ISSN 1908-5567

BOLETIN ECLESIASTICO de FILIPINAS

VOL. LXXXIV, NO. 869 NOVEMBER-DECEMBER 2008

The *Ber* of the Matter

It may be perceived as somewhat peculiar by others, but for many Filipinos, Christmas season starts way ahead of the usual schedule as observed in other parts of the Christian and non-Christian (at least for the mere consumerist motivations) world. In fact this anticipated festive mood is unofficially inaugurated by the beginning of the "ber"-months, and continues until the first weeks of the New Year, as if to savor the atmosphere for the longest possible time.

It used to be a trivial thing of short-lived fascination for me, but the thought of exploring the teleological nature of the "ber"-months also brought me to some form of flimsy inquiry. Written sources indicate that the old Roman calendar began with March, and continued to the sixth month with names based on the agricultural cycle. The fact that the last four months of our present calendar end with a common suffix simply affirms the historical note that they were in the old calendar merely numbered, as can be realized from their etymological reference. However, no matter what the chronicles indicate, our present regard of the "ber"-months as "Christmas months" will always be an experience of encountering both realities of birth and death.

As early as September, Christmas carols resound on the airwaves; malls are seen partially introducing bits of decorations; and businesses promote profitable schemes to lure prospective clients into the festivity. People, on the other hand, are drawn into the induced euphoria, and get into the band-wagon of cheaper-when-done-early preparations for the celebration: homes slowly light up with the season's lanterns; families

flock to the discount-markets for advanced gift purchase; and television networks begin their own versions of the Christmas countdown. This continuous domino-like sequence of events is suddenly brought into a standstill, however, towards the end of October, when the buoyant ambiance of looking forward to the commemoration of the birth of the Lord is abruptly replaced by a downcast disposition in anticipation of paying tribute to the dead. In adherence to the Church's commemoration of the faithful departed, November has been, to some extent, regarded as a month of momentary interruption to the festive journey to December that began in September. Even malls with the previously installed Christmas ornaments take great pains in donning their shops with Halloween motifs if only to accommodate the similarly popular observance. For a while, grief apparently takes the place of joy. It is like having to go to school on a day sandwiched between a national holiday and the weekend. It is like a brief spoilsport that dampens an otherwise unbroken cheerful mood.

Perhaps it is the reality of death that scares most people into a disposition that is devoid of rejoicing, such that the commemoration of the dead becomes an instance of sadness rather than happiness. Dying opens one's consciousness of the truth that earthly existence is not forever, that each will have to face one's mortality some day. This aversion to death becomes an unconscious impetus that prompts a person to prolong life, at times even at the expense of another. In fact, people at the brink of physical collapse can be so driven as to disregard another life in an effort to save one's own. Today, the Holy Father even had to remind those in the health-care profession to exercise caution in removing organs for transplant from dying donors who might not actually be dead yet. Thus, the recent call from Benedict XVI on the scientific community to find a new consensus to define when someone's life ends, a fundamental manifestation of the basic respect to each person's life.

We experience death everyday of our lives, in the same way that we also constantly experience birth. This is because change itself is a dynamic interplay of dying and birthing. The end of one thing becomes the beginning of another. However, dying may involve the end of something that has come to be valued in a profound way. That is why it is often hard to let go of what was, and move on to what is. With the consistency that change manifests itself in the world, one may at times reach a point when

too many new things become harder to adjust to, and one simply gets tired. A worse condition happens when one does not simply stop learning new things, but rather becomes resistant to all things new.

In a study conducted last year among American centenarians and published in a local paper, it was discovered that, for the majority of the 80,000 people who have reached a century of age, longevity did not depend on "clean" living, that is, without smoking or drinking alcohol. The so-called "secret" to their long life was that they kept abreast of the changing times. The respondents were found to be attuned to current events, the latest gadgets, and even with recent programs on the television. The Discovery Channel has already busted the myth that one cannot teach an old dog a new trick. For humans, this could actually mean survival, as the findings of the study prove.

But life is not simply a matter of reaching over a hundred in age. One's ability to adapt to life's changes contributes to a healthier disposition, because it makes allowances for openness to something not previously present in the same way. As Bob Dylan quips, *"He who is not busy being born is busy dying."* When one continues to brood over what has long been gone, he will not have time to rejoice over the blessings that accompany the things that come. One may even be too preoccupied with evading death that he forgets to live. One can speak of a readiness to embrace the future only when one is able to welcome change, even that involving earthly existence. The same truth resonates in our life of faith, as the Holy Father articulates in his address, *"When a life is extinguished... we should not only see this as a biological factor which is exhausted or a biography which is ending, but indeed as a new birth and a renewed existence offered by the Risen One to those who did not deliberately oppose his Love. The earthly experience concludes with death, but through death full and definitive life beyond time unfolds for each one of us."* It is not simply a matter of a starting point and an end point, but the journey in between. It is not the quantity measured by the number of years endured, but the quality of life enjoyed *to the full* (John 10:10). The *Ber* of the Matter is to remember – that death is not simply a matter of one's bodily parts having to dismember, that birth is not just about having an additional family member, that life is more than surviving years in the most number.

Indeed, as the Bhagavad Gita says, *"For certain is death for the born and certain is birth for the dead; Therefore over the inevitable thou should not grieve."* There is, according to George Santayana, no cure for birth and death, except to enjoy the interval. As the Scriptures affirm, *"All things have their season, and in their times all things pass under heaven... And I have found that nothing is better than for a man to rejoice in his work, and that this is his portion. For who shall bring him to know the things that shall be after him?"* (Ecclesiastes 3:1, 22) ■

Moral and Philosophical Dilemmas in Death and Dying

SYMPOSIUM ON DEATH AND DYING

Victoria Infirmary, Glasgow, 15.10.94

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1. THREE VIEWS OF THE DIFFERENCE BETWEEN KILLING & LETTING DIE

I would like to address this morning some of the moral and philosophical dilemmas concerning death and dying which have been highlighted by a number of recent legal cases and government reports, both here in Britain and more widely in Europe.

Apart from their influence on law and society, these reports illustrate and illuminate much about contemporary attitudes and trends. In particular I will treat some of the recent answers given to the problem of when to treat and when not to treat, when to save, cure and care, and when not to, when to kill and when not to kill.

These are questions which will not go away. Rapid biotechnological advance, especially since the Second World War, has meant more and more can be done by way of diagnosis and treatment. If much more is now possible medically, much more is also now expected. New and better treatments are naturally greeted with enthusiastic demand. The Hippocratic ethic of doing everything possible to help the patient has

become in our culture 'hi-tech', 'spare-no-expense' medicine. A good case can be made for the proposition that we expect too much from medicine and from healthcare systems.

At the same time there are pressures to withdraw from the save-sure-care ethic of traditional Hippocratic medicine. The constant upward pressure on health budgets is being resisted not just here in Britain but throughout the Western world. Economic factors and a change in ideology have led to a trend to withdrawal from the commitment of a previous generation to universal health-cover, or at least a redefinition of expectations. Changing views of the value of life, especially of the value of supposedly low-quality lives such as those of the handicapped, elderly, comatose and dying, and a diminishment of taboos against medical killing, have fuelled a growing and vociferous pro-euthanasia lobby. They feed on fears of over-treatment, of people being kept in agony or else unconscious and barely alive on hi-tech life-support when they ought more appropriately to be allowed to die with dignity. It is the moral and philosophical dilemmas raised by these trends which I shall address today.

1.1 The common sense view

Most people, whether they are health professionals or not, say 'boo' to killing and 'hooray', or at least no 'boo', to letting die. But what's the difference, apart from how we feel when we hear the words? I will begin by outlining three views of the difference, which I take to be representative ones, the first which says it makes all the difference in world, the other two which say it makes no difference at all. According to the common sense 'all the difference in the world' view, deliberately killing people is obviously evil, whatever the circumstances, ulterior motives or consequences. In a medical environment it conjures up images of health workers secretly and possibly involuntarily killing their patients, of handicapped infants and elderly people in institutions being quietly snuffed out, of wicked experimental or eugenics programmes. But even more benevolent killing has, at least until recently, been forbidden according to the common view. 'Letting people die', on the other hand, suggests the much more acceptable practice of 'letting nature take its course', facing up to the limitations of medicine and the fact of impending death, and avoiding heroic measures such as aggressive surgery, drug therapies or intrusive devices. In the end

it is not our responsibility to keep everyone alive, nor could we if we tried. And it is a good thing to be allowed to die in peace.

This kind of view is common place in conventional morality, in law, and in medical practice.[1] It is presumed in the traditional codes of medical ethics which forbade euthanasia.[2] The judges in several recent cases, and the Lords in their recent report, sought to appeal to this tradition by distinguishing between illicitly doing some act which hastens someone's death, and licitly omitting to act to extend life where this is in accord with good medical practice and in the best interests of all concerned. Whether this is an accurate interpretation of the classical tradition will be considered later. What is of interest here is that the weight of the distinction is placed on the difference between *acts*-causing-death, which are said to be immoral and illegal, and *omissions*-causing-death, which are said at least in some situations to be moral and legal.

1.2 The consequentialist view

The consequentialist 'no difference at all' view says that all that matters are consequences. If a person dies because we kill them or just because we sit by and let them die, the result is the same. Any attempt to distinguish the two morally is transparent hypocrisy, designed to appease our queasy consciences and evade our responsibilities. Furthermore, this distinction might well have terrible effects, as when a person who would obviously be better off dead is forced to endure a long period of suffering or undignified existence or expense to self and others, just because no-one is willing to assist her in ending it all.

This view, promoted by some philosophers,[3] is gaining currency among sections of the medical profession and healthcare bureaucrats, and increasingly in the popular press. Such a view underlay some of the reasoning in Bland's case,[4] and was strongly put by several of those who testified before the House of Lords Committee.

1.3 The vitalist view

The vitalist 'no difference at all' view is that we have an absolute duty to save as many lives as possible for as long as possible. Letting a person die when some intervention might save her is just as wicked, or

almost as wicked, as killing her yourself. Any attempt to distinguish the two is (again) a transparent sophistry, designed to cover up a murderous or suicidal activity.

This is the view popularly attributed to the pro-life movement and to its sympathizers such as the mainstream churches, often by those who would like a convenient caricature to criticize,[5] but sometimes by members of those groups themselves.

2. MY VIEW

I think all these views are wrong. I want to propose instead a qualified form of the (first) common sense view. Properly understood, there *is* an important difference between killing and letting die; and while intentionally killing the innocent is unethical, letting someone die, can be permissible, even required. This requires careful explanation.

2.1 Two kinds of euthanasia: active and passive

In medical situations there are lots of opportunities to save life; there are likewise many ways and means to kill people. When killing is done in the course of medical care for the patient's supposed good (i.e. to alleviate suffering, indignity etc.) we call it *euthanasia*; where a health-professional does something to hasten a patient's death in these circumstances it is called *active euthanasia*; when a health worker aims to hasten a patient's death by omitting to do something she should otherwise have done for a patient she did not wish dead, it is called *passive euthanasia*.[6]

The most celebrated recent case of active euthanasia in this country was that of Dr Nigel Cox. He gave a lethal dose of potassium chloride to a 70-year-old patient who was in severe pain, terminally ill and asked to be killed. He was convicted by the Winchester Crown Court of attempted murder, given a one-year suspended sentence, reprimanded by the General Medical Council, and required to do retraining in palliative care. But in many places there is considerable lobbying for the legalization of this practice, called euphemistically in the US "physician aid-in-dying". Holland is the first European country to have formally legalized voluntary active euthanasia by physician. Earlier this year the House of Lords

committee however came out against it. But we have already accepted as commonplace active euthanasia for the handicapped in the womb; and if we were to accept passive euthanasia the pressure to allow a more active, and in some people's view, more compassionate kind of euthanasia would be considerable.

Passive euthanasia – by means of dehydration, starvation, failure to perform appropriate operations or to give appropriate drugs – is far more common in British hospitals than killing in the more active way. Thus I am advised that infants with certain handicaps are less likely to survive hospitalization today than they were a decade ago, despite the advances in medicine. Two recent cases of what was arguably passive euthanasia of older handicapped persons were those of Tony Bland and S. Tony Bland was left by the Hillsborough football stadium disaster in a 'persistent vegetative state' ('PVS') and it was held by the courts that his continued tube-feeding (and by implication, his continued living) was not in his best interests. Thus all food, water and antibiotics were withdrawn from him and, as expected, he died nine days later. S was a 24 year old man with acute brain damage resulting from a drug overdose. His feeding-tube became dislodged, perhaps accidentally, and the court ruled that it need not be reinserted. There were some differences between the cases. Bland's received a great deal of court time and media attention; S's case was treated hurriedly and received little media comment. Bland's was a clear case of PVS and severe PVS at that; in S's case medical opinion was equivocal and no independent medical opinion was sought.[7]

Medical killing by neglect or abandonment, rather than by overt action, sanctioned not by statute but by non-prosecution, gradual erosion of the common law by judicial decisions, and gradual change in medical practice, is the most likely way for more widespread euthanasia to be introduced here in Britain. In many places there is considerable lobbying for the legalization of this practice, called euphemistically in the US 'benign neglect by physician'. Bland's case was the test case in this area.

2.2 Moral equivalence

I believe active and passive euthanasia are morally equivalent. Usually, of course, the distinction between action and omission, intervening

and 'letting nature take its course', is morally important, even decisive,[8] and much of law and social practice follows this. There are only so many things we reasonably can choose and do, and we are not guilty of failing to choose or do all the other possibilities. We are not morally responsible for the deaths of every person we might conceivably have helped, if we are devoting our time and energies to other morally reasonable purposes, fulfilling our responsibilities.

But it is also the case that we can intend to kill someone but organize or exploit the situation so that this requires no positive act on our own part: only our failure to do something. Obvious examples of this would be where a parent sees her baby drowning in the bath and fails to intervene; or where children fail to feed a starving elderly parent;[9] or where ancient Greeks or modern health-professionals abandon handicapped infants. Of course in these situations the agents can say "I didn't do anything": but that is precisely the problem: they should have, and someone died as a result. These situations are morally equivalent to acts of killing.

Whatever the legal situation, from the moral point of view – as the judges in Tony Bland's case openly recognized – it makes no difference whether one uses active or passive means to kill: once you have decided to hasten someone's death (and everyone agreed in both the Cox and Bland cases that that was the intention), whether one uses active or passive means is simply a question of strategy. Thus on 7 March 1994 Judge Geoffrey Grigson in Old Bailey convicted an unnamed man of manslaughter by omission when his baby son died of neglect. But it seems that the law will allow killing in certain circumstances: for now, only by a strategy of omission or neglect, of failing to do things we would do for patients we wanted alive; for now, the law will only allow this is grave cases such as PVS; for now, our motives must be respectable ones such as the relief of torment to the onlookers and the community; and for now there must be support for the practice in at least some quarters of the medical establishment. But the intention can still be to hasten the patient's death.

My assertion of the moral equivalence of active and passive euthanasia may seem strange, since I said only a few minutes ago that I thought the difference between killing and letting die is important, vitally important. Where, then, would I draw the line between immoral killing

(euthanasia, whether active or passive) and morally permissible letting die, and how would I justify the difference? I would suggest that we might consider four basic principles.

3. THE SANCTITY OF HUMAN LIFE

The first basic principle has traditionally been called 'the sanctity of human life',[10] a principle much referred to in the Cox and Bland cases and in the House of Lords report. The principle was said to be deeply embedded in our law and ethics, in Britain and throughout the world, included in international human rights documents, and strongly felt by people of all religions and none. It is basic to our common morality. Human beings are held to be entitled to great and equal respect; their lives are of such intrinsic importance that no choice intentionally to bring about an (innocent[11]) person's death can be right. Thus the principle has traditionally been worded "you shall not kill" or "everyone has (an equal and inalienable) right to life".

The House of Lords concluded:

Society's prohibition of intentional killing...is the cornerstone of law and social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia...Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.[12]

Applied medically the sanctity of life principle excludes medical killing: amongst the ways in which health workers may not deal with their patients, killing them is one.

Thus classical medical ethics has held that physicians might not be called upon to act as public executioners.[13] Likewise it has traditionally excluded both active and passive euthanasia. Thus the court and the GMC held that Dr Cox had acted contrary to his duty as a doctor when he killed a patient even though she was in severe pain and had asked to be killed.

Most people regard killing someone simply for advantage or convenience of others as inconsistent with recognition of that person's dignity, and immoral. But dilemmas arise both for health-professionals and for others when a patient keeps asking to be killed, or is in excruciating pain, or is very dependent, or is a great strain on the financial and personal resources of others, or is living in a state of permanent unconsciousness. Then we will certainly sympathize with the person who feels permitted, even driven, to killing. Most people, for instance, would have agreed with or at least understood the hope of Mr. Bland's family and S's mother and their medical care teams that the young men would die sooner rather than later. True, neither was on any life support machines, despite the press talk of switching their life support off: they were only receiving tube-feeding and the ordinary nursing care which thousands of temporarily or permanently disabled people receive all the time in Britain. But they were unlikely ever to regain consciousness and were a significant burden on others. The question was: should we hurry up their deaths?

I think we must face up to the fact that we cannot do so and at the same time give full force to the sanctity of life principle. Thus proponents of active and passive euthanasia must deny the principle in some way.[14] Some for instance argue that there is nothing about human beings which is especially or equally valuable or deserving of respect. Some would hold that only human beings with certain qualifications are entitled to such respect: consciousness was the crucial qualification in the mind of the judges in Bland's case, so much so that they were sometimes unclear about whether he was really a living human being.[15] Again, some would argue that some human beings, such as Tony Bland, are simply 'better off dead': their value is overridden by their suffering or degradation.[16]

There are also those who would respect every person's right to life in principle, but hold that in some situations it might legitimately be compromised to serve other important values. When we talk, for instance, of "putting granny out of her misery", what we often mean is "putting granny out of our misery". Lord Mustill, who approved the decision to discontinue Tony Bland's tube-feeding, confessed the hollowness of the claim that this was in Mr. Bland's 'best interests'. (The same language was used in S's case.) He suggested that the interests of the family, the medical staff, and the paying community were decisive here. He concluded that "the

distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Tony Bland". His life would be compromised to serve other interests or values.

The underlying premise of all these approaches – that our mere existence as human beings has no value as such, or that it can be discounted by some countervailing disvalue – is clearly inconsistent with the traditional doctrine of the dignity and inalienability of every human being, whatever his or her condition. However benignly, it ultimately assesses some people as being of negative value. This in turn highlights the fact that essential to the killing / letting die distinction is a high view of human dignity and equality, and of our moral responsibilities in acting and forbearing to act with respect to it.

