Foundation:
Cry out with joy to the Lord, all the earth. / Serve the Lord with gladness. / Come before him, singing for joy.
Know that he, the Lord is God. / He made us, we belong to him, / we are his people, the sheep of his flock.
Go within his gates, giving thanks. / Enter his courts with songs of praise. / Give thanks to him and bless his name.
Indeed, how good is the Lord, / eternal his merciful love. / He is faithful from age to age. (Psalm 100)

Introduction
As we journey through life, most of us will have to make decisions regarding medical care, either for ourselves or for others. While some of these decisions are minor, others will be literally “life and death”, when we are confronted with decisions regarding life-sustaining treatments of various sorts. For the person who wants to pursue the good, and make these decisions in an ethical way, this can present a challenge. It would be much easier if we could compile a list of “do’s and don’ts” which could make everything clear and simple. However, these choices, especially at the beginning and end of life, are seldom that simple. Health care decisions at the end of life are usually much more gray than black and white. There are exceptions, but in most cases, the situation of the person (patient) will be a major factor in discerning the ‘right’ action.

Those of us who adhere to the Catholic tradition are not left all alone in this task. By God’s grace, we have a rich tradition going back hundreds of years, as believers in various places and times have asked that question, “What is the right choice?”, as they sought to pursue the good. While our situation today is radically different, especially with regard to technology, our ancestors in the faith have clarified certain fundamental principles that continue to serve us well into the present age.

Our goal here is to present those fundamental principles which can then be applied to the various and diverse situations in which we might find ourselves, taking into account the person’s medical condition, their attitudes and values, and the broader social and financial background. In this way, we respect the truths of our faith, even as we meet the challenges of dealing with health care today, in this time and place, in the midst of a culture that is often less than diligent about seeking the good. We will attempt to present these principles in order to enable each person to make the choices that are best for all concerned.

The Dignity of Human Life
In 2009 the U.S. Bishops updated a teaching document called the Ethical and Religious Directives for Health Care. This document is intended to provide moral and ethical guidance to those engaged in providing health care in Catholic institutions. In the first paragraph of that document, we read:

The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: “I was ill and you cared for me” (Mt 25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death. (Ethical and Religious Directives for Health Care, USCCB:2009)

In a document primarily concerned with “what to do” the Bishops begin in exactly the right place, asking the question about “who we are”. The fact that we are persons created in the image and likeness of God means that we are endowed with a dignity that is not earned, and that can never be lost, even though it can be obscured. This fundamental human dignity is only enhanced by redemption by Christ Jesus who fully embraced our human condition, while remaining for us our saving God. When faced with questions involving end of life care, we begin with that fundamental dignity of the human person. All our decisions must not only take into account that dignity, but must also be crafted so as to respect and uphold that dignity as much as possible.

The Stewardship of Life
When some in our society are faced with end-of-life decisions, they will often ask the question, “Well, whose life is it anyway?” Usually society’s answer is one that affirms the complete liberty of individuals to do as they will with life, shunning any input or considerations from society or community. Rooted in a radical individualism and ignoring our fundamental membership in community, the frequent reply is simply, “It is my life (my property), and I can do with it as I please.” We, as Catholics, discover a radically different answer to that question, rooted in the human dignity of the human person we spoke of above. As we read in Psalm 100, quoted above, “Know that he, the Lord is God. / He made us, we belong to him, / we are his people, the sheep of his flock.” God is the author of life, not us. As a result, we are not owners of our lives, but rather stewards of our lives. Our
lives simply are not our property, to do with (or dispose of) as we wish. Rather, as stewards of life, we are responsible to God for the way in which we live our lives, which includes the decisions we make leading up to the end of life.

This truth is essential to good decision-making at the end of life. Because we treasure life as gift, and are called to be good stewards of that life, we have a positive duty to preserve our lives. As a result, there will be situations where we have a clear obligation to make choices that preserve life. There are exceptions of course, which we shall explore in due course. But because we begin with this principle of the stewardship of life, we strive to fulfill that duty to preserve life, whenever it is not inappropriate or excessively burdensome.

