CODE OF ETHICAL STANDARDS FOR HEALTHCARE

Code of Ethical Standards For Healthcare

The Consultative Group on Bioethics &
the Council for Healthcare
of the
Irish Catholic Bishops' Conference

Feast of St Francis of Assisi
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Amoris Laetitia: Pope Francis, *Amoris Laetitia* (On Love in the Family), 2016

Bunreacht na hÉireann: *Bunreacht na hÉireann* (The Constitution of Ireland), 1935

Caring for Health: The Council for Justice and Peace of the Irish Episcopal Conference, *Caring for Health in Ireland,* Dublin: Veritas, 2012

Caritas in Veritate: Pope Benedict XVI, *Caritas in Veritate* (On Integral Human Development in Charity and Truth), 2009

Catechism: *Catechism of the Catholic Church*, 1992

Christifideles Laici: Pope St John Paul II, *Christifideles Laici* (On the Vocation and the Mission of the Lay Faithful in the Church and in the World), 1988

Compendium: Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, 2004

Declaration on Euthanasia: Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, 1980

Dignitas Personae: Congregation For the Doctrine of the Faith, *Dignitas Personae* (Instruction on Certain Bioethical Questions), 2008

Donum Vitae: Congregation for the Doctrine of the Faith, *Donum Vitae* (Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation), 1987

End of Life Care: Irish Bishops' Committee for Bioethics, *End of Life Care: Ethical and Pastoral Issues,* Dublin: Veritas, 2002

Ethical and Religious Directives: National Conference of Catholic Bishops (USA), *Ethical and Religious Directives for Catholic Healthcare Services*, 5th edition, 2009.

Evangelii Gaudium: Pope Francis, *Evangelii Gaudium* (The Joy of the Gospel), 2013

Evangelium Vitae: Pope St John Paul II, *Evangelium Vitae* (The Gospel of Life), 1995

Familiaris Consortio: Pope St John Paul II, *Familiaris Consortio* (On the Role of the Christian Family in the Modern World), 1981

Gaudium et Spes: Vatican Council II, *Gaudium et Spes* (Pastoral Constitution on the Church in the Modern World), 1965

Human Life is Sacred: Irish Catholic Bishops' Conference, *Human Life is Sacred*, Dublin: Veritas, 1975

HSE: Health Service Executive

Irish Bishops: Irish Catholic Bishops' Conference

Humanae Vitae: Pope Paul VI, *Humanae Vitae* (On the Moral Principles Governing Human Procreation), 1968

Laudato Si': Pope Francis, *Laudato Si'*, (On Care of our Common Home), 2015

New Charter for Healthcare Workers: Pontifical Council for Pastoral Assistance to Healthcare Workers, *Charter for Healthcare Workers*, Philadelphia: NCBC, 2017

Populorum Progressio: Pope Paul VI, *Populorum Progressio* (On the Development of Peoples), 1967

Salvifici Doloris: Pope St John Paul II, *Salvifici Doloris* (On the Christian Meaning of Human Suffering), 1984

Veritatis Splendor: Pope St John Paul II, *Veritatis Splendor* (The Splendour of the Truth), 1993

UNDHR: *United Nations Declaration of Human Rights*, 1948.

Preface

This *Code* has been developed to assist those responsible for leading, managing and delivering the healing ministry. The Catholic Church seeks to assist every person in living a full and enriching life in this world and in reaching the ultimate human goal of eternal life. Each person is a unity of body and soul, and our living bodies are integral to our personhood. Appropriate care for the human body is an integral element of respect for the person. For that reason, healthcare has always been integral to the mission of the Church, which recognises life as a gift from God. The Council for Healthcare is committed to fostering a culture which affirms life and healing – a concern of Catholics and non-Catholics alike - and which promotes the common good. The common good is understood as the sum total of conditions that allow human beings to flourish and reach their potential. With regard to health, the common good is served by the provision of treatment and care in an equitable and compassionate manner, by the promotion of healthy lifestyles and by the just distribution of health-giving resources in society. Our concern for others is motivated by the belief that proper respect for human beings entails respect for their dignity as people created and loved by God. The sanctity and inviolability of their lives is an inevitable consequence of this.

The provision of healthcare is one element of the totality of services associated with the physical, mental and emotional well-being of people. It goes hand-in-hand with health promotion, health maintenance and disease prevention. The provision of healthcare to the sick, the frail, the poor and the dying is a field in which Catholic services have historically played a pioneering role.[1] Together with others who are engaged in healthcare, we offer expertise and experience and are committed to acting for the good of patients, residents and clients. We also acknowledge the spiritual significance of health and illness, suffering and death. This leads us to understand healthcare as a project of care for the whole person, often beyond the limits of what medical science can achieve, when patients are at their most vulnerable and in greatest need.

The Code is offered as a service to all who are involved in healthcare, whether Catholic or not, but the principles and guidance contained in it express the ethos which defines healthcare as Catholic. Respect for the dignity of the person and the promotion of the common good are its goals. It articulates the ethical standards by which healthcare ought to be pursued. The term 'healthcare' in this document should be taken to include the care of the elderly, people with disability, the unborn and those for whom medical treatment other than palliative care is no longer of benefit.

This Code is adapted from *The Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, published in 2001 by Catholic Health Australia.[2] The Council for Healthcare of the Irish Catholic Bishops' Conference is very grateful to our colleagues in the Southern Hemisphere for giving us their willing permission to build on their excellent work. The Code has been reviewed to take into account developments in healthcare and ethical challenges which have come to the surface in the time since the original document was published. Care has also been taken to ensure that references to legislation and public health policy apply specifically to the Irish context.

Catholic institutions involved in the delivery of healthcare services are encouraged to ensure that their staff and those in leadership positions are aware of and understand the vision which underpins this code and the standards which flow from it. This is important as the Code is a public statement of the Catholic understanding of healthcare and what the wider community can expect of Catholic healthcare services.

This Code is not only a crucial resource for the Church's mission in healthcare, but is offered as a service to all people of good will seeking to care for the sick, those with disability, the elderly, the frail and the dying.

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1. The Catholic Church in Ireland has been in the forefront of the development of modern healthcare services. In addition to overseas religious congregations, such as the Brothers of St John of God and the Bon Secours Sisters, native congregations, such as the Sisters of Mercy and the Irish Sisters of Charity, were established by women who, inspired by the Gospel, served in a particular way the needs of the poor. This combination of expertise and care was brought by the Irish Church to developing countries through congregations such as the Medical Missionaries of Mary. Furthermore, congregations such as the Little Sisters of the Assumption provided nursing care at home, akin to the current Public Health Nurse System, in many areas of the country. For a selection of resources on the development of the Irish Catholic Healthcare system, see Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900-70,* Dublin: Institute of Public Administration, 2000; FOC Meenan, *St Vincent's Hospital 1834-1994 An Historical and Social Portrait,* Dublin: Gill

and Macmillan, 1995; Sr Eugene Nolan, *Caring for the Nation*; Dublin: Gill and Macmillan, 2013; P. Scanlon, *The Irish Nurse – A Study of Nursing in Ireland: History and Education 1718-1981,* Manorhamilton, 1991.

2. For other examples of National Health Care Codes see The Pontifical Council for the Assistance of Health Care Workers, *New Charter for Health Care Workers* (2017); Catholic Health Alliance of Canada, *Health Ethics Guide*, 3rd editon (2012); United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th edition (2009).

Introduction

In preparing this Code, we have been mindful of two features of any Catholic approach to healthcare. We have sought:

a) to explore how the meaning and significance of health and of healthcare as well as the appropriate goals of medical interventions are understood in the Catholic tradition. We realise that while this understanding has been very influential, at least in the Western tradition of healthcare, it is not always well understood in our contemporary Western culture.
b) to show that there is no conflict between ethics at its best and most humane, on the one hand, and Catholic theological and moral teaching on the other.

We hope that this Code will be educational as well as action-guiding. By outlining the biblical grounds as well as the rationale in Church teaching for Catholic healthcare ethics, this Code seeks to be more than merely a list of directives or norms. It should be read as a whole document as well as being referred to for specific guidance. We hope that the detailed index and the use of cross-referencing within the text will enable the reader to gain a comprehensive understanding of the issues relevant to any particular topic.

A word about terminology; The terms 'healthcare service' and 'healthcare facility' are intended to refer inclusively to any hospital, community care facility, nursing home, hostel, hospice, palliative care service or related facility or service for people who are sick, aged or disabled.

The term 'healthcare practitioner' should be understood to refer inclusively to all healthcare professionals, to doctors, nurses, allied health practitioners, chaplains, community carers, administrators, etc. The words 'family' and 'relatives' are understood to apply to all those people who are related to a sick or elderly person. We recognise that in many contexts it will be appropriate to consult with those who have a long-standing relationship of care or friendship with a sick or elderly person.

This Code will be reviewed from time to time to take account of new clinical or ethical developments. In the meantime it must be read alongside any new documents or directives issued by the Church. It should also be read in conjunction with relevant national legislation and EU directives, although it should not be assumed that there will be agreement in all respects between the Catholic Church, or indeed people of good will, and public policy in respect of what is perceived to be ethical.

PART I

Healthcare in the Catholic Tradition

Basic Principles

Preamble

THE NATURE OF HEALTH CARE

So in everything, do to others what you would have them do to you, for this sums up the Law and the Prophets. (Mt 7:12)

Healthcare is first of all a relationship between people. It is a relationship between professional carers and the patient who, together with his or her family, relies on them to provide the best possible care. This requires that professionals respond to the trust placed in them by caring for patients as they would wish to be cared for themselves, with expertise but also with empathy. It involves seeking the good of the patient as a whole person, taking into consideration the authentic freedom of the person and his or her own sense of what is good, both practically and morally.

A person who comes to a doctor, or who enters a hospital, is often anxious and vulnerable and perhaps feels lost. He or she depends on the expertise of people who have the knowledge and skills to assess and treat his or her condition. Beneath all the intricacies and specialist areas of modern health care and the complex structures of a large hospital, what is actually taking place for each patient is a personal relationship with one or more carers. If such a trusting relationship can be established and maintained, this can make an enormous difference. Healthcare professionals who see their caring role as a vocation to that kind of personal relationship become increasingly frustrated and dissatisfied if they find that they lack the resources or the time to give patients the personal attention they are called to give and sincerely want to give.

Healthcare ethics are first and foremost a question of being true to the nature of that relationship and to the responsibilities towards patients that it involves. The 'Golden Rule', which tells us to treat others as we would like to be treated ourselves, is found in various forms in many religions and philosophies. It expresses the truth that human beings, in their dignity and their fundamental rights, are all equal.[1] That said, it will be important to recognise that the issues that arise in modern health care are more complex than the application of that basic principle can easily solve.

Catholic Healthcare Ethics are based on the Catholic tradition and its understanding of the nature and source of human dignity. It sees the relationship between human beings with a depth that comes from what God reveals in the life, death and Resurrection of Christ. Pope St John Paul II said that when we look at ourselves in the light of that revelation, the result is not just worship of God but deep wonder at ourselves.[2] We believe that this vision speaks profoundly to the human heart and we trust that it may also find an echo in the hearts of those who do not share our beliefs.

Perhaps the fact that this document is called a 'Code' may suggest that it is primarily a collection of rules It does, of course contain principles and directives, but the starting point of all ethical thinking is the question 'who are we?'[3] A Catholic-inspired ethic of healthcare sees every person in the complex healthcare relationship as a unique individual formed of body and spirit who seeks fulfilment across every dimension of his being, emotional, physical, spiritual and communal. Catholic healthcare ethics always seeks to answer ethical questions in a way that is also capable of being understood by everybody. Where rules are given in this code, it is because they protect and enhance human dignity, and not because of some esoteric knowledge unavailable to others.

Faith is relevant to the ethics of healthcare, because it is relevant to human existence.

a) Faith places ethical questions in the context of what we believe human life means. The healthcare relationship is between persons who have been invited by the Creator of all things to share a relationship with him, a relationship which is the source of meaning and hope for everyone. The carer(s) and the patient are equally dependent on that invitation, and their authentic acceptance of it is integrally related to their acceptance of one another as brothers and sisters who have received the same invitation. They are brothers and sisters of Christ. For those who care for the sick, the words of Jesus that what we do or fail to do for his hungry, thirsty, sick brothers and sisters we do or fail to do for him, have a particular resonance. Rather than giving a different set of answers to ethical questions, faith sharpens our perception of what our common humanity calls us to do and to be.

b) The rich young man in the Gospel asked 'what must I do to inherit eternal life?' The answer to that question was not a set of rules. Referring to the young man's question, Pope St John Paul II explains that the full meaning of life is found in 'the aspiration at the heart of every human decision and action, the quiet searching and interior prompting which sets freedom in motion.'[4] In the end, all our energy and all our searching is prompted by our ultimate goal which is not just life, but eternal life.[5] Our hearts are restless until they rest in God.[6]

1. See also *Bunreacht na hÉireann*. The preamble states that the Constitution seeks ‘to promote the common good, with due observance of Prudence, Justice and Charity, so that the *dignity* and freedom of the individual may be assured.’ (Italics added.)
2. Pope St John Paul II, *Redemptor Hominis*, 10
3. See P. Hannon, ‘Morality in Medicine,’ *Irish Theological Quarterly*, 2 (1977); A. Kearns, ‘Codes of Ethics in a Secular Age: Loss or Empowerment of Moral Agency?’ in Ian Leask ed., *The Taylor Effect: Responding to a Secular Age*, Cambridge: Cambridge Scholars Publishing, 2010
4. *Veritatis Splendor*, 7
5. See St Thomas Aquinas, *Summa Theologiae* 1-2 q.1 a.6
6. St Augustine, *Confessions,* 1.1.

Basic Principles

1. RESPECT FOR PERSONS: A CULTURE OF LIFE

Our care for people who are sick, aged or disabled is founded on love and respect for the inherent dignity of every human being, which needs to be upheld and affirmed in a particular way in times of ill-health and personal crisis.

Lord, our Lord, how majestic is your name in all the earth! You have set your glory in the heavens … what is mankind that you are mindful of them, human beings that you care for them? You have made them a little lower than the angels and crowned them with glory and honour. You made them rulers over the works of your hands; you put everything under their feet …
(Ps 8:1, 4-6)

In Jesus of Nazareth the Word of God took flesh among us (Jn 1:14). As 'one like us in all things except sin' (Heb 4:15), Jesus reaffirmed the dignity and inviolability of every human being as a person created in the image of God (Gn 1:27). Through Jesus Christ, all men and women are called to a communion of life with God forever.

Life is a precious gift held in trust: we do not own our lives, nor do we have absolute dominion over life (Ps 8:6). From conception to death our lives are entrusted to our responsible stewardship as we take all reasonable measures to care for our health. We are invited at particular times to entrust this gift of life and health to others in a one to one relationship of care. These professionals are called to respond generously to that trust both at an individual level and a collective or institutional level. This trust is the whole basis of the ethos of healthcare.[1] Care for people who are sick, frail, aged or disabled is fundamental to our Christian love of neighbour in imitation of Jesus, who came that we may have life to the full (Jn 10:10).

It is when a person's life is most vulnerable – when just beginning or when about to end, and during times of illness and disability – that more vigilant and effective care is required.[2] While never abandoning those in need, we also recognise the limits of human endeavour, and when life is ending we trust in the providence of God who knows us intimately and cares for us, counting 'even the hairs of our heads' (Mt 10:30).

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Healthcare is integral to the mission of the Church. The Council for Healthcare is committed to developing a culture which affirms life and healing, and which promotes the common good through just and compassionate health, aged, disability and community services and organisations.

2. THE GOALS OF HEALTHCARE

The goals of healthcare are:

- **to promote health and to prevent disease;**
- **to save life, cure illness or slow the progress of disease;**
- **to relieve suffering and disability;**
- **to care for people when they are sick, disabled, frail or elderly;**
- **to assist a person in his or her passing from this life;**
- **to assist those who are caring for family members as serious illness unfolds and as they grieve the death of their loved one.**

Healthcare research could be described as an intermediate goal which helps us to deepen our understanding of the causes of disease and to develop new forms of treatment.

'Then the righteous will answer him, "Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?" The King will reply, "Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me."' (Mt 25:37-40)

Advances in healthcare are allowing people to live longer and to enjoy better quality of life to a degree that was unimaginable in the past. These advances are underpinned by research which is valuable in so far as it yields knowledge which has the potential to further the authentic goals of healthcare.[3] This research often depends on the generous involvement of people who freely participate in a research project and whose participation is an expression of their solidarity with others.

It is widely recognised that medical advances can bring with them new ethical challenges. Good medicine and sound ethics go hand in hand; ethical judgements have to do with distinguishing between right and wrong ways of seeking to promote the good of the human person, and the various particular goods, including life and health, which constitute human fulfilment.[4] Clarity about what constitutes health in the context of the overall good of the person, about the proper goals of medicine and research, and about the responsibilities of patients and healthcare practitioners is crucial to ethically sound healthcare.[5] Research activities must respect the dignity of all involved.