4. CARE FOR THE SICK

A second basic principle in this area is the duty to care for others. Negatively this means we may not harm people or treat them negligently or with disrespect. Positively it refers to 'Good Samaritan' duties to show kindness to others, especially the most needy, and to our special responsibilities towards dependant persons in our particular care. These duties are again supported by beliefs and documents ranging from the Bible and Koran to the International Covenant on Economic, Social and Cultural Rights. Thus certain basic measures such as food, water, shelter, clothing, sanitary and nursing care must be maintained out of respect for the human dignity of every person; anything less is unjust discrimination.[17]

In addition to these common humanitarian duties we have towards each other, there are the special duties of care peculiar to health workers. Because of the special vulnerability of patients, it is important that health-professionals have a clear sense of what is owing to their patients by way of action and restraint. The western medical tradition has developed an ethic of *medicine-as-therapy* ('medical beneficence and non-maleficence'), i.e. that a health worker will do no harm to, nor take any undue risks with, her patients, but will, rather, seek to promote the patient's good health. [18] The principle of medicine as therapy excludes the use of medicine for other purposes such as social engineering, exploitative experimentation, profit maximization etc. And it has traditionally excluded euthanasia: killing

cures no one, is not nursing care, not therapy. Thus when Dr Cox injected his patient with a lethal drug that had no possible curative or alleviative potential, he was, in the words of the General Medical Council reprimand, acting "wholly outside his duty".[19]

5. RESPECT FOR PATIENT AUTONOMY

That the dignity of human beings requires respect for their free will, autonomy or right of self-determination is a third basic bioethical and medico-legal principle. 'Autonomy' has become an umbrella-term for a range of ideas which might be summarized as follows. The dignity of human beings requires that we give absolute respect to their free choices. In law and ethics health-professionals only have as much authority as they are given by their patients: this is the basis of the doctrine of consent in healthcare and the right (contrary to traditional paternalism) to refuse medical treatment. It underlies much of the recent talk of patient empowerment, advocates and charters. And some claim that it means health workers must respect the directions of their patients *whatever they might be*. People's views of what matters in life and what is a meaningful death differ: some would want to hold onto life to the bitter end whatever their quality of life (though this might be rather irrational and selfish); others would rather die while they are in full control, their quality of life is still high, and they are happy; others would want to die somewhere in between, when for instance their powers are failing, their quality of life is falling, and they are unhappy. Given the variety of people's preferences, so the argument goes, the important thing is to leave it up to each individual to decide for herself rather than imposing someone else's standards.[20]

All this sounds very reasonable in our individualistic, consumer culture, and was a powerful theme in the Bland case and in much of the evidence given to the House of Lords Committee by groups such as the Department of Health, the BMA and some philosophers. But it is a very partial view of human dignity and freedom. First, because few sick people fit the bill of the idealized freely choosing agent. As the BMA itself recognized "even apparently clear patient requests for cessation of treatment sometimes stem from ambivalence or may be affected by an undiagnosed depressive illness which, if successfully treated might affect the patient's attitude".[21]

And the Lords opposed euthanasia because "vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined".[22]

The second problem with much autonomy talk is that it fails to situate human freedom within the range of opportunities and values which are the context of human choice. Human beings are certainly free and equal; but this means not only that they have an inalienable right to make free decisions but that they have an inalienable duty to make responsible decisions. So the flip-side of patient consent is that patients, for their part, must exercise this freedom properly, in pursuit of their own good health and respect for the good of persons in community. Free will or autonomy is not mere whimsy: we are not free to do 'whatever we choose'. We have to take into account the intrinsic morality of our choices and their self-constitutive effects, what they do to us, what they make us and say about us.

The third problem with the autonomy line is that it is radically asocial, even anti-social: all that matters is that I get my own way. But we are social animals and human freedom is always exercised within a web of relationships. So we have to respect others. We have to consider the implications of our choices for their lives and for the common good. If we want to be 'put out of our misery' someone else must be involved: so someone else's 'autonomy' is unavoidably affected.

The House of Lords grasped part of this when it insisted that decisions about suicide and voluntary euthanasia are never purely personal ones: they always affect others. "Dying," they said, "is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole."[23] Furthermore, the Committee said, healthcare is a partnership of the patient and the health-professionals in pursuit of a common good. It is not like someone impulse-buying a chocolate bar.

Thus 'autonomy', 'respect for autonomy' and 'patient empowerment', at least as understood in classical morality, are not just slogans for a range of supposed rights guaranteeing to the individuals that

they can pursue their own life and death plans whatever they are. But detached from its richer ethical context autonomy seems to many people to allow, or even require, euthanasia, at least with consent, and by a dubious but common extension, involuntary euthanasia as well.[24]

6. THE SANCTITY OF HUMAN DEATH

A fourth principle is what I call the sanctity of human death. The classical moral tradition recognizes that one need not strive relentlessly to preserve the last vestiges of physical life. It is not a survival at any costs ethic, however often it has been portrayed as such. Indeed a survival at any costs approach can well be due to therapeutic obstinacy, a refusal to face up to the limitations of healthcare and human mortality, a product more of despair than respect for life. Death is an evil, but not the greatest evil. For many people it is a merciful release, the natural end to a life-story well-written, and as believers claim, the door to eternal life.

At some point in most people's life death becomes, as it were, 'inevitable' and, if there is an opportunity to do so, it is important to compose oneself to die well, a need which can be frustrated by too strenuous an effort to prolong life. While one should always value the gift of life, one may not be obliged to prolong it with highly intrusive treatments. Care and respect for the dying often requires that kind of specialized help known as palliative and hospice care, and if this is to be applied it will be necessary for people to accept that death is near and that there is little more that human effort can properly do to postpone it.

Thus traditional medical ethics (and Christian faith) counsel against over-treatment and allows that some treatments will be withheld or withdrawn for good therapeutic reasons.[25] Their continued use may be futile, i.e. of no therapeutic value. Or they may impose a burden (in terms of pain, indignity, disruption, confinement, risk, cost etc.) which those concerned judge is greater than the benefit gained.[26] In Bland's case, for instance, it could well be argued that the surgery and strong antibiotic drugs he received in the year before he died were not required;[27] and in S's case that the repeated surgical reinsertion of the tube was overly burdensome. In this situation treatment would traditionally be termed 'extraordinary' and optional. Furthermore, sometimes treatments are properly given or

withdrawn for the therapeutic good of the patient even though this risks shortening life though not with this as the object.

Again, *prima facie*, this principle might be thought to allow euthanasia, at least by omission, in some cases. In Bland's case Lord Goff, for instance, highlighted the fact that traditional medical ethics has allowed the removal of ventilators and the administration of pain-relieving drugs to the terminally ill even where it is known that this would abbreviate the patient's life, suggesting that therefore the sanctity of life principle is not absolute.[28]

7. RECONCILING THESE FOUR PRINCIPLES: WHEN LETTING DIE IS NOT THE SAME AS KILLING

How are we to resolve the moral and philosophical dilemmas which these matters present us with? The simple answer is: *it is all a matter of intention.*[29] When health workers give a pain-relieving drug, or withhold or withdraw some treatment, and death results earlier than it might otherwise have done, hurrying up death may or may not be why they chose such a course of action. Encouraging death is often no part of the health-professional's reason for such chosen conduct. Death may or may not be foreseen, but it is not intended; it belongs neither to the health worker's precise purpose, nor is it the means used to achieve that purpose.

On the other hand, a health-professional may give a pain-relieving drug or fail to treat because the health worker believes the patient would be 'better off dead', or others would be better off were the patient dead, etc. In this case hurrying up the patient's death is certainly part or the whole of the reason for the health-professional's chosen conduct. It is all a question of intention.

From what I have said so far it should be clear that in healthcare contexts, as elsewhere in live, the negative norm "do not kill" is *not* the same as the positive norm "preserve life in all circumstances and at all costs". Obviously whether or not a medical treatment will prove disproportionately burdensome will depend upon the circumstances and condition of the patient and others: one cannot simply list ordinary and

extraordinary treatments as such. But the judgment that a treatment is too burdensome is *not* the same as a judgment that a life is too burdensome. It does *not* involve any arbitrary quality-of-life judgment that a person lacks overall value and so for that reason may justifiably be ended. If a health worker discontinues a treatment in order to avoid imposing disproportionate burdens on a patient, even if in consequence death is likely to result earlier than it otherwise would have done, killing is neither her purpose in making that decision nor her chosen means to avoid the burdens.

In Bland's case, however, the judges have made a radical departure from this traditional ethic and law, allowing that tube-feeding be withdrawn not because of the futility or burdensomeness of the so-called treatment, but because Tony Bland's continued life was a source of indignity and humiliation to him, a violation of how he would want to be remembered, and an ordeal for others.

Lords Browne-Wilkinson and Mustill – the two who were most openly uneasy about the decision – recognized how subjective such 'quality of life' judgments really are; in the end they reduce to "a matter of personal choice, dictated by background, upbringing, education, convictions and temperament". Lord Mustill also noted that these quality of life judgments are not ones that doctors and jurists have any special skill or expertise to make.

This, then, is where the difference between killing and letting die lies: *not* in the difference between acting and omitting to act (the route the Lords in Bland's case and the Select Committee Report tried to go); *not* in whether a person's life is of good enough quality or burdensome to them or others (again important in the Bland decision); *nor* in whether the agent is well-meaning (which the doctors probably were in both the Cox and Bland cases). The distinction lies crucially in the difference between intentionally bringing about a person's death – which is always a harm to the victim, the killer and the common good – and taking a course of action possibly foreseeing but not intending a person's death – which may harm no-one directly. *Whereas intentionally killing, whether by commission or omission, is immoral, it is permissible to withhold or withdraw treatment where such treatment is futile or overly burdensome, and in this sense (and this sense only) 'let the person die'.*

There is room for a considerable range of opinion even within classical medical ethics (and Christian faith) about what care is appropriate for the permanently comatose, the elderly, the handicapped and the dying. Tube-feeding is one such controversial question. A sound case could conceivably be made for discontinuing Tony Bland's tube-feeding (though I think only with difficulty[30]) and can more easily be made for not reinserting S's tube. The problem with these cases is not so much their outcomes as *the reasoning* behind the decisions, what this reveals about trends in law and practice, and what this kind of thinking is likely to allow in the near future. For, at least in the Bland case, we are confronted with what seems to have been a case of intentional killing.

The importance of intentions lies in getting to the heart of who we are and what we are about, our real purposes. The difference between intending-and-causing and foreseeing-and-causing is not always simple, and people's intentions are often as confused as their motives are mixed. But for the most part what is intentional is not in doubt, and various questions and what-if tests can be used to clarify intentions.

8. SOME CONCLUDING REFLECTIONS

8.1 Hard cases

We should have great concern for patients such as those in the Cox, Bland and S cases, and seek by whatever means are morally and practically available to ease their suffering and respect their dignity. We should have tremendous sympathy for the family and health-professionals surrounding such patients: when people take a long time to die, those who must accompany them often suffer the most. Perhaps we could do a lot more to support them. In hard cases like these sympathy and compassion also tempt us to compromise our basic norms and to fudge our laws. The temptation, one we all know in our moral lives, is to think that we can allow just one, or a few, exceptions; we can still hold the line 'as a general rule'. But rational reflection – and human experience – suggest that the implications of such exceptions go far wider than the relief of hard cases.

8.2 Victimization

Apart from the intrinsic evil of killing people, medical killing changes us individually, as healthcare professions and as a society. Even discounting the person killed, euthanasia is not victimless because the person who does it is also significantly harmed in the process and so almost inevitably is the community. The health worker's character will be very significantly shaped by killing a patient, however noble the motivation. It will change her attitudes, habits, dispositions, taboos. A health-professional disposed to think that some patients lack inherent worth or may be killed has, however well-meaningly, seriously undermined a disposition indispensable to the practice of medicine: a willingness to give what is due to patients just in virtue of their possession of basic human dignity. And the absence of that willingness is likely to be fateful for other patients. Ethically, psychologically and sociologically, euthanasia invites further extension of 'therapeutic killing', whether by the same health worker or others. It also discourages alternative approaches to suffering, such as research into cures and the provision of good palliative care and pain management.[31]

8.3 Other problems with euthanasia

There are other problems with the euthanasia answer which I have no time to explore here. So I might just flag a few. There are problems of interpreting the plea of patient or by-standers for euthanasia: is it perhaps really a plea for better pain-relief, better support, comfort and love? There is the problem of the pressures, subtle and overt, conscious and unconscious, on patients, families and health-professionals to seek or co-operate in euthanasia once it is permitted: pressure all the harder to resist when one is very vulnerable, one's freedom very limited, one's self-esteem very low.[32] License for euthanasia would quickly become a duty to take part in it, and there may be little respect for individual conscience in all that. There is the problem of the effects on the doctor-patient relationship, and family relationships, poisoning the atmosphere with suspicion and guilt. The BMA told the Lords that "if doctors are authorized to kill or help kill, however carefully circumscribed the situation, they acquire an additional role, alien to the traditional one of healer. Their relationship

with all their patients is perceived as having changed and as a result some may come to fear the doctor's visit."[33] Medical ethics and wider societal respect for human life would be further eroded.

As the Lords pointed out: "To create an exception to the general prohibition on intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation."[34] License for euthanasia would quickly become a duty to take part in it; and it would not be possible to stop the slide from voluntary to non-voluntary euthanasia.[35] And there is the specter of the economic argument, in a rapidly-aging society in which healthcare costs are escalating, to keep extending the occasions for medical killing as a cost-cutting measure. The Lords were right to conclude that "these dangers are such that we believe any decriminalization of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address."[36]

The conduct of the Bland case raises many more questions. Why, for instance, were counsel for the Attorney-General and the judges so eager to rule that 'advance directives' or 'living wills' are legal, when this issue had no bearing on the case?[37] Counsel for the Attorney-General appeared with the self-styled brief to be an 'independent and impartial' friend of the court: why was he the strongest proponent of withdrawing Tony Bland's tube-feeding and legalizing this kind of passive euthanasia? Why was the common law on homicide by omission and the medical ethics of ordinary and extraordinary means not raised by counsel or considered by the judges? Having been brought (in my view improperly) to the courts, S's case was treated hurriedly and thus received little public scrutiny, the parents were not agreed as to what should be done, and there was considerable doubt about the patient's medical status and prognosis. Given this – and all the appeals for caution in Bland's case – one might have expected the judges to require that S be fed intravenously at least until such time as they could have full and fair hearings. S's counsel was right to claim that he had been denied due process by the urgency with which the court treated the matter. What was the urgency? The only 'emergency' seems to have been that if the declaration were not granted promptly, S's tube might be reinserted by someone and he would live!

Did cost-cutting play a part in the attitude of the Government and courts? Press estimates put the total cost of caring for PVS patients at somewhere between 40 pounds to 150 pounds million a year; were some or all of them 'allowed to die with dignity', there would be significant savings. The parties to the cases were unwilling to raise the money matter; but counsel for the Attorney-General in Bland's case did so, and the judges followed the lead. But how can a society as affluent as Britain, even in recession, justify abandoning the severely handicapped on financial grounds. [38]

And who, we might ask, will be the next listed as too expensive to treat: the semi-conscious, the Alzheimer's patients, the handicapped, everyone over a certain age? Will the burden of caring for such people be gradually shifted from the community to families? Will we invent a new kind of abandonment called 'care in the community' for the comatose and senile?

8.4 Compassionate and Merciful?

But finally, we might question just how caring, compassionate and merciful euthanasia really is. Euthanasia is so often presented as the 'merciful' or 'compassionate' way to treat those in severe pain or incurable incompetence. But compassion is not the same as giving people whatever they want, or say they want, or we think they want. Nor is mercy the strategy of curing misery by killing the miserable. No one thinks the merciful answer to the starving millions is to poison them. Compassion is wanting the best for the other, and having empathy with them in their suffering.[39] Mercy entails staying by their side, offering good therapeutic and palliative care, and through friendship helping them to recover hope, meaning, and a sense of being loved.[40]

The Bland and S cases confront us with to the question of why it is that we care for people with PVS, permanent coma, profound intellectual handicap, Alzheimer's Disease, the elderly and the dying. For some of them we may hope that they might regain consciousness and some greater measure of health and independence. But many will not.[41] By supporting them we affirm that bodily life is not merely an instrumental good in some way distinct from the human person, but basic to humanity so that death is

always a harm. We conform to our basic duty of respect for every human life however wounded or handicapped. And we express our respect for that patient and each person's humanity, express our love for them, maintain our human solidarity or communion with them, and humbly confess our awe and ultimate impotence before the mysteries of suffering and death. This is a kind of respecting and loving which no one should pretend is easy.

But for all the polemics about 'dignified death' used by the euthanasia movement and now by the courts, we can forget that dignity is not recognized by telling the old, infirm or comatose how undignified their condition is, or how they would be better off dead – as when judges called Tony Bland 'grotesquely alive', 'an object of pity', 'the living dead', and called S a mere body for whom starving to death would be 'no ill effect', or when the judge in a similar case called some handicapped children 'cabbages'. It is not recognized by abandonment. It is certainly not recognized by standing by and watching someone die of thirst and hunger. The 'mercy' killer adds the final rejection to the many already heaped upon the sick, invalid and dying by our community. Dignity in old age, handicap, unconsciousness, and suffering are above all a matter of knowing you are respected and loved. Surely we can find more creative ways of demonstrating love and respect than by killing. ■

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ENDNOTES

[1] I will rely here on *conventional* or *common* morality: the mainstream Judeo-Christian and Greco-Roman ethics, as developed over the past two thousand years, including secular moral philosophy at least until Kant and often beyond. This morality can be formulated in terms favorable to natural reason without theological foundations being necessary, although it will be compatible with them. And it is a morality which has informed much of Western medical ethics, law and practice at least until recent times.

[2] Thus in 1988 the World Medical Association proposed: "Euthanasia, that is the act of deliberately ending the life of a patient either at his own request or at the request of his close relative, is unethical. This does not prevent the physician from respecting the will of a patient to allow the natural process of death to follow its course in the terminal phase of sickness." Likewise the British Medical Association declared in 1988: "The law should not be changed and the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy. It is, instead, an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel."

[3] The classic examples are Glover (1977) and Rachels (1980).

[4] A much fuller analysis of the reasoning in this case is given in Fisher (1993a), (1993b), (1993c), and (1993d).

[5] e.g. Kelly (1993).

[6] The House of Lords (1994) at #21 dismissed this distinction because 'passive euthanasia' is commonly confused with therapeutically warranted withholding or withdrawal of treatment (what I call in this lecture 'letting die'). Unfortunately the Lords failed to provide any alternative language for withholding or withdrawal of treatment with euthanasist intent (e.g. 'euthanasia by omission'), and failed to provide any serious analysis of this practice.

[7] In fact S was noisy, restless, threw himself around and pulled on his tube. As a result he was very heavily sedated--over-sedated in the opinion of one of the consultants. The nurses (and perhaps some of the doctors) were convinced that S could experience pain. He might even have experienced the thirst that presumably killed him.

[8] See Finnis (1980), pp. 176-77,195 contra Glover (1977).

[9] This kind of consideration seems to be behind Gratian's maxim: "Feed the man dying of hunger, because if you do not feed him you are killing him." (*Decretum* (c.1140), c. 21, #86; adopted by Vatican Council II, *Gaudium et Spes* (1965), #69).

[10] See Boyle (1989), Clouser (1973) and Donagan (1977).

