QUESTIONS OF ETHICS REGARDING THE FATALLY ILL AND THE DYING
27 June 1981

I. INTRODUCTION

1.1. The Working Group

From the 12th to the 14th of November 1976, in keeping with its mandate of co-ordinating the Activities of the Church in the Health Sector, the Pontifical Council COR UNUM got together a Working Group to study various questions of ethics related to the fatally ill and the dying. The Group was composed of some 15 persons, and was interdisciplinary: there were theologians, doctors, members of Religious Congregations dedicated to the care of the sick, trained nurses, and hospital chaplains.

1.2. The subject discussed by the Working Group

Recent developments in science are influencing medical practice more and more, particularly in the treatment of the fatally ill and the dying. This state of affairs raises problems of a theological and ethical order on which the health professionals are eager to be authoritatively enlightened. Christian members of these professions working in Christian surroundings have long been much concerned about these problems. All the more so are Christians obliged to work in non-Christian surroundings, and who for this reason desire that their work be inspired by their Faith and bear witness to it.
Unfortunately, medical ethics are for many persons a matter of speculation, of more or less accurate information of erroneous ideas and all this begets great confusion. COR UNUM is not in a position to undertake a vast programme of doctrinal or scientific research: this is for higher and better qualified authorities. The purpose of our Working Group was simply to analyse basic concepts, point out certain distinctions which must be understood clearly, and formulate practical answers to questions brought up by pastoral directives and by the treatment of the dying.

1.3. The Sacred Congregation for the Doctrine of the Faith

On the 5th of May, 1980, this Congregation published a "Declaration on Euthanasia". In it were authoritatively set forth principles of doctrine and morals on this very serious problem, which has attracted and held the interest of large sectors of the public. As a result, mostly, of special cases that have received wide publicity -cases of what has been called "therapeutic obstinacy"-, people's consciences were aroused and much self-questioning had been going on. This important document first recalls to the reader what the value of human life is, and then proceeds to deal with the subject of euthanasia: it provides Christians with principles for making decisions and taking action where suffering and the use of painkillers are concerned and also where the use of one or another therapeutic treatment is possible.

1.4. Publication of the report on COR UNUM's Working Group

Our 1976 Working Group's reflection is for the most part pastoral: it answers precise and concrete questions put to COR UNUM by hospital chaplains, doctors, and trained nurses. As a result of the publication of the "Declaration on Euthanasia" by the S.C. for the Doctrine of the Faith, our Pontifical Council has been requested to publish the report of its Working Group. Let this be the occasion for us to thank all those who, with a competence deriving only from great experience, contributed to its realization.

2. FUNDAMENTAL CONCEPTS

2.1. Life

2.1.1. The Christian meaning of life

Life is given to mankind by our Creator. It is a gift bestowed in order for man to accomplish a mission. Thus, a person's "right to live" is not what is of foremost importance, since this right is not man's but, rather, belongs to God, who does not give life to human beings as something of which they may dispose as they see fit. Life is directed towards an end toward which it is the responsability of human beings to direct themselves: toward the perfecting of themselves according to God's plan.
The first corollary of this fundamental concept, is that to give up life of one's own choice is to give up striving towards an end which not we but Gof has established. Mankind has been called upon to make his life useful; he may not destroy it at will. His duty is to care of his body, its functions, its organs; to do everything he can to render himself capable of attaining to God. This duty implies giving up things which in themselves may be good. This duty somethimes requires that we sacrifice health and life: our concern for them cannot allow us to deny the claim of superior values. All the same, in the matter of cares to be taken for mantaining good health and preserving life, a correct proportion must be arrived at, regarding both the superior goods perhaps at sake and also the concrete condition in which man lives out his existence on earth.