Healthcare incorporates the care of people at the beginning and the end of life, including children and the elderly, people with intellectual and physical disability and those who are chronically ill. The goal of healthcare is to assist people in sustaining health which is fundamental to their quality of life. This means helping them maintain good health, endeavouring to save life when it is at risk, curing illness if that is possible or slowing the progress of disease, relieving distressing symptoms and otherwise caring for people.

It is worth noting that the measures required to slow the progression of disease may involve additional burdens (physical, emotional or economic) which, when measured against the likely benefits, may make this an option that some patients do not wish to pursue. In such cases, healthcare professionals are not obliged to attempt to slow the progression of disease but should, rather, respect the wishes of the patient and let nature take its course. The provision of palliative care under such circumstances would of course be required of healthcare professionals.

Life is sacred from conception to death and we may never deliberately hasten death. There comes a time, however, when death ought to be accepted. The goal then is to keep patients as free of pain and other sufferings as possible so that they may die comfortably, with dignity and at peace with God, themselves and others.[6]

3. Justice in Healthcare

Everyone has the right to receive essential healthcare services. These services should be allocated justly across a society, with special provision for those who are most disadvantaged or most vulnerable to neglect.

… and the scroll of the prophet Isaiah was handed to [Jesus]. Unrolling it, he found the place where it is written: 'The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free, to proclaim the year of the Lord's favour.'
(Lk 4:17-19, cf. Is 61:1-2)

Health is a fundamental human good. In any society, the State, which has responsibility for the common good, has the task of overseeing the allocation of healthcare resources in such a way that people are enabled to meet their basic healthcare needs.[7] This can be done according to a variety of economic models. It is important to recognise that justice in the allocation of public resources is 'distributive' justice. In other words, it is not about 'getting what I paid for' or about 'absolute entitlement'. To take a simple example, when it comes to public resources, a hospital bed or a CT scanner could not be kept on stand-by for each taxpayer 'just in case'. Distributive justice is a balance of fairness. It balances the need of the individual at a particular time against the needs of others and the availability and most effective use of resources.

Modern medicine can be very expensive and the cost of drugs is a significant factor in this. The just use of society's limited resources for the common good depends upon wise allocation decisions between health and other public goods, and within healthcare itself. The Church's teaching on the principle of subsidiarity requires us to recognise where responsibilities for decision making properly lie, so that decisions are made either by, or at least in consultation with, those who will be most affected by them.[8]

Catholic healthcare must be distinguished by its willingness to work for justice in healthcare. We seek to serve and be advocates for those at the margins of society who are especially vulnerable to discrimination. All involved should regularly ask themselves 'are we inclusive in our care?'[9]

Collaboration with other providers and integration of healthcare delivery can be effective ways of ensuring the just stewardship of limited resources. In these arrangements, it is essential that Catholic institutions and services be faithful to their Catholic identity, mission and ethical standards.

Ireland is a pluralist society, and Catholic healthcare organisations may at times be asked to provide services not in keeping with the Church's moral teachings. While there may be specific procedures which a Catholic healthcare facility cannot provide, by virtue of its ethos, those whose particular request we are unable to satisfy will, of course, be treated and cared for to the highest possible standard, with courtesy, respect and empathy. Our doors will always remain open to them should they wish to avail of the services which we do provide.

4. COLLABORATION IN HEALTHCARE

In the provision of healthcare, service-users, practitioners, family and carers become a small community united in working for a person's good. The relationship which unites them is best understood as one of trusting collaboration in a common purpose.

Just as a body, though one, has many parts, but all its many parts form one body, so it is with Christ … while our presentable parts need no special treatment. But God has put the body together, giving greater honour to the parts that lacked it, so that there should be no division in the body, but that its parts should have equal concern for each other. If one part suffers, every part suffers with it; if one part is honoured, every part rejoices with it. Now you are the body of Christ, and each one of you is a part of it.
(1 Cor 12:12, 24-27)

Healthcare depends upon trusting collaboration between patients, residents, practitioners and carers. These relationships must never be reduced to contractual or commercial arrangements; on the contrary, they should reflect the 'covenant' relationship of faithful love between God and his people (cf. Gn 15:18).[10] They thus require mutual respect, trust, appropriate confidentiality, and honest yet sensitive communication.

Without appropriate collaboration it is impossible to ensure that justice is done or that the dignity of the person is upheld. Patients and residents in care facilities, assuming that they are competent, are the experts in determining what 'ends' matter to them, including how they should live their everyday lives, what risks they will take and what degree of privacy or non-interference they desire. They have the primary responsibility for judging which of the treatment and care options proposed to them serve their authentic good in the totality of their circumstances. The healthcare practitioner, often working as a member of a team, has a duty to provide people with sufficient information to make wise judgements about their treatment and care options. With rare exceptions, the competent service user's right to refuse an intervention applies even when their decision seems unwise to the health and social care professional. Healthcare practitioners must respect a person's convictions and spiritual needs, and the moral responsibilities of all concerned. They should be sensitive to individual and cultural differences which are relevant to healthcare. Patients and residents, in their turn, have a responsibility to use (to the best of their ability) the physical and spiritual resources available.[11]

When people are incapable of making their own decisions, the responsibility of discerning what is in the patient's or resident's best interest, factoring in what is known of the patient's own wishes, devolves onto the healthcare professionals, family members and legal representatives of the patient, always remembering that clinical decisions must be made by healthcare professionals.

The Church recognises that it does not have a ready answer to every question that may arise, and it respects the competence and experienced judgement of professionals in their fields of expertise. In their turn, staff at all levels in Catholic healthcare organisations should exhibit the professionalism expected of them, and abide by the principles and norms identified in this code.

5. HEALTHCARE AND THE MISSION OF THE CHURCH

Catholic healthcare is called to respond to a person's healthcare needs with compassion and in fidelity to the healing ministry of Jesus Christ.

After this the Lord appointed seventy-two others and sent them two by two ahead of him to every town and place where he was about to go. He told them … 'When you enter a town and are welcomed, eat what is offered to you. Heal the sick who are there and tell them, "The kingdom of God has come near to you."' (Lk 10:1-2, 8-9)

The healing of the sick was one of the major signs to accompany Jesus' proclamation of the reign of God. Jesus' example has inspired countless men and women to reach out to people who are sick or disabled, to those who mourn the death of loved ones, and to all who are forced to the margins of society. In caring for those in need, in fidelity to the teachings of Jesus, we meet Christ himself (cf. Mt 25:31-46) and participate more deeply in the mystery of his death and resurrection, the mystery of grace that transforms human life and death.[12]

Catholic healthcare is open to all. A statement of Catholic ethos is not about defining other people. It is simply about proposing a vision of the dignity and worth of the human person. What we do flows from who we are as disciples of Jesus Christ and reflects his desire to heal all who come to him.

Until recently the Church's institutional healing ministry was led chiefly by religious congregations of women and men. Their ministry is now being continued by, and under the leadership of, lay men and women in collaboration with congregational sponsors and local churches. Catholic healthcare is also enriched by the contributions of those many staff whose religious, spiritual and other fundamental beliefs may differ from our own, but who share the convictions which motivate the Church's commitment to healthcare.

Catholic healthcare is not confined to the treatment of disease or bodily ailments and resists a mechanistic or utilitarian approach to dealing with illness. It embraces or at least connects with every dimension of the human person: physical, psychological, social, emotional, spiritual and moral.[13] Illness often leads people to renew or deepen their religious faith, and to appreciate their spiritual needs more keenly.

The availability of the sacraments and the pastoral care of patients, residents and their families are integral to and characteristic of Catholic healthcare services. The right to religious freedom in a pluralist democracy requires equally that Catholic patients in public hospitals must be facilitated in celebrating the sacraments. All patients, wherever they are accommodated for their treatment or nursing care, should be facilitated, in so far as is practically possible, in having access to spiritual and pastoral care according to their own tradition.

6. RESPECT FOR PERSONAL EMBODIMENT

Because the human person is a unity of body and spirit, a person's body is not simply an instrument to be manipulated in isolation from the authentic good of the person. Human sexuality and procreation in particular are personal, not just biological, realities.

Then God said, 'Let us make mankind in our image, in our likeness, so that they may rule over the fish in the sea and the birds in the sky, over the livestock and all the wild animals, and over all the creatures that move along the ground.' So God created mankind in his own image, in the image of God he created them; male and female he created them.
(Gn 1:26-27)

The unity of the human person is not just a matter of Church teaching. Our experience of ourselves tells us that the human person is a unity of body and spirit, in which the body is not just a complex of organs, functions and energies but an integral part of a human person, by virtue of which he or she relates to others, God and the world. Respect for the human person thus includes respect for his or her physical life and for the integrity of the body. 'Learning to accept our body, to care for it and to respect its fullest meaning, is an essential element of any genuine human ecology.'[14] Respect for one's body means taking reasonable care of one's health with appropriate rest and relaxation and moderation in food and drink. The misuse of drugs and other substances undermines a person's freedom and capacity for relationships with others. Respect for the integrity of the body also requires that organ and tissue donation by a living donor must never destroy that person's own functional integrity.

We welcome those advances of science which help couples to identify times of fertility, or which assist the natural life-giving potential of sexual intercourse while protecting every embryo so conceived. However, our understanding of the human body as a personal reality, and of the marital and procreative significance of human sexuality, leads us to reject treatments and procedures which compromise a person's bodily integrity, or which separate the bodily dimension of human sexuality from the reality of the person as a whole, as if it were simply a biological process.

7. SOLIDARITY AND THE MYSTERY OF SUFFERING AND DEATH

Healthcare seeks to relieve illness, disability and suffering. There are, however, limits to what healthcare can achieve. Even when suffering and death cannot be eliminated, they can nonetheless acquire a positive, life-giving and redemptive value, especially from the perspective of religious faith.

Then he said to them, 'My soul is overwhelmed with sorrow to the point of death. Stay here and keep watch with me.' Going a little farther, he fell with his face to the ground and prayed, 'My Father, if it is possible, may this cup be taken from me. Yet not as I will, but as you will.'
(Mt 26:38-39)

Sufferings of various kinds are unavoidable. Death, although it completes the natural cycle of life, is also 'the last enemy' (1 Cor 15:26). In that sense it is a physical evil because it puts an end to this life in all its goodness. Suffering can be borne courageously and even offered as a participation in the Cross of Christ. This is diferent from saying that suffering is something to be sought or valued as a good in itself. Christians should participate actively in the common human task of alleviating suffering and seeking solutions to the causes of suffering.[15]

Suffering and death can, however, acquire a positive value in a person's life. For Christians in particular, the encounter with suffering and death, when endured with courage and patience, and supported by others, can take on a life-giving meaning in the light of Jesus' suffering. The Christian hope of Resurrection transforms the mystery of death, and the dying person is encouraged to place his or her trust in Christ whose life, death and Resurrection have given new meaning to all of human existence (1 Cor 15).

All those engaged in the delivery of healthcare are challenged to live with something of the struggle that their patients experience, through the limitations and frustrations of ill health and disability and, indeed, in the face of the prospect of death.[16]

Chaplains and pastoral care workers in Catholic healthcare services should be attentive to the possibility that illness or imminent death may lead the person who is ill, and also his or her relatives and friends, to explore anew or rediscover their religious beliefs, love of God and desire to be fully in communion with him. (For Catholics, this will involve the Sacraments of Reconciliation, Anointing and Eucharist.)

Catholic healthcare services should be marked by a material and spiritual solidarity with people who are sick, disabled, frail, elderly or dying which is not governed primarily by economic considerations.[17] We must never harm or abandon a fellow human being, but like the women who waited by the cross of Jesus (cf. Mt 27:55) strive to accompany those in need, no matter how distressing or disadvantaged their circumstances may be.

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1. *New Charter for Health Care Workers*, 4: 'Health care is carried out in everyday practice in an interpersonal relationship characterised by the trust of a person who is experiencing suffering and sickness, who has recourse to the knowledge and conscience of a health care worker who encounters him in order to support and care for him, thus adopting a sincere attitude of "compassion", in the etymological sense of the word'. See also, D. O'Mathuna, 'Trust and Clinical Research,' *Research Practitioner*, 10.5 (September-October 2009), 170-177.
2. *Evangelium Vitae*, 7-28.
3. See *Caritas in Veritate*, 14, 68-77.
4. D. Murray, 'The Doctor's Dilemma,' *The Furrow*, 38 (3) 1987, 139-150; P. Corkery, 'Ferment in Bioethics,' *The Furrow*, March 2002.
5. See T. Iglesias, *The Dignity of the Individual: Issues of Bioethics and the Law*, Dublin: Pleroma Press, 2001, 20 ff.
6. Irish Catholic Bishops' Conference, *Cherishing Life, Accepting Death: Pastoral Message for the Day of Life 2015*. See *End of Life Care.*
7. See *Catechism of the Catholic Church*, 2288. See also *Healthcare Allocation: an ethical framework for public policy,* Anthony Fisher & Luke Gormally, eds. Oxford: Anscombe Centre for Bioethics, 2001.
8. The *Principle of Subsidiarity* holds that larger associations, including governments, should not seek to absorb *lesser and subordinate organisations, but should assist them in doing what they are well able to do for themselves. Subsidiarity is a particular expression of solidarity, in that it facilitates participation.* See Pius XI *Quadragesimo Anno* (1931), 79; *Catechism of the Catholic Church*, 1883; *Compendium of the Social Doctrine of the Church*, 185 ff.
9. See The Council for Justice and Peace, *Caring for Health in Ireland,* Dublin: Veritas, 2012; The Council for Justice and Peace of the Irish Episcopal Conference, *From Crisis to Hope: Working to achieve the common good,* Dublin: Veritas, 2011.
10. See William F. May, 'Code and Covenant or Philanthropy and Contract?' in Stephen Lammers and Allen Verhey, eds., *On Moral Medicine: Theological Perspectives in Medical*

Ethics, Grand Rapids: Eerdmans Publishing Co., Grand Rapids, MI, 1987, 121-136.

11. Regarding conscientious objection see articles 7.19 and 8.19 of this code.

12. See Pope St John Paul II, *Dolentium Hominium* (1985), # 3.

13. See C.G. Vella, *Ethics in the Service of the Sick,* Dublin: Veritas, 1999.

14. Laudato Si', 155.

15. Salvifici Doloris, 28; *Gaudium et Spes*, 88.

16. See D. O'Mathuna, with B. Cusveller, and A. Sutton, eds, *Commitment and Responsibility in Nursing: A Faith-based Approach,* USA: Dordt College Press, 2004.

17. 'Solidarity is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all.' Pope St John Paul II, *Solicitudo Rei Socialis* (1987), 38; *Compendium of Catholic Social Doctrine*, Section VI.

PART II

Specific Issues

1. Decision-Making in Healthcare

INTRODUCTION

1.1 Life and health, along with many other good things such as knowledge, friendship, and a sense of one's vocation, are among the elements involved in human happiness and well-being.[1] Since each of these goods has value in a person's life, decisions about one's healthcare are sometimes difficult: health has to be sought in the context of a life in which things other than one's health also matter. In addition, decisions sometimes have to be taken in healthcare institutions away from the support which is often to be found in one's personal household. Accordingly, Catholic healthcare should seek to support and collaborate with people as they face important healthcare decisions in their lives.

RESPONSIBILITY AND CAPACITY

1.2 The primary responsibility for safeguarding and maintaining one's health, so far as that is reasonable, belongs to each person in his or her own right. Each person is primarily responsible for making decisions concerning his or her own health (and that of any person for whom he or she has responsibility). Since people sometimes need to seek help and advice in order to make reasonable healthcare decisions, this responsibility may at times be best exercised in consultation with others.

1.3 In healthcare decision-making a person who is able to understand their diagnosis and what is proposed and to evaluate healthcare options, is described, in ethical and legal terms, as being competent. Sometimes a patient's capacity to make his or her own healthcare decisions is reduced, either partially or entirely, temporarily or permanently (e.g., by immaturity, mental illness, feelings of fear and vulnerability, sickness, pain, ignorance or confusion). For this reason, healthcare practitioners may need to assist patients to make their own decisions, and in some cases may need to assess the patient's competence to make decisions. A clinical diagnosis of a mental health disorder (such as an acute psychotic episode) relevant to a patient's decision-making capacity must be made by a healthcare professional with appropriate expertise. If the patient is either temporarily or permanently incompetent, or reduced in his or her ability to understand or make decisions, the patient's family, primary care givers or those legally appointed (either by public authorities or by the patient's own prior decision) to represent the patient should be consulted (see also 1.6).

