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**Keynote Address by Archbishop Zygmunt Zimowski
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**The Church's Pastoral Care for the Sick and the Ethical Responsibility
of Health Care Professionals for their Patients in Medical Decisions**

1. From the Mission of Jesus, the Mission of the Church

Faithful to the action (Mt 4:23-24; Mk 1:14-41) and the mandate (Lk 10:8-9) of her Founder and Teacher, Jesus Christ, the Church, ever since her origins, has always attended to caring for and healing the sick (I Cor 12:9; Jm 5:13-14; Acts 4:29-30), proposing as a synthesis of Christian law the Parable of the Good Samaritan (Lk 10:30-37) and as contents of the final judgement the identification of Christ with his brethren, in particular the poor and the suffering (Mt 25:31-46).

Care for illness and preaching the kingdom have been, therefore, an inseparable tandem in the messianic activity of the Son of God and then in the mission of the Church. *The Acts of the Apostles and the Fathers of the Church* were faithful to this. Down the course of history, the Church has in addition promoted works of charity and created hospitals, which we can still see, and in which a large number of Saints and Blessed carried out their long service to the suffering and to pilgrims (cf. Benedict XVI, encyclical letter *Deus caritas est*, part II).

This history continues to the present day through health-care professionals as the Blessed John Paul II observed: 'From century to century the Christian community in revealing and communicating its healing love and the consolation of Jesus Christ has reenacted the gospel parable of the Good Samaritan in caring for the vast multitude of persons who are sick and

suffering. This came about through the untiring commitment of all those who have taken care of the sick and suffering as a result of science and the medical arts as well as the skilled and generous service of healthcare workers. Today there is an increase in the presence of lay women and men in Catholic hospital and healthcare institutions. At times the lay faithful's presence in these institutions is total and exclusive. It is to just such people—doctors, nurses, other healthcare workers, volunteers—that the call becomes the living sign of Jesus Christ and his Church in showing love towards the sick and suffering. It is necessary that this most precious heritage, which the Church has received from Jesus Christ, “Physician of the body and the spirit”, must never diminish but always must come to be more valued and enriched through renewal and decisive initiatives of *pastoral activity for and with the sick and suffering*. This activity must be capable of sustaining and fostering attention, nearness, presence, listening, dialogue, sharing, and real help toward individuals in moments when sickness and suffering sorely test not only faith in life but also faith in God and his love as Father. Such pastoral initiatives find most meaningful expression in sacramental celebrations with and for the sick, as a source of strength amid pain and weakness, hope amid despair, and as an occasion of joyful encounter.’ (Apostolic Exhortation *Christifideles laici*, nn. 53-54).

I would now like to refer to certain aspects of general ethics and provide examples of certain situations of greater interest for clinicians, or ‘bed-side’ situations, to employ the term now used.

I will offer my contribution starting with an anthropological vision which in part or in whole could also be shared by those who do not have Christian faith but who hold dear the centrality of the patient, of the sick person.

2. Transformations in Medical Ethics

Prof. Edmund Pellegrino writes that over the last thirty years more changes have taken place in medical ethics than took place over the previous twenty-five centuries.¹ From the famous Hippocratic Oath, which upheld the sacredness of the art of medicine, and from a certain late reading of so-called medical paternalism, there was a move towards a secular vision of medical science and a strong emphasis on the autonomy of the patient, with consequences which are in front of us all. The causes of this transformation can be attributed to three factors: the democratic management of power; public education; and moral pluralism.

Bearing these factors in mind, medical ethics cannot be understood as being as it was at the end of the 1960s. Beyond the fact that many questions which were the concern of medical ethics are now claimed by bioethics, the very relationship between doctors and patients in the approach of medical ethics is no longer to be understood in the traditional way.

For a long time different models of the relationship between the doctor and his or her patient have confronted each other. On the one hand there has been paternalism, whose foremost exponent was T. Percival who had a notable influence on Anglo-American medical ethics; and, on the other, there has been the principle of autonomy which gained prominence with the publication *Principles of Medical Ethics*, which put the principle of doing good, at the heart of Hippocratic thought, in a corner. After years of diatribes, these different positions appear to have drawn closer together.

