is the fear that analgesics will be used to such an extent that they will prevent the dying person from experiencing his or her dying and doing the work of dying. In the words of the Pontifical Council *Cor Unum*, the excessive use of analgesics “deprives him of arriving at a serene acceptance of [death], of achieving a state of

peace; of sharing, perhaps, a last intense relationship between a person reduced to that last of human poverties and another person who will have been privileged by knowing him. And, if the dying person is a Christian, he is being deprived of experiencing his death in communion with Christ” (Pontifical Council 1981). So while it is permissible to attempt to reduce or even eliminate pain, it is not optimal to plunge the patient into unconsciousness to do so, unless that is absolutely necessary. There must be a compelling reason to deprive someone of consciousness in the attempt to relieve pain (ERD, D. 61).

The other danger or concern is the belief that analgesics are sufficient to address pain and suffering. The same Pontifical Council document insists on the importance of human presence to help alleviate pain. In particular they call for health professionals to be trained in how to listen to the dying, how to provide support for one another, and how to help families provide loving care throughout the dying process.

The final issue in the use of pain medications is the problem of possibly hastening death through the use of analgesics intended to relieve pain. This issue was addressed by Pope Pius XII, and his position has been reiterated in several subsequent Vatican statements. The 1980 Vatican “Declaration on Euthanasia,” for example, states:

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 questions: “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.” 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.
(CDF 1980; ERD, D. 61)

Hence, the position of the church is that analgesics may be used in sufficient amounts to relieve pain even if they may also shorten life, provided the latter effect is not intended. The principle of double effect is operative here.

Forgoing life-sustaining treatment

Catholic thinking and teaching regarding the matter of forgoing life-sustaining treatment dates back to the sixteenth century. The first explicit discussion is to be found in the work of a Spanish Dominican theologian, Francisco di Vittoria. His fundamental principles are still valid: “God does not want us to worry about a long life, but a good life,” and, “It is one thing to end one’s life, and another thing to not prolong it.” He also addressed the moral obligation to employ food to prolong life. Subsequent theologians refined di Vittoria’s position. This development probably culminated in the well-known 1958 statement of Pope Pius XII. The most recent official statement on the matter is the 1980 “Declaration on Euthanasia” by the Congregation for the Doctrine of the Faith.

The Catholic tradition has long supported forgoing life-sustaining treatment in certain circumstances based on the principle of benefit and burden. In brief, there is a moral obligation to accept treatments that prolong life if they are of benefit to the patient and can be employed without excessive burden. The degree of burden is to be judged by the patient or the patient’s surrogate and includes emotional, psychological, spiritual, and economic burdens as well as physical ones. There is, however, no moral obligation to utilize treatments that are of little or no benefit to the patient or that impose burdens disproportionate to the benefits hoped for or obtained (CDF 1980).

Prior to the Vatican’s 1980 statement, forgoing treatment was usually discussed in terms of

“ordinary” and “extraordinary” means. Whether a treatment was ordinary or extraordinary was determined by assessing its benefits and burdens to the patient, not the nature of the treatment itself. For a particular patient, then, an IV, as simple and common as it is, could be considered “extraordinary means” if it would not benefit the patient considered holistically or if it would impose excessive burdens on the patient. Likewise, a ventilator could, in appropriate circumstances, be considered “ordinary means” for a given patient. In other words, what makes a treatment ordinary or extraordinary is not the simplicity or complexity of the treatment, its common use, or its availability but rather its impact upon the total well-being of the patient. Because of the ambiguity about the terminology of ordinary and extraordinary means, the language of benefit and burden is preferable, though it must be kept in mind that what is a benefit and what a burden will vary from patient to patient and should be determined from the perspective of the patient (ERD, D. 57, 58).

A particular form of forgoing life-sustaining treatment that is still a subject of discussion is the withholding or withdrawal of artificially administered nutrition and hydration. While there is no definitive Catholic position on this issue, a number of statements have been made by various bishops and ecclesiastical bodies. Some believe that artificial nutrition and hydration are to be considered medical treatments, and decisions about them should be made on the basis of the principle of burden and benefit. Others believe that since nutrition and hydration are so essential to life and such a basic form of care, they must always be provided. The *Directives* take the following position: “There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient” (D. 58).

Suicide, assisted suicide, and active euthanasia

Suicide, assisted suicide, and active euthanasia are forbidden in the Catholic tradition. On the matter of suicide, the CDF wrote in its “Declaration on Euthanasia” (1980):

Intentionally causing one’s own death, or suicide, is . . . 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 the 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 recognized, at times there are psychological factors present that can diminish responsibility or even completely remove it.

The church recognizes that most suicides occur as the result of psychiatric factors and, consequently, that the individual is usually not held to be fully responsible for the act.