Information Giving

1.4 To enable patients or their representatives to ask realistic questions and to make healthcare decisions responsibly, healthcare practitioners must take care to explain clearly and accurately the patient's condition, the nature of the treatment options, the patient's prognosis with and without treatment, and the risks and harms associated with any proposed treatment which the patient would be likely to think significant in making a decision. Where the decision to be made is a serious one, patients should be encouraged to have the assistance of a relative or friend and, if they desire, to seek a second opinion. Competent patients should be invited to give their consent to the sharing of information with family members or others, but such information should not normally be shared without their consent (see 1.9).

Consent

1.5 Except in the case of an emergency, physical and/or psychological tests or treatment must not be administered to any *competent* patient until all relevant information has been disclosed and considered, and the patient's free and adequately informed consent has been given and documented.[2] Allowing that the patient is competent to consent, the presentation of information should, nonetheless, take into account the differences beween one patient and another arising from their personal circumstances (e.g., level of education, age, experience etc.). Care should always be taken to ensure that the patient is competent to consent, and is not being coerced or intimidated.[3] For healthcare decision-making in the case of a minor, see 1.22 below.[4]

1.6 Except in the case of emergency, physical and/or psychiatric tests or treatment must not be administered to an *incompetent* patient until all relevant information has been disclosed and considered by the patient's legal guardian or representative, and the permission or input of that representative has been sought and given. The decision of the patient's representative(s) or guardian(s) should be based on a judgement about what is in the patient's best interests. In making these judgements, those concerned should take into account not only the patient's medical condition and prognosis but also, in the first instance, the patient's previously expressed and reasonable wishes, and then the views of the patient's family and relevant others.[5]

1.7 In the case of emergency, if consent cannot be obtained, healthcare practitioners must act in the patient's best interests, following the patient's previously expressed and reasonable wishes, where known, and taking into account the views of the patient's family and relevant others (see also 1.16-1.19).

TRUTH-TELLING

1.8 Patients need to be able to rely on their practitioners to be accessible to them and to communicate truthfully and sensitively with them. They need this for many reasons, for example, in order to fit their healthcare into the rest of their lives, in order to be able to consent in a free and adequately informed way and in order to be able to prepare for death. The information-giving process may need to take place over a period of time rather than all at once. On this matter, as on others, practitioners should be sensitive to individual and cultural differences.[6]

PRIVACY AND CONFIDENTIALITY

1.9 The privacy and the confidentiality of the patient's relationship with a healthcare professional are integral to any healthcare relationship.[7] In their absence, trust is undermined.[8] Information gained in the course of a healthcare relationship must be shared only with those in a therapeutic relationship with the patient on a 'need to know' basis. Respect for confidentiality will not normally inhibit/exclude the patient's family and/or friends from participating in the care of the patient. While healthcare practitioners should support the patient's family and friends in their efforts to care for the person who is ill, they should not fail to respect the patient's right to decide who shall be privy to healthcare and other personal information. Conversations with family and others should give priority to the patient's wishes and the time-frame that suits the best interest of the patient, except perhaps when death is imminent or there is some other pressing need. The patient must not be excluded from discussions or decisions about his or her own healthcare.

1.10 Much healthcare information is stored in medical files, electronic records, healthcare databases and genetic registers. Patients are entitled by right to have access to their medical records. To the extent that records identify a patient they must be treated as confidential and should only be accessible to those in a therapeutic relationship with the patient, unless he or she has consented to further access. In some situations it may be appropriate for healthcare professionals to encourage patients to share information for the sake of the health of others. In rare cases it may be morally or legally necessary for healthcare professionals to divulge confidential information in order to prevent serious harm to the patient or to others. Appropriate forms of protection of healthcare information should be implemented to ensure patients have confidence in the system of recording and maintaining information.

1.11 Though clinical education depends in part on the generosity of patients who are willing to be seen by students, the patient's wishes on this should always be sought and respected.

LEGITIMATE HEALTHCARE INTERVENTIONS

1.12 Medical interventions will normally be therapeutic, that is to say, they will be oriented to the health of the patient. Healthcare professionals must have a clear understanding of the purpose for which an intervention is proposed: for instance, to provide diagnostic or prognostic information, to save a life, to improve or to maintain the patient's health by curing an illness or slowing the course of an illness or stabilising the patient in a reasonably satisfactory condition, to relieve pain or other symptoms of illness, to nourish and sustain the patient. A medical intervention is only ethical if it is proportionate to the medical needs of the patient and his or her overall good. Nutrition and hydration have to do with the basic care of the person, which is essential, even when medical treatment no longer holds any prospect of recovery or cure (see also 5.12). They must never be withdrawn for the purpose of ending human life. Healthcare professionals should try to ensure that patients clearly understand the purpose of a proposed intervention.

THE LEGITIMATE EXERCISE OF FREEDOM

1.13 It is totally in keeping with the dignity of the person that a man or woman should wish to exercise his or her freedom by participating actively in decision making[9] and to express preferences about medical treatment which it is proposed that he or she should receive. These preferences may relate to therapy or to care. They may be about what the patient wishes to happen, or about what he or she wishes not to happen.

These preferences must always be taken seriously by healthcare professionals. While the competent patient has the right to refuse treatment (cf. 1.14 to 1.17), there is no absolute duty on the healthcare professional to implement preferences about what treatment should be provided (cf. 1.18, 1.20, and 1.21).

FUTILE AND OVERLY-BURDENSOME TREATMENT

1.14 Treatment may legitimately be forgone if it is either therapeutically futile (i.e., makes no significant contribution to cure or improvement) or overly-burdensome (i.e., the benefits hoped for do not justify the foreseeable burdens of treatment). This is the same as saying that treatment may legitimately be forgone when it is judged to be 'disproportionate' rather than 'proportionate'.[10] (See also 5.9-5.12).

1.15 The benefits of treatment include preservation of life, maintenance or improvement of health, and relief of discomfort. They do not include deliberately shortening the life of a person who is wrongly described as 'better off dead', nor exploiting a person's body for the benefit of others.

The burdens of treatment to be properly taken into account may include pain, discomfort, loss of lucidity, breathlessness, extreme agitation, alienation, repugnance and cost to the patient. In some cases, the burdens of treatment may also include excessive demands that the treatment makes on family, carers or healthcare resources. Judgements about the futility of a treatment outcome must be distinguished from judgements about the 'futility of a person's life': the former may be legitimate, the latter are contrary to the equal intrinsic dignity of the lives of all persons.

QUALITY OF LIFE

1.16 Good healthcare presupposes the sanctity of human life, that is, the truth that every human life is of unconditional worth. Care should be taken with the use of the term 'quality of life'.[11] This term is used in two quite different ways, one of which is consistent with a recognition of the unconditional worth of every human life, the other which denies this truth. It is consistent with the principle of the sanctity of human life to recognise that the burdens a life-sustaining treatment may impose on a patient may be such as to make it permissible to omit that treatment. This judgement will be made with reference to the proportion or otherwise between the positive effects and the burdens of the treatment. It is not consistent with the principle of the sanctity of human life, however, to claim that any patient's life can lack all value, for example, due to illness or disability, or that any human being is morally unimportant and, on that basis, to refuse or withdraw treatment.

REFUSAL OF TREATMENT

1.17 Patients have the right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable, and such refusals must be respected.[12] In addition, healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not they agree with the patient's refusal (see also 5.4). There is, however, an obligation to prevent suicide when this is possible and healthcare professionals must not, under any circumstances, cooperate with a suicidal act on the part of the patient (see also section 1.21).[13]

UNREASONABLE REQUESTS

1.18 Sometimes patients may request a test or treatment or place conditions on their treatment which a healthcare professional or facility judges to be unreasonable. Healthcare practitioners should endeavour to explain to the patient why they think the desired test, treatment or conditions are unreasonable, and thus why they are not obliged to comply with the patient's request or, in some cases, to undertake further care of the patient. They should, however, offer the patient the opportunity of a second opinion.

THE ROLE OF THE FAMILY AND OTHERS

1.19 The patient's family and emotional ties must be respected and supported.[14] When a patient is unable to participate in decision-making about treatment, family members and relevant others should be consulted by the healthcare practitioner who has ultimate responsibility for making healthcare decisions under those circumstances. In the case of conflicting opinions, people should be helped to reach an understanding of the decisions that have been taken. The relative competencies of healthcare professionals and family members should be respected. Clinical decisions are primarily the responsibility of healthcare professionals, though, in the case of children, parental permission for treatment will be required (see also 1.22 below).

POWER OF ATTORNEY

1.20 Patients should be encouraged to talk with their family, doctors and other relevant people about their hopes for, and fears of, treatment, and to communicate to them their preferences about treatment should a situation arise in which they are unable to make their will known. Patients and residents in care must be informed of their right to appoint one or more people with the Power of Attorney to make decisions on their behalf about finances, residence, care-plans etc., should a situation arise in which they are incapable of doing so themselves.

ASSISTED DECISION MAKING

1.21 *Advance Care Directives* allow a person to indicate in advance how he or she would want to be treated, in the event that he or she should no longer be competent to make or communicate those decisions, at a future time.[15] In Ireland, Advance Healthcare Directives (AHD) are provided for under the terms of the *Assisted Decision Making (Capacity) Act 2015*. The Act is based on the presumption that, in general, all adults have the capacity and the legal right to make their own decisions. It seeks to provide assistance to people in making decisions in such a way that they can retain the maximum autonomy, in situations where they may lack, or may shortly lack capacity. The guiding principles of the Act , contained in Section 8, can be summarised as stating that assisted-decision making must:

- Only be considered when necessary
- Respect the person's right to dignity, bodily integrity, privacy and autonomy
- Permit, encourage and facilitate the person to participate as fully as possible
- Give effect, so far as is practicable, to the person's past and present will and preferences
- Take account of the person's beliefs and values. [16]

The *Assisted Decision-Making (Capacity) Act 2015*, Section 8 (7b), shifts the focus away from a current assessment of the 'best interests' of the patient, and places it instead on what is known of the previously expressed wishes of the patient. While this would appear to assure the autonomy of the patient, it carries with it the very real risk that the 'best interests' of the patient 'here and now' may not actually be well served and that the healthcare professionals involved may be constrained to act in a manner which conflicts with their professional judgement or conscience. The Medical Council's *Guide to Professional Conduct* *and Ethics 2016* seems to recognise this concern:

> If you are concerned about an advance healthcare plan or directive, for example because of questions about the patient's capacity at the time of making the plan, or whether it applies in the current circumstances, you should make treatment decisions in the patient's best interests. In making such a decision, you should consult anyone with legal authority to make decisions on the patient's behalf, the healthcare team and the patient's family, if possible.[17]

The presumption in the Act that valid Advance Care Directives are to be considered by healthcare practitioners as legally binding, gives rise to ethical concerns because of a number of very practical difficulties:

- The complexities of the future cannot be easily contained or adequately expressed within the narrow confines of an advance directive
- Treatment which may appear unduly burdensome in some hypothetical situation, may appear in a different light when the situation is real
- Scientific or technological advances over time may render certain conditions more treatable and certain treatments less burdensome.

For all of these reasons, we believe that it would be preferable to speak in terms of Advance Care Preferences. Such expressions of preference do certainly have the benefit, when a patient is no longer able to communicate, of allowing healthcare practitioners to be guided by having some real insight into his or her wishes at a particular point in time.

Minors and Decision-Making

1.22 Parents have the primary responsibility for the health and well-being of their infants, young children and early/mid-adolescents.[18] Until a child is able to take legal and moral responsibility for his or her own healthcare decisions, treatment must not be administered (except in the case of emergency) without consultation with, and the consent of, the child's parent(s) or other duly-appointed guardian(s). A child's ability to understand healthcare decisions, and thus to agree to treatment, depends on his or her level of understanding and maturity. This competence normally develops over time and thus should be (re)assessed in relation to each proposed medical intervention. Whenever possible both parents and child should be assisted to understand proposed treatment options and their consequences and implications. Where appropriate, the agreement of a child to treatment should be sought. If parents refuse life-saving treatment for their child, which is clearly clinically indicated, emergency treatment should be given and a court order or the appointment of a guardian may be appropriate (see the note at 1.5 above).

NON-THERAPEUTIC INTERVENTIONS

1.23 Persons with the maturity to make decisions freely and with understanding may allow themselves to be subjected to procedures which are not therapeutic for them and which involve some risk to their own life and health, for example, in tissue donation (see also 3.14 and 3.18-3.20) and research (see also 6.4 and 6.5). Because such decisions should be motivated by generosity, they may not be imposed on a person, or made on behalf of those unable to give consent.[19]

In some cases the question arises whether a young child who is unable to give consent may be subjected to a minor, non-therapeutic intervention conducted with a view to a critical intervention that is expected to be therapeutic or life-saving for another family member (e.g. obtaining bone marrow to treat a sibling with a terminal illness such as acute leukaemia). Out of respect for a child's personal bodily integrity great caution should be exercised in this matter. Parents or guardians, taking into account a child's fears and lack of understanding, should never expose their child to a non-therapeutic intervention which carries a significant risk or which the child, if he or she were competent, might refuse on reasonable grounds. Similar restrictions apply to non-therapeutic interventions on other people who are not competent.

SELF-MEDICATION

1.24 At times, patients admitted to healthcare facilities may already be using alternative treatments or prescribed treatments and medications unrelated to the condition for which they were admitted to the facility. The proliferation of websites, through which various drugs and remedies can be purchased without a prescription or even expert advice, gives rise to a significant risk of antagonism between drugs which a patient may self-administer and those who may be prescribed by a doctor. Patients should be asked if they are taking any medications or alternative treatments, and informed that it is in their interests to make such use known to healthcare practitioners.

UNDERGOING TESTS

1.25 Since decisions about whether to undergo certain tests may have significant consequences not only for the person being tested but also for his or her relatives and others, healthcare practitioners must provide advice and assistance to help individuals to make these decisions. Tests should only be undertaken when the results will be of use in the healthcare of the person being tested (or relevant others), or when they are required by law for public health reasons. In cases where healthcare professionals are legally and/or ethically obliged to breach confidence (e.g., in the case of notifiable diseases, see 1.26 below), it should be done only to the extent necessary and only to the relevant party or authority.

Because of the seriousness of the information which may be obtained through some testing (e.g. testing for HIV, Hepatitis C, genetic status), counselling should be offered about the implications of the possible results before such tests are undertaken. The results of such tests must not be divulged to others for purposes that are not of therapeutic benefit for the person tested, unless those concerned have consented to this use, or others are endangered, or there is a public health requirement.

Bedside Allocation Issues

1.26 In providing care for an individual patient, healthcare practitioners should be aware of the need to be just in the way they allocate healthcare resources (such as allocating time and attention and in the use of expensive therapies). However, no one should be denied basic or ordinary care.

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1. See *Veritatis Splendor*; See also John Finnis, *Natural Law and Natural Rights*, Oxford: Clarendon Press, 1980; Germain Grisez, *The Way of the Lord Jesus*, 3 vols, Chicago IL: Franciscan Press, 1983, 1993, 1997.
2. Cf. National Consent Advisory Group, *National Consent Policy,* Dublin: HSE, 2015; also Medical Council. *Guide to Professional Conduct and Ethics*, 8th edition, Dublin: The Medical Council, 2016, Ch. 3
3. Pope St John Paul II, 'To the World Congress of Catholic Doctors,' 3 October, 1982.
4. It should be noted that there is a distinction between practical competence and legal capacity. In the case of minors particularly, while the *Non-Fatal Offences against the Person Act* (Section 23) indicates that a sixteen year old may be presumed to have the capacity to consent to medical treatment, it does not clearly exclude the possibility that a younger minor might also have that capacity.

5. Cf. *New Charter for Health Care Workers*, 98

6. Cf. *New Charter for Health Care Workers*, 156-158

7. See Kevin J Murrell, 'Confidentiality' in Edward J. Furton, Peter J. Cataldo and Albert S. Moraczewski, eds, *Catholic Health Care Ethics: A Manual for Practioners*, 2nd edition, Philadephia: The National Catholic Bioethics Center, 2009, 19-22.

8. *Catechism of the Catholic Church*, 2491

9. See *Gaudium et Spes*, 17

10. See Pope Pius XII, *Address to an International Congress of Anesthesiologists* (1957); *Declaration on Euthanasia*, section IV. This corresponds with the classical distinction between 'ordinary' and 'extraordinary' means of treatment, which will be familiar to many practitioners. The responsibility of the practitioner is to help the patient to appreciate why a particular form of treatment may be 'extraordinary' or 'disproportionate'.