The conflict between the autonomy of the patient and the duty of the medical doctor can be solved solely in a relationship of mutual trust. 'Doing good in trust' is the formula used by Pellegrino and Thomasma to express this relationship. But because of the changes referred to above, this

¹ PELLEGRINO E.D. and THOMASMA D.C., *Medicina per vocazione* (Dehoniane, Rome, 1994).

relationship is no longer confined to the medical doctor and his or her patient. The family, other professional figures of health care and health-care policy are factors which have come into play, as a result of which, simplifying, one can say that medical ethics relates to three components: the patient, the medical doctor and other professional figures, and society, in an inverted order of importance compared to the past.

Today, therefore, people prefer to speak not about 'medical ethics' but about 'health-care ethics' or 'health ethics' or even of 'bio-medical ethics', seeking by this phrase to focus in on another aspect: the biological foundation of medicine and thus a new horizon that opens up to ethics which is called 'bio-medical' ethics. As is evident, one is not dealing only with formulations but with contents. The inter-disciplinary character involved means references to 'medical ethics' or 'health-care ethics' or 'bio-medical ethics'.

Medical practice must walk together with *wisdom*, technological and organisational progress, and an assessment of meaning and possible applications. By this we determine the meaning of the ethos of the health-care profession and the telos of medicine and the art of health care. Not only health but also prevention, the treatment of illness, relieving suffering, a fair and good management of healing and the good and right decisions to be taken for the sick individual, are the telos of medicine. If, therefore, the first activity of the art of health care is treatment, the second component of the encounter is of a moral character.

There is a need, therefore, for principles and values that must guide medicine and the art of health care in general, given that it is not a theory but a practice!

3. Anthropology, Ethics and Science²

Leaving to one side an examination of ethical theories which as everyone knows are classified as deontological theories, teleological theories and utilitarian theories, I would like to refer now to a second stage which is deserving of investigation – the relationship between science, ethics and anthropology.

If the ethics of principles, advanced at the beginning of the twentieth century by D. Ross and advanced again at the end of the 1970s by T. Beauchamp and J. Childress, with the clear intention of distancing any religious reading of medical ethics, demonstrated in turn all its limits, opening the field to other ethical readings – the ethics of virtue with, for example, A. Mc Intyre and E. Pellegrino himself, and the ethics of caring advanced by various authors, amongst whom the editor of the *Encyclopaedia of Bioethics*, W. Reich – it appears evident that ethics and bioethics require a meta-ethics and a meta-bioethics.

The roots of bioethics and ethics are to be found in anthropology, and even before that in ontology. I will here sum up some of the passages of this close relationship.

In line with the thinking of A. Scola, ‘every experimental science, understood in modern terms, in terms of Galileo, formulates hypotheses by rigorously applying a specific method and tends to generate a praxis of the transformation of man and the world. In doing this, that is to say in order to exist and to develop, it in fact involves an anthropology and ethics...

First of all, this statement is understandable inasmuch as these human sciences have as their subject man, because they are concerned with man. But also taken in themselves, inasmuch as they formulate a hypothesis about reality and work within reality, they involve a subject who cultivates them and

² SCOLA A., ‘Antropologia, etica e scienza’, *Anthropotes*, 1985, pp. 215-226.

gradually through them channels a vision of man and things. Given, in addition, that this subject is a being endowed with freedom and responsibility, he cannot but carry out acts charged with intentionality. Now the very cognitive act or act that manipulates the real that the scientist engages in always brings with it a *Weltanschauung* (an overall vision of man and the cosmos) and an ethical responsibility. No science, therefore, can barricade itself behind its objectivity, the limitations of its field and method and claim to be neutral and thus objectively indifferent to the destiny of man and thus in itself amoral, that is to say without any moral reference to what is good and what is bad.

Given the inevitable intertwining of science and anthropology and ethics, what is the hierarchy of these three disciplines? That is to say, which comes first and which comes second, or again, to put it this way, which of the disciplines is after a certain fashion determining, a criterion, as regards the others?