Understanding Euthanasia

Some will be glad to hear that in Church teaching regarding these issues, there are some clear bright lines which we may not cross. One is that as stewards of life (not owners), we may never intentionally end our own life or that of another in a misguided attempt to be ‘merciful’. This would include so-called ‘mercy killing’, as well as ‘physician assisted suicide’. In a key 1980 document on euthanasia, we read:

“By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia’s terms of reference, therefore, are to be found in the intention of the will and in the methods used. (Congregation for the Doctrine of the Faith, 1980)"

It is essential to recognize the central role of both causing and intending in this definition. Not every result which follows a decision is necessarily caused by that decision. In addition, what one is trying to accomplish is central as well. It is possible to allow, or even cause the death of another (e.g., in an accident) which being guilty of euthanasia. Intention is key.

Killing and Letting Die

One of the hard facts about end-of-life issues is that eventually, life will end. None of us lives forever on this earth, and we do reach the limits of our capabilities, finding ourselves no longer able to prolong life. This reality of the human condition is inescapable, and acceptance of this fact is essential to good decisions. In the same document quoted above, the Church taught:

“It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community. . (Congregation for the Doctrine of the Faith, 1980)

There are two questions at work here. The first is whether I must always do everything possible, and the second, what does it mean when the withdrawal or withholding of treatment is followed by death. The passage quoted above is clear that there are situations in which it is permissible to “make do with the normal means” that are available for preserving life. When and why this is permissible will be dealt with in the next section. The key point here is that when we legitimately choose not to “do everything”, we are not choosing suicide, or directly causing death. In these cases, it is the underlying disease or illness which is actually the cause of death. We are ‘letting die’, because continuing to preserve life has become either inappropriate or impossible. This is not killing.

Ordinary/Extraordinary Means (Proportionate/Disproportionate)

In discussing the distinction between direct killing versus letting someone die, we have affirmed above that there are situations when available treatments need not be utilized. The challenge of course is to discern what treatments are ethically mandatory, and which are not. Here we benefit from the fact that our Catholic tradition has been asking this question for centuries now. As a result, a key principle has been developed which guides us in making this decision.

We return to the duty to preserve one’s life, as an expression of the stewardship of life tradition. The question arose, what must one do if the treatment is expected to offer little to no benefit, or if the treatment is in some way excessively burdensome. Consensus was reached: One must strive to balance the expected benefits against the projected or known burdens of the treatments itself. If those benefits are greater than the burdens, then the treatment is ethically “ordinary” (proportionate), or mandatory, meaning one has a duty to pursue the treatment. On the other hand, if in the informed best judgment of the patient or proxy the burdens imposed by the treatment...
would outweigh the expected benefits, then the treatment is judged ethically “extraordinary” (disproportionate), and thereby becomes optional. One may choose to make use of that “extraordinary” treatment, but to decline or withhold that treatment would not be seen as suicide or as directly causing death. No one is required to do what is perceived as heroic.

Thus we have the distinction between “ordinary” (mandatory) and “extraordinary” (optional) means. In more recent years, many in the medical professions and others have come to misunderstand those two terms, thinking that ordinary simply means frequent or readily available, while extraordinary means rare or experimental. To avoid this misunderstanding, the church sometimes frames the distinction as that between proportionate and disproportionate means, which are ethically mandatory and ethically optional respectively. Whichever terms are used, the key distinction remains the same: When expected burdens (pain, side-effects, risk or financial cost) are judged to outweigh the expected benefits for this particular patient, then one is not required to have recourse to that treatment. This balancing of the expected benefits against the perceived burdens will take into account the situation of the particular patient in question. (This is why it is impossible to compile a list of treatments which are always either mandatory or optional.) It should also be noted that this is true whether the treatment has been begun or not, making withdrawal ethically identical to withholding from the beginning, if the treatment is extraordinary/disproportionate. In 1992, the U.S. Bishops taught:

Everyone has the duty to care for his or her own life and health and to seek necessary medical care from others, but this does not mean that all possible remedies must be used in all circumstances. One is not obliged to use either “extraordinary” means or “disproportionate” means of preserving life -- that is, means which are understood as offering no reasonable hope of benefit or as involving excessive burdens. Decisions regarding such means are complex, and should ordinarily be made by the patient in consultation with his or her family, chaplain or pastor, and physician when that is possible. [5] (Nutrition and Hydration: Moral and Pastoral Reflections, 1992, NCCB CPLA)

Do Not Resuscitate (DNR) Orders (“No Code”)

In order to better understand this distinction between ordinary (proportionate) and extraordinary (disproportionate) treatments, it may be helpful to look at one particular intervention clearly aimed at preserving life. It is not unusual for a patient or the family to be asked by their physician about writing a DNR order, or making the patient a “no code”. This means that if the patient were to go into cardiac or respiratory arrest, attempts at resuscitation would not be made. It should be kept in mind that a “Do Not Resuscitate” (DNR or ‘No code’) order is in essence the revocation of a standing order. Every hospital has standard procedures for trying to revive a person who stops breathing, which do not require a physician’s order to be started.