11. *Evangelium Vitae*, 23

12. *Catechism of the Catholic Church*, 2278

13. See *Gaudium et Spes*, 27; *Declaration on Euthanasia*, 1-3

14. *Familiaris Consortio*, 22-26

15. *Ethical and Religious Directives for Catholic Healthcare Services*, 24-25

16. Cf. Irish Statute Book, *Assisted Decision-Making (Capacity) Act 2015*, Section 8, Dublin: Government Publications Office, 2015

17. The Medical Council, 'Guide to Professional Conduct and Ethics', 8th edition, Dublin: The Medical Council, 2016, Chapter 3

18. *Catechism of the Catholic Church*, 2208

19. *Catechism of the Catholic Church*, 2296

2. Human Sexuality, Procreation and the Beginning of Life

2.1 In Catholic teaching, the human body as male or female has a 'nuptial significance':[1] marital love is sacred and purposeful, a gift from God which is intended to be a fully human, reciprocal and total gift of self, faithful, exclusive, complementary and open to new life.[2] Healthcare facilities act reasonably and with no disrespect to anybody when they offer only those services which they believe to be in keeping with the truth about the human person.[3]

2.2 In matters relating to fertility, pregnancy and child-birth, the responsibility of Catholic healthcare is to give counsel which is both medically accurate and consistent with the teachings of Christ and his Church. Catholic healthcare must treat all persons with respect, compassion and sensitivity whatever their sexual or marital status, orientation or lifestyle (see also 4.12 and 4.13).

FERTILITY AND INFERTILITY: AWARENESS AND RESPONSIBLE PARENTHOOD

2.3 Catholic healthcare recognises that couples should use their procreative capacity responsibly.[4] When a couple believe that they have as many children as they can reasonably care for and provide for, or when there appears to be a high risk of a serious genetic disorder, they may reasonably decide to avoid pregnancy. They should be assisted in gaining the appropriate knowledge and skills to enable them to determine times of fertility and infertility so that they can decide when to engage in sexual intercourse.

2.4 An understanding of modern methods of natural family planning increases a couple's knowledge of the reproductive cycle and thus enables them more easily to take responsibility for their marital life, for procreation and for their own health and that of their unborn children.[5] In addition, that knowledge can also enhance their self-confidence with respect to their sexuality and fertility. Couples using natural family planning methods can experience a mutual personal enrichment and a deepening of their own marital relationship, drawing them closer to each other. Catholic healthcare professionals and healthcare facilities have a special responsibility to support scientific and professional natural family planning services, and to ensure that advice offered in this area respects the integrity of marriage and sexual and procreative dignity.

STERILISATION AND CONTRACEPTION

2.5 In Catholic teaching the marital act has both a unitive and a procreative purpose or dimension, which mutually condition each other. It is an act of love which is open to the gift of new life. If either dimension is deliberately excluded from the marital act, the other is also radically affected. The use of procedures or drugs deliberately to deprive the marital act of its procreative potential, whether temporarily or permanently, is not consistent with the Catholic ethos.[6] Also inconsistent with Catholic teaching are birth control methods that involve a significant risk of preventing an embryo from implanting or induce the shedding of the lining of the womb together with any already implanted embryos: such methods are in fact abortifacient not contraceptive. In other words, they destroy an already existing human life.

2.6 Treatments intended to cure or alleviate a serious physical pathology (e.g. irradiation of the ovaries in the treatment of cancer) which as an undesired side-effect cause sterility, whether temporarily or permanently, are permitted if an equally effective and less-harmful treatment is not available. If the woman happens to be pregnant, she must still be offered effective treatment which is necessary to save her life, even if there is a risk that this treatment will result, as an unintended adverse side-effect, in the death of the unborn child. Under those circumstances, however, consideration should be given as to whether an alternative treatment or course of action might pose less risk to new human life, while not significantly increasing the risk to the mother. The decision to undergo or forego, any such treatment is entirely up to the woman herself (see also 2.5 and 4.13).

INFERTILITY COUNSELLING

2.7 Infertility can be a cause of great suffering to a married couple, given the integral connection between marriage and the transmission of life. The causes are various and, in a significant proportion of cases, the cause is unidentified. As with other medical conditions, education can contribute to prevention and reduces the need for treatment, especially where infertility is caused by sexually transmitted infections. Infertility is seldom merely a straightforward medical problem capable of being resolved by simple therapeutic intervention. Infertility counselling is thus of considerable pastoral significance and the practitioner who engages in it is immediately involved in the emotional and spiritual development of the couple. Such care properly involves pastoral and other care professionals.

2.8 Infertile couples now have various options for overcoming their infertility by technological interventions.[7] Some of these possibilities greatly increase the chances of conception and at the same time can be undertaken in a way which is respectful both of human life and of the dignity of all the participants.

2.9 Other forms of intervention may similarly increase the chances of conception but only at the risk of undermining respect for human life and dignity. For example, many embryos produced in vitro are discarded and even those who survive are at risk of being treated as the objects of technology. Many couples presenting for fertility treatment are never informed of these concerns. Clear and compassionate counselling should advise couples on these matters. Couples should be encouraged to explore alternatives such as NaPro (Natural Procreative Technology).

ASSISTING PROCREATION

2.10 Investigations and treatments for infertility must respect the integrity of marriage as a unique committed relationship between a man and a woman and the sacredness of sexual expression in marriage.[8] Semen for analysis should only be collected in ways respectful of human dignity and the integrity of the marital act.

2.11 Procedures which assist the marital act to achieve its purpose are morally permissible, but those which substitute for it are not. For this reason Catholic healthcare facilities and practitioners should not provide technological interventions such as in vitro fertilisation (IVF), intra-cytoplasmic sperm injection (ICSI) or artificial insemination by donor (AID) (cf.8.3 & 8.19)[9].

2.12 Theological discussion continues on the question of the permissibility of the procedure in which the husband's sperm is obtained as a result of a marital act of love, perhaps prepared in various ways, and then reintroduced to the wife's reproductive tract with a view to fertilisation. The question to be answered conscientiously, both by couples considering them and by Catholic facilities or practitioners providing them, is whether the relevant procedure assists the marital act or alternatively replaces it in the origin of the child.

2.13 Procedures and treatments designed to assist procreation, which are morally appropriate in themselves, should only be made available to couples who are able to give a child the security of a mother and father in a marital relationship. Catholic healthcare facilities and practitioners should not use sperm, ova or embryos derived from third parties. Provision should always be made, as is now the case in the Republic of Ireland, that a child who is born as a result of assisted procreation (often referred to as Assisted Human Reproduction) would have access to information about and freedom to contact his or her genetic parents.[10]

2.14 Surrogacy involves a woman in carrying a baby throughout pregnancy and giving birth, only to hand that baby over to the commissioning couple. Even when a direct payment for the child is not involved, the child is usually the subject of a financial agreement and is treated as a product to be delivered as part of that agreement. This is not consistent with the dignity of the person. The surrogate mother provides the commissioning couple with a function that, regardless of the social relevance, a woman usually exercises in her private sphere, in close conjunction with her family, more specifically with her spouse. The potential for the exploitation of impoverished women is very real. Catholic healthcare facilities and practitioners should not assist in conception with a view to a surrogacy arrangement.[11]

Respect for Human Embryos

2.15 The human being from the moment of fusion of the sperm and ovum is to be respected and treated as a person with an inviolable right to life.[12] Healthcare facilities and practitioners must not engage in procedures which intentionally and in themselves damage or destroy an embryo. In this document, the term 'embryo' is used to refer to the new human organism in the early stages of life, from the moment of fusion of the sperm and ovum.

2.16 Procedures carried out on an embryo *in vivo* (e.g. in the womb) are permissible, with the consent of the mother, where they do not involve undue risks to the embryo but are directed toward the improvement of the embryo's health or prospects of survival. Best practice would be to consult the father also, assuming that this is appropriate under the circumstances. A relevant distinction is to be made between germinative cells which are intimately connected to the identity of the new person on the one hand, and somatic cells on the other. Interventions which are eugenic in nature or which are intended to alter the personal identity of the embryo are not ethical and, therefore, not permissible.

CLONING AND OTHER ASEXUAL REPRODUCTIVE PROCESSES

2.17 Cloning undermines the creative partnership between mother and father and turns human generation into a laboratory process.[13] It leaves the human embryo open to the very real possibility of manipulation and quality-control, which are elements of all laboratory processes. Cloning makes it possible to select the precise genetic make-up of a child. The cell-nucleus which is used in cloning can come from any human being, man or woman, including the woman herself whose ovum is used. The whole meaning of parenthood is radically transformed.

Some scientists distinguish between reproductive cloning (for the purposes of having a child) and therapeutic cloning (for the purposes of medical research). This is a false distinction.[14] All cloning is reproductive, because it produces living embryos. Once stem cells for therapeutic purposes are extracted from the cloned human embryos, however, the embryos themselves are destroyed. It is never morally justifiable to deliberately destroy one human life in order to save another. To do so is to undermine the dignity of every human being because it implies that a human being (any human being) can be used as a means to an end.

2.18 Catholic healthcare facilities must not take part in procedures which lead to the asexual production of human embryos, or beings who may be or resemble human embryos, or procedures which are otherwise contrary to respect for human life in its origins or to respect for human dignity. Examples of such procedures include attempting to form a human embryo other than by the fertilisation of a human ovum by a human sperm, deliberately causing twinning by fission of an embryo, or attempting to gestate a human embryo outside the womb (ectogenesis).

PREGNANCY

2.19 We affirm the unique dignity of every woman carrying a child in her womb. In pregnancy a mother becomes bound to her unborn child physically, emotionally and spiritually, and so fulfils a unique role in God's plan for the creation of new life.[15] Catholic healthcare services must support parents and their unborn children throughout pregnancy and childbirth as an expression of respect for the inherent dignity of every human being.

PRENATAL DIAGNOSIS

2.20 Once pregnancy is confirmed, parents potentially have access to a wide range of diagnostic procedures to gain information about the health and progress of the embryo or foetus and the health of the mother. Before a diagnostic procedure is undertaken, the significance of the procedure, its risks for the foetus and the mother, and the reliability of its possible results, should be explained to the parents to enable them to make an informed decision about whether to go ahead with the procedure. No procedure which carries undue risk should in any case be offered (see below).

PRENATAL AND SPECIALIST COUNSELLING

2.21 The proper purposes of prenatal diagnosis are to monitor the health of the child, to enable earlier and more effective therapy, and/or to inform and assist parents as they prepare to welcome their new child.[16] The consent of the parents, or at least of the mother, when the consent of both parents is not possible, is required and the methods used must safeguard the life and health of the embryo or foetus and the mother. Prenatal diagnosis must not be undertaken with a view to aborting an unborn child for any reason. Prenatal diagnosis must not involve any disproportionate risks for the unborn child or the mother. As a matter of respect for women and children, and to ensure the just allocation of resources, facilities should resist pressures to provide unnecessary and/or medically futile prenatal tests.

2.22 The results of prenatal testing and diagnosis should be presented to the parents fully and objectively, and in a manner which respects the life of the unborn child. Responsible counselling and pastoral support are to be made available to parents and family, especially when foetal disabilities, including life-limiting conditions, are diagnosed. Counselling must not create a link to abortion. Parents should be made aware of the support available to them during pregnancy and following the birth of their child. If foetal abnormalities are diagnosed, parents must have the benefit of the advice of paediatricians with expertise in the prognosis management and treatment of these conditions.

2.23 Because of a family history or for other reasons, genetic testing and specialist counselling may sometimes be appropriate, ideally before marriage, to inform couples of the likelihood of any children of theirs, having a genetic abnormality, of the difficulties this would involve, and of the assistance available should that occur. Specialist counselling may also include advice about fertility and infertility which is in keeping with the dignity of human sexuality and marriage, so that couples may make responsible decisions about forming a family and about the timing and spacing of children (see also 2.3).

ABORTION

2.24 No healthcare facility or practitioner should provide, or refer a patient for, an abortion, i.e., any procedure, treatment or medication whose primary purpose or sole immediate effect is to terminate the life of a foetus or of an embryo before or after implantation. Such procedures, treatments and medications are morally wrong because they involve the direct and deliberate killing of, or a direct lethal assult on, an innocent human life in the earliest stages of development.[17] The threat of suicide is not a morally justifiable reason for procuring an abortion, both because it involves a direct assault on the unborn child and because abortion is not a treatment for suicidal tendencies. To procure an abortion under such circumstances would not be consistent with the mission of a Catholic healthcare facility (cf. 2.28 regarding necessary medical treatment for the mother, and 8.3 & 8.19 regarding conscientious objection).[18]

2.25 Women (and men) are often hurt by abortion. While not condoning the decision to abort an unborn child, Catholic healthcare services must treat with courtesy and respect all who seek assistance and should be ready to offer compassionate physical, psychological, psychiatric, moral and spiritual care to all who have suffered from the trauma of abortion. Women (and men) who have been through abortion should be made aware of the post-abortion counselling services offered by Cura and similar organisations.

MISCARRIAGE

2.26 Parents who lose a baby through miscarriage or stillbirth should be provided with pastoral care that is sensitive to their emotional and spiritual needs. Appropriate options should be provided for the burial of the body or human remains in ways respectful of the dignity of human life and in keeping with the parents' wishes. A child who is miscarried but who may be still alive should be baptised if this is possible and is desired by the parents. This can be done by any person who intends what the Church intends, by saying while pouring water on the child's head, 'I baptise you in the name of the Father, and of the Son, and of the Holy Spirit'.[19]

Difficulties During Pregnancy

2.27 Catholic healthcare has a special commitment to providing material and emotional support to parents for whom pregnancy is not a welcome event, or for whom, though welcome, pregnancy brings with it significant burdens. Women must be assisted to continue with their pregnancy and should also be directed to agencies whose ethos respects life (e.g., Cura) which may be able to provide additional help with the many matters that arise during pregnancy.

2.28 Should situations arise during pregnancy in which the health of either the mother or her unborn child is at risk, the goal of Catholic healthcare facilities is to provide the best possible care for both mother and child, and to help parents make prudent judgements about treatment options which may affect the health of mother or child.

Threats to Health and Life

2.29 In some cases a woman may develop, during pregnancy, a life-or health-threatening condition for which the only effective and available treatment is one that would endanger the life or health of her unborn child. Such treatment is permissible provided any harm to the child is neither intended not disproportionate to the threats facing the mother. Every effort consistent with good medical care for the mother should be taken to minimise the adverse effects of her treatment on the child, both before and following birth. In cases in which the focus of treatment is on the pregnancy itself (for example, deliberately inducing labour post-viability – see below) it will be a matter of weighing risks, rather than certainties, of harm for mother and child when considering possible interventions. The aim is always to save whatever life can be saved.

2.30 An ectopic pregnancy can pose a grave threat to the life of both a pregnant woman and the embryo she carries. A woman's life must never be endangered by an inappropriate delay in treatment. When treatment is required, the pathological situation should be resolved quickly, though without intending the death of the embryo (i.e., only by accepting the inevitable death of the embryo as a negative side effect of the life-saving intervention, see also 2.23).

INTERVENTIONS PRIOR TO BIRTH

2.31 Unless there is a serious risk to the life of the mother and/or the baby, which indicates the need for an early delivery, she should be encouraged to carry her child until approximately full term. However, when the continuation of pregnancy poses a serious threat to the health of the mother or child, post-viability therapeutic interventions (e.g. induction of labour, caesarian sections) are permitted provided they do not involve a direct assault on the unborn child, nor involve an unwarranted risk to the child's life or health, taking into account the medical resources available and the child's prognosis if the intervention is delayed.[20]

SEVERE ABNORMALITIES ARISING DURING PREGNANCY

2.32 Parents awaiting the birth of their child face particular difficulties when the condition is so severe that their child, even if born alive, is unlikely to be able with ordinary assistance to maintain life outside the womb for long, if at all. The terms 'fatal fetal abnormality' or 'lethal fetal abnormality', though frequently used, are not clinically accurate, because the conditions they describe are not inevitably fatal for the child in the womb or immediately after birth. Such terms approximate more closely to value judgements, and are associated with the concept of a 'useless life' or a 'life without value'. The value of a human life cannot, however, be calculated in terms of its length or 'usefulness'. In the eyes of the Creator 'one day is as a thousand years, and a thousand years as one day' (2 Pt 3:8). What is required is an approach to care which seeks to minimise the trauma of the parents, while treating the unborn child with the same unconditional respect that is due to any child.

NEONATAL CARE FOR CHILDREN WITH LIFE-LIMITING CONDITIONS

2.33 Parents should be made aware of perinatal hospice services and Catholic organisations and practitioners involved in healthcare should consider whether they might be in a position to provide such services where they do not already exist. Parents might also be made aware of support groups, such as One Day More or Every Life Counts, established by parents who have had similar experiences in pregnancy.

2.34 The care of new born children with life-limiting conditions, or with extremely low birth weights or other serious health needs, can involve difficult ethical decisions both about the just allocation of resources and about the benefits and burdens of treatment. Ordinary care and comfort is to be given to all newborn children, regardless of their life expectancy (see also 5.10-5.12).[21] The appropriateness of more extensive measures, for example, surgery and specialised neonatal intensive care, is to be determined in the light of the child's condition and the foreseeable benefits and burdens of the treatment options for the total good of the child.[22]

2.35 Surgery may in some circumstances permit earlier and more effective treatment of foetal disorders, or may be necessary to ensure the safe delivery of a child. The mother is also the subject of the surgical intervention, and it is her responsibility, both prudently and conscientiously, to determine the appropriateness of surgery, given the benefits, burdens and risks it would pose for both herself and her unborn child.