The answer is: anthropology. Another question then arises: which anthropology is suited to man and thus to his science? From here begins the examination of the nature of the relations between anthropology and science which will bring out the task of ethics as the appropriate modality of the nexus between anthropology and science.

Moving out of the intermediate passages to the development of my analysis, we can say with A. Einstein: 'the most beautiful and deepest emotion that we can have is a feeling of mystery. Here is the seed of every art, of every true science...Concern about man and his destiny must always constitute the principle interest of all theoretical efforts. Never forget about this amidst your diagrams and your equations'

If this statement of that great scientist applies to all those engaged in research, it does so even more, in my view, to health workers. Science and medicine are not, therefore, neutral but channel ideological meanings. The

reason for this depends on the fact that an experimental science or a medicine has been formed which still has a positivist colour, both placing the subject in brackets in the name of a purported objectivity.

To free oneself from the totalising claim of science or the organicistic vision of medicine is possible. The pathway to this is to recognise in the Christian approach or at least in the religious approach to man the evaluative criteria of scientific progress as regards its true or purported purpose of the progress of man.'

'The task of carrying out' – these are once again the words of A. Scola – 'such a final assessment of the projects, the method and the results of science is the task of ethics. Ethics can and must assess the nature of the anthropological method that *a/ways* moves a scientific project.

Ethics then becomes the essential go-between of the inescapable nexus between anthropology and science. This nexus, then, is by its nature dialectic, in the sense that it goes through ethics from anthropology to science and from science to anthropology.

Science can be a great opportunity for humanisation and as such offers anthropology important contributions for the most suitable achievement possible of God's project for man, revealed in Christ who died and rose again. It meets the cultural imperative of Genesis to transform the world of which God made man, who was made in His image, '*dominus*', and also allows the taking up of the invitation of Paul to build up a civilisation worthy of man, contained in the very fine programme 'as far as possible live in peace' (Rom 12:18).'

4. Morality Within the Medical Profession

But for those who do not have this religious vision of life, it is at least possible to bear in mind a morality which is born within the medical or health-care profession itself, as preferred.

In our epoch, which is marked by moral pluralism and thus by a rejection of a single moral approach, which in the Western tradition of medical ethics was the Judeo-Christian approach, unless one wants to reduce medicine to what for more than a few it already is, a source of gain and a pretext for a career, there is still a possibility of looking at what in this profession of care distinguishes it from other professions.

The four phenomenological characteristics on which is based – in line with the thinking of E. Pellegrino and D. Thomasma – the moral character of medicine as a profession are: - the nature of the human needs to which it addresses itself (health, wisdom, salvation, justice); - the state of vulnerability of those who serve (the relationship between the doctor and his or her patient is not on the same level: the power to help or otherwise the patient is in the hands of the professional); - the expectation of trust that it generates (this expectation is based on the profession itself of the medical doctor, on his or her wish to help the sick person and make his or her medical knowledge available to that person); - and the social contract that it involves (or in line with the Anglo-Saxon phrase, drawn from the Biblical image, the Covenant of Pact-Alliance, which is installed between the medical doctor and his or her patient).

Here is designated the picture in which the art of medicine must rediscover its lustre, defeating nostalgic temptations, on the one hand, and attitudes of abandonment on the other.

5. Some Ethical Problems

I will now refer to certain ethical problems in relation to which the responsibility of health-care professionals comes into play.

a) First of all the retrieval of the centrality of the relationship between the medical doctor and the patient

Despite the changes that have taken place in medical ethics, in my view in contemporary ethics and bioethics one cannot neglect the chapter involving the relationship between the medical doctor and his or her patient.

‘Doing good in trust’ is the formula, as we have seen, of Pellegrino and Thomasma, directed towards healing the conflict between paternalism, on the one hand, and autonomy, on the other. If yesterday it was the will of the doctor that decided, today emphasis is laid on the decision of the patient, with the consequence of resort to courts and the search for self-defence by the medical doctor, as already takes place in this country and in others. It is necessary to rediscover, beyond easy accusations, mutual trust between the patient, his or her family and the medical doctor.