2.1.2. We cannot freely dispose of the life of someone else

If one may not destroys one's life at will, this is also true, a fortiori, of someones else's life. A sick person cannot simply be made the object of decisions which he himself does not make or of which, if he is unable to make them, he would not morally approve. Each human individual, as the person principally responsible for his life, must be at the center of all assistance. Others are present in order to help him, not substitute him. This does not mean, however, that doctors or members of the family may not at times find themselves in the positions of having to take decisions for a sick person, who for various reasons cannot do so himself, concerning therapeutic measure and treatments to be applied to him. But to the doctors and others in this position, more than to anyone else, it is absolutely forbidden to make an attempt on the life of the patient, even out of compassion and pity.

2.1.3. The fundamental rights of the human individual

It is this quintessentially doctrinal subject which the Working Group takes as the basis for its considerations. We are well aware of how immensely difficult it is for those who are not Christians or who have no belief in a life beyond this life on earth, to give meaning to life and to death. Christians will admit, too, that their positions is not specific. But what really is at stake is the defense of the fundamental rights of the human individual. We cannot waver where these are concerned. All the less so, because these rights are so very much in the foreground of political and legislative activity. In order to convince people for whom everything ends at death, of what respect is due their own life and the life of others, the surest arguments are those which show what consequences are brought about in a society by the lack of rigid measures taken for the protection of human life.

2.2. Death

2.2.1. The meaning which death has for Christians

The death of a human being is the end of his corporeal existence. It brings to an end that phase of his divine vocation which is his striving, within the compass of time, toward his total perfection. For a Christian, the moment of death is the moment of his finally being united forever to Christ. Today more than ever, it is pertinent to recall this religious and Christological conception of death. It must go hand in hand with a very real perception of the contingency of our living in our body and of the connection between death and our human condition of being sinners. "For ... whether we live of whether we die, we are the Lord's" (Romans, XIV: 8). Our attitude toward the dying must be inspired by this conviction, and must not merely be reduced to an effort made by science to put off death as long as possible.

2.2.2. The right to die a human and dignified death

Concerning this topic, the members of the Working Group from the Third World emphasized how important it is, for a human being, to end his days on earth with his personality, as far as possible, whole and entire, both in itself and in its relationships with its milieu, and especially with the family. In countries which are less developed techically and less affected by sophistication, the family gathers round the dying person, and he himself feels a need -almost an essential right- to be thus surrounded. When he observe the conditions required for certain therapies and the total isolation imposed by them upon the sick person, we do not find it out of place to state that the right to die as a human being with dignity demands this social dimension.

2.3. Suffering

2.3.1. The meaning of "suffering" for a Christian

Neither suffering nor pain -between which we must be careful to distinguish- is ever to be considered an end in itself. Scientifically speaking, there is still great uncertainty as to what constitutes pain. As for suffering, Christians see in it only Love that can be expressed thereby and the purifying effects which it can have. Pius XII pointed out, in his Allocution of the 24th of February 1957, that suffering which is too intense is likely to keep the mind from maintaining the control it ought to have. We are thus not obliged to think that all pain must be endured at any price, or that, stoically, one must not attempt to reduce and calm them. The Working Group feels that we can do no better than to refer the reader to the text of Pius XII.

2.3.2. Effects of suffering and pain

The capacity for suffering varies from person to person. It is for the doctor, the nurses, and the hospital chaplain (let him not be overlooked!) to determine what spiritual and psycological effects suffering and pain are having on a patient, and to decide whether a certain treatment is to be carried out or not. What the patient says must also be carefully listened to, in order to determine what the real nature of his suffering is: for he, after all, is the best judge of it. Of course a doctor may well think that a patient could have more courage and that he can really put up with more suffering than he believes he can; but the ultimate choice is up to the patient.

2.4. Therapeutic measures

2.4.1. Ordinary measures and extraordinary measures

The Working Group considered at some length the distinction between these two kinds of therapies. It is true that the terms are becoming somewhat outmoded in scientific terminology and medical practice, but in theology they are indispensable to the consideration of the validity or invalidity of points of great moral importance. For the theologian applies the term "extraordinary" to measure to which there never exists any obligation to have recourse.
The distinction permits us to draw certain complex realities more closely together. It acts as the "middle term". Life within the compass of time is a basic value but is not an absolute; and we find, consequently, that we must demarcate the limits of the obligation to keep oneself alive. The distinction between "ordinary" and "extraordinary" measures expresses this truth and applies these limits to concrete cases. The use of equivalent terms, particularly the words "care suited to the real needs", perhaps expresses the concept more satisfactorily.