FOETAL SURGERY AND EXPERIMENTATION DURING PREGNANCY

2.36 In some cases where intra-uterine surgery is indicated, the parents may find it impossible to arrive at a decision on which they are agreed. In other cases the decision arrived at by the mother and/or father might unjustifiably risk the life of the child in the womb, or risk causing permanent damage to his or her health. In these circumstances, healthcare practitioners may need to provide expert counselling for the parents and/or take other ethical and lawful measures to enable the unborn child to receive appropriate treatment. The decision of a competent pregnant woman to refuse surgery should, however, be respected.

1. Pope St John Paul II, *Theology of the Body*, Pauline Books, 1997
2. *Gaudium et Spes*, 47-52; *Familiaris Consortio*, 11-14
3. *Humanae Vitae*; *Familiaris Consortio*, 29-34; *Catechism of the Catholic Church*, 2399
4. *Gaudium et Spes*, 50; *Humanae Vitae*, 10
5. *Familiaris Consortio*, 32
6. *Humanae Vitae*; *Familiaris Consortio*, 29-34; *Catechism of the Catholic Church*, 2399
7. Irish Catholic Bishops' Conference, *Towards a Creative Response to Infertility* (2007)
8. The Catholic Church, in common with many other religious and cultural traditions, understands marriage to be a committed relationship between a man and a woman, which has as its objects the dynamic communion of the couple themselves and the gift of life to children
9. See *Evangelium Vitae*, 14; *Donum Vitae*, section 2. Also *New Charter for Health Care Workers*, 26-30
10. See Irish Statute Book, *Children and Family Relationships Act*, Section 33ff
11. *Donum Vitae*, Section A.3; New Charter for Health Care Workers, 31; COMECE, *Opinion Of The Reflection Group On Bioethics On Gestational Surrogacy*, Brussels, 2015.
12. *Evangelium Vitae*, 62; See also Congregation for the Doctrine of the Faith, *Dignitatis Personae*, (2008); *Life is Sacred,* Dublin, Veritas, 1975. Care should be taken to distinguish between *person* and *personality.* A distinct individual of a rational nature, such as a human embryo, is correctly described as a person, even though he or she lacks a personality. Personality is an expression of the rational nature which gradually takes shape over time in the person.
13. *Dignitatis Personae*, 28-30
14. See Pontifical Academy for Life, *Reflections on Cloning* (1997). See also UN General Assembly, 59th Session, 6th Committee, 'United Nations Declaration on Human Cloning' (A/RES/59/280), 23 March, 2005
15. John Paul II, *Mulieris Dignitatem* (1988), 18-19
16. Cf. *New Charter for Health Care Workers*, 33-36
17. *Evangelium Vitae*, 58; *Caritas in Veritate*, 28, 75; *Amoris Laetitia*, 83
18. The *Protection of Life in Pregnancy Act*, specifically provides for abortion in the Republic of Ireland, in the case of a risk of maternal suicide, when it is belived by healthcare professionals that abortion is the only means of averting that risk. It is not correct to describe abortion as a 'medical procedure'. Neither is it possible to be sure in any given case that it would avert the risk of suicide. Cf. Irish Statute Book, *Protection of*

Life in Pregnancy Act (2013), art. 9

19. *Catechism of the Catholic Church*, 1284

20. Peter J Cataldo and T. Murphy Goodwin, 'Early Induction of Labor,' in Edward J. Furton, Peter J. Cataldo and Albert S. Moraczewski, eds, *Catholic Health Care Ethics: A Manual for Practioners*, 2nd edition, Philadephia: The National Catholic Bioethics Center, 2009, 111-118

21. While medical interventions may, in such cases, be regarded as unlikely to achieve any improvement in the child's condition or prognosis, the child should be kept warm and provided appropriately with nutrition and hydration.

22. For further ethical and legal background cf. Simons, Caroline, '"Incompatible with Life": Does Article 40.3.3 Permit Abortion for "Fatal Foetal Abnormality"?', *Medico-Legal Journal of Ireland*, 2015, Vol. 1, 11-14

3. Respect for Bodily Integrity in Healthcare

INTRODUCTION

3.1 The human person is a unity of body and soul, and our living bodies are integral to our personhood.[1] While injury, disease or congenital malformation may reduce a person's ability to participate fully in the goods of this life, he or she always remains a member of the human family. Every sick or disabled person is to be respected and protected at every phase of development, from conception until death. Catholic healthcare facilities and Catholic practitioners have a particular mission to continue to care for a person when disease or disability has severely diminished his or her capacity to participate in social, economic and even spiritual life.[2]

HEALTH PROMOTION

3.2 Research and education to promote healthy living, to maintain health and to prevent illness and disability are a significant element of Catholic healthcare, which has a particular vocation to assist those who are impoverished or lacking educational or employment opportunities and whose health and well-being are therefore at greater risk.

HARM PREVENTION

3.3 Catholic healthcare institutions will always give positive witness to respect for life and health. They must combine this witness with a commitment to being a place of welcome and safety for those who are particularly at risk, including those who endanger themselves by attempting suicide, misusing substances, engaging in high-risk sexual activity, or undertaking other activities which endanger health and life.[3] They will assist those in danger of self-harm to believe in their own worth, to recover and maintain good health, and to be rehabilitated. If patients are determined to act in dangerous or self-destructive ways, health professionals may intervene with morally and practically available means to help avoid that harm.

DRUG REHABILITATION

3.4 Misuse of substances such as alcohol and drugs jeopardises the ability of the human person to think and act responsibly and has the potential to gravely damage the person and others. The care of those who misuse substances must always be directed to the good of the person with an addiction rather than to mere containment of drug problems. Accordingly, in their care for these people and their families, Catholic healthcare facilities should be places of welcome, providing outreach and support with the immediate goals of detoxification, rehabilitation, sustaining the person in abstinence and responsible behaviour thereafter and throughout caring for the family.[4]

3.5 Catholic inspired programmes aimed at dealing with the harms associated with the misuse of substances should have rehabilitation as the primary goal and will seek to give clear witness both to the evil of the misuse of substances and to the goal of overcoming addiction.

CARE OF PERSONS WHO HAVE BEEN SEXUALLY ASSAULTED

3.6 Rape and other sexual assaults are terrible acts of violence and violations causing great personal suffering. By what they say and do, healthcare professionals in Catholic facilities hope to be agents for restoring the person's trust and confidence in others, his or her self-esteem and sense of security. When caring for victims of sexual assault, Catholic healthcare facilities must seek primarily to be a source of support and reassurance to those who have been brutally abused. Catholic health services should, wherever possible, have trained staff to care for those who have been sexually assaulted.

3.7 The privacy of those who have been sexually assaulted is a major concern. Catholic healthcare facilities should endeavour to shelter them from further hurt and to protect their privacy, while at the same time respecting legal requirements and the need to bring perpetrators to justice.

3.8 A woman who has been sexually assaulted may well be apprehensive about the prospect of pregnancy. Catholic facilities can assist her in establishing whether she is pregnant, or what the likelihood of this may be, by identifying periods of fertility and infertility, ovulation and menstruation, and by providing her with the best scientific information available. They should advise her regarding the morally permissible treatment options (see 3.9 below), giving reassurance, counselling and support based on that information.

3.9 A woman who has been the victim of rape is entitled, as a matter of justice, to defend herself against its continuing effects. Interventions following an assault which are aimed at preventing the union of sperm and ovum through, for instance, suppressing ovulation are therefore permissible in principle. Interventions aimed at causing abortion after rape, however, are not permissible, because they seek to 'heal' by bringing about the death of another human being. Measures designed to prevent ovulation or fertilisation may only be used when they involve no significant risk to the life of a developing embryo. Healthcare professionals need to recognise clearly that so-called emergency contraception frequently acts as an abortifacient.

BODY IMAGE, GENDER REASSIGNMENT AND MUTILATION

3.10 Catholic healthcare facilities should resist cooperation in the excessive cultural emphasis on physical appearance. Those suffering from various psychological and spiritual disorders associated with body image should be assisted to resist the misuse of drugs, and surgical and genetic procedures in pursuit of some idealised 'perfect body'.

3.11 The first priority in dealing with adults who experience body dysmorphia or gender dysphoria is sensitive psychological and/or psychiatric management.[5] Positive means should be found to assist the person to come to terms with his or her bodily nature. Interventions should be limited to authentic therapies for pathological conditions. Procedures or interventions that deliberately render a healthy sex organ dysfunctional, mutilate it or remove it, as a treatment for a psychological or psychiatric problem, are not consistent with the dignity of the person.[6]

3.12 The care of children born with ambiguous sexual physiology should allow for and/or assist a developmental resolution. A proportionate weighing of the risks and benefits of the available treatment options always takes into account the good of the child as a person (see also 1.20).

3.13 For the sake of a person's bodily health as a whole, it may be advisable or even necessary to repair, modify or even remove a part of the body. The principle which applies here is the principle of totality, according to which the good of the whole takes precedence over the good of the part.[7] Respect for the human body, however, excludes procedures which unnecessarily damage or destroy any part or function of the body, for example, direct sterilisation, female genital mutilation, and some kinds of cosmetic surgery.[8]

ORGAN AND TISSUE REPLACEMENT

3.14 Today many people owe their lives to organ and tissue transplants. Such new technologies are welcomed by the Church, at least in principle, as a great service to life.[9] One way of nurturing a culture of life is through a willingness to donate organs and tissues with a view to offering a chance of health and even life itself to people who are sick.

3.15 Patients who need these interventions often have few options if they are to survive, may be especially dependent, and may be offered interventions which are experimental and/or very expensive. Care must therefore be taken to ensure that their participation is fully voluntary and that information about the burdens and risks associated with the transplant procedure is presented realistically. The willingness of a healthcare professional to continue to care for and treat a patient must in no way require or be dependent on the patient's willingness to participate in experimental treatment.

3.16 Parts of the human body are not to be treated as commodities. Trade in human body parts is unacceptable, as is any other disrespectful use of the organs or tissues of a living or deceased person, whether born or unborn.

3.17 Organ and tissue replacement technology involves significant costs and burdens and can present especially acute dilemmas for the just allocation of resources. Patients must be treated impartially when being admitted to transplant programmes. There should be no unjust discrimination on the basis of social factors such as inability to pay, mental illness, past misuse of substances, lack of family support, lack of education or English language skills, advanced age, remoteness or ethnicity. Only clinical factors such as urgency, need and ability to benefit should be taken into account.

TISSUE PROCUREMENT FROM LIVING DONORS FOR RESEARCH OR TRANSPLANTATION

3.18 The giving of excess or regenerative tissue or organs, for the purposes of testing, research or donation to others, is to be encouraged provided there is appropriate consent and there are no serious risks to the donor.

3.19 Donation of non-regenerative tissue or organs (e.g. a kidney) by a living donor is only permissible where this will not seriously impair function, be detrimental to the discharge of the donor's responsibilities, or involve serious harm or danger to the donor's life, future health or identity. Best practice suggests that a psychological assessment be offered to the donor prior to the donation.

3.20 Respect for the inherent dignity and inviolability of the human person demands that removal of tissues from living donors is done in response to an informed decision to donate the tissue as an act of genuine charity. (In the case of children and others unable to comprehend the implications of the intervention see also 1.20 and 1.21)

3.21 Special care should be taken to ensure that members of families or ethnic groups are not unduly pressured to consent to tissue removal or reception for the sake of other members. Healthcare personnel must ensure that confidentiality is maintained and that potential donors and recipients have a real opportunity to refuse.

TISSUE PROCUREMENT FROM THE DECEASED ('CADAVERIC ORGAN DONATION')

3.22 The donation of organs and tissue after death is a generous act of charity which can give life to someone else. Respect for the inviolability of every member of the human family, however incapacitated or disabled, requires that the death of the prospective donor be clearly established before vital organs are removed for transplant (see also 5.21-5.23).

3.23 Respect for the body as the principal relic of a deceased person and as a focus of grieving requires that the body never be treated merely as a field for 'harvesting'. Organs and tissues may only be removed from a deceased person who has bequeathed them verbally or in writing or perhaps, in the absence of such clear expression of the deceased person's 'will', with the permission of the family. Even in the face of a clear expression by the deceased of intent to donate organs at death, Catholic facilities should always take into account the wishes of those grieving the person's death and seek to ensure that sufficient time and information have been given for them to comprehend the situation before proceeding.

3.24 The families of potential donors, together with relevant others, must be treated with sensitivity to their grief and to their religious and cultural background. They should be given counselling and accessible information about issues such as the manner in which death is determined, about organ and tissue procurement and transplantation. They should be offered adequate evidence that provides them with appropriate assurance that death has occurred (see also 5.22, 5.23 and 5.25). Appropriate signs of reverence for the deceased and pastoral care for those grieving are especially important at this time.

Determination of Death with a view to Cadaveric Organ Procurement

3.25 To avoid any conflict of interest, a determination of death should be made by appropriate healthcare practitioners committed to the care of the deceased person, rather than by those associated with the organ procurement or transplantation process. However, because successful transplantation is dependent upon the organs being as viable as possible, it is legitimate to keep a body on artificial life-support after the person has been declared dead.

3.26 Death cannot be defined simply in terms of the presence or absence of a particular function. These functions, such as breathing, heartbeat, or even electrical activity in the brain or brain-stem, while they are significant, are really only indicators of life. As medical science and therapy progresses, such 'markers' may cease to be regarded as definitive indicators that death has occurred. Death occurs when the body has irreversibly ceased to operate as an organic whole. The criterion of brain function remains only one criterion (cf. 5.21 and 5.22)[10].

3.27 People who are comatose or in a permanent vegetative state (PVS) should not be treated as dead for the purposes of organ procurement. Similarly, infants born with anencephaly or who have prolonged loss of consciousness must not be treated as dead for the purposes of organ procurement. They are living persons with a right to their bodily integrity.[11]

Foetal Tissue Procurement for Transplant

3.28 Though embryonic and foetal tissues may be considered by some transplant practitioners to be preferable to tissue taken from more mature human beings, great care must be taken with respect to the sources of such materials. It is unethical to take tissue from a live foetus for transplantation. Only cadaveric foetal material derived from natural miscarriages or from ethically obtained cell lines may be used for transplantation.

XENOTRANSPLANTATION

3.29 For the transplantation of animal organs or tissues to human beings to be permissible, it is necessary that the procedure will not impair the integrity of the recipient nor impose inordinate risks on the recipient or others (see also 6.4-6.11).

3.30 The introduction of parts of the human genome into animal tissue or vice versa must not involve extensive animal-human hybridisation, the use of human sperm or eggs in fertilisation or cloning-type procedures, inheritable changes to a human being, or the formation of an organism possessing some human and some animal material which is or resembles a human embryo.

TRANSPLANTS OF REPRODUCTIVE CELLS

3.31 The fabrication of 'artificial' gametes from skin cells (by *in-vitro* gametogenesis) may eventually render the procurement of gonads from other human beings redundant. While the use of artificial gametes would be regarded by some as a legitimate way of circumventing infertility, it would give rise to a situation in which the process of life-giving, separated from the act of love, would become a laboratory process, with all that this involves. This is inconsistent with the dignity of the human person.

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1. Cf. *New Charter for Health Care Workers*, 45-46; *Catechism of the Catholic Church*, 362-368

2. Pope St John Paul II,*Christifideles Laici*, 53; Pope Francis, *Evangelii Gaudium*, 48

3. See Irish Catholic Bishops' Conference, *Life is for Living* (2008)

4. See Pontifical Council for the Family, *From Despair to Hope: Family and Drug Addiction* (1992)

5. These are technical terms in current use. Following the enactment of the *Gender Recognition Act 2015*, however, care should be taken in using the term 'gender', the meaning of which is legally unclear.

6. Pope Francis comments: 'The acceptance of our bodies as God's gift is vital for welcoming and accepting the entire world as a gift from the Father and our common home, whereas thinking that we enjoy absolute power over our own bodies turns, often subtly, into thinking that we enjoy absolute power over creation. Learning to accept our body, to care

for it and to respect its fullest meaning, is an essential element of any genuine human ecology. Also, valuing one's own body in its femininity or masculinity is necessary if I am going to be able to recognise myself in an encounter with someone who is different. In this way we can joyfully accept the specific gifts of another man or woman, the work of God the Creator, and find mutual enrichment. It is not a healthy attitude which would seek "to cancel out sexual difference because it no longer knows how to confront it".' (*Laudato Si'*, 155).

7. 'The Principle of Totality states that the part exists for the whole, and that consequently the good of the part remains subordinate to the good of the whole; that the whole is decisive for the part and can dispose of it in its own interests'. Pope Pius XII, 'The Moral Limits of Medical Research and Treatment,' An address given 14 September 1952 ; cf. New Charter for Health Care Workers, 88

8. *Catechism of the Catholic Church*, 2297.