Normally, if one’s heart stops, one wants efforts to be made to re-start that heart. Even if one is unconscious, implied consent is presumed and those who are available will attempt to perform CPR. The expected benefit is clearly the preservation of life. While there are risks associated with the procedure – it may not work, chest compressions may actually crack ribs, etc. – in most cases the judgment is that the benefits outweigh the burdens, making the treatment ‘ordinary’ or proportionate.

However, there do arise situations (e.g. physical weakness, pre-existing heart damage, other disease processes or other reasons) where the best medical judgment is that if the person’s heart stops, efforts at resuscitation will probably fail. Here, the burdens are seen as being greater than the expected benefits. If resuscitation is not attempted, it is clear that death will follow. However, when it is recognized that such efforts would be unduly burdensome with little hope of success or benefit, or would only prolong the dying process, they may be withheld. The DNR order may be written, with confidence that one is not failing in one’s duty to preserve life. This is not killing, but letting die. Because the expected burdens are judged to outweigh the benefits, the treatment (CPR) is deemed extraordinary (disproportionate), and therefore is not mandatory.

Artificial Nutrition & Hydration

For several reasons, the question of whether or not to provide artificial nutrition and hydration (ANH) is one of the most difficult. The first reason is that there is an emotional and social aspect to providing food and water to the hungry and thirsty that is not usually present with pills and surgeries. Feeding the hungry is not only a fundamental gospel imperative, but in many cultures it is literally one of the ways we show love. Sharing meals together is one of the ways we build community. Food and water are basic necessities of life whether we are ill or not, and acquiring, preparing, and consuming food and water are some of the most fundamental of our daily activities.

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Another source of difficulty can arise when we ask too much of ANH. Someone was once speaking of providing ANH to a person with dementia. This person actually stated that food and water for this patient would be futile because ‘it would not cure their dementia’. Why anyone would expect this to happen was not explained. If supplying food and water, with or without medical assistance, provides nutrition and hydration, then it has achieved its purpose, or its ‘natural finality’. Expecting anything more is unreasonable.

ANH also has something of a two-fold nature that can sometimes confuse the issue. On the one hand, providing artificial nutrition and hydration is clearly a medical procedure, though often a simple one. Medical intervention (often minor surgery) is required, for example, to insert the tube, and perhaps to monitor the benefits of the feeding. At the same time, the procedure is providing something (food and water) that we need whether we are ill or not. The same cannot be said of most surgeries, medications, etc. One Catholic ethicist has described ANH as simply ‘using a very long spoon’. There is truth in that.

So we apply the same principles we have spoken of above. Does the expected benefit (preserving life) outweigh the burdens imposed by the treatment? The fact is that compared to many other medical procedures, usually ANH is not terribly burdensome. For example, the surgery to insert a feeding tube is easily tolerated, and relatively low risk. The cost of providing tube-feeding is not much more than the cost of eating and drinking normally. This is why the Church says that ANH will normally be proportionate or ordinary (mandatory) care. In the vast majority of cases, the benefit of preserving life will outweigh the burdens.

There are exceptions. In some parts of the world, even the basic technology required for ANH may not be available. Particularly for those who are eminently dying (e.g., the last few weeks of life), the treatment may actually become ineffective, if for example, the body becomes unable to metabolize (make use of) the food. In other cases, confusion or dementia may make simply keeping the tube in place impossible.

Note that in each of these cases, the treatment itself becomes excessively burdensome, or can no longer achieve its purpose of nourishing or hydrating the person. In none of these cases has there been a judgment that the person’s life is no longer worth preserving. There is a radical difference between the treatment that is no longer worth giving, and the life judged not worth living.