If this always applies, in my view it applies even more in situations of emergency where human life hangs on a thread of hope. This virtue should come out both in the provision of help and in the relationship with the patient and/or his or her family relatives.

b) Second, the defence of the health of the patient

This goes beyond the diatribe underway between the right to treatment and so-called ‘exaggerated treatment’. Certainly, there will be limit cases

where the conscience of the medical doctor is called to decide but that conscience and not the solicitations of extraneous elements must intervene.

The medical doctor should not in every case be reduced to being an accountant of the state but must, instead, conserve the function of being the gatekeeper of the patient, as Prof. Pellegrino has written at length.

c) Again, respect for the patient and/or his or her family relatives

Laws are not enough to impede the expression of what is constitutive in human dignity. Here it appears to me that there are many observations to be made, given that American jurisprudence puts the autonomy of the patient in a primary position.

d) Lastly, respect for unborn life and dying life

These are perhaps the most dramatic chapters of bioethics. Unfortunately, today in the field of health, side by side with positive and encouraging results there are disturbing opinions and lines of thought such as in the case of the questions and issues ‘connected with the so-called “reproductive health”, with recourse to artificial techniques of procreation that entail the destruction of embryos, or with legalized euthanasia... the protection of life from conception to its natural end and respect for the dignity of every human being should be upheld and witnessed to, even going against the tide’.³

The boundary of life is not subject to the decision of someone or other. It is marked by Someone Else for those who are believers. Whatever the case, science clearly lays down the beginning of life and determines the

³ Benedict XVI, *Message to Those Taking Part in the XXV International Conference of the Pontifical Council for Health Care Workers*, 15 November 2010.

criteria by which its end is indicated. This intellectual honesty must accompany the decisions made at the bedside of the patient, always and everywhere. An honesty that must also lead to the rejection of a certain equivocal and non-scientific terminology which acts only, ideologically, to cover non-ethical decisions, for example *'pre-embryo'*, *'surplus embryos'*, *'vegetative life'*, *'good death'* and *'state incompatible with life'* etc. A greater adherence to reality would allow an exercise of medicine more in conformity with the tradition from which it arose. The ancient Hippocratic maxim, *Primum non nocere*, would be enriched by a positivity linked to the pursuit of the good of the patient.

It seems to me to be advisable at this point to make certain clarifications from a bioethical point of view as regards people in the so-called 'persistent vegetative state' (PVS). For the philosophical foundations of this subject I refer those present to other presentations. In this paper and in highly summarising form we may say that human life is life at every stage – from conception to death. Recently, as well, the Church has intervened in a clear way and stated that human life, even if the patient is without cognitive functions, cannot in any way be called vegetal. The Congregation for the Doctrine of the Faith expressed itself in a clear way in response to certain questions of the Bishops' Conference of the United States of America: 'In response to those who doubt the "human quality" of patients in a "permanent vegetative state", it is necessary to reaffirm that "the intrinsic value and personal dignity of every human being do not change, no matter what the concrete circumstances of his or her life. *A man, even if seriously ill or disabled in the exercise of his highest functions, is and always will be a man, and he will never become a 'vegetable' or an 'animal'*".⁴

⁴ Congregazione per la Dottrina della fede, 'Il paziente in coma è persona da rispettare', *L'Osservatore Romano*, 14 Sept. 2007.

To assimilate human life, such as the embryo, to a lettuce leaf, as, for example, P. Singer does,⁵ or to place individuals in a persistent vegetative state on the list of those who may be declared dead, such as some medical and non-medical associations have done since 1990,⁶ can only seem to be violence to those who conserve an upright use of reason.

For that matter, the same Congregation, quoting a previous statement by John Paul II, is explicit as regards the care and treatment to be given to such patients: ‘The sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.), and to the prevention of complications related to his confinement to bed. He also has the right to appropriate rehabilitative care and to be monitored for clinical signs of possible recovery. I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, to the extent to which, and for as long as, it is shown to accomplish its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering’.⁷ In this John Paul II and the Congregation for the Doctrine of the Faith do nothing else but restate the position of the Pontifical Academy of Sciences of 1985.⁸

As is always the case, however, the Church is realistic when it outlines the limits of this treatment and care: ‘When stating that the administration of food and water is morally obligatory *in principle*, the Congregation for the

⁵ Singer, P., *Etica pratica, op.cit.*

⁶ Council on Scientific Affairs and Council on Ethical and Judicial Affairs, ‘Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support’, *JAMA*, January, 19, 1990, vol.263, n. 3, pp. 426-430.