9. *Catechism of the Catholic Church*, # 2296; See also, Pope St John Paul II, 'Address to the 18th International Congress of the Transplantation Society, 29 August 2000; also Pope Benedict XVI 'Address to the Pontifical Academy of Life', 7 November 2008.

10. See Pope St John Paul II, *Address to the 18th International Congress of the Transplantation Society*, (29 August 2000), 3

11. See United States Conference of Catholic Bishops, *Moral Principles Concerning Infants with Anencophaly* (1996)

4. Older Patients and Other Persons with Particular Needs

INTRODUCTION

4.1 Catholic healthcare services should be distinguished by their care for and protection of people with particular healthcare needs, including older people, people with chronic illness, physical or intellectual disability, HIV/AIDS, mental illness or dementia, and children and adults who have been abused. The care of people with particular needs involves some distinctive ethical standards, in addition to those standards of care generally applicable.

CARE OF OLDER PERSONS

4.2 As people age they may become frail, some of their capacities may be reduced, they may suffer various health problems, and they may become less self-sufficient. The community has a responsibility to ensure that they receive appropriate assistance in these circumstances.[1] Catholic healthcare services should provide such help at every stage of the ageing process.

4.3 Respect for the dignity of older persons and solidarity with them requires care which fosters their opportunities to participate in family, Church and community life and, if possible, to live in their home environment.[2] Catholic healthcare should seek to provide a continuum of care from high quality home-and community-based programmes to independent, semi-independent, dependent and acute residential care, as required.

4.4 Every effort should be made to ensure that institutional environments for older persons respect their individuality and are as homelike as possible. In addition to high quality nursing care and social services as required, special provision must be made for the spiritual and sacramental needs of older persons.

CARE OF PEOPLE WITH CHRONIC ILLNESS AND/OR PHYSICAL DISABILITIES

4.5 Persons with chronic illnesses and/or disabilities have the same basic needs and desires as other human beings, and enjoy the same basic rights and responsibilities. The community has a responsibility to ensure that people who are chronically ill and/or disabled are provided with appropriate assistance. Catholic healthcare services should promote the dignity of persons with chronic illnesses and/or disabilities by ensuring that they enjoy a positive environment and have access to appropriate services which enable their own personal development and their participation in family, Church and society.[3]

4.6 Respect for the dignity of persons with chronic illnesses and/or disabilities and solidarity with them requires the provision of high quality home- and community-based programmes and institutional care where appropriate. No one person can meet all of these needs, but the committed engagement of all those involved, healthcare professionals, family members, and, in so far as it is appropriate, the local parish community is required, to provide support both for the person with chronic illness or disability and for those who are in the 'front-line' of caring for them. All of this must be done in a way which allows a person, however dependent, to experience himself or herself as equal in dignity to those who provide the care.[4]

Care of People with hiv/aids

4.7 hiv raises many of the same issues as does any infectious disease and aids raises many of the same problems as do other life-threatening illnesses such as cancer and chronic heart disease. In addition, hiv/aids currently raises other complex issues both in Ireland and in the global context in which it is a pandemic. People affected by hiv have the same rights and responsibilities as every other member of the community. Catholic healthcare services must seek to promote the dignity of people living with hiv/aids by ensuring that they have access to appropriate medical, nursing and pastoral care, regardless of how they contracted the infection, and by ensuring that they enjoy the same opportunities as people afflicted with any other serious disease.[5]

4.8 The complexity of the experience of hiv highlights the fact that health has not only physical but also psychological and spiritual dimensions. For most people, notwithstanding the significant improvement in prognosis in recent years, the information that they have hiv can be devastating. They may find it very difficult to tell family and friends about their condition or, indeed, about the manner in which it was acquired. They may have to contend with anger and grief, with anxiety about infecting or having already infected others, and with limitations on their future opportunities and relationships. In addition to high quality medical and nursing care as required, special provision should therefore be made for the emotional and spiritual needs of people with HIV/AIDS. They may also need advice about not putting other people at risk of infection. Such advice should not demean them by assuming they are incapable of radical decisions which are appropriate to their own particular marital and medical status (bearing in mind that risks will vary depending on factors such as viral load).

4.9 Care of the individual as a whole, including counselling prior to and after HIV testing, should continue throughout the course of the disease. Every effort should be made to ensure that the social and personal complications of the disease do not jeopardise the provision of supportive, compassionate care.

CARE OF PEOPLE WITH INTELLECTUAL DISABILITY

4.10 Intellectual disabilities vary in extent and kind. Attention should be given to both the biological and the psychological causes of and available treatments for intellectual disability. People with intellectual disability have the same rights as any other person. The community has a responsibility to ensure that they are provided with appropriate assistance. Because this tends to be an under-resourced area of care, Catholic organisations should seek to ensure that such people have access to appropriate services which enable them to achieve the greatest possible development of their gifts and abilities and the highest possible degree of participation in the life of family, church and wider society. In addition to high quality health, educational and social services as required, special provision must be made for the spiritual and sacramental needs of people with intellectual disability.

4.11 The general principle that responsibility for healthcare decision making rests in the first place with the individual also applies to people with intellectual disability. As far as possible they must be enabled and encouraged to take an appropriate part in decision-making regarding their care. Such decision making power should only be overridden in the case of diagnosed incompetence to make rational decisions. Even where a person is incapacitated to consent and the input of the legal guardian is required, as far as possible the agreement/assent of the person should also be sought.[6]

4.12 Sexuality and fertility are God's gifts and parts of our common human nature and, indeed our health. For that reason, mutilating interventions upon the intellectually disabled, such as sterilisation and hysterectomy, which are not therapeutic but which are simply aimed at resolving social problems, are unacceptable. Catholic disability services should seek to assist people with disabilities in their individual vocations as single people, spouses or parents.

4.13 Every effort should be made to ensure that persons with an intellectual disability have sufficient understanding and discretion to consent to any marriage, sexual intercourse and/or responsible parenthood. If a person is intellectually impaired to the point that he or she does not understand the consequences of sexual intercourse or is easily manipulated into giving supposed consent, then sexual intercourse with that person constitutes an assault. Caregivers have an obligation to take all reasonable care to protect people with intellectual disability from sexual assault. Only where this is genuinely impracticable may temporary measures to prevent conception be used as a last resort (see also 2.6, 3.6-3.9).

4.14 One goal of the care of those with intellectual disabilities is to assist their integration with family and community. 'Mainstreaming' their care and assisting their living within the community are, in principle, to be applauded, as long as this serves the best interests of the person concerned rather than prioritising economic or social goals, and as long as such care is appropriately supported by human and financial resources.

CARE OF PEOPLE WITH MENTAL ILLNESS OR DEMENTIA

4.15 Mental illnesses and dementia vary in extent and kind. In any case, people with mental illnesses or dementia have the same basic rights as everyone else. The community has a responsibility to ensure that they are provided with appropriate assistance.[7] Because mental health services, unjustly, tend to be an under-resourced area of healthcare, Catholic organisations should seek to ensure that people who have mental-health needs have access to appropriate services which enable them, as far as possible, to recover health and to participate in the life of family, church and wider society.[8] In addition to high quality mental health and social services as required, special provision must be made for the spiritual and sacramental needs of people with mental illness.

4.16 Psychiatry and counselling have as their goal not social control but care and support of the individual. They must always be conducted in ways which respect the dignity and privacy of patients. Physical and chemical restraints should only be used as a last resort to protect the patient or others from harm.

4.17 Every effort should be made to ensure that institutional environments for people with dementia or mental illness respect their individuality and are as familiar and supportive as possible.

4.18 Appropriate principles, as discussed for those with intellectual disabilities, may also apply to those with mental illness or dementia, in areas such as responsibility for decision making, sexuality, and integration with family, Church and community.

Care of Sick Children and Babies

4.19 Children and babies have particular needs when they are sick. Pain and other symptoms of illness can be overwhelming for young children who are unable to understand fully the causes of their distress, or to find meaning in their experience. A child naturally looks to his or her parents and family for support. As far as is practicable, Catholic healthcare services should provide facilities to enable the family to remain with a sick child. Whenever this is not possible or appropriate, the matter should be discussed with the family and the patient if possible. Every effort should be made to respect the individuality of each child and to enable the child's participation in his or her care at the level to which that child is capable (see also 1.20, 1.21, 3.20 and 6.8).

4.20 Where possible, children should be cared for in facilities specifically designed for them. If it is necessary to accommodate a child in an adult ward, every effort should be made to ensure the child has private space and is screened and sheltered from the other activities of the ward. The care of children should normally be supervised by clinical staff experienced in their care and supported by the appropriate equipment and staff.

4.21 The holistic care of children requires an acknowledgment of their spiritual and emotional needs and recognition of the significance of their family. When children are ill, spiritual and pastoral care will often need to be extended to close family members and should, where possible, be provided by people experienced in such care.

Care of Children who have been Abused

4.22 Child abuse fragments and distorts a child's confidence in themselves, parents, family, friends and the whole community of adults. Catholic healthcare facilities and welfare services should aim to prevent any further harm to children who have suffered physical, psychological or sexual abuse, and to re-build the child's trust, confidence and sense of security (see also 3.6-3.9).

4.23 Suspected child abuse requires immediate investigation and intervention by the appropriate civil authorities and this means that any person having concerns is obliged to report those concerns to the police and social services in the relevant civil jurisdiction. With due regard to the position of parents and their primary responsibility for their children, the responsibility of reporting suspected abuse applies, regardless of the wishes of the parents. Services provided by Catholic agencies and facilities must always comply with both Catholic Church protocols and civil legislation, which require training for and vigilance on the part of all staff members.[9]

4.24 In addition to caring for those with particular needs, Catholic healthcare facilities should also seek to assist family members and neighbours who care for people with particular needs. Through education, support services, pastoral care and opportunities for respite, these facilities should seek to help family, friends, volunteers and practitioners who care for dependent persons.

4.25 Physical, emotional or verbal abuse of vulnerable adults is intolerable. Catholic healthcare facilities must bear witness to the dignity of every person by ensuring appropriate training and supervision of staff engaged in the care of dependent adults. Suspected elder abuse requires immediate investigation and intervention by the appropriate civil authorities and this means that any person having concerns is obliged to report those concerns to the police and social services in the relevant civil jurisdiction.

Care of the Carers

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1. See Pope St John Paul II, *Letter to the Elderly*, (1999)
2. See United States Conference of Catholic Bishops, *Society and the Aged: Toward Reconciliation* (1976)
3. See also Pope St John Paul II, *Jubilee of the Disabled* (3 December 2000); Irish Catholic Bishops' Conference, *Celebrating People with Disabilities – Pastoral Letter for Day of Life* (2006); United States Conference of Catholic Bishops, *Pastoral Statement of the United States Catholic Bishops on Handicapped People* (1978)

4. See *Caring for Health in Ireland*

5. See United States Conference of Catholic Bishops, *The Many Faces of AIDS: A Gospel Response* (1987); See also, Enda MacDonagh, 'Theology in a time of AIDS', Irish Theological Quarterly, 2 (1996); Suzanne Mulligan, *Confronting the Challenge: Poverty, Gender and HIV in South Africa*; Oxford: Peter Lang, 2010.

6. Consent involves a free decision on the part of a person who can understand clearly what is being proposed. Assent (or agreement) is an affirmative response of a person who, though not necessarily competent to give consent in his or her own case, would normally be invited to participate in an intervention rather than undergoing a procedure without any reference to him or her (cf. *Assisted Decision Making (Capacity) Act, 2015*, Section 8 (7a)).

7. See Mette Lebech, 'The Recognition of Human Dignity in the Person Living with Dementia,' in Enda McDonagh and Vincent McNamara (eds.) *An Irish Reader in Moral Theology*, Dublin: Columba Press, 2013.

8. Irish Catholic Bishops' Conference, *The Lord is Close to the Broken Hearted, Pastoral Letter for the Day of Life* (2008)

9. This code therefore must be read in conjunction with the latest guidelines of *The National Board for the Safeguarding Chidren in the Catholic Church* (*http://www.safeguarding.ie*) as well as recent legal developments in Ireland *http://www.tusla.ie/services/child-protection-welfare*) and *www.health-ni.gov.uk*

5. End of Life

Introduction

5.1 Healthcare practitioners are called upon to respect, love and care for patients and residents in care (and their families). They seek to give hope at a time when many people find it very hard to face the dependency, helplessness and discomfort which may accompany the process of dying. Catholic healthcare witnesses to the belief that God created each person for eternal life. Christians affirm that death is the end of life on earth and the beginning of an eternity of fuller personal life with God. Death is thus regarded with awe, profound respect, faith and hope.[1]

5.2 A patient who knows that his or her life is nearing its end, and in particular that an illness is likely to end in death, may need an increased level of support from family members, carers and healthcare practitioners. Those caring for the person must therefore seek to establish a relationship of trust, compassion and confidence with all those in their care, and, should thereby place their humanity, knowledge, experience and skill at the service of the dying person.

5.3 The use of life-sustaining technologies needs to be evaluated in the light of Christian beliefs about life, suffering, death and Resurrection. Since good medicine treats a person rather than a condition, respect for persons requires that they neither be under-treated nor over-treated; rather, when people are dying they should have access to the care that is appropriate to their condition. When we focus unduly on clinical outcomes, we risk overlooking the other real needs of the person. The fact that people die is not the only 'challenge' facing healthcare. Indeed, death is the natural outcome of every life. The far greater challenge, in many respects, is to ensure that each person is supported in living in a manner consistent with his or her intrinsic and enduring dignity until such time as death comes naturally. In so doing two extremes should be avoided: on the one hand, an insistence on futile and overly-burdensome treatments which provide little or no benefit to the patient, on the other hand, the deliberate withdrawal of treatment in order to bring about death.[2]

5.4 Patients' religious and other beliefs, especially those concerning suffering, dying and death, must be respected. When their patients' beliefs differ from their own, those caring for the patient should, in ways consistent with their own conscientious beliefs, endeavour to help their patients to find meaning in their dying (see also 1.16 and 1.17).

CARE FOR THE WHOLE PERSON

5.5 Patients nearing death are entitled to and will benefit greatly from measures designed to respect their personal dignity and privacy. They may need help not only with the many symptoms of illness such as pain and discomfort and its psychological sequelae such as anxiety, fear and distress, but also with its spiritual effects such as crises of faith, hope and love. Depression is often an unrecognised and untreated symptom of illness and practitioners should strive to relieve it by clinical and other means (see also 1.4). Vulnerable patients may need to be protected from pressures which lower their self-esteem or give rise to serious discouragement or despair.

PALLIATIVE CARE

5.6 Specialist palliative care is oriented to caring for, and accompanying, a dying person and his or her carers in the final phase of life, affirming that person's inherent dignity and respecting his or her spiritual, physical, emotional and social needs. It also encompasses care for the bereaved family and others. Though it is integral to all healthcare, the relief of symptoms has a special place in the care and support offered to people with advanced and inevitably progressive disease.

5.7 Catholic hospitals should develop this area of healthcare, by advancing knowledge of palliative medicine, by perfecting the skills involved in the provision of good palliative care, by educating healthcare practitioners, and by organising their resources to ensure that all patients have access to first-class palliative care.[3]

PASTORAL CARE

5.8 The work of Catholic healthcare facilities is illuminated by hope in the Resurrection. It should, therefore, be distinguished by the quality and accessibility of the pastoral care offered to the dying person and to his or her close family and friends. A supportive context in which the dying person has the opportunity to find meaning in death should be provided.[4] Healthcare practitioners in all healthcare facilities must be alert to the particular religious needs of the dying person and be ready to link the person with his or her clergy and community, where this is appropriate. Offers of pastoral care to those who are not currently practising any religion, including non-practising Catholics, should be made with sensitivity but also with confidence. In the case of non-practising Catholic patients, reconciliation with the Church and reception of the sacraments may prove not only possible but deeply welcome.

WITHDRAWAL OR WITHHOLDING OF TREATMENT: GROUNDS FOR THE DECISION

5.9 Decisions about life-sustaining treatments for patients who are terminally ill raise two sorts of challenge: which treatments should be recommended and who should be involved in the decision making process. The fundamental ethical principle in this regard is that treatments may legitimately be forgone (withheld or withdrawn) if they are therapeutically futile, overly-burdensome to the patient or not reasonably available without disproportionate hardship to the patient, carers or others (see also 1.12-1.14).[5]

5.10 Artificial means of life support (including dialysis and ventilation) are often appropriate. Cases do arise, however, in which patients judge the burden of using a life support, to themselves and/or to others to be very grave. If so, a decision to withdraw a complex means of life support may be justified.