2.4.2. Criteria for distinguishing

The criteria whereby we distinguish extraordinary measures from ordinary measures are many. They are to be applied according to each concrete case. Some of them are objective: such as the nature of the measures proposed, how expensive they are, whether it is just to use them, and what options of Justice are in the matter of using them. Other criteria are subjective: such as not giving certain patients psycological shocks, anxiety, uneasiness, and so on. It will always be a question, when deciding upon measures to be taken, of establishing to what extent the means to be used and the end being sought are proportionate.

2.4.3. The criterion of the quality of life: its importance

Among all the criteria for decision, particular importance must be given to the quality of the life to be saved or kept living by the therapy. The letter of Cardinal Villot to the Congress of the International Federation of Catholica Medical Associations is very clear on this subject: "It must be emphasized that it is the sacred character of life which forbids a physician to kill and makes it a duty for him at the same time to use every resource of his art to fight against death. This does not, however, mean that a physician is under obligation to use all and every one of the life-mantaining techiches offered him by the indefatigable creativity of science. Would it not be a useless torture, in many cases, to impose vegetative reanimation during the last phase of an incurable disease?" (Documentation Catholique, 1970, p. 963)
But the criterion of the quality of life is not the only one to be taken into account, since, as we have said above, subjective considerations must enter into a properly cautious judgement as to what therapy to undertake and what therapy not. The fundamental point is that the decision should be made according to rational arguments that have taken well into account the many and various aspects of the situation, including what effect will be had upon the family. The principle to follow is, therefore, that no moral obligation to have recourse to extraordinary measures exists; and that, incidentally, a doctor must follow the wishes of a sick person who refuses the measures.

2.4.4. Obligatory minimal measures

On the contrary, there remains the strict obligation to apply under all circumstances those therapeutic measures which are called "minimal": that is, those which are normally and customarily used for the

maintenance of life (alimentation, blood transfusions, iniections, etc.). To interrupt these minimal measures would, in practice, be equivalent to wishing to put an end to the patient's life.

3. EUTHANASIA

3.1. Inaccuracy of the word "euthanasia"

Historically and etymologically, the word "euthanasia" means "a peaceful death without suffering and pain". In present-day usage, the word implies performing an action or omitting to perform an action, with the intent of shortening the life of a patient. This common acceptation of the word brings into debates about euthanasia a considerable amount of confusion. It is urgent to clear this up. Documents on the subject, like those which parliamentary assemblies have recently been formulating, show what harmful effects can result from the current lack of precision. Furthermore, present-day progress in medicine has rendered similarly ambiguous -and perhaps also superfluous- the distinction between "active euthanasia" and "passive euthanasia", a distinction that it would be preferable to give up making.

3.2. Actions and decisions which are not a part of euthanasia

Consequently, the Working Group is of the opinion that, at least in Catholic milieux, a terminology should be used which does not include the word "euthanasia" at all:
1) neither to designate the actions involved in terminal care which aim at making the last phase of an illness less unbearable (rehydration, nursing care, massage, palliative medication, keeping the dying person company ...);
2) nor to designate the decision to stop certain medical therapies which no longer seem to be required by the condition of the patient. (Traditional language would have expressed this as "decision to give up extraordinaty measures") It is thus not a matter of deciding to let the patient die but, rather, of using technical resources proportionately following a reasonable course suggested by prudence and good judgement;
3) nor to designate an action taken to relieve the suffering of the patient at the risk of perhaps shortening his life. This sort of action is part of a doctor's calling: his vocation is not only that of curing diseases or prolonging life but -much more generally- also that of taking care of a sick person and relieving his suffering.