[11] I qualify the prohibition on intentionally killing with 'innocent' here in line with the Western moral tradition, which allowed intentional killing in the two cases on capital punishment and the killing of unjust aggressors in self-defence, especially in war. On no reading of the Cox and Bland cases could the patients be seen as unjust aggressors against whom proportionate force was used in defence of

another person's life etc. On the justification for the 'exceptions' see Fisher (1993d) and sources therein. Hereafter I use the term person and victim presuming (or at least allowing) the traditional qualification 'innocent'.

[12] House of Lords (1994) at #237.

[13] See Emanuel (1991) at 19-20.

[14] Much of this section relies on the work of Gormally (1993) and (1994) and the Linacre Centre (1982).

[15] This is the reasoning of Warnock (1992) and Dworkin (1993) so effectively rebutted by the Linacre Centre in Gormally (1994).

[16] This is ultimately the reasoning of Kelly (1993).

[17] To deny food and water to medically stable but severely mentally handicapped patients--as occurred in Bland's case--is discriminatory because they can enjoy the same substantial benefits of food and water as anyone with no neurological impairments.

[18] This derives from the notions such as: human dignity and its individual bearers are deserving of special respect; healthcare professionals and patients are moral equals; we may not choose to harm an innocent; we each have a duty to maintain our own life and health, and to seek appropriate care from others; this is a duty which we share with those who care for us; we each have responsibilities to care for the weak, sick and suffering; and healthcare professionals have special duties in this respect. In addition to these ethical grounds, there are good sociological and psychological reasons for promoting an ethic of beneficence among healthcare professionals. Such an ethic encourages high medical standards and a good doctor-patient relationship.

[19] The council's judgment was that "The public rightly needs reassurance that doctors will do their utmost to make a patient's death bearable and dignified by easing pain and suffering. But it is wholly outside that duty to shorten life to relieve suffering."

[20] e.g. Dworkin (1993).

[21] House of Lords (1994) at #45.

[22] House of Lords (1994) at #239.

[23] House of Lords (1994) at #237.

[24] Thus it is argued that if conscious adult patients can refuse treatments not burdensome in themselves, in order to allow self-determined liberation from 'a life not worth living', it would be inconsistent or discriminatory not to give the same 'right' to the permanently unconscious. Emanuel (1991) demonstrates the emptiness of this notion when the patient concerned is by definition in no position to exercise such a right.

[25] House of Lords (1994) at #240. "Some of those who advocated voluntary euthanasia did so because they feared that lives were being prolonged by aggressive medical treatment beyond the point at which the individual felt that continued life was no longer a benefit but a burden. But, in the light of the consensus which is steadily emerging over the circumstances in which life-prolonging treatment

may be withdrawn or not initiated, we consider that such fears may increasingly be allayed." At ##252-253: "Obviously it is inappropriate to give treatment which is futile in the sense that it fails to achieve the hoped-for physical result...In other cases, a decision to limit treatment may depend on the balance between the burdens which the treatment will impose and the benefits which it is likely to produce..."

[26] Finnis & Fisher (1993); Gormally (1993); Linacre Centre (1982).

[27] The House of Lords (1994) at #257 make this point, but unfortunately come to this result by a potentially misleading formula: that recovery of a PVS patient from infection "could add nothing to his well-being as a person". The implication seems to be that there is some difference between 'merely physical' and 'fully personal' life. 'Well-being' is code in contemporary philosophy for 'quality of life'. See e.g. Griffin (1986).

[28] See Fisher (1993c) & (1993d) on the question of pain-relieving drugs which shorten life and the removal of ventilators.

[29] 'Intentional' here is a term of ethical art. It refers to what one does, identified by reference to one's chosen purpose in acting and the means which are chosen precisely because of their relevance to that project. When death is foreseen but not intended, its causation does not feature among the reasons one has for acting; it is unintended, even regretted; it is not contrary to respect for human dignity. Some people treat intentional and foreseen – but – unintended causation as morally equivalent. But were intentional and only foreseen causation of death morally equivalent, one could never build roads, engage in high-risk sports, perform risky surgery, give analgesics for pain control which might reduce life span, withhold treatment, and so on, while being opposed to killing. For a fairly good untechnical presentation see: House of Lords (1994) at ##242-244.

[30] See my articles listed in the bibliography.

[31] House of Lords (1994) at #241: "there is good evidence that, through the outstanding achievements of those who work in the field of palliative care, the pain and distress of terminal illness can be adequately relived in the vast majority of cases... within hospices... home-care teams... general practitioners... in hospitals and in the community, although much remains to be done. With the necessary political will such care could be made available to all who could benefit from it. We strongly commend the development and growth of palliative care services.

[32] House of Lords (1994) at #239: "We are also concerned that vulnerable people--the elderly, lonely, sick or distressed--would feel pressure, whether real or imagined, to request early death... we believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life."

[33] House of Lords (1994) at #103.

[34] House of Lords (1994) at #238.

[35] House of Lords (1994) at #238: "we do not think it possible to set secure limits on voluntary euthanasia... it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalized. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalization of the law was not abused."

[36] House of Lords (1994) at #238.

[37] The House of Lords (1994) at #263 commended the development of advance directives, as enabling patients to express their preferences and priorities in advance, stimulating discussion, assisting the healthcare team and other cares in decision-making. The committee sensibly emphasized that these directives should not contain requests for any unlawful intervention or omission; nor could they require treatment to be given which the healthcare team judged clinically inappropriate. Rather than supporting legislative provision in this area, the committee thought that it was already the common law that a doctor who acted in accordance with an advance directive would not be at risk of criminal prosecution or action in tort; they thought that "it could well be impossible to give advance directives in general greater legal force without depriving patients of the benefit of the doctor's professional expertise and of new treatments and procedures which may have become available since the advance directive was signed." (at #264) Various other safeguards might well be included: for instance a prohibition on the abandonment of patients (denial of the reasonable provision of food, water, warmth, shelter, pain relief etc.). One might still argue that such provision as imprudent: it could well be used maliciously and be another step towards euthanasia. On the other hand it might be thought to ensure patient rights and undermine the euthanasia cause by vitiating the fear of people being given overly burdensome treatments against their will and contrary to their dignity. Strangely the committee was opposed to appointment of proxies, a procedure which seems to me to have many of the virtues of an advance directive without drawbacks (such as the problem of the directive not being able to deal with new clinical situations). Most of the committee's objections to proxies (at #270) logically apply at least as well to advance directives.

[38] House of Lords (1994) at #260 concluded that the law should not create a new offence of 'mercy killing': "To distinguish between murder and 'mercy killing' would be to cross the line which prohibits any intentional killing, a line which we think is essential to preserve. Nor do we believe that 'mercy killing' could be adequately defined, sine it would involve determining precisely what constituted a compassionate motive." Again, at #262: "We identify no circumstances in which assisted suicide should be permitted, nor do we see any reason to distinguish between the act of a doctor or of any other person in this connection."

[39] In my view the ultimate question for bioethics today, and especially for the euthanasia debate, is how we face ineradicable suffering. In the end we have to admit in all humility we can only do so much to combat pain, disease and death. The mystery of evil, of innocent suffering, must be faced head-on, against the pervasive temptation to demand an immediate technological, consumer or government 'fix' for every discomfort, and to marginalize those who cannot be quick-fixed so that the rest can withdraw undisturbed. In the face of unfixable suffering our consumer culture stands in gaping incomprehension, or rails like a petulant child demanding immediate satisfaction. The fact is that there are evils we cannot 'solve' in any simple, morally acceptable way, and that call forth much that is most noble in the human spirit: patient endurance, fortitude, even heroism on the part of patients, doctors, families and communities. Sometimes this will be more demanding upon the caring bystanders than the patients themselves.

[40] The plea for euthanasia is most often a cry for help, a cry of pain, loneliness, alienation, hopelessness. The answer is surely not despair, seeking some easy way out, sweeping the problem under the carpet. As the American Medical Association concluded in 1991: "There is evidence to suggest that most requests for euthanasia or assisted suicide would be eliminated if patients were guaranteed that their pain and suffering will be eased and their dignity promoted." The hospice movement in Britain, which is the envy of the world, has demonstrated that we can provide a positive and loving environment where the seriously ill and dying patient can end their lives with dignity, with their pain properly managed, and knowing that they are cared for and loved.

[41] I have argued in several articles that the court's attitude to Tony Bland as a person was fundamental. In various ways doubts were expressed by several of the judges about whether he was really human, whether he was really alive, and whether he should be dead. The same happened last month in *S's Case*. Bingham MR noted that S had "no cognitive function worth the name" and "no conscious being at all". He quoted with approval the consultant's view that S had "no conscious self" and that if the tube were reinserted and feeding resumed "there is no chance whatever of this being to his benefit". The man's mother "clearly wished his *body* to be allowed to die" and though his father had wanted treatment to continue, keeping "S's body" alive would only delay the father's grieving. Were feeding not recommenced "this would cause death within a limited period but there was absolutely no reason to expect lack of food or fluid to cause suffering or ill effect". The suggestion here, as in *Bland's Case*, was that the patient and his body are somehow two different entities. His very being is seen to depend upon his having consciousness. Otherwise death by starvation and dehydration is "no ill effect". The House of Lords (1994), which otherwise has much to recommend it, unfortunately has adopted some of this same thinking. At #255 the committee claims that the guiding principle in treating the incompetent is whether the treatment will add to "the patient's well-being as a person".

SOURCE:

The Eternal Word Television Network (EWTN) Global Catholic Network
http:// www.ewtn.com/library/PROLIFE/KILLET.TXT

Examining "Quality of Life, Ethics of Health"

GENERAL ASSEMBLY OF THE PONTIFICAL ACADEMY FOR LIFE ON THE THEME: "QUALITY OF LIFE AND THE ETHICS OF HEALTH"

February 21-23, 2005

REPORT BY H.E. MSGR. ELIO SGRECCIA

Today, to evoke these two terms, *quality of life* and *health,* is equivalent to focusing public opinion on something more than a political programme; it is almost like invoking "absolutes", the greatest or even the only forms of good, to be pursued to the point of a sort of *divinization* of health.

On the other hand, there are some who bring light to bear on the emergence of new illnesses (those due to so-called "well-being") and the abysmal injustice that is being created between the well-off and those excluded from their table, which is evident within the individual health-care sectors and also in the perspective of globalization.

QUALITY OF LIFE: MAGIC WORDS

The words or message, "quality of life", which first appeared in a political document (a speech by United States President Johnson, who succeeded John Kennedy as President), permeated Western cultures as a

political and financial ideal deemed sound for peaceful, powerful societies, capable of producing the means not only to satisfy their basic needs but also those that aspired to "well-being": social security, health care, the enjoyment of their wealth, the improvement of the ecological environment and the satisfaction of a certain number of desires. After satisfying their needs, people affirmed the urge to satisfy their desires; however, these have no predetermined limit.

This message converged with the utilitarian philosophy widespread in English-speaking societies. Elaborated by the philosopher J. Bentham, it has been renewed in our day by other philosophers (such as P. Singer, in a sensist and materialist conception) to become an ideal: ethical good must produce pleasure and eliminate pain. The political programme based on the quality-of-life concept thus becomes an ethical obligation.

This change gave rise in turn to a corollary: the human being who does not possess the desired minimal "quality" does not deserve to be kept alive, hence, the proposal of eugenic parameters for the purpose of selecting those who do deserve to be accepted or kept alive and those who are to be abandoned or suppressed via euthanasia.

Self-awareness and the capacity for relating, that is, the *"signa personae"*, without which the person himself would not exist, have often been proposed among the features that connote the *minimum quality* of a life held to be worth living. This is how it is, for example, in neo-contractual thought.

Such an ideal conception of "quality of life" thus inevitably challenges the more traditional concept of the "sanctity of life", misinterpreted as *biological vitalism.* This has also given rise to contraceptive programmes: happiness means few, for quantity is the enemy of quality.

HEALTH AS WELL-BEING FOR ALL

In the meantime, the complementary concept of "health" had also received a utopian and hedonistic impulse, since it was defined by the World Health Organization (Preamble of the Constitution, 22 July 1946) as a state of "complete physical, mental and social well-being, not merely... as the absence of disease or infirmity". In another document published by

the same Organization, health is described as "the physical and mental well-being necessary to live a life that is enjoyable, productive and rich in meaning".

Such an ideal consequently impels society to plan "health for all", even "free of charge".

It was soon noted, however, that financial resources are insufficient, even for the most developed countries; so health programmes have been downsized in order to face the problem of the "allocation of resources for health care". This is a key theme for the economy, for medicine and for all societies.

Obviously, some people are considering reducing expenditures on the hospital "businesses", obliging them to revise the system of admitting patients. Others seek to identify and define "needless expenses". For example, might "needless expenses" be the sums spent on the terminally ill? And this is a recognizable incentive to the legalization of euthanasia.

THE RESULTS

The consequences of this cultural process in the concept of health have brought to the limelight the opposite of what had been proposed: a culture that does not accept self-control, sacrifice or hardship, not even in things that are paradoxically harmful to health; the rejection of the element of "responsibility" for lifestyles; the overwhelming desire to eliminate the concepts of disease, pain and death.

The miserable conditions, in terms of health and well-being, of the developing continents and countries should also be remembered. In many areas of Africa and Asia, for example, health service has been reduced to the minimum due to the total lack of organized health care, doctors and medicines, and has led to the interruption of therapeutic treatment. The Pontifical Academy for Life also focused on this aspect during its General Assembly.

However, the relators and participants were also asked the straightforward question: what concept of "quality of life" and what ideal of "health" are compatible with cultural and historical realism and further, with Christian anthropology?

We are convinced that the winning solution will consist in working out a new, critical and positive perspective that approves the non-reductionist concept of the human being (for this is the crux of the matter), a concept that respects the unchangeable and equal dignity of every human person as a creature of God, from conception until natural death; a perspective that will refer to the fundamental value of life and respect for the principle of ethical responsibility and will consider the human being in the perspective of spiritual life, open to transcendence.

The 18 reports and 12 announcements that comprised the General Assembly certainly made a valuable contribution to rethinking the principles underpinning the society of "well-being", social justice and the vision of the human being. ■

SOURCE:

The Pontifical Academy for Life

http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pont-acd_life_doc_20050223_report-health_en.html

My Father's Greatest Legacy

JOEY DOMINGO DOMINGUEZ

Delivered during the funeral mass of Panfilo O. Domingo
July 2, 2008 at Our Lady of Mt. Carmel Shrine.

Our present pope, Pope Benedict XVI, wrote an encyclical letter entitled *Spe Salvi.* In this encyclical, he mentions *suffering.* He says that the *true measure of humanity is how one embraces his sufferings.*

I mentioned this part of the encyclical because I look at my father's life from the point of view of suffering, from two levels of suffering.

The first level is the suffering he endured in order to transform the lives of other people. He was always passionate about making a contribution to society, in creating better financial and educational institutions, in reaching out to as many people as possible and helping them. But in this type of suffering, he was always in control. He executed well-thought out plans in utmost precision and worked relentlessly with great focus to achieve these goals. This is the P.O. Domingo most of you know.

But the P.O. Domingo I saw that emerged the past year was a man transformed by the second type of suffering. My father endured physical suffering as the result of the progression of his diabetes and its consequent complications. In this type of suffering, my father was not in control, but God was. This time my father suffered not to transform lives. Instead, his suffering transformed him.

It is ironic that I saw my father most beautiful when he was most vulnerable. The past year has become one of my treasured memories of my father, especially the 31 days he stayed in the hospital. Everyday became a testimony of God's love as the Lord unceasingly poured out his loving mercy on my father, helping him carry his cross when it became too heavy, yet allowing him enough for his own purification.

There was one day, around 4:30 in the morning, when my sister, Gigi, woke me up because my father wanted us to pray together. Despite the pain killers given to him, the debilitating pain on his right knee caused by osteo-arthritis, gout and neuropathy persisted. But before praying, he told us that he felt the Lord was not listening to his prayers anymore. We assured him otherwise and started to pray the Novena to Jesus Nazarene, a devotion he started when he was a teenager and kept faithfully up to the end. He slept calmly after that.

That evening a priest administered the Sacrament of the Anointing of the Sick. He confessed to the priest that he felt abandoned by the Lord to which the priest replied that even our Lord Jesus felt abandoned by His Father as he was hanging on the cross in Calvary. That was a poignant moment for me, seeing my father in total humility admit to his helplessness. For it is during these times of helplessness that we truly find our God.

There was another evening when he took my hand by his side and started to say repeatedly, "I'm tired, I'm tired, I'm tired". He said it in a manner I was not used to, with a hint of resignation. I called my sister, Gigi, who told my father to rest as she started to caress his head, and I, his arm. Our silent prayers lulled him to sleep.

Another time we prayed the rosary together. I have never seen him meditate so much on each word of the Lord's Prayer and the Hail Mary. He recited the last part of the Hail Mary with much contemplation "... pray for us sinners now and at the hour of our death, Amen". He said the Hail Mary five times but soon got tired so we told him just to follow quietly without reciting the words aloud.

The beauty of suffering lies not only in how we endure suffering but in suffering with someone, our beloved, because it purifies our love for our beloved. We have always been close to our father but as we suffered

with him, we felt the bond of our love for each other solidify even more. Every wailing sound he made out of pain that struck our heart with such hurt and desperation was a chance for us to purify our love for him.

My father was a loving, caring, kind, sweet and understanding father and grandfather. We could not have asked for a greater gift from God. Again he expressed the depth of his love for us while he was in the hospital. He never stopped thinking of our welfare and happiness.

He called me by his bedside one time and started to cry. I asked him, "Papa, why are you crying?" Referring to my sister, Gigi, the doctor of the family who had taken care of my father the longest, he said, *"Naawa na ako sa kapatid mo. Pagod na pagod na siya sa kakaalaga sa akin"*. I reassured him and said, *"Huwag po kayong mag-alala kay Gigi. Inaalagaan din po namin siya.* It is an honor for us to serve you because you have sacrificed so much for us". It calmed him down and he stopped crying.

Another time he was wailing again because of the pain on his right knee, but this time I was the one who cried because I could not bear to see him suffer. My crying silenced him for a while. When the pain subsided that afternoon, my sister informed me that my father started to walk around the room. He said, "My son (referring to my brother Rene) will be happy to me see me this way and so that Joey won't cry anymore" (referring to me).

He waited for my sister, Sonia, who arrived from the United States two Mondays ago. He cried when my sister embraced him. My sister got a chance to serve my father too. Then there's my sister, Lizza, who had to undergo surgery last Wednesday. My father died the following day but not without asking about my sister and how the operation went.

My father suffered but the Lord embraced him in his suffering. *For me, this is the greatest legacy of my father. He taught me how to carry one's cross. He showed it by example.*

The true measure of a man is neither in his financial accomplishments nor in the number of titles and accolades he received. The true measure of a man is how he embraces his sufferings. My father embraced his suffering out of love and it is this love that transformed his suffering into the many

graces he received... the grace of persistence of faith, the grace of love, and most especially, the grace of peace for my father died peacefully in his sleep last Thursday.