In some cases, (e.g., the last stage of life for the terminal cancer patient), the tube-feeding might be legitimately discontinued, and the person will die relatively soon because of the cancer itself. If, however, one discontinues tube-feeding that was working and not overly burdensome, leaving the person to die of malnutrition, it is hard to see how this is not euthanasia. The so-called ‘burden’ that is being eliminated is not the treatment, but the person’s life itself, and the burden is relieved only at the person’s death. The intention is clearly to starve the patient to death.

In 1992, the U.S. Bishops taught as follow:

According to international codes of medical ethics, a physician will see a medical procedure as appropriate "if in his or her judgment it offers hope of saving life, reestablising health or alleviating suffering."

Nutrition and hydration, whether provided in the usual way or with medical assistance, do not by themselves remedy pathological conditions, except those caused by dietary deficiencies. But patients benefit from them in several ways. First, for all patients who can assimilate them, suitable food and fluids sustain life, and providing them normally expresses loving concern and solidarity with the helpless. Second, for patients being treated with the hope of a cure, appropriate food and fluids are an important element of sound health care. Third, even for patients who are imminently dying and incurable, food and fluids can prevent the suffering that may arise from dehydration, hunger and thirst.

The benefit of sustaining and fostering life is fundamental, because life is our first gift from a loving God and the condition for receiving His other gifts. But sometimes even food and fluids are no longer effective in providing this benefit, because a patient has entered the final stage of a terminal condition. At such times we should make the dying person as comfortable as possible and provide nursing care and proper hygiene as well as companionship and appropriate spiritual aid. Such a person may lose all desire for food and drink and even be unable to ingest them. Initiating medically assisted feeding or intravenous fluids in this case may increase the patient's discomfort while providing no real benefit; ice chips or sips of water may instead be appropriate to provide comfort and counteract the adverse effects of dehydration. Even in the case of the imminently dying patient, of course, any action or omission that of itself or by intention causes death is to be absolutely rejected. (Nutrition and Hydration: Moral and Pastoral Reflections, 1992, NCCB CPLA)
Persistent Vegetative State

Persons who are diagnosed as being in a ‘persistent vegetative state’ (PVS) provide a special case of the question of whether to provide ANH. While the name is quite unfortunate (persons are never ‘vegetative’), the PVS patient is different. These people are not in a coma (from which they might wake up), they are not brain-dead (in which case they would be deceased), nor are they terminally ill. People in a persistent vegetative state, if provided with basic care and with nutrition and hydration often live for years.

In 2005, the case of Terri Schiavo, a woman in Florida diagnosed as being in a persistent vegetative state, came to the fore in the American consciousness. After having been cared for (and receiving ANH) for a number of years, her husband petitioned her doctors and then the courts to discontinue her tube-feeding. Unfortunately, other family issues clouded the ethical issues, but eventually the courts did allow her husband to proceed with discontinuing ANH for Terri. She died soon after. While it is true that this woman would have never woken up, she was not terminally ill. Clearly, it was depriving her of food and water which ended her life. Seeing his wife’s life itself as a burden (to himself?), the husband relieved all of that burden by choosing to end her life, starving her to death. In the aftermath of this rather public case, the U.S. Bishops sent to the Vatican two questions regarding such cases. The questions and the 2007 replies were as follows:

First question: Is the administration of food and water (whether by natural or artificial means) to a patient in a “vegetative state” morally obligatory except when they cannot be assimilated by the patient’s body or cannot be administered to the patient without causing significant physical discomfort? Response: Yes. The administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented.

Second question: When nutrition and hydration are being supplied by artificial means to a patient in a “permanent vegetative state”, may they be discontinued when competent physicians judge with moral certainty that the patient will never recover consciousness? Response: No. A patient in a “permanent vegetative state” is a person with fundamental human dignity and must, therefore, receive ordinary and proportionate care which includes, in principle, the administration of water and food even by artificial means. (Congregation for the Doctrine of the Faith, August 2007, Responses to certain questions of the USCCB)

These two responses are simply an application of the principles we have been discussing to the normal situation of the PVS patient. While hope of recovery is nil, and while caring for this person may seem quite burdensome or expensive at times, the treatment in question – providing nutrition and hydration via artificial means – is not in itself usually excessively burdensome and it usually achieves its purpose. Since the intention here is clearly to end the patient’s life, it is impossible to deny that withholding food and water from this non-terminal patient is euthanasia.