3.3. The strict meaning of the word

"Euthanasia" must be used only to mean "to put an end to a patient's life by a specific act". Pius XII makes it abundantly clear that, understood in this meaning, euthanasia can never be sanctioned. (Allocution of the 24th of November 1957, Documentation Catholique, p. 1609)
Despite the fact that, in practice, the distinctions stated above are sometimes difficult to make, they are nonetheless capable of giving to the word "euthanasia" a meaning free of ambiguities. They can thus be points of reference for the attending physician, who, after consultation with the other doctors and the nurses on the case, with the hospital chaplain, and with the family, will then make his decision.
It will be a decision based upon the principle that neither moral values nor values inherent to the human individual, are to be meddled with; that the best judgment concerning what must or must not be done, continued, stopped, or undertaken, will be based upon these values according to each case, and can never be arbitrary.

4. THE USE OF PAINKILLERS IN TERMINAL CASES

4.1. There are various ways to ease suffering

The use of painkillers affecting the central nervous system, involves the risk of secondary effects: they can affect respiratory functions, alter the state of consciousness, cause dependency, and, losing their effect, necessitate larger and larger doses. This is why it is always better not to use them so long as the patient's suffering can be relieved by other means.
These latter are not few in number: remedies such as aspirin, the immobilization of certain parts of the body, various radiation therapies, even surgical operations... and, above all, combatting the solitude and anguish of the patient simply with the presence of another human being. There are also quite new methods coming into use, which enable the patient to acquire a certain mastery of his own body.

4.2. The use of painkillers acting on the central nervous system

In many cases, however, the relief of sometimes truly unbearable suffering does require the use of painkillers acting on the central nervous system (for example, morphine along with other narcotics) at least at the present state of medical knowledge and techniques.
There exists no reason to refuse to make use of such drugs, especially as their side effects can be greatly reduced if they are used judiciously: that is, in appropriate dosages and at accurately determined intervals. For the using of drugs against pain while still keeping the patient as conscious as possible, requires a perfect knowledge of these products: the ways to give them, their secondary effects, and their contra-indications. When decisions are being made concerning them, it becomes important for the pharmacologist to be consulted and, even, actually to be with the patient.

4.3. The necessity of a human presence

When speaking of the narcotics, we must warn against the temptation of believing that they are a sufficient remedy for suffering. Human suffering very frequently contains an element of anguish, of fear in the face of the unknown, brought out by severe illness and the nearness of death. Drugs can diminish anguish but, more often than not, are powerless to relieve it completely. It is only a human presence, discreet and attentive, that can procure the relief so much needed, by allowing the sick person to express his thoughts and by giving him human and spiritual comfort.

4.4. Is it permissible to put the sick person into a state of unconsciousness?

We can now approach the question of whether it is right, when death is very near, to use narcotics to put the patient into a state of unconsciousness. In certain cases, the use of them for this purpose is necessary, and Pope Pius XII has recognized the moral rightness of doing so under certain conditions. (Allocution of the 24th of February 1957)
The problem is, however, that there exists a great temptation to have recourse to narcosis as a general practice, doubtless, at times, out of pity, but often more or less deliberately, in order to save the doctors, nurses, family, and others around the patient, the emotional wear and tear of being with a person on the verge of death. This clearly indicates that it is not the good of the patient which is being sought; rather, it is the protection of people who are perfectly well but who are members of a society that is afraid of death, that flees death by any means at its disposal.
Yet systematic narcosis deprives the dying patient of the possibility of "living out his death". It deprives him of arriving at a serene acceptance of it, 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 thus knowing him. And, if the dying person is a Christian, he is being deprived of experiencing his death in communion with Christ.
What is therefore important, is to protest vigorously against any systematic plunging into unconsciousness of the fatally ill, and to demand, on the contraty, that medical and nursing personnel learn how to listen to the dying. They must learn how to create relationships among themselves which will sustain them to help families be with their near and dear one during the last phase of life.