⁷ Congregazione per la Dottrina della fede, *op .cit.*, 14 Sept. 2007. For a more ‘secular’ vision one could also cite the document of the Italian CNB ‘L’idratazione e la nutrizione ai pazienti in stato vegetativo persistente’ of 30/09/2005, which, however, expresses the same position.

⁸ Pontifical Academy of Sciences (C. Chagas ed.), *Working Group on the Artificial Prolongation of Life and the Determination of Exact Moment of Death* (Vatican City, 1985).

Doctrine of the Faith does not exclude the possibility that, in very remote places or in situations of extreme poverty, the artificial provision of food and water may be physically impossible, and then *ad impossibilia nemo tenetur*. However, the obligation to offer the minimal treatments that are available remains in place, as well as that of obtaining, if possible, the means necessary for an adequate support of life. Nor is the possibility excluded that, due to emerging complications, a patient may be unable to assimilate food and liquids, so that their provision becomes altogether useless. Finally, the possibility is not absolutely excluded that, in some rare cases, artificial nourishment and hydration may be excessively burdensome for the patient or may cause significant physical discomfort, for example resulting from complications in the use of the means employed'.⁹

This position, notwithstanding those who 'exaggerate' in talking about 'exaggerated treatment', is and always has been present in the position of the Church, beginning with Pius XII¹⁰ and on to the document of the Congregation for the Doctrine of the Faith on euthanasia.¹¹

6. The Advance of Technology and Ethical Problems

Certainly the advance of new technologies has posed new questions to bioethics. I would like now to refer to at least some of these.

a) The transplant of organs and the ascertainment of death

The question of the transplant of organs in truth is not a new one. It goes back to the beginning of the last century with the work of the Nobel Prize winner for medicine, Alexis Carrel, who did the first transplant

⁹ Congregazione per la Dottrina della fede, *op .cit.*, 14 Sept. 2007.

¹⁰ Pio XII, *Allocuzione al Congresso Internazionale di Anestesiologia*, 24 nov. 1957, AAS 49 (1957), pp. 1031-1032.

¹¹ Congregazione per la Dottrina della fede, *Dichiarazione sull'eutanasia*, 5 May 1980, AAS 72 (4), p. 542.

experiment, with a dog. It was only in 1953 that the first transplant took place with a human being, in this case a kidney transplant carried out by Murray.

This and subsequent transplants opened up new horizons for surgery, with a move from removal surgery to replacement surgery, but they did not create particular problems from an ethical point of view. The consent of the patient and the 'donor' alone was asked for and in the case of a minor the consent of the parents (or *proxi*) of the individual involved.

The question became more delicate immediately following the first heart transplant carried out by Chris Barnard in Cape Town in 1967. The question moved to the ascertainment of the death of the 'donor'. In truth, this also had been predated, by certain studies in France, and more specifically in 1959 with the definition of *coma dépassé* by Mollaret and Goulon.

But since 1968, the year of the *Report of the Ad Hoc Committee of the Harvard Medical School*, to 1981 and *A Proposed Uniform of Death Act* (UDDA) of the President's Commission until our days there has been a series of 'definitions' of death and the issuing of criteria for the ascertainment of death, with, as a consequence, by no means few controversies, in particular as regards so-termed 'brain death' referred to individuals with encephalic lesions and subject to reanimation, as potential 'organ donors', for whom 'brain death' was introduced, understood as the irreversible cessation of all the functions of the encephalon, for the ascertainment of which was required: a) a state of unconsciousness; b) the absence of reflexes of the brain stem and of spontaneous breathing; cerebral electric silence; the determining of a cessation of cerebral blood flow through exogenous instrumental methods (somatic-sensorial evoked potentials) which demonstrate the absence of a cerebral blood circulation (cerebral angiography, Doppler constant wave flow meter, intracranial Doppler flow meter, cerebral scintigraphy, and computerised tomography with the use of individual photons - SPECT).