5.11 Likewise, the decision not to initiate a form of treatment (e.g. some forms of resuscitation) would be justified if the burden of treatment would be disproportionate to its expected therapeutic benefits or if it would involve an unreasonable burden on the patient (in particular on a frail, elderly or dying patient). Healthcare facilities should draw up protocols for the use of resuscitation and ensure that these protocols are well known by their staff and patients.

5.12 Continuing to care for a patient is a fundamental way of respecting and remaining in solidarity with that person. When treatments are withheld or withdrawn because they are therapeutically futile or overly-burdensome, basic care in its various forms, such as appropriate feeding, hydration and treatment of infection, comfort care and hygiene must be continued. Nutrition and hydration, whether delivered ‘naturally’ or ‘artificially’ should always be provided to patients unless they cannot be assimilated by a person’s body, they do not sustain life, or their only mode of delivery imposes grave burdens on the patient.[6] It should not be assumed that patients who are capable of receiving nutrition and hydration 'naturally' always have the capacity to feed themselves and, where this capacity is lacking, they should be assisted. The treatment of infection should be continued unless it becomes overly burdensome in the circumstances of the particular patient (see also 1.12-1.14).

WITHDRAWAL OR WITHHOLDING OF TREATMENT: THE DECISION-MAKING PROCESS

5.13 Patients and residents in care should be encouraged while they are still competent to discuss their hopes for, and fears of, treatment options with their families, their doctors and other relevant people. They should be informed of their right to appoint someone to make decisions about, or share in decision-making about their healthcare should they become unable to make their own decisions.

5.14 Because physical or mental illness may impair a person's decision making capacity, it will sometimes be necessary to assess whether a patient or resident is competent to make decisions about life-prolonging treatment, or indeed any form of treatment (see also 1.4).

5.15 In the case of a *competent* patient or resident, a decision to withhold or withdraw a treatment normally requires that the responsible doctor discusses the matter with the patient and establishes that he or she is informed appropriately why the treatment in question would be therapeutically futile.

5.16 In the case of an *incompetent* patient, a decision to withhold or withdraw a treatment must only be made after the responsible doctor has judged that the treatment would be therapeutically futile or overly-burdensome. There should be discussion between the responsible doctor, the family, any legal guardian or representative and others relevant to the care of the patient. In particular, proper account should be taken of:

a) any information about what the patient would have wanted (if anything is genuinely known about that),
b) any signs as to what the patient in fact wants now,
c) any relevant authority required by law.

In taking account of (a) to (c) above the responsible doctor should decline to take into account any proposition which presupposes that the *life* of the incompetent person, as distinct from the *treatment* being provided to the incompetent person, is futile.[7]

5.17 Treatment decisions should be communicated and explained to nursing and allied staff. The family and relevant others should be given opportunities for discussion and pastoral care. Sensitivity must always be shown towards the religious and cultural background of patients and residents, especially when it is proposed that a treatment be withdrawn or withheld.

5.18 Treatment decisions (including decisions to limit, withdraw or withhold a treatment) must be documented in the patient's record. Documentation should include a brief statement of reasons for the decision, together with a note on the consultation process. These decisions should be reviewed regularly and in response to any significant change in the patient's condition or at the request of the patient, family or relevant others.

PROFESSIONAL ACCOUNTABILITY

5.19 While the ultimate responsibility for decisions about a patient's treatment usually lies with the patient, in consultation with his or her medical practitioner, all those involved in the care of the patient should be given the opportunity to make their own professional contribution to these decisions and should be held accountable for their own practice. With due regard for the privacy of the patient, they have a right to appropriate information about the rationale for a particular intervention they are asked to perform, or for the withholding or withdrawing of a particular form of care they are asked to undertake, and they in turn have an obligation to provide the medical practitioner and others involved in the care of the patient with relevant information.

EUTHANASIA/ ASSISTED SUICIDE

5.20 Euthanasia means any action or omission by a third party healthcare practitioner to cause the death of a patient.[8] In relation to the mental state of the patient, euthanasia may be said to be accomplished voluntarily (with the consent of the patient), non-voluntarily (when the patient is unable to consent) or involuntarily (when the patient has the capacity to consent, but does not do so, either because he or she does not want to die, or because he or she was not asked). Examples of euthanasia include administering deliberate overdoses of otherwise appropriate medications, and the unjustified withholding or withdrawing life-sustaining forms of care. It is never permissible to deliberately end a person's life, or to participate formally in such an act, whether on the part of another practitioner or on the part of the patient himself or herself (i.e., assisted suicide, see also 8.7-8.9). Euthanasia is to be clearly distinguished from care decisions which sometimes carry the risk or have the side-effect of shortening life but which are not intended to hasten death (e.g. the giving of appropriate pain relief, the withdrawal of burdensome treatments).[9] Advances in palliative care are now such that the control of pain should not normally lead to side effects such as loss of lucidity or consciousness or to the shortening of life.

DEATH

5.21 Since death is of significant spiritual and legal importance (for instance, prayers for the dying are replaced with prayers for the dead, and organs may be made available for donation to others), it is crucial that judgements about the determination of death can be made with confidence and accuracy.[10] The death of a human being consists in the total disintegration of that unitary and integrated whole that is the personal self. Although death is an event which cannot be directly identified, biological signs or 'clinical markers' that inevitably follow can be recognised with increasing precision. These clinical markers indicate the irreversible loss of the integrated and coordinated life of the person as a single living organism.

CLINICAL MARKERS OF DEATH

5.22 In current Irish medical practice and legislation, a person is said to be dead when there is either irreversible cessation of the circulation of the blood or irreversible cessation of all function of the brain (so-called 'brain death'). Generally death is determined by the irreversible loss of cardio-respiratory function. However, modern medical technology can circumvent the need for normal cardio-respiratory function. It has thus become necessary to recognise that in the absence of all brain function it is impossible for a person to live as an integrated and coordinated organism. Total and irreversible loss of all brain function, accompanied by an evident cause, is thus, at the present time, a valid medical criterion of death.[11] It is not, however a 'definition' of death.[12]

5.23 Pressures to change the way death is determined from the loss of *all* brain function to the loss of *some* brain function should be resisted. Rather, Catholic hospitals should lead the way in trying to perfect the diagnostic criteria for death.

5.24 There is no obligation on healthcare professionals to maintain biological life by mechanical means when it is clear that the patient is clinically dead.

In most cases it is an affront to the dignity of the patient to do so, unless there is a higher good to be achieved (e.g. the possibility of donation for transplantation purposes). In such cases the better decision is to let someone die naturally, surrounded by care.

Respect for the Deceased, for Families and for Relevant Others

5.25 Appropriate professional services and support should be provided not only to patients, but also to their families, care givers and others. This includes support through the period of dying, grief and bereavement. After death has occurred, the body of the deceased must be tended with care, reverence and in accordance with the religious beliefs and expressed desires of the deceased.[13]

Post-mortem Examination

5.26 Information gained from even a limited post-mortem examination may be valuable for both the family and friends of the deceased person and the wider society. Benefits may include accurate analysis of a pathology, identification of the medical cause of death, knowledge of a poorly understood disease, the evaluation of new medical therapies and techniques, as well as provision of a factual basis for counselling those concerned about any anxieties they may have about the death. Where a post-mortem is required by law, information about the reasons for the post-mortem, the procedures involved and any tissue to be retained for coronial purposes should be made available to the next-of-kin and relevant others. If the post-mortem is not legally required and has not been authorised by the deceased, the consent of the next-of-kin must be sought if they are available before even a limited post-mortem is conducted or any tissue is retained for medical and scientific research and educational purposes (see also 3.23).

5.27 When tissue or organs are retained for post-mortem or research purposes, clear protocols must be established regarding the ultimate timing and manner of disposal of what remain elements of the body of a person. These protocols should be explained to family members and followed with care and reverence.

1. Pope St John Paul II, *Redemptor Hominis* (1979), 18; See also *Congregation for the Doctrine of the Faith*, 'Letter concerning certain questions of eschatology,' (1979)
2. Cf. *New Charter for Health Care Workers*, 144-149
3. See *Catechism of the Catholic Church*, 2279; COMECE (Secretariat of the Commission of the Bishops' Conferences of the European Community), *Opinion of the Working Group in Ethics in Research and Medicine on Paliative Care in the European Union*, Brussells, 2016.
4. See Catholic Bishops' Conference of England and Wales, *A Practical Guide to the Spiritual Care of the Dying Person,* London: Catholic Truth Society, 2010.
5. *Evangelium Vitae*, 65; *Declaration on Euthanasia*, section IV
6. See United States Conference of Catholic Bishops, *Nutrition and Hydration: Moral and Pastoral Reflections* (1992)
7. In considering what is required by law, the healthcare facility or individual practitioner may have to confront the legal implications of the 1996 *Ward of Court* case. This raises the issue of co-operation in an immoral act and also the operational freedom of the religious institution to act in accordance with its ethos. Historically the basis for decision-making in the case of an *incompetent* patient was the *best interests* standard with input from family, focused on whether there was any prior expression of preferences that would contribute to this. The *Convention on the Rights of Persons with Disabilities* now places primacy on the prior expression of preferences on the part of the incapacitated individual. Where this is not known, a proxy decision-maker may make a substitute decision based on what he or she thinks the person would have wanted. The *best interests* principle (i.e., the attempt to establish what represents the objective good of the person here and now) is therefore supplanted by wishes or preferences that may have been expressed in the past. The UN Committee on the Rights of Persons with Disabilities, in its *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities,* adopted in September 2015 states: 'The Committee has also called for States parties to ensure that persons with disabilities are not denied the right to exercise their legal capacity on the basis of a third party's analysis of their "best interests", and that when after significant efforts have been made it is impracticable to determine a person's will and preferences, practices associated with 'best interests' determinations should be replaced by the standard of 'best interpretation of the will and preferences' of the person.' Adopted September 2015, this approach is reflected in recent Irish legislation. See Irish Statute Book, *Assisted Decision-Making (Capacity) Act, 2015*. This shift of emphasis, has the economic,

ethical and, indeed, emotional disadvantage that family members who could and would provide appropriate care for an incapacitated person, may not now be asked or encouraged to do so.

8. *Evangelium Vitae,* 64-66; See also Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*

9. *Evangelium Vitae,* 65; *Declaration on Euthanasia*, section IV.

10. Pius XII, *The Prolongation of Life: Address to an International Congress of Anesthesioloigsts* (24 November 1957)

11. See Pontifical Academy of Sciences, *Report on Prolonging Life and Determining Death* (1985).

12. What we now consider to be clinical markers of death began, in many cases, as clinical indicators that further treatment, as distinct from care, would be futile, because the process of death had already begun. See T. Iglesias, 'Death, The Beginning of Life, and Human Embodiment' in *The Dignity of the Individual: Issues in Bioethics and the Law,* Dublin: Plemora Press, 2001. Cf. *New Charter for Health Care Workers,* 115-116.

13. *Catechism of the Catholic Church*, 2300

6. Research

INTRODUCTION

6.1 Research may be defined as any systematic activity undertaken for the purpose of gaining new knowledge, understanding or insight or confirming current knowledge.[1] Catholic healthcare affirms and promotes the value of research, recognising that new knowledge, when it is used ethically, is good and may often have the potential for application in new therapeutic options.[2] Research into healthcare policy and bioethics, underpinned by the mission and values of Catholic healthcare, has the potential to contribute to the development of a compassionate and equitable healthcare system (see also 6.19). Those Catholic services in a position to do so should give special attention to research of particular relevance to Catholic teachings, for example, in relation to palliative care, fertility and infertility, and genetic interventions which respect the marital context of human conception (see also 2.1).

6.2 Research differs from *clinical practice* in that the primary purpose of research is to gain knowledge, whereas the primary purpose of clinical practice is to benefit the patient, whether by diagnosis, cure, stabilisation or palliation, etc. It is also important to distinguish between research which is *therapeutic*, that is, conducted with the intention of providing a direct clinical benefit to the participant along with the gaining of knowledge, and research which is *non-therapeutic,* that is, conducted not with the intention of providing a direct benefit to the participant but rather with the intention of gaining information that may in time benefit others.

6.3 Research in Catholic facilities should meet all professional, scientific and legal requirements as determined by appropriate bodies. Relevant guidelines, for example those derived from privacy and data-protection legislation and those of the Health Research Board, should be taken into account.

RESEARCH INVOLVING HUMANS

6.4 Research involving human persons must always both respect the personal dignity of the research participant and be consistent with the common good.[3] Good research will never pose an unreasonable risk to a person’s life, sanity or health. However, a person who understands the extent of the risks involved may choose to accept some risk, discomfort or inconvenience in order to contribute to developments in medicine and thereby contribute to the common good.

CONSENT

6.5 Research depends upon a partnership between participants and researchers with a view to meeting the needs of future beneficiaries. Researchers must, therefore, seek the adequately informed and freely given consent of potential research subjects. Each person must be informed of the risks and benefits involved in participating in the research. Participants must also be informed that they are free to withdraw at any time. Researchers, in particular those conducting clinical trials, have a responsibility to ensure that participants understand they are enrolled in a research project. Reimbursements should not be so large as to become unwarranted inducements. Where it is proposed that epidemiological or retrospective studies will use identifying data, the consent of participants should be obtained, in accordance with the policy of the healthcare facility involved.

VULNERABLE PARTICIPANTS

6.6 In the case of any person, or group of people who may be particularly vulnerable (such as incompetent participants, children, people with mild intellectual impairment, those highly dependent on medical care, the poor and people who are institutionalised), in addition to the consent mentioned in 6.5 above, there is a more stringent requirement to ensure that benefits justify risks. Research involving vulnerable people may only be undertaken when the knowledge to be obtained is sufficiently important to warrant involving such vulnerable people and this knowledge cannot be obtained by other means.[4] The research method must be designed to meet the specific needs of the particular participants with their best interests being paramount. The involvement of vulnerable participants in non-therapeutic experimentation is only acceptable if a direct benefit to them can reasonably be anticipated. Cross-checking by an independent healthcare professional should be used to ensure that the interests of the researcher do not obscure an objective judgement as to the importance of the research for healthcare.

6.7 When a potential research participant is in a dependent position in relation to the researcher, for example, as the patient of a doctor- researcher, there is need for extra diligence in the obtaining of consent to ensure that the patient can distinguish between the procedures of the research project and those needed for his or her care. Patients must be assured that their healthcare needs will be met, without discrimination, even if they choose not to participate in, or to withdraw from, a research project. Likewise subordinate staff, prisoners, students and others must be assured that they will not lose any entitlements if they choose not to participate in, or to withdraw from, a research project.

INCOMPETENT PARTICIPANTS

6.8 Consent for participation in a research project by an incompetent person is to be sought from the person who has legal responsibility for his or her medical treatment decisions. In these matters the person responsible and the researcher are to be guided by what is known of the participant's wishes and by what is judged to be in his or her best interests. In practice, unless the research is therapeutic, it is very difficult to see how it can be in the 'best interests of the patient'. It is possible, however, that research with minimal risk, for which the participation of competent patients would not be suitable, might be beneficial to a particular category of patients and could perhaps be permitted.

RESEARCH DESIGN AND METHODOLOGY

6.9 All reasonable precautions must be undertaken to minimise the potential harm to participants. Where appropriate, prior experimentation with non-living models and animals should be undertaken to determine possible harmful effects of the trial (re animal research see also 6.22 below).

6.10 To be ethically acceptable, research must also be scientifically sound. If the research project fails to provide its expected benefits, a new consent must be sought from the participants or the research discontinued. In the event that the research unexpectedly harms participants, it should be discontinued until such time as it is clear that the cause of the harm has been identified and removed. Researchers must provide participants with any new information about the risks of participation.

6.11 Patients may choose to forego standard treatments which offer little or no benefit in order to receive experimental treatments. However, patients must never be denied access to standard or accepted forms of treatment. The use of placebos, or non-treatment control groups, is acceptable only if they are necessary for the purposes of the research, do not deprive the patient of available, beneficial and needed standard treatment, and do not place the patient at risk of harm. Participants must be informed in advance of, and give their consent to, the possibility of receiving a placebo.

DONATION OF BODY FOR RESEARCH AND TEACHING

6.12 Some research and some teaching of healthcare practitioners requires the use of cadaveric tissue. The use of such tissue is permissible, where necessary and other than when required by law for autopsy, if the use is in accordance with the prior expressed wishes of the deceased person or when the consent of the family or other authorised person has been obtained.

6.13 Particular care should be taken regarding the storage of human blood and tissue samples and also the raw data of research, especially if storage is to take place outside the state. Taking into account the limitations already imposed by the law, a healthcare facility, through its ethics committee, must set enforceable regulations regarding the length of time that biological material and data can be stored and also regarding the protocols to be followed for obtaining the renewal of consent, in the event that further research is proposed which is not covered by the original consent.

6.14 Arrangements should be made, in keeping with the last will and testament of the deceased, for the return of the bodily remains to the next of kin for interment or cremation, when no longer required for research.