4.5. Narcosis and the decision of the patient

The fundamental principle has been laid down, in this entire question, by Pius XII: it must be left to the patient to make decision. "It would be clearly unpermissible to narcotize the dying patient against his express wish (when he is sui iuris). If there are serious reasons in favour of deep narcosis, then it must be remembered that the dying person cannot summit to it morally, if he has not yet discharged all the duties that are so urgent when life draws to a close". (See below, Section 6.1.1.). If the doctor is requested by the patient to give him a deep narcosis, "the doctor will not do so -especially if he is Christian- without first having asked the patient, or better, still, having had an intermediary ask him, to fulfill all his duties beforehand". Pius XII goes on to state that, if the dying person refuses to fulfill his duties but still insists upong being narcotized, the doctor may do so: "He may consent to it without making himself guilty of formal collaboration in the sin committed. This sin does not derive from the act of narcotization, but rather, from the immoral wish of the patient: for whether he is given narcosis or not, his behaviour will not have changed: he will not have discharged his duties".

5. CEREBRAL DEATH

5.1. It is for the science of medicine to define this

In his Allocution of the 24th of November 1957, Pius XII states that "it is for the physician ... to give a clear and precise definition of 'death' and 'the moment of death'". Naturally, we cannot ask of medical science any more than a detailing of criteria whereby it can be established that death has taken place. But what Pius XII means, is that it is for medical science and not for the Church to establish these criteria. To the reasons he gives as practical illustrations of his point, can today be added requests for organ transplants, and the resultant necessity of precisely establishing the donor's moment of death before proceeding to remove the organ to be transplanted.

5.2. The difficulties involved in arriving at this definition

Setting up a medical definition of death is complicated by the fact that, at the present state of our knowledge, death apparently does not take place all at once. It is not an instantaneous cessation of all the functions of the body, but, rather, a series of cessations of our various life processes, one after the other. It seems that what stops first is the mechanism that regulates the functioning togeher of all the organs of the body. This mechanism is situaded in the brain. After it stops, necrosis then begins to spread to the varios systems: the nervous system, the cardio-vascular, respiratory, digestive, urogenital, and locomotor systems. And last of all, necrosis reaches the cellular and subcellular components. Yet even today, one cannot be too cautious in this matter, for many uncertainties still exist concerning the "medical definition of death".
There is, however, a growing consensus of opinion that considers a human being dead in whom a total and irreversible absence of life activity in the brain has been established. This is known as "cerebral death". Various autrhoritative groups have drawn up lists of criteria concerning it. These criteria may not be completely identical, but there is sufficient correspondence among them to make up a list of

symtoms of death whose accuracy can be taken as very highly probable. Conventional agreements and administrative procedure are already in effect or are being arrived at, which, if all the required criteria can be demonstared, permit or will permit the release of death certificates and, thereafter, the removal of the organs to be used in transplant operations.

5.3. The Church has been asked for a declaration

On the other hand, families are showing increased reticence in the matter of giving permission for the removal of organs for transplant. The Working Group was informed that this is why certain highly authoritative medical groups have requested the Church to make an official declaration on the validity or non-validity of taking cerebral death, duly established, as the "moment of death" of the human being.
TheWorking Group feels that it is for a higher authority than itself to make such a declaration officially, but has agreed to call attention, by means of this report, to the need for making it. However, the theologians in the Goup point out that, even though the proper ecclesiastical authority complied with the request, the Church would not be able to answer the question merely by making its own any scientific assertion or, still less, by issuing a list of criteria whereby cerebral death is to be determined. The very most the Church could do, would be to reiterate the conditions that would make it legitimate to accept the better judgement of those to whose specific competence has been entrusted the determination of the moment of death.

5.4. Measures to be taken in cases of apparent death

As Pius XII states, it is the physician's duty, in cases of apparent death, to do everything he can do, by every ordinary means, to restore life activity. Nonetheless, a moment always comes when death can be considered as having taken place, and when reanimation measures can be stopped without committing either a professional or a moral eror. (Pius XII, Allocution of the 24th of November 1957).