Advanced Directives – Durable Power of Attorney for Health Care

When the person who is in pain walks into the emergency room, signing consent forms is probably the last thing the newly arrived patient wants to do. Yet this necessity, and it is essential, is an expression of one of the core principles of our health care system. No one may give anyone medical treatment without their informed consent. There are exceptions (mental incapacity, unconsciousness), but they are exactly that: exceptions. Normally we are the decision makers when it comes to accepting or refusing medical treatment for ourselves.

From a legal perspective, one has the right to refuse any and all medical treatments, and said refusal can only be overruled by another when one loses the capacity to make decisions for oneself. For Catholics, however, because of our fundamental duty to preserve one’s life, things are quite different. If a proposed life-sustaining treatment is judged to be proportionate (ordinary, beneficial without excessive burdens), the Catholic would have a moral responsibility to accept the treatment. This moral duty, however, in no way limits one’s right to refuse treatment under the law.

That said, there are times when we cannot make decisions personally. In those situations, it is the norm for someone else, specified by law, to make those decisions in our place. Normally the next of kin, that person can also be someone specifically appointed to that task, either in advance by the patient, or when necessary by the courts. Traditionally, the proxy decision maker simply has the right to consent to treatment for their patient. When, however, the issue is one of withholding or withdrawing life-sustaining treatment, the medical profession and the courts have been reluctant to allow the proxy the same freedom as the patient would have. The practice has often
been to err on the side of preserving life, and providing treatment that was not explicitly rejected/refused by the patient. In other words, it is more difficult for the proxy to decline life-sustaining treatment than it is for the patient. In the early 1990’s, the question was raised, “How can I exercise my fundamental right to refuse treatment, even after I become incapacitated or incompetent?” The view was that I still had the right to refuse, (or consent to) treatment, but was prevented by circumstances from exercising that right.

The solution offered was the ‘Advanced Directive’ (often called a ‘Living will’). Every state in the nation passed legislation providing for this directive, and federal law was passed which required asking patients at admission to medical facilities whether they had an Advanced Directive. The goal is a worthy one. We want to act in accord with a given patient’s wishes (as long as those wishes are consistent with moral principles). The written Advanced Directive provides the individual with a way in which to make their wishes known, should they become incapable of deciding for themselves. In and of itself, there is nothing about the idea of an Advanced Directive which goes against Catholic teaching. That said, a Catholic person’s advanced directive should not call for actions that would be contrary to Church teaching. Our bishops have taught:

The kind of treatment desired by patients, the place where they want to spend their final days, the use of cardiopulmonary resuscitation (CPR), and the desire of organ donation are among the topics that should be addressed, and are usually included in advance directives, or living wills. The Church approves of the use of advance directives since they can be very helpful when a person is incapacitated or at the end of life. The best advance directive documents should include an agent/proxy with health care power of attorney who would be able to communicate the patient’s desires in real time. (The Final Journey, Catholic Bishops of Louisiana, 2013)

Several practical issues should be kept in mind if one chooses to execute an advanced directive. You do not need an attorney, nor does it need to be notarized. Two witnesses are required, who must know you but cannot be anyone who would benefit from your death (e.g., your heirs). Do not tuck it away in a safe-deposit box, but rather make copies and give them to your physician(s) and your next of kin. Bring a copy with you when you go to the hospital. And you can revoke an advanced directive at any time (taking care to destroy any copies), and the most recent document is the one that will be honored.

While the law provides for the selection of person to make medical decisions for us when we are incapacitated, it is also possible to make that decision for oneself, by for example choosing one of several children to be the decision-maker. The Advanced Directive document we recommend (available on the website http://labove.com/today/end-of-life/) includes a ‘Durable Power of Attorney for Health Care’ section at the bottom. Appointing a specific person to make decisions for you is highly recommended, particularly if you sit down and talk to that person about your wishes. No advanced directive can provide for every situation, and usually someone must make decisions at the bedside.

LaPOST

While we currently have some 25 years of experience with Advanced Directives, a different instrument has recently appeared on the scene, called in Louisiana the “Louisiana Physician’s Order for Scope of Treatment”. Less than a third of states in the U.S. have passed legislation for this document (usually called POLST – Physician’s Order for Life Sustaining Treatment). In Louisiana, the law was passed recently, and education and policies are still in process in many medical facilities. Because of its nature, the majority of people will never need to have a ‘LaPOST’.