It is in this spirit of love that my family and I would like to thank all of you for the tremendous outpouring of love you have shown us... so many of you from all walks of life whose stories about my father have uplifted us. No words would be eloquent enough to describe our gratitude and appreciation to all of you.

I love you, Papa. Thank you for everything. Be at peace for we too are reaping the fruits of your sufferings... especially the grace of peace that has allowed us to surrender totally to the will of the Lord and to return you with love to your Creator.

We honor you by moving on. Our gratitude will always be greater than our sorrow. ■

Why the Concept of Brain Death is Valid as a Definition of Death

STATEMENT BY NEUROLOGISTS AND OTHERS

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THE NOTION OF BRAIN DEATH

The notion of 'brain death' was introduced to refer to a new criterion for the ascertainment of death (able to go beyond the criteria relating to the heart and breathing and the criteria relating to the destruction of the soma) that had become evident with new discoveries about the working of the brain and its role within the body, as well as necessary with the changed clinical situations brought about by the use of the ventilator and the possibility of sustaining human organs despite the loss of the unity of the organism as a whole.

BRAIN DEATH IS DEATH

Brain death has been a highly important and useful concept for clinical medicine, but it continues to meet with resistance in certain circles. The reasons for this resistance pose questions for medical neurologists, who are perhaps in the best position to clarify the pitfalls of this controversial

issue. To achieve consistency, an important initial clarification is that brain death is not a synonym for death, does not imply death, or is not equal to death, but 'is' death.

'COMA', THE 'PERSISTENT VEGETATIVE STATE', AND THE 'MINIMALLY CONSCIOUS STATE' ARE NOT BRAIN DEATH

The inclusion of the term 'death' in brain death may constitute a central problem, but the neurological community (with a few exceptions) acknowledges that something essential distinguishes brain death from all other types of severe brain dysfunction that encompass alterations of consciousness (for example, coma, vegetative state, and minimally conscious state). If the criteria for brain death are not met, the barrier between life and death is not crossed, no matter how severe and irreversible a brain injury may be.

BRAIN DEATH IS THE DEATH OF THE INDIVIDUAL

The concept of brain death does not seek to promote the notion that there is more than one form of death. Rather, this specific terminology relates to a particular state, within a sequence of events, that constitutes the death of an individual. Thus brain death means the irreversible cessation of all the vital activity of the brain (the cerebral hemispheres and the brain stem). This involves an irreversible loss of function of the brain cells and their total, or near total, destruction. The brain is dead and the functioning of the other organs is maintained directly and indirectly by artificial means. This state results solely and specifically from the use of modern medical techniques and, with only rare exceptions, it can only be maintained for a limited time. Technology can preserve the organs of a dead person (one appropriately pronounced dead by neurological criteria) for a period of time, usually only hours to days, rarely longer. Nevertheless, that individual is dead.

DEATH IS THE END OF A PROCESS

This process begins with an irreversible fact of health, namely the beginning of the failure of the integrative functions exerted by the brain and brain stem on the body. It ends with brain death and thus the death of the individual. Generally, this process involves an uncontrollable and

progressive brain edema, causing the intracranial pressure to rise. When the intracranial pressure exceeds the systolic blood pressure, the heart is no longer capable of pumping blood through the brain. The swollen brain becomes compressed within its rigid 'shell', the skull, and herniates through the *tentorium* and the *foramen magnum*, which eventually totally blocks its own blood supply. Brain death and the death of the individual take place as the end of this process. There is a second process which begins with the death of the individual and involves the decomposition of the corpse and the dying of all the cells. The ancients were aware of these two processes and knew, for example, that hair and nails continue to grow for days after death. To think today that it is necessary to maintain the sub-systems of a corpse receiving artificial support, and to wait for the death of all the cells in the body before pronouncing the death of an individual would be to confuse these two processes. This latter approach has been termed 'exaggerated treatment' or, more specifically, the slowing down of the inexorable decomposition of a corpse through the use of artificial instruments.

THE CONSENSUS ON BRAIN DEATH

The criterion of brain death as the death of an individual was established about forty years ago and since that time consensus on this criterion has increasingly grown. The most important academies of neurology in the world have adopted this criterion, as have most of the developed nations (the USA, France, Germany, Italy, the UK, Spain, the Netherlands, Belgium, Switzerland, Austria, India, Japan, Argentina and others) that have addressed this question. Unfortunately, there is insufficient explanation by the scientific world of this concept to public opinion which should be corrected. We need to achieve a convergence of views and to establish an agreed shared terminology. In addition, international organizations should seek to employ the same terms and definitions, which would help in the formulation of legislation. Naturally, public opinion must be convinced that the application of the criterion of brain death is carried out with the maximum rigor and efficacy. Governments should ensure that suitable resources, professional expertise and legislative frameworks are provided to ensure this end.

STATISTICS ON BRAIN DEATH

In the USA, most of the statistics on cases of the diagnosis of recognized brain death since its full definition, its application, and the clinical histories involved are generally available in organ procurement offices. The Mayo Clinic has information on about 385 cases (years 1987-1996). Flowers and Patel (*Southern Medical Journal* 2000; 93:203-206), reported on 71 individuals who met the clinical criteria of brain death and then were studied by the use of radionuclide brain scans. No blood flow was demonstrated in 70 patients and in 1 patient arterial blood flow was present on the initial evaluation but disappeared 24 hours later. The authors concluded that using established medical criteria the accuracy of the diagnosis of brain death was 100%. The famous Repertinger meningitis case ironically demonstrates that it is possible to keep a body and organs perfused for a long period of time. One possibility is that this patient may not have been brain dead for a long period of time (cf. the detailed discussion on this possibility during the meeting and question 15, p. LXIX ff.). Another possibility is that this represents a valid case of brain death since all of the clinical tests were performed to ascertain brain death except the apnea test. The absent evoked potentials and the flat EEG were consistent with brain death. If this was a validly documented case of brain death, it makes the point that in extraordinarily rare exceptions this kind of case occurs. However, many years have passed since this case, there is a great deal of uncertainty about it, and one cannot generalize from it to invalidate the criteria for brain death. With the technologies available in modern intensive care units, we may see more of such prolonged cases, as technological capacity develops to reproduce some of the functions of the brain stem and hypothalamus in the integration and coordination of all the sub-systems of the body. The neurological community does not believe that this case disturbs the conceptual validity of brain death as being equivalent to human death.

A COUNTERINTUITIVE REALITY

The history of science and of medicine contains many discoveries that are contrary to our perceptions and seem counterintuitive. Just as it was difficult for common sense to accept, at the time of Copernicus and Galileo, that the earth was not stationary, so it is sometimes difficult now

for people to accept that a body with a pumping heart and a pulse is 'dead' and thus a corpse; 'heart-beating death' appears to defy our common sense perceptions. In part, this is because the dead brain, like the moving earth, cannot be seen, conceptualized, or experienced by the onlooker. Indeed, the common man does not easily accept that a deep sleep-like state with a heartbeat, accompanied by electrocardiogram activity, is death. Since the use of medical technology is so ubiquitous, it is easy to fail to comprehend that a ventilator machine is a necessary intermediary in maintaining this state. This may give rise to a deep-seated reluctance both to abandon brain-dead individuals and to accept the removal of organs from their bodies for the purposes of transplantation.

ORGAN TRANSPLANTATIONS

The concept of brain death has been at the centre of a philosophical and clinical debate, especially after advances made in the field of transplantations. In particular, it has been asked whether this criterion – and this is the view, for example, of Hans Jonas – was introduced to favor organ transplantations and is influenced by a dualistic vision of man that identifies what is specific to man with his cerebral activities. Yet, as emerged during discussions of the meeting, the criterion of brain death is compatible at a philosophical and theological level with a non-functionalist vision of man. St Augustine himself, who certainly did not identify the brain with the mind or the soul, was able to say that when 'the brain by which the body is governed fails', the soul separates from the body: 'Thus, when the functions of the brain which are, so to speak, at the service of the soul, cease completely because of some defect or perturbation – since the messengers of the sensations and the agents of movement no longer act –, it is as if the soul was no longer present and was not [in the body], and it has gone away' (*De Gen. ad lit.*, L. VII, chap. 19; PL 34, 365). Indeed, the criterion of brain death is in conformity with the 'sound anthropology' of John Paul II, which sees death as the separation of the soul from the body, 'consisting in the total disintegration of that unitary and integrated whole that is the personal self'. Thus, in relation to the criterion of brain death, the Pope was able to declare: 'the criterion adopted in more recent times for ascertaining the fact of death, namely the *complete* and *irreversible* cessation of all brain activity (in the cerebrum, cerebellum and brain

stem) if rigorously applied, does not seem to conflict with the essential elements of a sound anthropology' (Cf. Address of 29 August 2000 to the 18th International Congress of the Transplantation Society).

From a clinical point of view, almost the whole of the medical community agrees that the concept of brain death as death should not serve an ulterior purpose (specifically: organ transplantation). Indeed, the ascertainment of brain death, which in historical terms was the result of the independent study of the brain, preceded the first transplantation procedures and thus was (and therefore is) unconnected with the related subject of transplants (cf., e.g., S. Lofstedt and G. von Reis, 'Intracranial lesions with abolished passage of X-ray contrast throughout the internal carotid arteries', *PACE*, 1956, 8, 99-202). Few physicians are convinced that the removal of organs from brain-dead individuals amounts to murder, and there is no reasonable legislation that adopts this point of view. The advent of cardiac and hepatic transplantation in the 1960s, and the need for organs from heart-beating donors to ensure successful results, generated an evident relationship between brain death and transplants. In the future, it is possible and to be hoped, that this relationship will diminish with new discoveries in the use of natural non-human and artificial organs.

UNSOUND ARGUMENTS

Most of the arguments against brain death are not sustainable and are incorrect diversions when scrutinized from a neurological perspective. For example, the erroneous or imprecise application of the criteria of brain death, the fact that the neurological examination in individual cases may be misinterpreted, or variations in the criteria chosen by specialist groups, can all too easily be used as spurious arguments against the concept.

THE APNEA TEST

The claims that apnea testing poses a risk to the patient are largely invalid when the testing is performed properly. Authorities should ensure that apnea testing is always carried out with the maximum of professional and technological expertise, and dedicate resources to this end.

IRREVERSIBLE SITUATIONS: ALL DEATH IS BRAIN DEATH

Assertions as to the existence of 'awakenings' from brain death have been used to discredit the concept and to prolong artificial ventilation, feeding and medical support in the hope of a recovery. A small number of cases of brain-dead individuals maintained in this state with ventilators and other medical measures for weeks, or even years, have given rise to unfounded claims that these subjects were in conditions other than death. In reality, as observed above in the section on 'statistics on brain death', where the proper diagnostic criteria have been employed all such assertions are not valid.

PREGNANCY

Pregnancies have been carried to term in brain-dead mothers. These cases are exceptional and do not involve potentially reversible conditions different from brain death. The mother's uterus and other organs are being supported as a technical vessel for pregnancy, in much the same way that the heart or the kidneys are kept perfused. Thus, it is possible for an individual who is brain dead to give birth, if maintained with a ventilator, or other measures, for a certain period.

ANTIDIURETIC AND OTHER PITUITARY HORMONES

Other spurious arguments, such as the residual excretion of antidiuretic and other pituitary hormones in some cases of brain death, refer to transient phenomena, and are technical arguments that can be dealt with on a practical level. There is no need for every single cell inside the cranium to be dead for brain death to be confirmed.

AXON REGENERATION

Recent reports of axon regeneration in patients with severe brain damage (which require corroboration and more study) are not pertinent to brain death.

RECOVERY EXCLUDED

It follows, as mentioned earlier, that there is no chance of recovery from brain death and that discussions regarding recovery from various states of coma must be distinguished from brain death.

THE NEED FOR AN EXPERT NEUROLOGICAL EXAMINATION

If the criteria of brain death are correctly applied, and if the neurological examination is carried out correctly by an experienced physician, then full reliability can be achieved. As mentioned above, there have been no documented exceptions. The neurological examination evaluates consciousness and reflexes to confirm death of the neurons involved in these functions. Although every neuron in the central nervous system is not assessed during the examination, as stated earlier it is not necessary for absolutely all neurons to be dead for brain death to be reliably diagnosed. In a sedated or previously sedated patient, the lack of perfusion of the brain must be demonstrated for brain death to be ascertained beyond all doubt.

THE LOSS OF HEART ACTIVITY

When the cardiologist pronounces death as a result of cardiac standstill, the diagnosis is less certain than in the circumstance of brain death. Many documented cases exist of patients pronounced dead after failure of cardiac resuscitation who have subsequently been discovered to be alive. It should be further stated that the traditional definition of natural loss of heart activity as 'death' is not satisfactory because it is now possible to keep the heart beating by artificial means and blood circulation to the brain can be maintained artificially to a brain that is dead. Confusion arises from the presence of mechanical systems that artificially replace the role of the brain as the generator of the functioning of essential organs. Therefore, brain death is a much more certain diagnosis than heart death. The reluctance to accept brain death may be mostly related to the fact that it is a relatively new concept (the invention of the ventilator by Ibsen took place fifty-six years ago) compared to the traditionally accepted notion of cardiac and respiratory arrest.

THE LOSS OF BREATHING

If one proposes that the loss of spontaneous breathing defines death, then all brain-dead patients are, by definition, 'dead'. When the patient has been pronounced dead after the application of the appropriate criteria of brain death, the decision to continue with ventilation can only be justified with reference to the life and well-being of another person.

NO VENTILATOR, NO HEART ACTIVITY

If one removes the ventilator from a brain-dead patient, the body undergoes the same sequence of events and physical dissolution as occurs in an individual who has undergone loss of heart activity.

ARTIFICIAL INSTRUMENTS

Thus, it is as illogical to contend that death is the loss of heart activity as it is to affirm that the loss of kidney activity is death. Indeed, both renal activity (through dialysis) and heart activity (with a non-natural instrument) can be supported artificially, something that is impossible in the case of the brain: no artificial instrument exists that can reactivate or replace the brain after it has died.

NO CIRCULATION TO THE BRAIN MEANS BRAIN DEATH

One does not have to be a Cartesian to assert the central importance of the brain. Today, after advances in our knowledge of the workings of the brain, it is the medical-philosophical view that the body is 'directed' by that marvelous organ, the brain. Certainly, we are not a 'brain in a vat' but it has to be recognized that the brain is the receiving centre of all sensory, cognitive, and emotional experiences and that the brain acts as the neural central driving force of existence. We must acknowledge that the loss of circulation to the brain causes death. This loss of circulation can be documented in virtually all cases of brain death if tests are performed at the proper time.

THE CAMOUFLAGING OF DEATH

In reality, the ventilator and not the individual, artificially maintains the appearance of vitality of the body. Thus, in a condition of brain death, the so-called life of the parts of the body is 'artificial life' and not natural life. In essence, an artificial instrument has become the principal cause of such a non-natural 'life'. In this way, death is camouflaged or masked by the use of the artificial instrument.

EDUCATION AND BRAIN DEATH

One of the tasks of physicians in general and neuroscientists is to educate the public about discoveries in this field. As regards the concept that all death is brain death, this task may be difficult, but it is our duty to continue in such an endeavor.

At a specific level, the relatives of brain-dead individuals should be told that their relative has died rather than that he is 'brain-dead', with the accompanying explanation that the support systems produce only an appearance of life. Equally, the terms 'life-support' and 'treatment' should not be employed because in reality support systems are being provided to a corpse. ■

SOURCE:

The Pontifical Academy of Sciences, Excerpt of *Scripta Varia* 110, Vatican City

http://www.vatican.va/roman_curia/pontifical_academies/acdscien/2008/excerpt_signs_of_death.pdf

Response to the Statement and Comments of Prof. Spaemann and Dr. Shewmon

STATEMENT BY NEUROLOGISTS AND OTHERS

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Dr. Shewmon criticizes many of the conclusions of the statement 'Why the Concept of Brain Death is Valid as a Definition of Death' and some of the views expressed during the general discussion. His points could be considered contributions to the debate. Aristotle teaches us to be grateful not only to those whose views we share but also to those who express different opinions, because they too have contributed to the stimulation of reflection.[1] We regret that Dr. Shewmon could not attend the PAS in September, so that we could have debated his criticism in person, rather than in retrospect.

Dr. Shewmon and Prof. Spaemann may never agree that death of the brain is the death of the individual. However, there are certain statements upon which we all agree:

1. Meeting the clinical criteria for brain death establishes that that

individual will never, ever, recover any semblance of consciousness or conscious activity.

2. The vast majority of bodies meeting the brain death criteria will suffer multi-organ failure including cardiac arrest within a short period of time, despite major efforts to preserve somatic organs. This is true despite the original injury being restricted to the brain, as for example a massive cerebral hemorrhage.

3. In a small minority of such bodies, somatic organs, including the heart, may be kept functioning for a period of time, usually a few days, sometimes weeks and in extremely rare instances for an extended period. No matter how long somatic function is sustained, when brain death has been appropriately diagnosed, no semblance of consciousness or conscious activity will ever occur.

4. That the phrase 'physiological decapitation' applied to brain death should be avoided because a decapitation is contrary to physiology, which refers to the normal functions of living organisms and their parts, and because brain dead subjects can still, indeed, have heads.

An overwhelming number of medical experts, including those attending the Vatican Symposium, agree with the above propositions. One finds it difficult to understand why Dr. Shewmon and Prof. Spaemann, while accepting these statements about brain death, do not accept that brain death is the death of the individual. However, we can say that their refusal is based on personal physical/biological and philosophical views. From the physical/biological point of view, they affirm that the integration and coordination of the bodily sub-systems are not performed exclusively by the brainstem and hypothalamus. And thus for them, there is a holistic vital unity of the organs of a body without the brain.

Perhaps this point can be further clarified if we contrast brain death with a vegetative state. Why is the persistent vegetative state different from brain death? Given the same supportive care as a brain-dead body, a patient in a vegetative state is unlikely to die, suggesting that the brainstem, and particularly the lower brainstem, is important for the integrative function of the rest of the body, whereas the cerebral hemispheres are not.

There are other differences between the vegetative state and brain death. 1) Functional MRI suggests that elements of consciousness may be present in patients who are vegetative. 2) There are reports describing recovery of at least minimal consciousness after many months in a vegetative state. Thus, we should not make the diagnosis of a 'persistent' vegetative state for the first three months, and for the first year following head trauma. 3) Several papers, addressing the issue of keeping somatic organs functioning after the brain has died, demonstrate that it is extremely difficult and, with rare exceptions (not, as Dr. Shewmon suggests, 'common' exceptions), fails after a few days. This contrasts with the relative ease of maintaining individuals with severe brain or spinal cord injury who are not brain dead. That an individual whose spinal cord has been severed at the high cervical level and is ventilator-dependent, can be sustained to live and work at home, indicates the importance of the brain in the integrative function of the rest of the body. That it is easier to maintain the somatic organs of a vegetative patient than those of a brain dead subject also attests to the importance of the brain, in this case the brainstem, in integrating the function of the remainder of the body, which, in part, explains why the vegetative state is not equated with death.