The Vatican “Declaration on Euthanasia” defines euthanasia as “an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated” (CDF 1980). Hence, the key elements in determining whether an action is euthanasia are the intention implicit in the act and the means. These two elements are what distinguish “allowing to die” or “forgoing life-sustaining treatment” from euthanasia. In allowing to die, the intention of the external act is not directly to bring about death but rather to cease employing treatments that are ineffective or burdensome, even though it may be known that the patient will die sooner as a consequence. The principle of double effect is operative here. When a person is allowed to die, the cause of death is the underlying pathology, whereas in euthanasia, it is the means itself (which is entirely extrinsic to the pathology) that brings about death. Because death is directly intended and brought about in euthanasia, it is morally forbidden. It violates

the basic moral norm in Catholicism against taking innocent human life for the reasons discussed above. In the words of the Vatican declaration (CDF, 1980):

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.

This opposition to euthanasia is reiterated in at least three recent statements by the current pope (John Paul II, 1984b; 1985; 1995: n. 64-66; see also ERD, D. 60; CCC 1997: nos. 2276-83).

Autopsy and postmortem care

Autopsy is morally permitted in Catholicism, provided that the body is not treated merely as a thing and that consent has been obtained from the next of kin (Pius XII, 1954).

Last rites, burial, and mourning customs

The celebration of the Eucharist is central to Catholic belief and life and is likewise central to religious rites for the deceased. There is a special funeral liturgy for Catholics who have died: the Mass of Christian Burial. This usually takes place in the deceased individual’s parish church, with the body present, two or three days after the individual has died. In some locations, the visitation, wake, or vigil takes place in the church prior to the funeral liturgy.

Prior to the Second Vatican Council, the Catholic funeral ritual was somber. This tone was reflected in the prayers, hymns, and vest-

ments of the priest (black). Since Vatican II, the general theme of the Catholic funeral service has been resurrection. Now one finds the use of white vestments, hymns and prayers referring to Christ's resurrection from the dead, and use of the Easter candle which symbolizes the risen Christ (CCC 1997: nos. 1680-90).

Burial is normally in the earth, though use of mausoleums and even of cremation is permitted. Until 1969, cremation was banned because it was used by some as a denial of the resurrection. Today, however, it has become a practical way of dealing with the corpse and does not usually carry with it a denial of resurrection. The Code of Canon Law permits cremation, pro-

vided that it has not been chosen "for reasons which are contrary to Christian teaching" (C. 1176.3).

Stillbirths

Two issues arise in the case of stillbirths: baptism and burial. The practice of the church, reflected in an earlier Code of Canon Law (C. 747), is that if a fetus is delivered clearly dead, it should not be baptized. If, however, there is any doubt that it is dead, it should be baptized conditionally. Stillborn fetuses should be buried, for according to the church's teaching, they are considered human beings with all the rights of persons.

SPECIAL CONCERNS

ATTITUDES TOWARD DIET AND THE USE OF DRUGS

Catholics are required to fast on Ash Wednesday and Good Friday. On those days they cannot take solid foods between meals, and the smaller meals taken during the day cannot equal the main meal of the day. This applies to people between 18 and 59 years of age. Catholics must also abstain from eating meat on Ash Wednesday, the Fridays of Lent, and Good Friday. Both fasting and abstinence are occasions for reflecting on one's life, expressing sorrow for sin, and resolving to reform one's life. The local pastor can grant dispensations from these requirements. Illness would normally be a sufficient reason for such a dispensation.

In addition, Catholics must refrain from food and drink, with the exception of water and medicine, for at least one hour prior to receiving communion. This does not apply, according to the Code of Canon Law (C. 919.3), to those of advanced age or to those "who suffer from any infirmity" and those who care for them. There are no other dietary observances or requirements in Catholicism.

RELIGIOUS OBSERVANCES

Anointing of the sick

The sacrament of the sick or the "anointing of the sick" is among the seven sacraments that the church celebrates. The ritual part of the church's pastoral care of the sick and the dying, the practice goes back to the early days of the church. Until 1972, when the rite was reformed in accordance with the Second Vatican Council, it was referred to as "extreme unction" or the "last anointing" and was usually reserved for the imminently dying. Today it is offered to any Catholic who is experiencing illness or debilitation in order to provide spiritual strength as well as to express the support of the community. The ritual consists primarily in praying and in anointing with oil (CCC 1997: nos. 1499-1525).

Sacrament of reconciliation

The sacrament of reconciliation, also one of the seven sacraments, involves the confession of one's sins to a priest, the representative of Christ, in order to obtain forgiveness. It is the ritual whereby sinners are reconciled with God, the church, and fellow human beings. It is an

important part of the spiritual care of the ill, and of the terminally ill in particular (CCC 1997: nos. 1422-70).