6. COMMUNICATING WITH DYING PEOPLE

6.1. The right to know the truth

The communication with the dying patients brings up the moral question of their right to know the truth. The clergy, pastorally, and doctors and nurses, professionally, must consider what sort of behaviour a dying person has a right to expect from those around him. The dying, and, more generally, anyone with an incurable disease, have a right to be told the truth. Death is too essential an even for the envisioning of it to be avoided. In the case of a believer, its approach requires preparation and specific actions made in full consciousness. In the case of any human being, dying brings the responsibility of fulfilling certain duties towards one's familiy, of putting order to business affairs, bringing accounts up to date, settling debts, etc. In any case, preparation for dying should begin long before the approach of death and while a person is still in good health.

6.1.2. The responsability of those surrounding a dying person

Whoever is nearest the patient must inform him of the possibility of his dying. The family, the chaplain, and the group providing medical care, must assume their share in in this duty. Each case is different, depending on the sensitivities and capabilities of all concerned, and on the condition of the patient and his ability to relate to others. How he will react to the truth -by rebellion, depression, resignation, and so on- is what those surrounding him must try to forsee, in order to be able to behave

with tact and calm. A ray of hope may licitly be held out to the patient; death may even be presented as not 100% certain- but only provided that doing this does not totally conceal the possibility of dying, the serious probability.

6.1.3. The mission of the hospital chaplain

Here is where the continuous assistance of the chaplain during the illness has its utmost importance. His mission confers upon him a privileged role in preparing a patient little by little for death. Of course the duty to believe, right to the very end, in the efficacy ex opere operato of the sacraments (Confession, Viaticum, and Extreme Unction) and when necessary of giving them conditionally according to cannon law, remains untouched. And yet we must point out that the unexpected appearance of the priest at the last moment makes the performande of his ministry very difficult and, at time, impossible. The hospital chaplain will try, therefore, to create, through continual contacts, a relationship of confidence with the patients, especially in milieux where there are lax or indifferent Catholics. He must be careful not to talk of the nearness of death too soon, while at the same time not concealing the truth. The Working Group does not consider it superfluous, furthermore, to insist that, at least in Catholic hospitals and by Catholic doctors and nurses, the caplain be granted his rightful position, both in consultations about the patient and as one of the persons having access to him at all times.

6.2. Society's attitude toward death

6.2.1. In the Western World

Western Society, today, is going through what can only be called "flight in the face of death". Medical and hospital personnel are experiencing this phenomenon and families too. The representatives of the Committee for the Family who took parti in our Working Group, reported to us some very discomforming examples of the change in attitude toward death within the same families over the course of only 30 years. One case was that of a family which, around 1930, fully took on the death of the mother -even the youngest members; and which, in the 1960's, fled from death, did not even speak of it to children, totally abandonned a dying wife.

We find that, while the medical personnel is trying to put off as long as possible the moment of physiological death, under the pretense of calming pain, they are really causing by these measures the greatest anguish and moral suffering in the patient, who, in most cases, is more aware of the seriousness of his condition than those around him affect to think that he is. The dying person feels sadness, guilt, anxiety, fear, and depression, and all of that along with physical pain. Worst of all for him, is the isolation, the loneliness, which seriously influence him psychosomatically. The present-day tendency of cutting a dying person off, first from society, then from family, and finally from the other patients in the hospital, deprives him, in his distress, of any and every possibility of communicating with someone else. And there are so many ways to relieve his loneliness, without even taxing him physically: the expression of a human face, a hand to hold! Often merely a silent presence is all he needs, but he needs it with every fibre of his being.

Thus, the practice of Western hospitals in these cases must be revised completely. Even the hospital personnel, for reasons not totally without cause, now tend to protect themselves against what seems a nerve-racking contact: they avoid being with dying patients, whose distress requires the very confort their presence might give. Once again, it should be a matter for group work-teamwork- to keep the dying from being deprived of this moral support. And doctors, nurses, and chaplains alike, must share in this teamwork.

6.2.2. In other parts of the world

In other societies, quite to the contraty, we find respect of the patient's right to be assisted by his near and dear, and of the family's right to be with their dying loved ones. Often the family even prefers to remove the dying person from the hospital so that he may be sure to have their presence, and, if they are believers, so as to communicate with him throug prayer. It is true that sometimes, in the real interest of the patient, doctors must know how to curtail the demands of the family and their insistence upon having the right of decision in the matter of what treatment is to be followed -unless, that is, the patient is a child and thus under parental responsability. And yet this curtailment should in no way risk fostering the all too real Western tendency of ignoring the family, their presence, and, particularly, their just demands to know the truth.