Thus we believe that once the clinical criteria for brain death are present, the individuals are as dead as if their hearts had stopped.

In addition, as regards the precise issue of whether the brainstem and hypothalamus are the integrators of 'all' bodily function, Dr. Shewmon seeks to present evidence that the integration and coordination of the bodily sub-systems are not performed exclusively by the brainstem and hypothalamus. To what kind of integration and coordination does he refer? The vast majority of neurologists believe that all of the functions relevant to the state of life are performed there, in the brainstem and hypothalamus, structures that are indeed the integrators of the main systems and sub-systems of the body. The brain integrates all functions of the body, through nerves, neural transmitters and secreted substances, the latter a process that Dr. Shewmon ignores when he compares spinal cord sectioned individuals with those who are brain dead. Thus, it is unclear as to what sub-systems Dr. Shewmon is referring; the rare subjects who are brain dead, but whose organs survive for weeks or months, indicate that some organs such as the kidney and the digestive system can function independently of the brain,

but whether they can integrate with each other is less clear. For that matter, as certain papers demonstrated, if the technical support is adequate, one can maintain certain organs (i.e. heart) isolated from the body in a system of perfusion for days. Thus, it should not be surprising that if these organs are perfused within the soma (their natural location), they can remain active within a corpse. One can accept that the holistic physiological properties of the soma in a brain dead subject are greater than in a collection of perfused organs, i.e. that the interaction between organs within the ventilated soma is greater than that occurring with separated organs maintained in a vat. However, these experiments do not imply that an integration and co-ordination exists without the brain. Whatever 'integrative sub-systems' the rest of the body may have, they are few, fragile, and poorly coordinated, and one cannot sustain them once the brain has died. The other bodily structures that effect some integration (nerves in the heart and bowel or bones that make up the skeleton, for example) are entirely irrelevant in discussions about brain death as the death of the individual. The ancients knew about these other integrative forms through their observation of hair and nail growth in corpses, but did not doubt that the individual was dead. Thus, in opposition to Dr. Shewmon's affirmations, with the death of the brain an inexorable process of disintegration of the body begins that a ventilator can only slow down. Therefore, as affirmed in the Statement, this process of disintegration is different from the death of the individual, which begins with an irreversible fact of health and ends with brain death and thus the death of the individual.

Moreover, if it is asserted that the brain in the embryo does not 'mediate' the integrative unity of the organism, then it is evident that the word 'organism' is being used in an inappropriate way. The embryo is the first stage in the development of a multi-cellular organism (it immediately follows the fusion of the pronuclei in the ovule) but it is not properly an organic body. What is specifically called an organic body is one that has a diversity of organs. This is not the case with an embryo because it has not yet developed a system of organs. Thus there cannot be mediation between the organs, either between the brain and the other organs or between the various organs, because the organs have not yet developed and are still in potency. There is, therefore, a radical difference, from the point of view of integration, between a situation of brain death and that of an embryo that

has not yet developed its organs. This fact invalidates the parallel made between the embryo and a brain-dead body.

At this point, given their gross underestimation of the importance of the brain for the integrative function of the rest of the body, Prof. Spaemann and Dr. Shewmon affirm that the adoption of brain death as death by neurologists is not physical/biological but philosophical. In other words, according to Prof. Spaemann and Dr. Shewmon, since neurologists are not able to justify the presumed sub-integration of the body without the brain, to state that brain death is the death of the individual, neurologists are compelled to identify the brain with the mind or personhood, which is a philosophical statement.

It was clear from the direction of the meeting that the task was to focus first and foremost on the scientific approaches. Indeed, the only philosophical paper was that given by Prof. Spaemann who opposed brain death as the criterion for death. However, from the discussions during the meeting, it emerged (a point not answered by Prof. Spaemann) that although the mind is not the same as the brain, one cannot today reasonably doubt that human intelligence (and in part personhood) depend on the brain as the centre of the nervous system and other biological systems. Although we certainly do not currently have a detailed understanding of the physical modalities of human thought, it is an established scientific fact that human intelligence depends on the support of nerve cells and the organization of billions of connections between the billions of neurons that make up the human brain and its ramifications within the human body. This does not mean that one could conclude in haste that contemporary neuroscience has definitively demonstrated the truth of a materialistic monism and rejected the presence of a spiritual reality in man.

According to the post-Second Vatican Council and contemporary *Catechism of the Catholic Church*, 'The unity of soul and body is so profound that one has to consider the soul to be the "form" of the body:[2] i.e., it is because of its spiritual soul that the body made of matter becomes a living, human body' (n. 365). So, from a philosophical and theological point of view, it is the soul that confers on the body the unity and the essential quality of the human body, which are reflected in the dynamic unity of the cognitive (and inclinational) activities with the sensitive and

vegetative activities that not only co-exist, but can also work together in a participation of the nervous system with the senses and the intellect (and in a participation of the biological and sensitive inclinations with the will). Thus, Aristotle, using a geometric analogy of contemporary relevance that is explicitly appropriate for this operative order as well, declared that the vegetative is in the sensitive and this is in the intellective in the same way that a triangle is in a square and this is in a pentagon, because this last contains the square and even more.[3] This dynamic organic unity between the activity of the intellect, the senses, the brain and the body does not exclude but, on the contrary, postulates, at a biological and organic level, that there is an organ which has the role of directing, coordinating and integrating the activities of the whole body. Each specific function carries out its activity as an integral part of the whole. In contrary fashion, the fact of suggesting a sort of equivalence or equality of functions and of their activities leads us to acknowledge their relative independence, which is contradictory to the idea of 'organism'. So the brain is the centre of the nervous system but it cannot function without the essential parts of its connectivity throughout the organism, in the same way as the organism cannot function without its centre. We are not brains in a vat, but neither are we bodies without a brain.

Therefore, brain function is necessary for this dynamic and operative physiological unity of the organism (over and above its role in consciousness), but not for the ontological unity of the organism, which is directly conferred by the soul without any mediation of the brain, as is demonstrated by the embryo. However, if the brain cannot assure this functional unity with the organic body because the brain cells are dead or the brain has been separated from the organism, the capacity of the body to receive the being and the unity of the soul disappears, with the consequent separation of the soul from the body, i.e. the death of the organism as a whole.

The formula constituting the source of the definition of the Council of Vienna that the soul is '*forma corporis*', postulates, from the operative and dynamic point of view, the other formula of St Thomas (for that matter not cited by Prof. Spaemann) to the effect that 'the government of the body belongs to the soul in that it is its motor and not its form'[4] and thus 'between the soul [and the body], in that it is a motor and the

principle of operations, occurs something intermediary, because, through a first part moved first, the soul moves the other parts to their operations' ('*inter anima secundum quod est motor et principium operationem cadit aliquid medium, quia mediante aliqua prima parte primo mota movet alias partes ad suas operationes*').[5] Thus the overall formula obscured by tradition and by Prof. Spaemann is: 'the soul unites to the body as a form without an intermediary, but as a motor it does this through an intermediary' ('*anima unitur corpora ut forma sine medio, ut motor autem per medium*').[6] Therefore, when the cells of the brain die, the individual dies, not because the brain is the same as the mind or personhood, but because this intermediary of the soul in its dynamic and operative function (as a motor) within the body has been removed – 'that disposition by which the body is disposed for union with the soul'.[7] One must see this intermediation of the brain not as delegation from outside but as a part of reality and this is what the traditional notion of 'principal organ' or '*instrumentum coniunctum*' seeks to express. St. Augustine, who was the source of this Thomistic doctrine of the government of the body by the soul through an organ which is the principal instrument, is very clear in asserting *avant la lettre* that brain death is the death of the individual: 'Thus, when the functions of the brain which are, so to speak, at the service of the soul, cease completely because of some defect or perturbation – since the messengers of the sensations and the agents of movement no longer act –, it is as if the soul was no longer present and was not [in the body], and it has gone away' (*Denique, dum haec eius tamquam ministeria vitio quolibet seu perturbatione omni modo deficiunt desistentibus nuntiis sentiendi et ministris movendi, tamquam non habens cur adsit abscedit [anima]*).[8] Therefore, in reality the objections to the criterion of brain death as death advanced by Prof. Spaemann and Dr. Shewmon do not hold up either at a physical/biological or a philosophical level.

We also disagree with Dr. Shewmon's conclusion that the worldwide consensus on the equivalency of brain death with human death is 'superficial and fragile'. Although practices vary between countries, there does exist a consensus of sufficient strength to permit the successful declaration of brain death in dozens of countries in the developed Western world and the non-Western and developing world that have addressed this question and possess the necessary state-of-the-art technology. ■

SOURCE:

The Pontifical Academy of Sciences, Excerpt of *Scripta Varia* 110, Vatican City

http://www.vatican.va/roman_curia/pontifical_academies/acdscien/2008/excerpt_signs_of_death.pdf

ENDNOTES

[1] Cf. *Met.*, II, 1, 993 b 12 ff.

[2] Cf. Council of Vienna (1312): DS 902.

[3] Cf. *De Anima*, II, 3, 414 b 20-32.

[4] St Thomas Aquinas, *Q. De Spiritualibus Creaturis*, a. 2 ad 7.

[5] *Ibid.*, *Q. De Anima*, a. 9.

[6] *Loc. cit.*

[7] St Thomas Aquinas, *S.Th.*, I, 76, 7 ad 2.

[8] *De Gen. ad lit.*, L. VII, chap. 19; PL 34, 365. It would appear that St. Thomas Aquinas arrived at the same conclusion about the centrality of the head when he stated: 'The head has three privileges in relation to the other members. Firstly, it is distinguished from the others in the order of dignity because it is the principle and it presides. Secondly, because of its fullness of senses in that all senses are in the head. Thirdly, because of a certain influence of sense and movement on the members': '*Caput enim respectu aliorum membrorum habet tria privilegia. Primo, quia distinguitur ab aliis ordine dignitatis, quia est principium et praesidens; secundo in plenitudine sensuum, qui sunt omnes in capite; tertio in quodam influxu sensus et motus ad membra*' (*Super Colossenses*, cap. 1, lect. 5, Marietti, Rome, 1953, vol. 2, p. 135, n. 47).

Final Declaration by the 13th General Assembly

CONGRESS ORGANIZED BY THE PONTIFICAL ACADEMY FOR LIFE ON THE THEME: "CHRISTIAN CONSCIENCE IN SUPPORT OF THE RIGHT TO LIFE"

23-24 February 2007

1. On 23-24 February, the Pontifical Academy for Life organized an International Congress at the Vatican on the occasion of its 13th General Assembly. The topic of the Congress was: "Christian conscience in support of the right to life". Present were the Members of the Pontifical Academy for Life and other well-known experts from various countries, in addition to approximately 420 persons from around the world.

At the end of the meeting, on the basis of what emerged from the reports presented and from the lively and constructive discussion, the Pontifical Academy for Life offers the following considerations to the ecclesial community, the civil community and every person of good will for reflection.

2. "Deep within his conscience man discovers a law which he has not laid upon himself but which he must obey. Its voice, ever calling him to love and to do what is good and to avoid evil, tells him inwardly at the right moment: do this, shun that. For man has in his heart a law inscribed by

God. His dignity lies in observing this law, and by it he will be judged" (*Gaudium et Spes,* n. 16). Thus, acting in faithful obedience to the judgments of his own moral conscience, which honestly seeks good and is constantly nourished by known truth, every person expresses and realizes his human dignity deep within himself, edifying himself and the whole community through his own conscious and free choices.

3. So that man may always be guided in his actions by the judgment of his moral conscience to do good in truth, he must take every possible care of his continuing formation, nourishing it with values consonant with the dignity of the human person, with justice and with the common good, as the Holy Father recalled in his Address to the Pontifical Academy for Life:

"The formation of a true conscience, because it is founded on the truth, and upright, because it is determined to follow its dictates without contradictions, without betrayal and without compromises, is a difficult and delicate undertaking today, but indispensable" (Address to Participants in the 13th General Assembly of the Pontifical Academy of Life, 24 February 2007; *L'Osservatore Romano* English edition *[ORE],* 7 March, p. 3).

The Christian's conscience, in particular, is fully enlightened in his search for good by a constant encounter with the Word of God, understood and lived in the Christian community according to the teachings of the Magisterium.

4. This need for continuing formation and a deepening of the conscience is very obvious today in the face of the many cultural and social problems which are surfacing and affect the right to life in the context of the family, in the assumption of the duties proper to married couples and to parents, in the health-care profession and in political tasks.

It is the ever more necessary and pressing task of the Christian conscience, taking on authentic human values and starting with the fundamental value of respect for life in its physical existence and dignity, to view such problems in the light of reason illumined by faith in forming opinions on the moral value of one's own acts.

5. Furthermore, we cannot overlook the many difficulties that the Christian conscience of believers meets today in forming an opinion and in reasoning. These difficulties are due to the cultural context in which they live and in which they are experiencing the crisis of "authority", loss of faith and all too often a tendency to seek refuge in forms of extreme rationalism.

In addition to the cultural context, another area that tests the Christian conscience is constituted by the juridical norms in force, both those that are codified and those defined by tribunals and the sentences passed by tribunals, which increasingly and under strong pressure from united and influential groups have opened and are opening the ruinous breach of decriminalization: exceptions to the individual's right to life are foreseen, various attacks on human life are being ever more widely legalized, and indeed end by denying that life is the basis of every other right of the individual and that the respect due to the dignity of every human being is the basis of freedom and responsibility.

In this regard, Benedict XVI has recalled that "the Christian is continually called to be ever alert in order to face the multiple attacks to which the right to life is exposed" (*ibid.* p. 3).

6. The specific requirements of the Christian conscience encounter their acid test in their application to the health-care professions; here, Christians face both their duty to protect human life and the risk of finding themselves in situations where in carrying out their professional duties they are cooperating with evil.

In such situations, the dutiful exercise of a "courageous conscientious objection" acquires importance on the part of doctors, nurses, pharmacists and administrative personnel, judges and parliamentarians, and other professional figures directly involved in the protection of individual human life, wherever the legislative norms provide for actions that threaten it.

However, at the same time it should also be stressed that recourse to conscientious objection occurs today in a cultural context of ideological tolerance, which paradoxically sometimes tends not to encourage the acceptance of the exercise of this right since it is a "destabilizing" element of the quietism of the conscience.

We wish to highlight that the exercise of the right to conscientious objection is particularly difficult for the health-care professions, since this right is normally recognized as the right of an individual and not of hospital structures or associations.

In the field of medical practice, the case of "emergency contraception" (generally using chemical expedients) may be mentioned. It is necessary first of all to recall the moral responsibility of those who make their use possible at various levels, and the need for recourse to conscientious objection since the effects of this form of contraception are abortive (preventing implantation or gestation). The moral duty to provide the public with complete information on the various mechanisms of action and the effects of these expedients should also be reasserted.

This of course goes hand in hand with the duty to oppose any medical intervention or research that is destined to destroy human life.

7. The mobilization of all who have at heart the protection of human life seems increasingly appropriate and must be extended to politics. Respect for the principle of equality that demands the rights of all to be honored and protected, especially in the case of the frailest and most defenseless beings, is an indispensable requirement of justice.

We present anew and with conviction the specific teaching concerning conscientious objection that is presented in the Encyclical *Evangelium Vitae* (cf. nn. 72, 73, 74), particularly in the perspective of the adherence of Christians to programmes proposed by political parties.

We are also hoping for legislation that will complete Article 18 of the Universal Declaration of Human Rights, proclaimed in 1948 by the United Nations to guarantee the right to conscientious objection and to defend this right against all forms of discrimination in the areas of work, education and the attribution of benefits by governments.

8. To conclude, we present anew the desire expressed by the Holy Father as a message of hope and of commitment in order to contribute to building a human society in proportion to man: "Therefore, I ask the Lord to

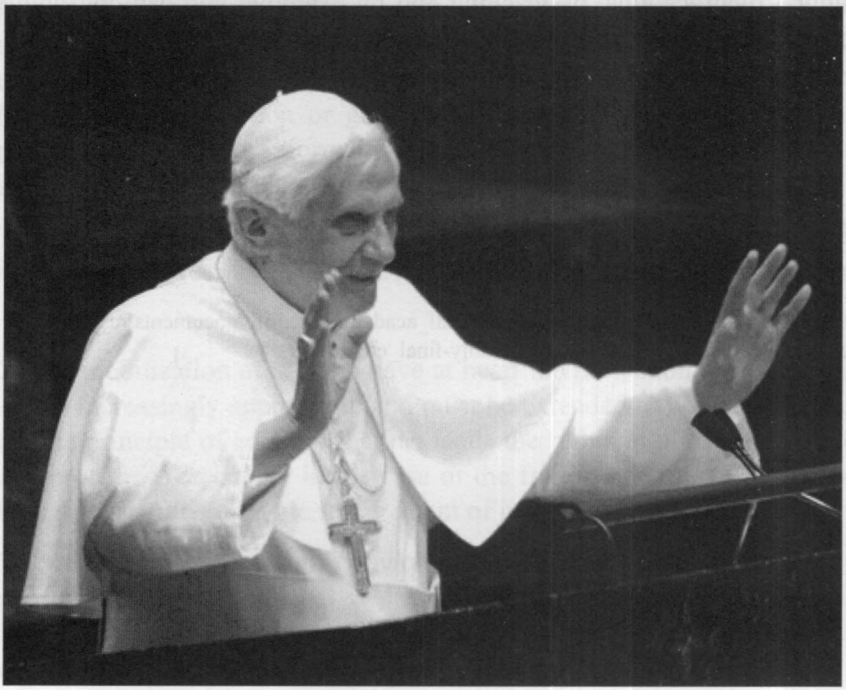
send among you, dear brothers and sisters, and among those dedicated to science, medicine, law and politics, witnesses endowed with true and upright consciences in order to defend and promote the "splendor of the truth" and to sustain the gift and mystery of life.

"I trust in your help, dearest professionals, philosophers, theologians, scientists and doctors. In a society at times chaotic and violent, with your cultural qualifications, by teaching and by example, you can contribute to awakening in many hearts the eloquent and clear voice of conscience" (*Address, ORE, op. cit.*, p. 4). ■

SOURCE:

The Pontifical Academy for Life

http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pont-acd_life_doc_20070315_xiii-gen-assembly-final_en.html



Pope Benedict XVI (photo courtesy of Getty Images, *http://www.daylife.com/photo/04qra5DeYR4qS*)

Address of His Holiness Benedict XVI

TO THE PARTICIPANTS IN THE CONGRESS ORGANIZED BY THE PONTIFICAL ACADEMY FOR LIFE ON THE THEME "CLOSE BY THE INCURABLE SICK PERSON AND THE DYING: SCIENTIFIC AND ETHICAL ASPECTS"

Clementine Hall
Monday, 25 February 2008

Dear Brothers and Sisters,

With deep joy I offer my greeting to all of you who are taking part in the Congress of the Pontifical Academy for Life on the theme: *"Close by the Incurable Sick Person and the Dying: Scientific and Ethical Aspects"*. The Congress is taking place in conjunction with the 14th General Assembly of the Academy, whose members are also present at this Audience. I first of all thank the President, Bishop Sgreccia, for his courteous words of greeting; with him, I thank the entire Presidency, the Board of Directors of the Pontifical Academy, all the collaborators and ordinary members, the honorary and the corresponding members. I would then like to address a cordial and grateful greeting to the relators of this important Congress, as well as to all the participants who come from various countries of the world. Dear friends, your generous commitment and witness are truly praiseworthy.