Unlike an Advanced Directive which simply states the patient’s wishes in certain situations, the LaPOST document is completed by the physician in consultation with the patient, and is actually a physician’s order. It is meant to be used for the person nearing the end of life or with life-limiting conditions who can be expected to be moving between different health care settings (e.g., hospital, nursing home, extended care facility, home, etc.) The fact that LaPOST is a physician’s order means that it can be honored across admissions and discharges, providing continuity of care, and avoiding unnecessary or burdensome treatment. Abundant information is available on the LaPOST website (http://www.lhcqf.org/lapost-home). The Louisiana Bishops wrote in 2013:

The Louisiana Physician Orders for Scope of Treatment (LaPOST) document is also available in the state of Louisiana for patients with life-limiting and irreversible conditions. It honors patients’ wishes based on their individual medical conditions and goals of care. To become valid, the document is signed by the patient’s physician after appropriate consultation and shared decision-making. This document, which can be found at www.la-post.org, is different from a living will in that it is a physician’s order that can be implemented immediately and in any place. This document adheres to all the official teachings of the Catholic Church with regard to end-of-life decisions. (Catholic Bishops of Louisiana, The Final Journey: 2013)
That being said, two things should be kept in mind. 1) As the bishops state, it is designed “for patients with life-limiting and irreversible conditions”, and should not be used indiscriminately, lest medical care be withheld inappropriately. 2) The physician’s orders documented on LaPOST are issued based on the patient’s condition at a given point in time, and should be re-evaluated should the patient’s condition change.

This second point requires some special attention. One significant limitation of LaPOST and similar documents is that the document chooses or rejects certain medical treatments based on the patient’s condition at a particular time. Should the patient’s condition change, the physician’s order documented in LaPOST must be re-considered and perhaps changed. Making good ethical decisions regarding health care is always based on this particular patient’s condition at this time, not on pre-determined judgments of this or that treatment. For example, one might hear someone say, “I never want to live on a feeding tube.” One might certainly desire never to be in a situation where that need would arise. However, the Catholic with a positive duty to preserve his or her life cannot know beforehand that artificial nutrition and hydration will never be effective in preserving life. If one is in a situation where ANH is both effective and not excessively burdensome, then one would have a moral duty to accept the feeding tube. To choose otherwise would be reject a medical intervention which one has a moral duty to pursue.

Organ and Tissue Donation – Brain Death

At its most basic, we can simply state that organ and tissue donation is a good thing. To choose and consent to being a donor is an act of charity which is life enhancing and sometimes life-saving for the other, and is rooted firmly in the Christian tradition of caring for our brothers and sisters. While the Church traditionally shows great respect for the human body after death (the honor of funeral rites, etc.), it is no desecration of the body of the deceased to allow parts of the body to be used for transplantation (or similarly for scientific education and research).

Some kinds of organ donation are possible with live donors. While not often thought of in this way, the act of donating blood at the local blood bank is actually organ donation. The person with two functioning kidneys can sometimes donate one kidney to a person in need, without disproportionate risk to the donor’s life. Informed consent is essential from all parties involved, and the dignity of each must be respected throughout the process. No one person’s life is ever worth more than another’s.

Other types of organ and tissue donation require that the donor be deceased. Vital organ donation (heart, lungs, liver, etc.) is only possible in certain situations. The donor’s cause of death will usually be some sort of injury to the brain (stroke, head trauma, etc.) and one will arrive at the hospital and be placed on life support before death. The original injury will eventually lead to death. In these cases, because artificial support is keeping the heart and lungs functioning, declaring death by the traditional criteria (cessation of heartbeat and breathing) is not possible. With these patients, death is declared using ‘brain death criteria’, using certain kinds of medical tests done to ascertain the total and irreversible cessation of all brain function (usually confirmed by two physicians). Unfortunately, the term ‘brain death’ is sometimes used inaccurately to describe someone who is in a coma, or who may never regain consciousness. One can rest assured that if one has been appropriately diagnosed as ‘brain dead’, then one is actually deceased. This is true, even if artificial support (ventilator, etc.) are sustaining core functions such as heartbeat and breathing. This artificial support of the vital organs is necessary until transplantation, so that the organs will be viable. What makes this difficult at times is that when the deceased patient is taken to surgery so that organs can be procured, the artificial support causes them to appear to still be alive, even if all brain function has ceased. Contrary to these appearances, the ‘brain dead’ person has actually died, while their heart is still beating.