Eucharist

Eucharist can refer either to the liturgical celebration of the Eucharist, the commemoration of Christ's last supper with his disciples and Catholicism's most important ritual, or to reception of the wafer (holy communion), consecrated during the celebration of the Eucharist and believed to be the body of Christ. This is a particularly important spiritual observance for Catholics because it symbolizes and effects union with Christ and with members of the Christian community. Eucharist is especially important during a time of illness (CCC 1997: nos. 1322-1419).

Holy days

Sunday is the primary day of worship for Catholics. On this day, Catholics are bound to participate in a celebration of the Eucharist (the Mass) and to refrain from labors that might distract them from the worship of God or impede physical and mental relaxation. "Holy days of obligation" are days that celebrate events in the life of Christ or that honor his mother or the saints (Christmas, the Ascension of Christ, Mary the Mother of God on January 1, the Assumption of Mary on August 15, the Immaculate Conception of Mary on December 8,

and the feast of All Saints on November 1). On holy days of obligation Catholics are required to participate in the celebration of the Eucharist, though their pastor can give them dispensation for a "just and reasonable cause." Illness and disability would normally be sufficient reasons for being granted dispensation from participating in the Eucharist.

Prayer

Prayer is an important part of Catholic life. In addition to praying to God, Catholics pray to Mary, as the mother of Christ, and to the saints. Many Catholics make use of representations of Mary or the saints in the form of pictures or statues. Two common forms of prayer among more traditional Catholics are the rosary and the novena. The former consists in the use of beads which have five sets of ten beads each. The prayer "Hail Mary" is said on each bead, and each "decade" is introduced by the Lord's Prayer and concluded with a prayer (the Doxology) that praises the three persons in God—Father, Son, and Spirit. A novena consists in repeating a particular prayer nine consecutive times (for example, nine days, nine Saturdays, nine first Fridays of each month). Usually novenas are prayed with a special intention.

Fasting

See "Attitudes toward diet and the use of drugs," above.

NOTES

1. The following sources inform this historical section: McBrien 1980: vol. 2, 569-655 (pt. 4, "The Church"); Melton 1993: vol. 1, 5-29 (chap. 1, "The Liturgical Family" [Western tradition]); and Numbers and Amundsen 1986: 40-145 (chaps. 2-4).
2. For further discussion of the development of Catholic medical ethics, see Kelly 1979.
3. Unless otherwise noted, all quotations of ecclesiastical documents have been taken from Kevin O'Rourke and Philip Boyle's *Medical Ethics: Sources of Catholic Teaching* (1993). This volume contains excerpts from ecclesiastical documents on a wide variety of topics in medical ethics. The topics are arranged alphabetically. Additional bibliographical information on the ecclesiastical documents can be found there.
4. *Ethical and Religious Directives for Catholic Health Care Services* (ERD), revised and published by the United States Conference of Catholic Bishops in 2001, provides authoritative ethical guidance to all Catholic healthcare facilities. It can also serve as a helpful resource for understanding a Catholic approach to ethical issues in health care. The 1997 *Catechism of the Catholic Church* (CCC) is another helpful resource for gaining a better understanding of the beliefs and practices of Catholicism.

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Introduction to the series

Religious beliefs provide meaning for people confronting illness and seeking health, particularly during times of crisis. Increasingly, healthcare workers face the challenge of providing appropriate care and services to people of different religious backgrounds. Unfortunately, many healthcare workers are unfamiliar with the religious beliefs and moral positions of traditions other than their own. This booklet is one of a series that aims to provide accessible and practical information about the values and beliefs of different religious traditions. It should assist nurses, physicians, chaplains, social workers, and administrators in their decision making and care giving. It can also serve as a reference for believers who desire to learn more about their own traditions.

Each booklet gives an introduction to the history of the tradition, including its perspectives on health and illness. Each also covers the tradition's positions on a variety of clinical issues, with attention to the points at which moral dilemmas often arise in the clinical setting. Finally, each booklet offers information on special concerns relevant to the particular tradition.

The editors have tried to be succinct, objective, and informative. Wherever possible, we have included the tradition's positions as reflected in official statements by a governing or other formal body, or by reference to positions formulated by authorities within the tradition. Bear in mind that within any religious tradition, there may be more than one denomination or sect that holds views in opposition to mainstream positions, or groups that maintain different emphases.

The editors also recognize that the beliefs and values of individuals within a tradition may vary from the so-called official positions of their tradition. In fact, some traditions leave moral decisions about clinical issues to individual conscience. We would therefore caution the reader against generalizing too readily.

The guidelines in these booklets should not substitute for discussion of patients' own reli-

gious views on clinical issues. Rather, they should be used to supplement information coming directly from patients and families, and used as a primary source only when such firsthand information is not available.

We hope that these booklets will help practitioners see that religious backgrounds and beliefs play a part in the way patients deal with pain, illness, and the decisions that arise in the course of treatment. Greater understanding of religious traditions on the part of care providers, we believe, will increase the quality of care received by the patient.



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