A mere glance at the titles of the Congress reports suffices to perceive the vast panorama of your reflections and the interest they hold for the present time, especially in today's secularized world. You seek to give answers to the many problems posed every day by the constant progress of the medical sciences, whose activities are increasingly sustained by high-level technological tools. In view of all this, the urgent challenge emerges for everyone, and in a special way for the Church enlivened by the Risen Lord, to bring into the vast horizon of human life the splendor of the revealed truth and the support of hope.

When a life is extinguished by unforeseen causes at an advanced age, on the threshold of earthly life or in its prime, we should not only see this as a biological factor which is exhausted or a biography which is ending, but indeed as a new birth and a renewed existence offered by the Risen One to those who did not deliberately oppose his Love. The earthly experience concludes with death, but through death full and definitive life beyond time unfolds for each one of us. The Lord of life is present beside the sick person as the One who lives and gives life, the One who said: "I came that they may have life, and have it abundantly" (Jn 10: 10). "I am the Resurrection and the life; he who believes in me, though he die, yet shall he live (Jn 11: 25), and "I will raise him up on the last day" (Jn 6: 54). At that solemn and sacred moment, all efforts made in Christian hope to improve ourselves and the world entrusted to us, purified by grace, find their meaning and are made precious through the love of God the Creator and Father. When, at the moment of death, the relationship with God is fully realized in the encounter with "him who does not die, who is Life itself and Love itself, then we are in life; then we "live"" (*Spe Salvi,* n. 27). For the community of believers, this encounter of the dying person with the Source of Life and Love is a gift that has value for all, that enriches the communion of all the faithful. As such, it deserves the attention and participation of the community, not only of the family of close relatives but, within the limits and forms possible, of the whole community that was bound to the dying person. No believer should die in loneliness and neglect. Mother Teresa of Calcutta took special care to gather the poor and the forsaken so that they might experience the Father's warmth in the embrace of sisters and brothers, at least at the moment of death.

But it is not only the Christian community which, due to its particular bonds of supernatural communion, is committed to accompanying and celebrating in its members the mystery of suffering and death and the dawn of new life. The whole of society, in fact, is required through its health-care and civil institutions to respect the life and dignity of the seriously sick and the dying. Even while knowing that "it is not science that redeems man" (*Spe Salvi,* n. 26), our entire society and in particular the sectors linked to medical science are bound to express the solidarity of love and the safeguard and respect of human life at every moment of its earthly development, especially when it is suffering a condition of sickness or is in its terminal stage. In practice, it is a question of guaranteeing to every person who needs it the necessary support, through appropriate treatment and medical interventions, diagnosed and treated in accordance with the criteria of medical proportionality, always taking into account the moral duty of administering (on the part of the doctor) and of accepting (on the part of the patient) those means for the preservation of life that are "ordinary" in the specific situation. On the other hand, recourse to treatment with a high risk factor or which it would be prudent to judge as "extraordinary", is to be considered morally licit but optional. Furthermore, it will always be necessary to assure the necessary and due care for each person as well as the support of families most harshly tried by the illness of one of their members, especially if it is serious and prolonged. Also with regard to employment procedures, it is usual to recognize the specific rights of relatives at the moment of a birth; likewise, and especially in certain circumstances, close relatives must be recognized as having similar rights at the moment of the terminal illness of one of their family members. A supportive and humanitarian society cannot fail to take into account the difficult conditions of families who, sometimes for long periods, must bear the burden of caring at home for seriously-ill people who are not self-sufficient. Greater respect for individual human life passes inevitably through the concrete solidarity of each and every one, constituting one of the most urgent challenges of our time.

As I recalled in the Encyclical *Spe Salvi*: "The true measure of humanity is essentially determined in relationship to suffering and to the sufferer. This holds true both for the individual and for society. A society unable to accept its suffering members and incapable of helping to share

their suffering and to bear it inwardly through "com-passion' is a cruel and inhuman society" (n. 38). In a complex society, strongly influenced by the dynamics of productivity and the needs of the economy, frail people and the poorest families risk being overwhelmed in times of financial difficulty and/or illness. More and more lonely elderly people exist in big cities, even in situations of serious illness and close to death. In such situations, the pressure of euthanasia is felt, especially when a utilitarian vision of the person creeps in. In this regard, I take this opportunity to reaffirm once again the firm and constant ethical condemnation of every form of direct euthanasia, in accordance with the Church's centuries-old teaching.

The synergetic effort of civil society and the community of believers must aim not only to ensure that all live a dignified and responsible life, but also, experience the moment of trial and death in terms of brotherhood and solidarity, even when death occurs within a poor family or in a hospital bed. The Church, with her already functioning institutions and new initiatives, is called to bear a witness of active charity, especially in the critical situations of non-self-sufficient people deprived of family support, and for the seriously ill in need of palliative treatment and the appropriate religious assistance. On the one hand, the spiritual mobilization of parish and diocesan communities, and on the other, the creation or improvement of structures dependent on the Church, will be able to animate and sensitize the whole social environment, so that solidarity and charity are offered and witnessed to each suffering person and particularly to those who are close to death. For its part, society cannot fail to guarantee assistance to families that intend to commit themselves to nursing at home, sometimes for long periods, sick people afflicted with degenerative pathologies (tumors, neuro-degenerative diseases, etc.), or in need of particularly demanding nursing care. The help of all active and responsible members of society is especially required for those institutions of specific assistance that require numerous specialized personnel and particularly expensive equipment. It is above all in these sectors that the synergy between the Church and the institutions can prove uniquely precious for ensuring the necessary help to human life in the time of frailty.

While I hope that at this International Congress, celebrated in connection with the Jubilee of the Lourdes Apparitions, it will be possible to identify new proposals to alleviate the situation of those caught up in

terminal forms of illness, I exhort you to persevere in your praiseworthy commitment to the service of life in all its phases. With these sentiments, I assure you of my prayers in support of your work and accompany you with a special Apostolic Blessing. ■

SOURCE:

Libreria Editrice Vaticana, Vatican City, 2008

http://www.vatican.va/holy_father/benedict_xvi/speeches/2008/february/documents/hf_ben-xvi_spe_20080225_acd-life_en.html

Immaculate Conception Church in Pasig in the 19th century (photo courtesy of Arnaldo Dumindin, *Philippine-American War, 1899-1902, http://www.freewebs.com/philippineamericanwar/combatinmanilasuburbs.htm*)

Pásig History Fulfilled: From Parish to Diocese (1571-2003)

DR. LUCIANO PR. SANTIAGO

The Lord of History must have long marked Pásig as the future seat of a diocese. From the dawn of its history as a Christian town through its subsequent unfolding in both the spiritual and secular spheres as reflected in the lives and labors of its priests, women religious and laity, Pásig comes to light as a magnificent center of Faith. Two or three generations before the Augustinian missionaries arrived in the big *barangay*, it had just been converted into a Muslim realm under Gat Arao and Dayang Calangitan. The royal couple bore sacred names referring to the sun god *(Arao)* and to heaven *(Langit),* respectively. Their son, Sulayman I became the first Muslim king of Maynila. When the *Adelantado,* Don Miguel López de Legaspi conquered Maynila in 1571, he declared it the capital of the new colony. Next he took Tondo under Lakán Dula, Sulayman I's second son, and then Pásig, their ancestral domain.

THE FIRST MARIAN PARISH

Initially dedicated to Our Lady of the Visitation, Pásig became the first Marian parish not only in the Philippines but also in Asia. (Christianized earlier by the Portuguese, Goa and Macao did not have a Marian parish in the 16th century.) The original parish of Pásig was far bigger than the newly created diocese at present, which embraces Pateros and Taguig. It had ranged North to San Mateo (now in Rizal Province)

and as far South as Baé in Laguna. One by one, through the centuries, the distant towns seceded as separate parishes from their matrix. In 1587, the spiritual territory of the Augustinians was reorganized.

The Titular of Pásig was changed to The Immaculate Conception, the Marian attribute it shared with the then Diocese of Manila (created in 1578). In the same year, Taguig was established as a town and parish under the advocacy of St. Anne, the Virgin's mother. It would take more than two centuries later for the barrio of Agojo, now known as Pateros, to separate in 1815 with St. Roch as its patron.

THE *BEATAS* OF PASIG

The depth of evangelization of Pásig was first manifested by the early emergence of its *beatas* or holy women. Sor Sebastiana Salcedo de Jesús (1650-90) was an Indian mystic who became a forerunner of the Beaterio de Sta. Catalina de Sena in Manila, now the Congregation of the Dominican Sisters of St. Catherine of Siena. Her Spanish colleagues were astonished when, before her death, she correctly predicted when and where the religious house would be established in the walled city. This occurred in 1696.

Half a century later, in 1740, fourteen virtuous ladies of Pásig and nearby towns formed the Beaterio-Colegio de Sta. Rita under the direction of Fray Félix de Trillo, OSA, one of the most dynamic pastors in the history of the town. The religious community was the only major *beaterio* located outside Manila. It admitted native aspirants from all social classes. They professed their vows *in articulo mortis.*

In 1813, a pious widow, Doña Magdalena Pinga (1731-1815) of Maybunga set up two of the biggest *capellanías* (religious trust funds) in the Archdiocese of Manila which still sustains the Metropolitan See. Madre María de la Concepcíon (died 1852) who was born in Pateros, while it was still a *barrio* of Pásig, was elected in 1850 as the eighth prioress of the Beaterio de la Compañía, now the Congregation of the Religious of the Virgin Mary. The sisters Nicolasa (1789-1869) and Macaria Miguel y Tagle (1796-1868) together with their brother Patrick) (1791-1867), wealthy entrepreneurs from the Pariancillo, offered in 1865 a solid silver

carroza for the solemn processions of The Immaculate Conception. In gratitude, the Archbishop of Manila exempted the three elderly donors from paying burial fees upon their demise.

The old Beaterio de Sta. Rita de Pásig gave way in 1909 to the Colegio de Nuestra Señora del Buén Consejo (CBC). It is run by the Filipino Augustinian Sisters of Our Lady of Consolation and was the first foundation to be established by their co-foundress Mother Consuelo Barceló y Pages, OSA (1857-1940). The cause for beatification of Mother Consuelo is presently under consideration by the Sacred Congregation in Rome.

LANDS FOR THE SOULS

The gentry of the town did not renege on their responsibilities to contribute to the maintenance of the local church and the assistance of the poor and the needy. Besides the benefactors cited above, at least fifteen more *principales* donated rice lands in the form of *capellanías* between 1737 and 1826, the records of which have survived. The faithful still call these lands *"lupang pari"* (priest's lands) because they were offered to the parish priest and his successors in perpetuity and not to the religious order. In exchange for the donation, the testator requested a certain number of masses a year to be said "till the end of time" for the repose of his or her soul and those of forebears and family members. One of the donors in 1801 was Sor Mariana Flores of the Beaterio de Sta. Rita who became its prioress in 1810. (Unfortunately, modern day land grabbers have surreptitiously gained titles to some of these lands. But in their haste, they unwittingly left their tracks in the archives for researchers to marvel at.)

THE ORDER OF ST. AUGUSTINE

For more than 300 years, the Sons of Augustine faithfully served the local parish as well as those of Pateros and Taguig. (Sadly, their contribution is not acknowledged in the design of the seal of the new diocese.) They were assisted by Filipino priests as coadjutors. The latter became the pastors only in the first decade of the 20th century followed by the Belgian Fathers (CICM) who worked here until 1978. Since then, the parish has been led again by Filipino priests and prelates.

The fact that three Augustinian pastors of Pásig were elevated to ecclesiastical sees in the 19th century further attested to its importance as a religious hub. Fray Hilarión Díez, OSA became the Archbishop of Manila (1826-29). Fray Santos Gómez Marañón, OSA was promoted to the See of Cebú (1828-40). And Fray Manuel Grijalbo, OSA was named Bishop of Nueva Cáceres (1846-61). Three others were distinguished writers: Fray Gaspar de San Agustín, OSA, author of *Conquistas de las Islas Filipinas* (Madrid 1698); Fray Joaquín Martínez de Zúniga, OSA, writer of *Historia de las Islas Filipinas* (1803) and *Estadismo de las Islas Filipinas* (1893); and Fray Manuel Blanco, OSA, author of the monumental *Flora de Filipinas* (1837, 1845, 1877, 1883 & 1993). The Spanish pastor who served for the longest term (22 years) was Fray José Vagué, OSA (1849-71).

FILIPINO COADJUTORS & PASIGUEÑO PRIESTS

Among the prominent Filipino priests who labored in Pásig were the Bachiller Don (BD) Phelipe Antonio Garzía (1738), a Spanish mestizo who was one of the first native priests; Dr. Don Juán Sebastián Arámburu (1786), a Chinese mestizo who earned two doctorates, PhD & STD; BD Pedro Fermín Bernal (1825-28), the only Filipino priest who became acting pastor of Pásig during the Spanish Period; BD José Mariano Hocson (1831-61), the longest serving coadjutor (30 years); Dr. Don Vicente García, STD (1853-54) who was promoted as the vicar general of Naga and later, canon of the Manila Cathedral; BD Saturnino Pacheco (1870-71) & BD Silvino Manolo (1892), both avid religious writers.

The first Pásigueño priest was the Bachiller Don Jacinto Gutiérrez Bautista (1743-82), a descendant of the Lakans in the ancient barrio of Bambang. He was ordained by Manila Archbishop Basilio Sancho de Santas Justa y Rufina in 1768. He worked as the coadjutor of Cainta from 1768 to 1774 when he succeeded as its pastor upon the death of the incumbent. He served the parish competently and faithfully for eight years until his death in 1782.

Pásigueño priests who worked in their natal place included BD José Salazar (1838); BD Blás Florentino (1842-61); BD Engracio Miguel (1861-62) and his cousin, BD Pedro Miguel Cangco (1890-97); BD León Sison (c1890-94) and BD Cecilio Damián (1895-96) who was also an activist during the Revolution.

The first Filipino pastor of Pásig was Padre Patricio Calderón (1901-10), one of the ten distinguished native priests of the archdiocese at the turn of the century. His coadjutor was Padre Lupo Dumandán, a saintly Pásigueño from Santolan who eventually bequeathed his huge ancestral house and lot to the parish.

One of the first Filipino monsignori was a native of Pásig Msgr. Leocadio Dimanlig y Santiago (1849-1927). He worked as the vicar forane of the province of Batangas and then the vicar general of the Diocese of Lipá. For his dedicated service to the church, the pope appointed him as his domestic prelate in 1915.

Though a family man and not a priest, Don Joaquín Tuason (1843-1908) was a popular religious writer in the 19th century. He was in fact the most prolific Filipino writer in his time. A native of Pateros, he lived most of his adult life in Pásig across the street from the town plaza and with a full view of the church.

PISTA NG BAYAN

During the Spanish Regime, the mayor (*gobernadorcillo*) was the *ex-officio* president of the *comité de festejos,* which organized the annual town fiesta in honor of the Immaculate Conception. In the transition to the American Period in the 20th century, with the separation of the church and state, the two functions were also separated. Padres Calderón and Dumandán formed a new committee of lay faithful to take care of the religious celebration in the parish which the two priests supported spiritually as well as financially. Despite isolated attempts to disband it, the set up has been preserved to this day.

The most memorable town fiesta occurred on December 8, 1941 when it coincided with the start of World War II in the Pacific with the bombing of Pearl Harbor and Philippine military installations by the Japanese. For the next three years, the people dwelt in a veritable calvary. But they carried on under the merciful protection of their patroness.

THE BELGIAN FATHERS

The Congregation of the Immaculate Heart of Mary likewise contributed intrepid men of God to the parish. The first to serve, Fr.

Cornelio de Brouwer, CICM (1910-15) founded the Pásig Catholic School (now a college) in 1913. Fr. Victor de Klerk, CICM was the longest serving pastor for 33 years (1926-59) while his colleague, Fr. Urbano Timmermans, CICM was the longest serving coadjutor for 58 years (1915-67). Fr. Godofredo Aldenhuysen, CICM (1919-22 & 1924-25) was elected provincial of the congregation in 1925. So was Fr. Joseph Billet, CICM in 1935; a few months later, he was named the Prefect Apostolic of Mountain Province.

DEVOTION AND COURAGE

Through the centuries, the faithful of Pásig have been known for their great affection and devotion to their pastors. However, they also have the courage to draw the line and appeal to higher authorities when the pastor exhibits abusive or oppressive conduct towards them. Only on two occasions – more than a century apart – did this happen: in 1832 and the 1990s. The first case was against Fray Juán Rico, OSA for grave abuse of authority and the second, against a certain monsignor also for power tripping and destroying historical structures spared in the last war. Needless to say, Pásigueño deeply value their history and patrimony.

PRIESTS AND PRELATES

On the long but steady road to becoming a diocese, Pásig reverently received its first bishop pastor in 1979 in the person of Msgr. Manuel Sobreviñas, Auxiliary of Manila and Titular Bishop of Tulana (b. 1924). His enlightened reign lasted until 1993 when he was promoted to the See of Imus. In 1991, the main altar of the church, which had been redesigned and carved by Don Máximo Vicente in 1928, was enlarged and renovated through the courtesy of Mr. and Mrs. Renato Apacible (nee Rosario Ávarez). Together with Bishop Sobreviñas, Jaime Cardinal Sin solemnly dedicated the church of Pásig the following year.

For the Jubilee Year 2000, the Church of the Immaculate Conception of Pásig was proclaimed a Jubilee Church of the Archdiocese of Manila. The Ecclesiastical District of Pásig was set up in 2001 under Msgr. Nestor Cariño, Auxiliary Bishop of Manila and Titular of Tibiuca (b. 1938).

Finally, after only two years, Pope John Paul II created the new Diocese of Pásig in 2003. It was inaugurated on August 21 with the elevation of its huge church into a cathedral and the installation of its first Bishop, Msgr. Francisco San Diego, former Bishop of San Pablo, Laguna and Titular of Zica (b. 1935). A new era of hope and grace began in the ancient site of Pásig-Pateros-Taguig. The patron saints of the three places are now denoted in the coat of arms of the diocese, respectively, by the emblem of the Immaculate Conception, the cane of St. Roch and the book of St. Anne, the first teacher of the Blessed Virgin. Across the sacred shield, a representation of the Pásig River runs diagonally. ■

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From Diocesan to Pontifical Right: The Shifting of a Religious Institute

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QUESTION:

My religious Congregation was founded in 1980, approved by Rome in 1993, and given the Decree as a Congregation of Diocesan Right by the Bishop of the place of mother house. The Congregation has in the meantime grown in numbers, around 280 members in 2008, and spread in seven countries in four continents. This has prompted the need for it to become a Pontifical Right Congregation, thus allowing the Bishops, and also the Apostolic See, to refer directly to the governing body of the Congregation, rather than to a local Bishop where often language and culture wise communication is very difficult, if not at times impossible.