Also requested was the joint application of all the criteria indicated by the Task Force for the ascertainment of the death of a neonate, a sufficiently long period of time of observation and the greatest prudence in the assessment of the instrumental parameters currently available for a neonate threatened by death.

The President's Commission rejected, on the one hand, cortical death or higher brain death, which was supported by a large number of medical doctors, ethicists and philosophers, and, on the other, brain-stem death, which was supported in particular in the British world, but both of these have returned today in various publications, with the consequence that further confusion has been created.

The Pontifical Academy of Sciences also subsequently addressed this question and in its document of 1985 (*Prolungamento artificiale della vita*; 'The Artificial Prolongation of Life') concluded that 'an individual is considered to be dead when the irreversible loss of any capacity for the integration and coordination of the physical and mental functions of the body has been verified. Death takes place when: a. the spontaneous heart and respiratory functions have irremediably ceased, or b. the irreversible stopping of all cerebral functions has taken place', a definition which in substantial terms is the position of the President's Commission.

The question of 'brain death' is certainly not over given that still today one can list various supporters amongst those who defend 'brain death' (Bernat, Sgreccia, Bonelli, Martini, etc.) and those who oppose it (Jonas, Byrne, Shewmon, Seifert, Cicero Coimbra, etc.). A recent study has been presented by the President's Council on Bioethics and this, although it defends the idea of 'brain death', nonetheless demonstrates the limits of the philosophical and scientific foundations that have been defended hitherto (total somatic disintegration and the cessation of circulation within a definite

period of time) and invites people to engage in shared reflection on the subject for the purposes of new arguments in favour of 'brain death'.

Certainly the needs of patients on a waiting list have an urgent need, and the need to obtain an organ for a transplant, often the last resort for patients, is impelling. However we have to be vigilant to ensure that sufficiently safe criteria ascertain the death of the 'donor' and in practical terms foster a culture of donation.

Benedict XVI also expressed himself in this direction when he centred an address of his around the intrinsic value of the donation of organs and also on the need for certainty as regards the death of the 'donor': 'Organ donation is a peculiar form of witness to charity. In a period like ours, often marked by various forms of selfishness, it is ever more urgent to understand how the logic of free giving is vital to a correct conception of life. Indeed, a responsibility of love and charity exist that commits one to make of their own life a gift to others, if one truly wishes to fulfil oneself. As the Lord Jesus has taught us, only whoever gives his own life can save it (cf. Lk 9: 24)...Tissue and organ transplants represent a great victory for medical science and are certainly a sign of hope for many patients who are experiencing grave and sometimes extreme clinical situations. If we broaden our gaze to the entire world it is easy to identify the many and complex cases in which, thanks to the technique of the transplantation of organs, many people have survived very critical phases and have been restored to the joy of life. This could never have happened if the committed doctors and qualified researchers had not been able to count on the generosity and altruism of those who have donated their organs... It often happens that organ transplantation techniques take place with a totally free act on the part of the parents of patients in which death has been certified. In these cases, informed consent is the condition subject to freedom, for the transplant to have the characteristic of a gift and is not to be interpreted as an act of coercion or exploitation. It is helpful to

remember, however, that the individual vital organs cannot be extracted except *ex cadavere*, which, moreover, possesses its own dignity that must be respected. In these years science has accomplished further progress in certifying the death of the patient. It is good, therefore, that the results attained receive the consent of the entire scientific community in order to further research for solutions that give certainty to all. In an area such as this, in fact, there cannot be the slightest suspicion of arbitration and where certainty has not been attained the principle of precaution must prevail. This is why it is useful to promote research and interdisciplinary reflection to place public opinion before the most transparent truth on the anthropological, social, ethical and juridical implications of the practice of transplantation. However, in these cases the principal criteria of respect for the life of the donor must always prevail so that the extraction of organs be performed only in the case of his/her true death (cf. *Compendium of the Catechism of the Catholic Church*, n. 476). The act of love which is expressed with the gift of one's vital organs remains a genuine testimony of charity that is able to look beyond death so that life always wins. The recipient of this gesture must be well aware of its value. He is the receiver of a gift that goes far beyond the therapeutic benefit. In fact, what he/she receives, before being an organ, is a witness of love that must raise an equally generous response, so as to increase the culture of gift and free giving'.¹²