7. THE RESPONSABILITIES OF DOCTORS AND NURSES

7.1. Necessary knowledge of the medical deontology

It is becoming clearer and clearer that the scientific aspects and the ethical aspects of the medical profession cannot easily be considered separately. If progress in knowledge and technics is providing a doctor with new instruments and new therapies, the immediate result is that he is often being confronted by ever more complex moral questions.
We have spoken earlier of the fact that it is for the physician, in the last analysis, to make his decision by referring to objective moral criteria. This means, however that he must have been taught what these criteria are and must have been trained to apply them to specific individual cases. The teaching of moral theory and of codes of medical ethics is rightly, therefore, an essential part of the training of doctors and nurses.
Professors and students must in no way consider such courses as supplementary or "extra" only for those who wish to take them out of curiosity. In countries where there exists a tradition of common law, future physicians are at least encouraged to look into the requirements of moral theory and practice, by the very fact that their breaking an ethical and legal precedent would subject them to penal sanctions. But no future physician anywhere should avoid considering the essential interest of patients whom moral law defends and for whom codes of medical ethics have been evolved.
As to the best way to impart these teachings, it can be carried out, on the one hand, in special courses and, on the other, the moral aspects of scientific questions will be treated along with the scientific teaching itself, and thereby illustrated and insisted upon.

7.2. The choice of one therapy or another

As a general rule, and despite what the press leads people to believe, a doctor does not ask himself whether to allow or not allow a patient to die. He decides upon a certain medical treatment: what are its indications, what are its contra-indications? These all require him to consider various factors. He does so in the light of moral principles as well as of scientific knowledge; This is how it become of great value to a doctor to consider them while he reflects: what must or must not be undertaken? when should extraordinary measures be recurred to and when not? and if so, for what reasons and for how long? Too often, a doctor may come to question himself as to the advisability of continuing a certain treatment, and the question he may put to himself is: "Was it wise to have begun the treatment in the first place?". For, if there exist moral reasons for prolonging life, there also exist moral reasons for nor opposing death with what is known as "therapeutic obstinacy".

7.3. Massive therapy and choosing the persons to receive it

Among the ethical questions brought up by "massive therapies" requiring very higly evolved and expensive equipment and techniques, is to be considered the selection of patients to whom to apply a therapy that cannot be applied to everyone with the same malady. Is it legitimate to use the resources of refined medical tecniches for the benefit of only one patient, while others are still not receiving the most elementary treatment? One has a right to ask. If certain persons believe that such a question is "going against progress", Christians, at least, should bear it in mind in their valuation.

7.4. Trained nurses, male and female

7.4.1. The importance of their responsabilities

Despite the fact that many doctors tend to look upon them as purely auxiliary, nurses have a fundamental role of mediation between doctors and patients. Although nurses are, it is true, by no means free of the danger of avoiding the patient during the final stages of his illness, they are nevertheless responsible for actions that can often be of crucial importance. They must decide, for example, whether or not to call the doctor when they find that the patient has suddenly become worse; or must decide whether or not to give the patient calming substance the doctor has left it up to their judgement to use at th eappropriate moment, etc. Fortunately, in many hospitals tody, a true feeling of teamwork between doctors and nurses is beginning to prevail. Their close collaboration is essential to the relief and proper care of each patient.