Taking for granted that such is the rationale for the shifting of an Institute to Pontifical Right (is it not?), my question now is: What are the requirements and the procedures for such a shifting?

ANSWER:

Three questions are formulated in the above inquiry concerning the shifting of a religious institute of diocesan right into an institute of pontifical right, namely,

1. What is the *rationale* for such shifting?
2. What are the *requirements* for it?
3. What are the *procedures* for the shifting process?

Since the inquiry speaks of a Congregation, the context of our answer here refers directly to religious Institutes (Orders and Congregations), although most of the things said could also be applied analogically – in the measure that it is possible – either to Secular Institutes, to Societies of Apostolic Life or to any other approved form of consecrated life.

The inquiry speaks also of "diocesan right" and of "pontifical right" applied to a particular Congregation. Actually these two categories referred to a religious institute mark the last two stages in its normal development. The difference between an institute of diocesan right and another of pontifical right is that the latter has been established or approved by means of a formal decree by the Apostolic See, while the former not, as stated in canon 589: *"An institute of consecrated life is of pontifical right if it has been established by the Apostolic See, or approved by it by means of a formal decree. An institute is of diocesan right if it has been established by the diocesan Bishop and has not obtained a decree of approval from the Apostolic See."*

The pontifical recognition of an institute comes only at the end of a long and laborious period of growth undergone by the institute from the very moment of its foundation... Let us have a brief look at it.

1. The long Road towards Pontifical Recognition

Religious institutes are like living beings: they are born in time and they grow up. Each stage of their development is considered "transitory" inasmuch as the charism of religious life is for the whole universal Church. Thus, before reaching their full stature, religious institutes undergo a long process, which starts from their original charismatic foundation, and passes through their canonical recognition by the ecclesiastical authority first as private associations and then as a public ones, to become institutes of diocesan right, and finally, from there, to make their final shifting to pontifical right. The metamorphosis in a summary fashion is the following:

a. ***Emerging group.*** The future institute's life starts with its "charismatic" foundation. This is the time when the founder/ foundress inaugurates a new way of witnessing the Gospel with the creation of a group of followers; after some experimental

period of time they seek recognition from the Church in view of becoming an institute of consecrated life.

b. ***Association***. The canonical foundation enters now into the picture, that is, the moment when the ecclesiastical authority intervenes by giving the emerging group his recognition as an *association* (it used to be called a "pious union"), first as a *private* association, once its statutes have been reviewed (can. 299 §3), and then as a *public* one (can. 312). With this recognition the future religious institute is now a juridical body governed by laws and subject to the diocesan Bishop's direction and vigilance. As a public association, the future institute receives a mission (*missio canonica*) to act in the name of the Church, and its ends are formally public in view of the common good of the Church. The public association destined to become an institute of consecrated life normally "resembles" already a *true* religious institute – although juridically it is not yet such. In fact, its members are already living a life proper to the religious; they live a fraternal life in common, profess the three evangelical counsels of chastity, poverty and obedience, perform certain works of apostolate, wear their distinctive habit, etc.

c. ***Diocesan right institute***. For the association to be erected as an institute of diocesan right the approval or *nihil obstat* of the Apostolic See is needed (cf c. 579). Such approval will take place after the Congregation for Institutes of Consecrated Life and of Societies of Apostolic Life (CICLSAL) has examined everything that concerns the founder/foundress, the history of the group, the purpose or charism, the statutes, the prayer manuals, and other writings and documents. With such approval, and taking into account any possible reservations to the Apostolic See, the diocesan Bishop may, by a formal decree, establish the religious institute in his territory. The canonical consequences of this institutional establishment are important: (a) The Bishop can no longer suppress the institute because that belongs to the exclusive competence of the Apostolic See (can. 584); (b) the institute can spread to other dioceses with the sole consent of the diocesan Bishop of the particular church where it wishes to establish its presence (can. 609 §1; 733 §1); (c) the institute acquires an

ecclesiastical juridical personality with connotes a specific autonomy in administration (can. 634 §1; 718; 741), mission (can. 675 §3), authority (can. 618), etc., as defined by the law of the Church.

d. ***Pontifical right institute***. After an appropriate time, when the institute expands significantly to various dioceses, has a sufficient membership, and evidence of vitality, all assured by the testimonial letters from the various Ordinaries, the institute may be ready to apply to the Apostolic See for pontifical recognition or to seek from Rome what in the past (until 1975) was called *Decretum Laudis* ("Decree of Praise") and nowadays known as "Decree of Pontifical Recognition." Once such decree by the Apostolic See is formalized, the institute becomes one of pontifical right (can. 589).

2. What is the Rationale for an Institute of Diocesan Right to seek Pontifical Approval?

It is the mind of the Church that after a diocesan institute has developed its membership and spread to other geographic areas, it may apply for pontifical recognition. However, there is no juridical obligation to do it. In other words, even though in the normal course of development religious institutes of diocesan right are expected to seek pontifical approval, they are in no way bound to do it.

What are the reasons, in terms of advantages, that may move a diocesan right institute to seek pontifical approval?

a. First, one very practical related to *communication* with the institute once it has grown in numbers and spread to several dioceses, countries and even continents: to allow its members, the Bishops, and also the Apostolic See, to refer directly to the governing body of the Congregation, rather than to a local Bishop where often language and other cultural differential factors may make communication very difficult – if not at times impossible – with the corresponding problems.

b. Another reason is related to *exemption*, traditionally understood as withdrawal of institutes by the Supreme Pontiff from the power of the local Ordinaries "to better ensure the welfare of institutes and the needs of the apostolate" (c. 591): it is the advantage of greater autonomy at least concerning freedom in the internal order of the institute (governance, discipline, administration), in the exercise of apostolate, and in the jurisdiction over the subjects. Experience teaches that administrative matters are easier to handle from one central place that is neutral and equally open and available to all. The identity of each institute and the one of its individual members working in different countries and situations is likewise better safeguarded from a central point, with unity of authority and legislation. Even the future planning for the "apostolic action exercised in the name of the Church and by its command" (c. 675 §3) can be performed more in union with the Church by being directly under the Apostolic See, free from the limitations of a narrow, restricting provincialism.

Summing up, by attaining the status of pontifical right, a religious institute becomes more autonomous, acquires a greater stability and has greater opportunity to undertake new initiatives. Although its members still remain under the authority of the Bishops on specific matters ("care of souls, public exercise of divine worship and other works of the apostolate," c. 677 §1), however, the unity of government, the charism and the apostolate of the institute is strengthened and safeguarded and there is greater freedom to develop and grow.

Over all, pontifical recognition is a sign that the institute has matured and grown to its full ecclesial stature.

3. What are the Requirements for the Shifting to Pontifical Right?

The requirements are those presently prescribed by the Congregation for Institutes of Consecrated Life and of Societies of Apostolic Life (CICLSAL) for those Institutes seeking the formal decree of approval from the Apostolic See. They refer mainly to a series of documents necessary to show the physical and spiritual readiness of the concerned Institute.

A. DOCUMENTS NEEDED

In view of obtaining Pontifical Recognition, religious Institutes of diocesan right are currently required by the CICLSAL the submission of the following documents:

1. *A historical-juridical account of the religious Institute from its beginning* (not more than two or three pages). A copy of the document by which the ecclesiastical authority erected the religious Institute of diocesan right should be included. (The history of the Institute should include the following points: Name and surname of the Founder; purpose, date and place of the foundation; name of the Bishop who authorized its beginning in his diocese; names of the first members; erection, date and place of the first house of novitiate; name of the Bishop who erected it; number of the first novices and date of their admission to the novitiate; name of the Bishop who erected it; number of the first novices and date of their admission to the novitiate; the same for the first members in temporary and perpetual private vows; who was the first Master of Novices; dates of the General Chapters celebrated; who approved the first text of Constitutions and when; apostolic activities of the Institute at the beginning and at present; development of the Institute in other dioceses; particular spirituality of the Institute; in case of a clerical Institute: place where the members are studying for the Sacred Orders; other important happenings during the history of the Institute.)

2. *'Curriculum vitae' of the Founder and of the first Superior General of the Institute.* To be included: name and surname; date and place of birth, of baptism and of confirmation; parents' name and surname; place where he made his elementary and secondary studies; date of entrance in the Association and of his temporary and perpetual private vows; date of election as first Superior General and the period for which he was elected; his situation at present or date of death. If the Founder is (or was) a member of a religious Institute, the following are to be also included: place where he made his ecclesiastical studies; date of his admission to the novitiate and to temporary and perpetual religious profession;

date of his Sacred Ordination; what kind of permission he got to follow his foundation. *In case of a Foundress*: date of her admission to the novitiate and to the temporary and perpetual religious profession in her previous religious Institute and any dispensations granted to her.

3. *Up-to-date statistics of membership*: names and surnames of the perpetually and temporary professed members; number of novices and of postulants; age of the perpetually professed members; number of houses and name of the dioceses where the members are living and working. (To have a diocesan religious Institute recognized as of pontifical right, the number of members required is about 80-100 professed of whom the major part in perpetual vows.)

4. *Financial status*: Besides declaring any debts, if any, it should be pointed out only: a) the number of houses owned by the Institute; b) the sum of money (in USA dollars) in banks.

5. *A statement regarding the following points*: a) any facts of an extraordinary nature with reference to the Founder/Foundress, such as visions, etc.; b) whether in the diocese where the Generalate is located, there exists already any other religious Institute with the same name and charism.

6. *Description of the religious habit of a novice and of a professed member.*

7. *Eight copies of the Constitutions and the Directory*, revised in accord with the Code of Canon Law.

8. *Testimonial letter from the diocesan Bishop of the Generalate of the Institute and from the other Bishops of those dioceses in which the Institute is present.* Such letters are to be sent together with the opinion of the same Bishops about the following items, namely: a) stability and discipline of the Institute; b) initial and on-going formation; c) ability to ensure a responsible government of a religious Institute of pontifical right, besides the present Superior General; d) administration of goods; e) liturgical and sacramental dimension; f) collaboration with the local Church.

9. *Testimonial letter from the diocesan Bishop of the Generalate of the institute and from the Bishops of those dioceses in which the Institute is present.* Such letters are to be sent directly to the CICLSAL containing the Bishops' personal opinion on the following points: a) utility and stability of the Institute; b) regular observances of the members; c) liturgical and sacramental dimension; d) ecclesial sense and collaboration with the ecclesiastical hierarchy; e) initial and on-going formation; f) administration of their temporal goods; and g) ability to ensure a responsible government of a religious Institute of universal character.

B. PHYSICAL READINESS

The required documentation has to show, among other things, the "physical readiness" of the Institute for pontifical recognition. Such material readiness is reflected in the following facts:

1. *Growth in numbers*: While forty members is sufficient for a religious institute to get the approval as of Diocesan Right, about one hundred members, most of them perpetually professed, are needed before seeking approbation for Pontifical Right. (In the case of a contemplative Congregation the number may be inferior). The number of members speaks very often of the stability of the institute.

2. *Spread of the Institute*: Although it is not absolutely necessary for a religious institute to have spread into other dioceses, the normal pattern is that it has spread by now not only into other dioceses but also into other countries and continents. The pontifical recognition can then facilitate its identity and governance.

3. *Extension of the Apostolate*: According to the charism of the Founder/Foundress the apostolate of the institute must have been established in all the houses erected in the diocese or in the dioceses and continents.

4. *Future Vision*: There must be, besides the stability of the institute, openness to new interpretations of the original charism, prompting continuous growth according to the different situations met in different countries, cultures, and ages.

C. SPIRITUAL READINESS

Parallel to physical readiness, the Institute of diocesan right seeking pontifical recognition must also show its "spiritual readiness" before obtaining it. The spiritual readiness is mainly reflected:

1. *In the newness of the founder's charism*: "The 'charism of the founders' seems to be a certain experience of the Spirit which they pass on to their disciples so that the latter may live in accordance with it and preserve, deepen and constantly intensify it as the body of Christ grows ceaselessly... Any authentic charism brings with it a certain element of genuine newness for the spiritual life of the Church..."

2. *In the way the charism of the institute is lived out by its members*: The CICLSAL and the Congregation for Bishops have issued some norms to evaluate the charism of the founders as well as the validity of the institutes' spirituality, known in the end by their concrete fruits: "The charismatic note distinctive of each institute requires that both the founder and his disciples continuously test their fidelity to the Lord, their docility to the Spirit, their prudent attention to circumstances and careful analysis of the signs of the times, their determination to be an organic part of the Church, their consciousness of obedience to the sacred hierarchy, their intrepidity in carrying out their undertakings, their constancy in sacrificing themselves and their humility in suffering adversity. A proper relationship between a genuine charism, new perspectives and interior trials brings with it an unbroken historical link between the charism and the cross."

3. *In the preservation of the whole patrimony of the institute*: The Code of Canon Law describes the patrimony of a religious institute as comprised "of the intentions of the founders, of all that the competent ecclesiastical authority has approved concerning the nature, purpose, spirit and character of the institute and of its sound traditions" (can 578). It is formulated in the Rule and Constitutions – the legal framework of a religious institute – which, together with the universal law of the Church, govern the life of the religious.

4. What are the Procedural Steps?

Nothing is mentioned in the Code of Canon Law about the procedural steps of this "special process" neither in the canons dealing with religious Institutes nor in the books on procedures. However, from the current norms of the CICLSAL on the requirements in view of obtaining pontifical recognition of a religious institute of diocesan right, the steps may be reconstructed as follows:

A. PREPARATORY STAGE: DATA GATHERING

The approbation of an institute of diocesan right as an institute of pontifical right comes only after the petition for it by the supreme moderator of the institute to the Apostolic See has been formally raised. It will have to be supported by the relevant required documents, duly updated. Such documentation is aimed not only at showing statistics and numbers, but mainly at proving the physical and spiritual readiness of the institute to obtain pontifical recognition.

All this presupposes logically a period of research and of data gathering to be carried out by the institute through the person or persons entrusted by the competent authorities.

B. PETITION TO THE APOSTOLIC SEE

This is done by the supreme Moderator to the Institute to the Congregation for Institutes of Consecrated Life and for Societies of Apostolic Life (Palazzo delle Congregazioni, 00193 Roma, Piazza Pio XII, Rome).

C. SENDING THE REQUIRED DOCUMENTATION

The documents required in view of obtaining pontifical recognition of a religious institute of diocesan right have been already listed above in detail. The CICLSAL has regrouped them in seven chapters, namely,

1. A historical-juridical account of the religious Institute;
2. Curriculum vitae of the Founder and of the first Superior general;
3. Up-to-date statistics of membership;
4. Financial status;
5. A statement regarding

a. facts of an extraordinary nature with reference to the Founder/Foundress and
b. whether in the diocese where the Generalate is located there exists already any other religious Institute with the same name and charism;

6. Description of the religious habit of a novice and of a professed member; and
7. Eight copies of the Constitutions and the Directory.

D. TESTIMONIAL LETTERS

Testimonial letters from the diocesan Bishop of the Generalate of the Institute, and from the Bishops of those dioceses in which the Institute is present, are to be sent directly to the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life, together with the opinion of the same Bishop about the items already mentioned before in the list (n. 8) of documentation required.

In favorably endorsing the Institute, each bishop is to ideally attest something like "...In my honest opinion, the said Institute is now qualified to be recognized as of pontifical right for the following reasons..."

E. A CONTRIBUTION OF USA 500 DOLLARS

The Institute is kindly requested, if possible, to forward to the Cash Office of the CICLSAL "a deposit equivalent to 500 US $ on account for the expenses of the entire process."

F. ANY OTHER NEEDED FORMALITY

The CICLSAL may request, if needed, any other document, letter, updated information or testimony about the Institute that may contribute to a better judgment about its readiness for the sought status.

5. Personal Closing Remarks

In closing my answer to the questions formulated in the inquiry, I wish to stress a couple of points and advance a personal suggestion:

The first point to stress is that while there is no obligation for a religious institute of diocesan right to seek pontifical recognition, it remains an expectation on the part of the Apostolic See. Thus, as it was said before, when an institute has stood the test of time, growth and stability, and when its life and ministry are making a valuable contribution to the Church, it should seek full ecclesial recognition and assume the autonomy that is rightfully its own as a pontifical institute. (It is not necessary for a diocesan institute to have spread to other dioceses and countries for it to begin to seek pontifical status.)

The second point is rather a personal apprehension that has something to do with the required testimonial letter from the diocesan Bishop of the Generalate of the institute and from all the other Bishops in whose dioceses the institute is present. Surely not all bishops – particularly the one of the primary seat of the Congregation – may be willing to "give up" a religious institute (e.g., a Congregation) under their care and henceforth not seeing with good eyes its shifting to pontifical status. Other Bishops perhaps may not see at all the need for such shifting... A logical consequence follows: they may altogether refuse to send a favorable endorsement of it to the Apostolic See, even if the institute is ready for the shifting! An additional human factor: Even if those testimonial letters are confidential in nature and are to be sent directly by each Bishop to the CICLSAL, most probably the Bishop of the primary seat of the institute will discuss the matter with some of his fellow bishops, who in turn, will not easily go against their Brother in the episcopacy... Thus, again, it is very possible that some institutes may have little chance of getting the necessary testimonial letters required by Rome for the purpose.

What could be one possible solution to this problem? The following is just a suggestion: *Would it not be convenient to have a universal norm prescribing that all religious institutes of diocesan right, upon reaching their physical and spiritual readiness, should become of pontifical right as a natural growth process, and not as something that can be discretionary taken or left?* As for the moment there is nothing the said institute can do but keep talking to the local Bishop about the convenience for it to become an Institute of Pontifical Right... The answer may be left by now blowing in the wind. ■

JAN 1

SOLEMNITY OF MARY, MOTHER OF GOD

READINGS: Nm 6:22-27; Gal 4:4-7; Lk 2:16-21 (CYCLE B)

Mary the Woman, Mary the Mother

ENRICO GONZALES, OP

The abolition of man comes with the abolition of motherhood. There is nothing wrong of course when women go to streets to protest against the discrimination of their gender in the just distribution of rights and privileges in our society. What is appalling is when these same women start thinking – and they are ready to die for it – that men and women are absolutely the same. One thing for sure both men and women are equally human but having said that, we are quick to add that in the concrete, we appropriate this humanity in our personality each to our own way. Yes, there is such thing as individual difference. Differences though do not necessarily mean that the abolition of all common points as to exclude all opportunities for convergence. So, our conclusion: men and women are both human and yet different. So, don't expect us males to be mothers. Would that medical science and technology never invent a way to transplant wombs into the male anatomy! Unfortunately, we are a step close to this aberration. The contemporary generation is suffering terribly from *utero-phobia*. Women, specifically, are terrified to be mothers. Thanks to the socio-political planners, any additional baby is considered a threat. A baby – a threat?! Has the world gone so mad as to develop this grotesque imagination!