Many more people who have passed away in a more traditional fashion can be tissue donors (e.g., corneas, skin, bone, etc.), though age and medical history can be factors that disqualify a donor. These kinds of donations can help countless individuals who have blindness, who have been burned, or who have suffered other kinds of illness and injury.

There are several fundamental principles that underlie the ethics of organ and tissue donation. One is the ‘dead donor rule’: normally organs are taken only from people who are declared to be deceased. The only exceptions are those types of donation that do not cause death, e.g., giving blood or bone marrow, or donating one of two kidneys. Consent to donation is always required, and is not presumed. (If you want to be an organ donor, you must inform your next of kin, since most organ procurement organizations will not accept organs without family consent.) Human organs for transplantation are always a gift and are never ethically bought or sold (though the expense of transplantation services are billed to the recipient.) Another basic principle is that persons involved in doing the transplant may not certify the patient’s death, to avoid any appearance of conflict of interest. Lastly, while organ and/or tissue donation may delay funeral services somewhat, usually nothing is done which prevents having a normal viewing and funeral. Regarding organ donation, Pope John Paul II wrote in 1991:

Above all, 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 action 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. (Pope John Paul II, Address to International Society for Organ Sharing, June 1991)

And in 2000, the same Pontiff said,

It is a well-known fact that for some time certain scientific approaches to ascertaining death have shifted the emphasis from the traditional cardio-respiratory signs to the so-called ‘neurological’ criterion. Specifically, this consists in establishing, according to clearly defined parameters commonly held by the international scientific community, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum, and the brain stem). This is then considered the sign that the individual organism has lost its integrative capacity. . . . Here it can be said that the criterion . . . for ascertaining the fact of death, namely the complete and irreversible cessation of all brain activity, if rigorously applied, does not seem to conflict with the essential elements of a sound anthropology. (John Paul II, Address to the 18th International Congress of the Transplantation Society, August 29, 2000.)

A Word about Human Dignity

For us as Catholics, the core value of human life consists in being created in the image and likeness of God. While many other things such as relationships, accomplishments and independence can enhance and add richness in life, the sanctity of human life does not depend upon our accomplishments or achievements. But when one fails to recognize that core dignity of the human person, then abilities and conditions of life take on an exaggerated importance.

For example, in our culture independence of action, and personal autonomy are highly valued. While these are not bad things, sometimes we base the value of human life on the level of independence and autonomy we can exercise. Contrarily, if our independence and autonomy are compromised (especially through illness or injury), we begin to question the value of life itself. The life in question is easily judged to be a “life not worth living”.

This judgment sometimes leads individuals to craft a very particular idea of the “quality of life” and “death with dignity”. Individuals decide that if they cannot care for themselves, or cannot accomplish certain goals of life that they have chosen, then life is valueless. Simply being dependent on others for care and treatment is seen as ‘undignified’. They decide that they ‘would not want to live that way’.

Quite simply, there are times when the life we would choose is not available to us. There are times, (e.g., as infants) when we must depend on others for even the necessities of life. Sometimes as we journey through life, illness, injury or even advanced age can make us dependent and needy. We cannot stress enough that this dependence does not lessen our human dignity. The fact is that we are much more dependent on one another than we often care to admit, and being dependent upon another, even for the basic necessities of life, is not ‘undignified’. Likewise, since each person has a right to the necessities of life such as food and water, it becomes an assault on human dignity to choose to deprive the person of these basic goods, under the guise of a false and misguided notion of ‘mercy’. Our U.S. Bishops wrote in 1992:

7. Decisions regarding human life must respect the demands of justice, viewing each human being as our neighbor and avoiding all discrimination based on age or dependency. (8) A human being has “a unique dignity and an independent value, from the moment of conception and in every stage of development, whatever his or her physical condition.” In particular, “the disabled person (whether the disability be the result of a congenital handicap, chronic illness or accident, or from mental or physical deficiency, and whatever the severity of the disability) is a fully human subject, with the corresponding innate, sacred and inviolable rights.” First among these is “the fundamental and inalienable right to life.”

8. The dignity and value of the human person, which lie at the foundation of the Church’s teaching on the right to life, also provide a basis for any just social order. Not only to become more Christian, but to become more truly human, society should protect the right to life through its laws and other policies. (10) (Nutrition and Hydration: Moral and Pastoral Reflections: NCCB, April 1992)