As one can see, the Supreme Pontiff does not enter the question of 'brain death' but confines himself to suggesting certain parameters for the diagnosis of the death of the donor which respects the dignity of the human person, both the recipient and the donor. The task of the Church is not to define problems which are not of her competence but to clarify the

¹²BENEDETTO XVI, *Discorso ai Partecipanti al Congresso Internazionale sul tema: "Un dono per la vita. Considerazioni sulla donazione di organi"*, organised by the Pontifical Academy for Life, 7 November 2008.

anthropological point of view. The rest is entrusted to the scientific community.

7. Attitudes in the Face of Pain

If everything that I have said in this paper applies to addressing certain ethical questions and issues, we cannot forget the completely special attention that the health-care worker is called upon to have when faced with pain. We are helped here by a passage from the apostolic letter *Salvifici doloris* of the Blessed John Paul II: 'Human suffering evokes *compassion*; it also evokes *respect*, and in its own way *it intimidates*. For in suffering is contained the greatness of a specific mystery. This special respect for every form of human suffering must be set at the beginning of what will be expressed here later by the deepest *need of the heart*, and also by the deep *imperative of faith*. About the theme of suffering these two reasons seem to draw particularly close to each other and to become one: the need of the heart commands us to overcome fear, and the imperative of faith—formulated, for example, in the words of Saint Paul quoted at the beginning ['In my flesh I complete what is lacking in Christ's afflictions for the sake of his body, that is, the Church' (Col 1:24)]- provides the content, in the name of which and by virtue of which we dare to touch what appears in every man so intangible: for man, in his suffering, remains an intangible mystery' (*SD*, n. 4).

This is a mystery, therefore, which calls on our faith but also on our humanity. Now if appeal to professional ethics is of urgent importance, no less urgent, it seems to me, is the attitude that should be adopted towards a person who suffers and dies. Certainly scientific progress has helped to alleviate sufferings and provide solutions to a large number of pathologies. Nonetheless, a great deal remains to be done, and in any case the mystery of suffering and death remains.

Formulating laws and creating suitable health-care structures remains one of the primary tasks of legislators and those responsible for health care. But we cannot forget man, who indeed needs institutions but even more needs a heart that is capable of compassion and of being moved in the face of an experience of pain.

In a few words we cannot forget the Christian specific: charity, which Christ himself lived and the saints imitated. There come to mind again the words of the Holy Father to be found in his first encyclical, *Deus caritas est*: 'Love—*caritas*—will always prove necessary, even in the most just society. There is no ordering of the State so just that it can eliminate the need for a service of love. Whoever wants to eliminate love is preparing to eliminate man as such. There will always be suffering which cries out for consolation and help. There will always be loneliness. There will always be situations of material need where help in the form of concrete love of neighbour is indispensable. The State which would provide everything, absorbing everything into itself, would ultimately become a mere bureaucracy incapable of guaranteeing the very thing which the suffering person—every person—needs: namely, loving personal concern. We do not need a State which regulates and controls everything, but a State which, in accordance with the principle of subsidiarity, generously acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need. The Church is one of those living forces: she is alive with the love enkindled by the Spirit of Christ. This love does not simply offer people material help, but refreshment and care for their souls, something which often is even more necessary than material support. In the end, the claim that just social structures would make works of charity superfluous masks a materialist conception of man: the mistaken notion that man can live "by bread alone" (*Mt* 4:4; cf. *Dt* 8:3)-a conviction that demeans man and ultimately disregards all that is specifically human' (*DCE*, n.28).

The caress of the Nazarene continues today through the caress of the Mother Church.

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