We would like women to be liberated of course. Definitely we would like them to be liberated from male brutality which abets the practice

of wife-battering, rape, and misogyny in whatever form. But women cannot promote this liberation by becoming brutal themselves. If they find men a personification of all weaknesses imaginable, then, women cannot claim that they are a better sex by "masculinizing" themselves. In the end, women can save men only by being and becoming genuinely feminine. To be genuinely feminine, Mary – the Mother of Jesus – is undoubtedly the model. She is the strong woman who never flinches in the prospect of terrible pain which obedience to God's will entails. But her strength is gentle too. Her gentleness is a presence which could tame the impetuosity of an apostle as impulsive as John the Evangelist whom she adopted as her own son at the behest of Jesus, dying on the cross. (Jn 19:26) Without Mary, we too would be orphans. Not only to the Apostle John therefore that Jesus bequeathed his Mother but to us also: that we may have a mother to succor us in our needs at all times.

All the time points to Jesus as its alpha and omega. This new year is appropriately described as the Year of the Lord 2009 – and for that matter, all the years that come next. Jesus Christ is after all "yesterday, today, and forever". (Heb 138) No wonder then that the beginning of the year is dedicated to his mother. After all, Jesus entered into time through Mary. Eternity is born into time through this Mother – the perfect woman. So,

HAPPY NEW YEAR! HAPPY MOTHERS' DAY! HAPPY WOMEN'S DAY, TOO! ■

JAN 4

SOLEMNITY OF THE EPIPHANY OF OUR LORD
READINGS: Is 60:1-6; Eph 3:2-3,5-6; Mt 2:1-12 (CYCLE B)

Jesus Shares His Light With Us

ENRICO GONZALES, OP

The star of Bethlehem is not a proof that horoscope is one valid way to discover the will of God. It was the star of Bethlehem after all which guided the Magi to find Jesus. But mind you, the star of Bethlehem

was not just an astronomical phenomenon. It was a "theological fact", meaning, that more than astrology, the star of Bethlehem speaks of godly revelation: that *the light was born.* Was it not Simeon himself at the presentation of the infant Jesus who reiterated what had for centuries had been the prophesy about this baby: *"the light of the Gentiles".* (Lk 2:32) Yes, this light is universal. It is not a candle shining under a bushel basket but a heavenly brilliance which nothing on earth can prevent from dispelling darkness. And we were all there at the God's revelation to the Magi – our representatives to the royal infant – to pay homage and submit our absolute loyalty to this King who is also the Light.

How can we show then this absolute loyalty to the light? By becoming *photogenic.* This word is used here not of course in its usual contemporary context: "anyone who appears beautiful in pictures". Our context here goes deep into its literary origin. *Photogenic* is after all two Greek words which in English vocabulary became one to mean "congenial or friendly to light". To call ourselves *photogenic* means in this sense that we are friendly to light. This brings to focus the challenge that goes with our celebration of Epiphany or God's self-revelation to the Gentiles: *Are we friendly to the Light? Are we friends of Jesus?*

How can we show ourselves friends of Jesus? To be friends of Jesus, we must be faithful to the Light. We must be witnesses of Jesus and since Jesus is the Light, we must be his light-bearers. The Gospel-Message of Jesus should be reflected in our lives. In this case, the gospel ceases to be a book but an incarnate good news. When Jesus was born, the angels announced his coming by telling "I come to give you good tidings ...." (Lk 2:10) Does our presence proclaim the same angelic message? Do people feel whenever we are around that they are in the presence of good news? Or on the contrary, they shrivel in our presence because they find us as personification of bad news.

The great Gandhi of India once said that he admired Christ but not the Christians. Would that today we prove Gandhi wrong! Would that today we show not only Gandhi but the whole world as well that Christians are admirable precisely because they bear the light of Jesus who is himself the Light. Christians must indeed be *photogenic*, meaning, they must be good not only in pictures but in reality as well. Then, the world will be far , far brighter than this. ■

JAN 11

THE BAPTISM OF JESUS

READINGS: Is 42:1-4, 6-7; Acts 10:34-38; Mk 1:7-11 (CYCLE B)

In Baptism, We Are All Born in Grace

ENRICO GONZALES, OP

Never was a time when John the Baptizer was not true to himself. Notwithstanding the accolade that came from his people, the prospect of popularity had never gone to his head. Right from the start, the seduction of pretension had never won his heart. He was not the Messiah and he would not proclaim himself to be one even if his followers were wanting him to do so. After all, what did he know about grace? He was a prophet – the greatest of prophets as Jesus would describe him to be so – but still he was a prophet of the Old Testament. (Mt 11:7-15) He was almost there – the New Testament – being personally a witness of Jesus but he did not know exactly where Jesus comes from and the blessing that goes with his cousin's divine origin. No wonder, he could preach only what would happen to them if they would not follow Jesus but could not tell them exactly what they would experience if they obey him. (Mt 3:10) Only Jesus knew and he revealed to them the reward of such following through his own baptism. John the Baptist was ignorant about the dynamics of grace – the participation of man in the life of God himself – until that day when he baptized Jesus. While it is true that John the Baptist had the intimation that Jesus' baptism goes further than his ritual symbolizing repentance, he had never imagined though how the Holy Spirit would actually work in Jesus' baptism. (Mt 3:11) And then, the amazing thing happened: on Jesus' baptism, the heavens opened and the Father's voice resounded affirming that Jesus is indeed his beloved Son. (Mt 3:17) With his baptism Jesus inaugurated the reign of God in the New Testament. He put an end to symbols which were only shadows of what was to come, he made the symbols stand for the reality itself – effective symbols which we now call the *sacraments*. These sacraments, as the baptism of Jesus

showed, extend to us grace and bring us to communion in the life of Jesus. As Jesus was called the Beloved Son of the Father, so, we also enjoy the name as Jesus' Father begins adopting us as his own children during our baptism. Living in the same Spirit that binds together the Father and the Son in the indissoluble communion of love, we too with our baptism start living similarly. No wonder that when challenged to prove the reality of God's love present in the world, Tertullian, one great apologist during the first Christian era, pointed to the Christians themselves as the proof. Would that today, after thousands of years of the existence of the Church, we could do the same? When asked whether Jesus is truly alive, we could truly claim "Yes, he is. He has resurrected in us." ■

JAN 18

FEAST OF THE SANTO NIÑO

READINGS: Is 9:1-6; Eph 1:3-6, 15-18; Mk 10:13-16 (CYCLE B)

When Children Cry, Will God Not Listen?

ENRICO GONZALES, OP

When children cry, will not God listen? Certainly. Why not? To the children, after all, belongs the Kingdom of God. (Lk 18:16) No wonder then that when the disciples tried to disenfranchise them of their God-given privilege, Jesus himself reprimanded the disciples. But why the particular care of Jesus for children?

The world then treated children as practically nobody. They did not enjoy any right. They did not have any legal personality and, therefore, not protected by any law. The adults decided their fate. And what a fate! Children then were only to be seen, never to be heard, and when the adults got tired of watching them, they could make them disappear – literally at that! With a proclamation of a decree, did not Herod butcher hundreds of children? If adults, much less kings, cannot be trusted with children, who else can the children turn to? God was in fact

more than obliging. In today's Gospel-Reading, we heard Jesus himself reprimanding his own disciples for a gross ignorance of the dynamics of his Kingdom. His Kingdom was absolutely different from Herod's which for political expediency could dispose children with one sway of a hand. Jesus could not indeed tolerate this display of ignorance. It was for him so terrifying to imagine his Kingdom excluding children from its citizenship – and coming from the verdict of his disciples at that!

Alas, in this Catholic Philippines, which once prided itself to be the only Christian country in Asia, we are witnessing a very dangerous move of "Catholic kings" – read politicians who happen to be Catholics – proposing laws which will disenfranchise children not just of their ordinary rights but the foundation itself of their rights – the right to life! Herod must be laughing in his grave. He must be gloating that at last he would not be alone wherever he is now. There is now a prospect that sooner or later, the present-day Herods will join his court. The worse thing though is that those who claim today to be Jesus' close disciples are conniving with contemporary Herods by explicit cooperation or cooperation by silence and absence. Would Jesus himself speak now and scold us the way he did to his disciples hundreds of years ago! But have not the Popes the Bishops and the Episcopal Conferences spoken? If we would not listen to them, even if Jesus would come down again from heaven, he too would not find an audience. We would rather believe in statistics collated by some "smart" economists threatening us with a baby boom? A baby boom? Is this baby boom the sound of a nuclear explosion so that it terrifies us of an impending holocaust? Is statistics that lethal now? Are babies merely numbers? Are they not human too? Are they not children of God too? Was Jesus telling a lie when he proclaimed in today's Gospel-Reading that the Kingdom of God belongs to these little ones? Or are we just deaf and plain stupid?

The *Santo Niño* is the protector and patron of the Filipino nation. Shall we kill him too? ■

JAN 25

THIRD SUNDAY IN ORDINARY TIME

READINGS: Jon 3:1-5,10; 1 Cor 7:29-31; Mk 1:14-20 (CYCLE B)

The Amazing Call

ENRICO GONZALES, OP

Levi was Matthew and Matthew was a tax collector. Jesus met Matthew and called him to be his disciple. So, what was so extraordinary about that? Well, everyone avoided Matthew because he was a tax collector. A tax collector was a public sinner and no self-respecting Jew would associate with a tax collector, much less, befriend him as his disciple. Birds of the same feather flock together. If Jesus had a modicum of common sense he would know that by entering into Matthew's circle, he would be suspected as party to its crime. But no, from then on, he cavorted with Matthew's group – dining and drinking with them. Jesus with Matthew must be a scandalous sight! Was this the Messiah who was prophesied to liberate Israel? Not only was Jesus silent at the unpatriotic cooperation of Matthew with foreign ruler and at his corrupt practices in tax collection, he even enjoyed his parties, presumably subsidized by dirty money. Jesus' choice of companion scandalized the Pharisees. If Jesus would like to appear decent enough, he would have rejected this group and fraternized with another one: the Pharisees Party, of course! But Jesus must have sneered at the idea. Ah, the Pharisees, those hypocrites!

Jesus had the wisdom never to call the Pharisees to the hierarchy of his Apostles. Calling hypocrites into such highly religious organization would be tantamount into converting religion into a show business. For this is precisely what "hypocrisy" originally means: stage presentation! There is nothing wrong of course in such presentation if it were done in a legitimate theater. But not in the temple please! The temple is a place for worship and such worship is definitely intended to praise God, not just to entertain him. Temple worship is for real, not a vaudeville, much less, a burlesque! Jesus would rather have a tax collector for a disciple. Matthew was a sinner alright but he was a genuine person. And to Jesus, this was the only thing that mattered. Call in the sinner! An amazing call indeed! ■

FEB 1

FOURTH SUNDAY IN ORDINARY TIME

READINGS: Dt 18:15-20; 1 Cor 7:32-35; Mk 1:21-28 (CYCLE B)

Word that Makes Devils Tremble

ENRICO GONZALES, OP

Why does the word of Jesus possess an irrefutable authority? Because his word is the truth. The truth is in fact Jesus. Jesus and the truth are one. In our case, this unity between truth and ourselves are not particularly evident. We may be saying the truth but we may belie it with our action. We may be doing the very opposite of what we are proclaiming. We are prone to telling lies. There is no sin so common as telling a lie. In the confessionals, telling a lie is confessed so often that it appears easier to do than eating a peanut butter sandwich. The devil need not tempt humans to tell a lie since they are doing it even in the absence of external provocation. In the midst of the growing culture of lie, Jesus the Truth remains a beacon of light which guides us to our rightful destination: the home of the Father. And because Satan is the Father of lies, the presence of Jesus' Spirit is enough to make him and his cohort tremble. They recognize that with the Truth that is Jesus, their efforts to beguile men will come to nothing. Jesus the Truth serving mankind as its light will teach them the Way. With Jesus the Way, will humanity fail in its journey back to the Father? This explains why at one command of Jesus, the evil spirits shrieked and hurriedly abandoned the body which they had possessed and enslaved. Unfortunately, today the devils possess not just a human body but a whole human culture. The culture of lie spreads rapidly through out the world, thanks to prolific tools of mass media. As lies are advertised in the garb of arts, science and technology, they present themselves in attractive packaging which hide their rotten contents: lies. Would that Jesus once again come down from heaven and teach us the Truth and the Way? At the second thought, Jesus continues to come through upright men and women who have devoted themselves in fighting for the truth and refuting lies propagated by errant media. They like Jesus suffered his fate in this crusade for truth. They died a martyr's death – discredited

in this society which has grown comfortable with darkness. Well, what is new? Satan and his followers have never learned their lesson. They keep on killing the disciples of Jesus and witness history repeating itself again and again. Followers of Jesus, the Truth and the Way never die. They just resurrect! ■

FEB 8

FIFTH SUNDAY IN ORDINARY TIME

READINGS: Jb 7:1-4, 6-7; 1 Cor 9:16-19, 22-23; Mk 1:29-39 (CYCLE B)

The Missionary Dimension of Healing

ENRICO GONZALES, OP

Mothers-in-law are our relatives we love to hate. We have a good laugh every time we parody the idiosyncrasies which usually characterize mother-in-laws' behavior. But not in this case. The story of Peter's mother-in-law healed miraculously of her fever showed the kind regard which Peter and Jesus had paid to mothers-in-law. They were not witches who only hell can wholeheartedly accommodate. Peter's mother-in-law restored to health responded immediately with a gesture of kindness which she can afford: serve! Service is indeed the kind of response which God expects for the blessings which he grants us. God after all gives us the blessing of health because we need to live to finish the task which he assigns us to fulfill in this world. The dead no longer serves; in after life, they only praise and worship God who in this world gives them the privilege of serving. This brings home an incident which happened to me just recently. I was scheduled to undergo *angiogram* – an invasive medical procedure to find out whether my arteries are functioning well to let a normal flow of blood to and from my heart. Just the thought of a catheter inserted into the groin is enough to make even the strong-hearted grimace in imagined pain. I did but because it is necessary, I just relied on the assurance of my doctor that with the advancement of medical technology, the procedure would give me tolerable almost painless experience. So, it was. I did not even notice that the catheter was inserted and presto, I saw my heart right at the screen monitor beating as it should. No blockages! The blood was

flowing freely in the arteries. Observing it, the attending nurse whispered into my ears: "Father, you still have a mission to fulfill." "Yes, indeed!" I replied to her wise insight. If ever my heart is beating today, it is beating because of God and the mission he has for me to accomplish in this world. So, here I am now, trying to finish the errand which God tasked me for the rest of my life.

That was the experience of Peter's-mother-in-law, mine too, and all those persons whom God healed that they may still enjoy the joy of service, the joy of mission. ■

FEB 15

SIXTH SUNDAY IN ORDINARY TIME
READINGS: Lv 13:1-2, 44-46; 1 Cor 10:31-11:1; Mk 1:40-45 (CYCLE B)

The Healing Power of Touch

ENRICO GONZALES, OP

Today's Gospel-Reading continues the story narrated last Sunday and the picture it portrays has become repetitious to us: Jesus did it again, he healed once more! The story of Jesus' healing has become so routinary to us that probably, we could no longer detect the distinctive feature of Jesus' healing: Jesus healed by touching. To touch the healthy, the beautiful, the talented – in short, the lovable – this is understandable but a leper? But this was what Jesus exactly did. In so doing, he showed himself as genuinely human because to touch is a prerogative of humans not of angels. Because angels are pure spirits, they cannot touch. Touch after all is a physical encounter of two flesh. It is the human expression of affection. It is an affection which at once speaks of unity and distance. Take the case of a handshake. When I shake someone else's hand, I take his hand to symbolize unity with him. This unity though should be mitigated by enough distance if this unity would not turn into push. When we push, we come so close to another that we displace him from his location. In pushing, we actually invade his place. Touch does not do this. In our present case of a handshake, we maintain a certain distance so that

the other will not feel suffocated or strangulated by our nearness. Thus, in touch – in our example, a handshake – we are near enough to reveal our nearness but not too close as to absorb the other in our possessiveness and thus, destroy his individual identity.

Jesus touched the leper. In so doing, Jesus showed his unity with the leper, while maintaining a distance necessary to accentuate the otherness of the leper – an identity which even his leprosy could not destroy. Jesus indeed loved this leper with or without leprosy. After all, God loves all of us for who we are . Lepers or not, we are all children of God ■

FEB 22

SEVENTH SUNDAY IN ORDINARY TIME

READINGS: Is 43:18-19, 21-22, 24-25; 2 Cor 1:18-22; Mk 2:1-12 (CYCLE B)

Healing Our Roots

ENRICO GONZALES, OP

Here we are again. Another story of Jesus' healing which at this time accentuates its social dimension. The paralyzed must have been wishing to get cured and his desire was shared by his relatives and friends who were creative enough to bring this emergency to Jesus. Jesus must be amazed at this kind of creativity. Imagine him preaching intently to the people when all of a sudden something dropped from above. Who would expect that it would be a human body! Amazed or amused, Jesus did what has now become a routine: heal the sick. But to the scandal of the teachers of the law, they heard not just plain words of healing but more than these, words of forgiveness. Why? Jesus of course was not just revealing his divine nature but likewise the human nature of all the infirm. In the final analysis sickness entered into our humanity through sin. The advancement of medicine has growingly proved what our faith has told us long time ago. Just as the doctrine of original sin explains our moral frailty, so modern medicine always point to our present health problems to the genetic weakness of our ancestral origins. No wonder that Jesus when encountering a medical case, looked at it within a bigger picture. He went

to the root of human maladies: sin. Since physical sickness has a social dimension both in its origin and therapy, so does moral sickness. Because sin was more paralyzing than polio, Jesus absolved the paraplegic from his sins. For what does it profit a man to have strong legs to go around anywhere but misses the road to heaven?

Would that all of us make our way to heaven healthy in body and soul! ■

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BOLETIN ECLESIASTICO DE FILIPINAS
The Official Interdiocesan Bulletin

BOLETIN ECLESIASTICO DE FILIPINAS, the Official Interdiocesan Organ of the Philippines, is published bi-monthly by the University of Santo Tomas.

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	ONE YEAR	PER COPY
PHILIPPINES	**PhP 900.00**	**PhP 150.00**
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Subscriptions are paid in advance. In the Philippines, payments should be made by postal order, telegraphic transfer, or check with regional bank clearing only. All check and postal money order payments should be payable to **UST Boletin Eclesiastico**. Orders for renewal or change of address should include both old and new addresses, and go into effect fifteen days after notification.

Please address all communications to:

BOLETIN ECLESIASTICO DE FILIPINAS
Ecclesiastical Publications Office
University of Santo Tomas
España Blvd., Manila 1015 Philippines
TEL. NO.: (63-2) 406-1611 local 8251
TELEFAX: (63-2) 740-9710
E-MAIL: eccpubli@mnl.ust.edu.ph

ISSN 1908-5567