7.4.2. Co-operation and conscience

At times, especially when she of he works in non-Christian hospitals or for non-Christian doctors, the nurse is brought up against a moral dilemma posed by an order given by the doctor, the execution of which would gravely endanger, if not actually put an end to, the patient's life.
First and foremost, the nurse must adhere to the absolute prohibition against performing an act whose only purpose is to kill. Neither the doctor's order, nor the request of the family, nor even the plea of the patient, can free the nurse from responsability for such an act. Where actions are concerned which in themselves are not toward killing (even though the nurse knows that an unpermissible result is being aimed at), the case is different if the nurse performs these actions by order of the doctor. Examples of this are: doing something which will shorten the life of the patient, suspending a treatment which is not "extraordinary", depriving of consciousness a patient who has not been able to fulfill his obligations. The nurse may not take the initiative for such actions. The only possible way to look at a nurse's performing them, is as their being a "material co-operation" excusable only by necessity when examined in the light: 1) of the gravity of the action; 2) of the nurse's participation in the whole process and the obtaining of the immoral goal; 3) and of reasons which might have led the nurse to obey the order: fear of something personal being done to her or to him if the order is not carried out; an important personal good be protected by not exposing oneself to the risk of being dismissed. Insofar as her or his status permits, the nurse who finds her or himself involved in practices of which one's conscience cannot approve, will make every effort possible to bear witness to her or his personal convictions.
Catholic chaplains and physicians are in duty bound to help nurses face up to such difficult situations, in every way they can.

7.4.3. Ethical training in nursing schools

All that we have reported in Section 7.1. concerning the necessity of ethical training for doctors, pharmacologists, et alii, holds true in the case of nursing schools as well. Catholic nursing schools have the right and the duty to defend, through their teaching, the ethical principles of the Church's Magisterium, particulary in courses which treat of the exercise of the nurse's profession: the value of each human individual, respect for life, morality and marriage, and so on. It is the duty of Catholic nursing schools to make this ethical orientation clear to all students applying for entrance. The schools further have the right to demand of all students their acceptance of these principles and their attendance at courses specializing in the teaching of professional ethics. The students must arrive at the convinction that here is an essential element, a condition sine qua non, of the proper training of a responsible nurse. Nor should this teaching be limited to a casuistical presentation of the subject. Rather, the professors will in every way seek to inculcate a profound familiarity with such fundamental notions as life, death, the personal vocation which a nurse has, and so on.

7.4.4. Training for the nursing of the incurably ill

The familiarization of hospital personnel with the demands made by death and by the care of the dying, does not take place only at the intellectual level. The actual face-to-face ecounter with suffering, with a patient's anxiety, with death, can be a source of great anguish. Here is one of the main reasons why many professional people today are beginning to avoid having anything personal to do with the incurably ill, and are abandonning them to their loneliness. Thus must be added to the teaching of the theory and study of professional ethics, an education in how to relate to people, and especially to the incurably ill. If this is not taught, then any teaching of ethics is in danger, in the long run, of not being applied to the real situations encountered professionally.

8. THE RESPONSABILITIES OF FAMILY AND SOCIETY

8.1. Education for suffering and death

The ties between life and death have become so very much loosened, at least in our Western society, that death has little by little lost its significance.
The family and the society by which it is surrounded have each their own part in this situation, which can only be considered highly destructive. It is urgent that education about suffering and death be undertaken. This would perhaps be the solution to the numerous problems existing today concerning death and the dying.

8.2. Question we must ask ourselves

The family must begin to question itself on this subject;
1) in order to see whether suffering, death, failure, etc., are present or absent in its child-education habits, beginning with the earliest ages of life;
2) in order to determine what place it accords to sick persons, the handicapped, people who have failed in life, old people, and the dying.
If it is found that this education and this sharing are not a part or the family ways; if there is no family attitude and habit which are signs of love and of faith in the value of each and every human being -then how can we hope to create the communication so greatly desidered between the dying person and his family during the last moments of earthly life?

8.3. Society and the family. Legislation

Society, too, must also ask itself what it is bringing of any value to the family where this educative mission is concerned, whether it be to the family's habitat, to the various kinds of work its members perform, to its health, or to its problems with the sick and the aged.
Above all, we have every cause to be apprehensive lest the family's solidarity with its members who are suffering- and solidarity in every sort of suffering- be gravely threatened by certain kind of present-day legislations: for example, laws "regulating" divorce, contraception, and abortion and tomorrow, perhaps, euthanasia.