RESEARCH INVOLVING HUMAN EMBRYOS AND FOETUSES

6.15 Non-therapeutic biomedical research, which is the fruit of a therapeutic intervention, involving live embryos or foetuses may only be undertaken *in vivo* (within the body) and when there is a moral certainty of causing no harm to the life or the integrity of the embryo or the foetus, including long-term health subsequent to birth. The informed consent of the mother must be sought prior to any research. Best practice would also be to consult the father assuming that, under the circumstances, this is appropriate.[5]

6.16 When embryos and foetuses die, they are to be given the same respect as is due to every human being who dies. Researchers may undertake an autopsy, or other forms of research, with the consent of the parents. Research is never to be undertaken on an embryo or foetus, or on tissue from an embryo or foetus, that has been procured through deliberate abortion. This is partly because the possibility of research may be used to justify abortion which is in itself unethical. Such research and its results, however 'useful', are morally contaminated by their association with the act of abortion. There is a responsibility on researchers, in so far as practically possible, to establish the source of research material. Neither is it ever permissible to produce embryos for research purposes or use embryos discarded from IVF programmes for research purposes. Such research is a grave violation of the human dignity of these embryos and morally illicit, nothwithstanding laws which may permit it.[6]

GENETIC RESEARCH

6.17 Research in genetic and molecular science is yielding new knowledge which often has diagnostic and therapeutic potential.[7] Such research must always be pursued in ways which respect both the fundamental dignity of each human person in his or her uniqueness and the common genetic heritage of the human community.[8] Research may never be premised upon the assumption that a person is wholly reducible to, or determined by, his or her genes. Furthermore, knowledge of the human organism, as distinct from applications of that knowledge, must never be treated as the commercial property of individuals or organisations. Human cell lines should not be the subject of patenting. In the event that therapeutic benefits are available as a result of research involving patients in need of treatment, those patients have a right to have first call on the new therapy. One very obvious example of this is the need for retroviral drugs to be economically accessible to people with HIV in developing countries.

6.18 Genetic information may have particular significance to the participant and his or her family (see also 1.10, 1.23 and 1.24). Special protocols may be needed to ensure the appropriate counselling of participants and the confidentiality of records containing genetic information, including family pedigrees.

6.19 Genetic research must not be undertaken with a view to changing either the fundamental human nature or the unique identity of an individual person. Rather, research should be directed to applications of diagnostic or therapeutic value.[9] Researchers should seek to avoid contributing to the use of genetic information in a way which stigmatises or unjustly discriminates against certain people. Researchers in Catholic facilities should be prepared to explore possibilities which give witness to a respect for human embryos and the human genome.

6.20 Genetic research must not involve any techniques that may lead to the asexual creation or reproduction of human embryos or other eventualities that are contrary to respect for human life or human dignity. These techniques currently include: producing, damaging or dismembering a human embryo to remove stem cells or to ensure its truncated development; the creation of artificial gametes from somatic cells, producing totipotent cells which (without the addition of other genetic material) may be capable of human embryogenesis; introducing the whole or parts of the human genome into animal gametes; forming a chimera with or to create a human embryo; and animal gestation of human embryos.

HEALTH ETHICS RESEARCH

6.21 Catholic healthcare professionals, through their ethical reflection, can make a distinctive contribution, which extends beyond the ethical regulation of clinical practice and medical research, to an enrichment of the ethos of healthcare itself. Catholic healthcare facilities should actively encourage ethical research and education in ethics. By so doing they can also contribute to the development of social doctrine within the Catholic tradition.

ANIMAL RESEARCH

6.22 Animals must, at all times, be treated with the respect due to them as creatures of God. Research may be conducted on animals only when non-living subjects or experimental models cannot be used to obtain the necessary information. Reasonable care must be taken and needless suffering prevented. Any such research in Catholic facilities should meet all relevant ethical, scientific and legal requirements as determined by the appropriate bodies.

RESEARCH ETHICS COMMITTEES

6.23 Research involving human or animal subjects must have the approval of research ethics committee, duly constituted under the law. Several facilities may contribute to the formation of a combined research committee to ensure the relevant expertise. The responsibility of the committee is to ensure that the interests of potential research participants are protected, to ensure that the research is ethically sound, and to audit the scientific, social, and legal validity of the research.[10]

6.24 The membership of a Research Ethics Committee should include experts in all the related disciplines, (research, the appropriate sciences that inform the research, healthcare, moral theology and/or philosophy and the law), together with independent members of the community. The interests of potential research participant groups should also be effectively represented. The independence of the committee should be ensured, for example, by including a sufficient number of members not employed by the healthcare institution. Any conflicts of interest must be declared, and researchers should never be involved in the approval of their own projects.

6.25 Research Ethics Committees established under the EU clinical trials directive are authorised to provide a single ethical opinion which is taken as valid across a wide range of hospitals and healthcare facilities. The existence of such ethical opinions coming from outside an institution does not diminish the right, or indeed the responsibility, of healthcare professionals to satisfy themselves that the research in which they are involved is ethical and, in the case of Catholic healthcare facilities, consistent with the Catholic ethos of the institution.

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1. *Gaudium et Spes*, 35; *Donum Vitae*, 1-4
2. *Catechism of the Catholic Church*, 2292; cf. New *Charter for Health Care Workers*, 99-105
3. See World Medical Assocation, *Declaration of Helsinki: Ethical Principles for Medical Research involving Human Subjects*, 7th rev. (2013)
4. *Catehicsm of the Catholic Church*, 2295; COMECE, *Ethical Assessment of Clinical trials on Medicinal Products: Respect and Protection of Vulnerable Persons and Populations,* Brussels, 2013
5. Cf. National Consent Advisory Group, *National Consent Policy.* Dublin: HSE, 2015, Part 3
6. *Evangelium Vitae*, 63; *Donum Vitae*, 1-5, *Dignitas Personae*
7. For consideration of newly opening fields of synthetic biology, see COMECE, *Opinion of the Reflection Group on Bioethics on Synthetic Biology*, Brussels, 2016
8. *Dignitatis Personae,* 24-35; United States Conference of Catholic Bishops, *Critical Decisions: Genetic Testing and its Implications* (1996)

9. See Maureen Junker Kenny, 'Genetic Enhancement as Care or Domination?' *Journal of Philosophy of Education*, 39 (1) 2005

10. See, Edward J Furton, Peter J. Cataldo, Albert S Moraczewski, *Catholic Health Care Ethics: A Manual for Practioners,* Washington: The National Catholic Bioethics Center, 2009, Part II.

7. Healthcare Institutions

CATHOLIC HEALTHCARE INSTITUTIONS AS COMMUNITIES OF SERVICE

7.1 The human person is an inherently social being for whom life in society, relationships with others, and collaboration in significant endeavours contribute to human fulfilment. While individual Catholic healthcare professionals may achieve much within their own spheres of activity, they can often achieve more when they unite their efforts with others under the auspices of a Catholic organisation and so become a distinctive 'community of service' to those in need. A Catholic healthcare institution or organisation is always more than the sum of its parts and has its own identity, mission, and 'institutional conscience', in addition to the identity, mission and conscience of its individual members.[1]

7.2 A healthcare organisation bearing the name 'Catholic' has a special responsibility to witness to the presence of Christ and to Catholic teachings about the value of human life and the dignity and destiny of the human person. Tangible signs of the Catholic identity of an organisation include: sponsorship, ownership, governance and/or management by the local church in the form of a Catholic trust or a religious congregation and/or recognition by the bishop of the diocese; priority given to pastoral care and mission integration; availability of the sacraments and the prominence of Christian symbols; acceptance of Catholic teachings and observance of canonical requirements. All who work in and for Catholic healthcare should be distinguished by the highest ethical standards.

7.3 It is widely accepted that healthcare professionals have the right to freedom of conscience.[2] This includes the right to refuse to participate in a procedure or administer a treatment which, in their professional opinion, is unethical or indeed which is simply not good medicine. We believe that healthcare administrators, as responsible persons, have a similar right of conscientious objection.

7.4 Catholic healthcare is offered to all who need it, in keeping with the spirit of the Gospel, irrespective of whether or not they adhere to the Catholic faith. It also recognises that some members of the staff of its healthcare institutions do not share the Catholic faith. It is a characteristic of Catholic healthcare that the different cultures and religious traditions of all whom it serves and of those who work within its organisations are respected and accepted to the extent that this is compatible with Gospel values. At times a Catholic healthcare institution may be faced with difficult prudential decisions when the beliefs of patients, staff members or other stakeholders differ from the ethical teaching of the Catholic Church. Catholic teaching on cooperation with others gives guidance about how to resolve complex questions in this regard (see Chapter 8).

CATHOLIC HEALTHCARE IN IRELAND

7.5 Public and private Catholic healthcare institutions have long been integral to the provision of healthcare services in Ireland. Both Church and State have benefitted from close co-operation over the years. Collaboration between providers has increased in recent years in an effort to use limited resources more effectively (e.g., with the National Treatment Purchase Fund). It is important, for the continuation of such co-operation, that public funding of voluntary healthcare is seen as an exercise in shared responsibility, rather than simply the State funding Catholic healthcare facilities.

7.6 As recipients of public funding, Catholic healthcare organisations must recognise their responsibility to use public monies wisely, effectively and accountably. There should always be a transparent use of public monies for publicly provided services (see also 7.23 and 7.24.)

ISSUES OF GOVERNANCE AND INSTITUTIONAL RESPONSIBILITY

7.7 Until recently institutional Catholic healthcare was chiefly the responsibility of women and men religious. This ministry is now being assumed by lay people, for whom the small remaining numbers of dedicated religious sisters, brothers and priests are still a significant inspiration. When employing staff, particularly in executive positions, Catholic healthcare organisations must ensure that those employed are familiar with and supportive of this *Code of Ethical Standards*. This is in keeping with the provisions of the EU Council Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation.[3]

7.8 As a moral community, a Catholic healthcare organisation must always address the ethical dimension of decisions related to governance, management and administrative policy, and strive for effective communication and consultation with its staff. As an occupational community, a Catholic healthcare organisation should provide its employees with a context in which they can find personal and professional fulfilment and a means of earning a living. Staff are to be treated with respect and justice, and there should be mutual accountability between the organisation (represented by the board, executive and administration) and those who work in it.

7.9 There are various forms of governance and management in Catholic healthcare institutions in Ireland today. Where the ministry of a diocese or religious congregation has been incorporated as a limited company, the board of that company is to act in accordance with its mandate from the diocese or congregation. Owners and sponsors should seriously consider the long-term strategies and management policies established by their boards. Board members and executives should attend to the ethical dimensions of all board decisions, especially in financial considerations, and in setting policies and priorities. To this end competent ethical advice must be sought.

COLLABORATIVE RELATIONSHIPS

7.10 Collaboration and/or integration with another healthcare provider may be necessary or desirable if a particular institution is to continue or extend its ministry. The development of collaborative ventures should involve the owners and sponsors of the Catholic institution, along with the advice of Catholic ethicists and consultation with the diocesan bishop.

7.11 Catholic institutions should, in the first instance, seek collaborative relationships with other Catholic institutions and agencies. If such a relationship is not possible or appropriate to the need, Catholic institutions may wish to look to forming partnerships with other church or 'community benefit' ('not for profit') organisations and institutions, or with publicly funded health services.

7.12 When there is a question of collaboration with an organisation whose identity, history, sponsorship and mission are markedly different from that of the Catholic entity, contracting for specific services, rather than entering into commercial arrangements such as alliances or joint management, may often provide a more appropriate model. Care must always be taken to ensure that arrangements deriving from contracts with other parties are in accord with Catholic moral and social teachings.

7.13 In some cases, independent healthcare practitioners, consultants, groups and companies may be attached to, or may operate under the auspices of, a Catholic institution or organisation. To the extent that their practice and presence is identified as part of, or as linked with, the Catholic entity, these practitioners, groups and companies should agree to abide by this *Code of Ethical Standards.*

7.14 Every proposal to enter into a collaborative relationship with a non-Catholic provider must be closely evaluated to ensure that it would not compromise the identity, the mission or the ethical standards of the Catholic institution.[4] Indeed, the collaborative relationship should enhance the Catholic healthcare apostolate, furthering the provision of healthcare for the community, and ensuring the responsible stewardship of resources. The collaborative arrangements must not involve the Catholic institution in 'formal cooperation', nor in unjustified 'material cooperation', with activities contrary to Catholic teaching.[5] (See also Chapter 8)

7.15 In some instances the changed circumstances of healthcare delivery and/or the lack of suitable partners may require a Catholic entity to reassess its involvement in some or all aspects of its existing apostolate, and even to withdraw from those aspects which cannot be undertaken in keeping with the standards of Catholic healthcare. The diocesan bishop must be consulted in relation to these issues.

PASTORAL AND SPIRITUAL CARE

7.16 Catholic healthcare affirms that spiritual care is integral to the healing process. Pastoral care services must ensure that patients and clients are given the opportunity to reflect on and to engage with the spiritual and emotional dimensions of their healthcare needs, and to renew or reaffirm their religious beliefs (cf. 5.8).

7.17 Pastoral support is of crucial importance in the context of both aged care and palliative care. The shorter length of stay within many healthcare institutions means that the pastoral care of sick people is now often the responsibility of parishes and local communities, as it has long been in the case of the elderly. Where practicable, Catholic healthcare institutions should support this development by collaborating with parish and community based carers. They should also provide pastoral visits, counselling, group prayer, and opportunities for celebrating the sacraments and other religious rites within the institution.

CARE OF STAFF

7.18 Catholic healthcare institutions must be marked by a spirit of mutual respect and support among staff members, which promotes the healing and well-being of the whole person. Staff at all levels should be offered appropriate education and formation in the culture and traditions of Catholic healthcare. Student practitioners, in particular, should be able to draw upon the experience and wisdom of their teachers. Healthcare educators, in their turn, should ensure that students are treated justly and that their insights and contributions are respected.

7.19 No staff member may be required to participate in an activity that in conscience the person considers to be wrong. A Catholic organisation must ensure that conscientious objection may be exercised without threat of penalty. The exercise of conscientious objection should never put the person receiving care at risk of unjust harm or abandonment, nor conflict with the ethical standards of the Catholic organisation (cf. 8.19).

7.20 There may be genuine reasons, under the heading of occupational health, which would lead a staff member to opt out of treating patients with certain conditions. These reasons should be carefully considered and arbitrated on as appropriate, by management.

7.21 While protecting the Catholic identity of an institution or organisation (see also 7.16) and the requirements for individual positions, there must be no unjust discrimination in employment decisions. All staff are entitled to just remuneration. Workers must be treated as persons and never as mere commodities. The rights and responsibilities of staff who belong to trade unions should be respected.[6]

7.22 Boards and executives are responsible for ensuring staff have a safe working environment, and that staff concerns are heard and justly acted upon. Employers should recognise the right of employees to form associations to engage in collective bargaining, to provide various benefits for their members and to work for a better society. All members of healthcare organisations should take a collaborative approach to relations between unions and administration.

7.23 Respect for individuals and their participation in decision making requires that Catholic organisations develop guidelines for situations in which it becomes necessary to dismiss workers or reduce staff numbers. This implies consultation with those affected, examination of alternatives, open communication, and a willingness to honour the special needs of individuals. Staff retrenchment should be a last resort. Employees who are not members of a union should not be treated differently from those who are. Similarly, staff who are made redundant because of structural changes must receive their statutory entitlements and should not be treated differently from those who leave voluntarily. Staff who are dismissed with cause should be treated with compassion and respect.

FINANCIAL CONSIDERATIONS

7.24 Many Catholic healthcare organisations need to generate a reasonable surplus in order to fulfil their total mission, which includes caring for those who are unable to pay for services, providing services which may not, in themselves, be financially viable, and supporting sponsoring bodies, including their retired members. The pursuit of a surplus should never compromise quality of care nor the mission to those in need. To this end, Catholic institutions and services should be able to demonstrate the various social benefits they are providing to the community.

7.25 Transactions with third parties, including suppliers, contractors and funding bodies, must be conducted justly. The investment of an organisation's funds is to be consistent with the mission and values of a Catholic organisation. Referral of persons by a healthcare professional to facilities in which the referring professional has a financial investment is, in so far as it involves a conflict of interest, generally unethical.

ETHICAL REVIEW AND FORMATION

7.26 Catholic organisations must ensure that those with management responsibility reflect on the ethical and Christian dimensions of their work. This may be done through special seminars or as a routine part of a regular business agenda. Clinicians and other healthcare professionals should also be encouraged to participate in continuing education in the ethical aspects of their work.[7] Participation in such education might appropriately be an integral part of the career plan within a Catholic Healthcare organisation. It is imperative that board members regularly reflect on the mission and values of their organisation and on their implication for policy and priorities.

7.27 Catholic healthcare facilities must have, or have access to, the expertise of Catholic ethicists and/or a clinical ethics committee.[8] Such committees need a sufficient number of competent and independent members to ensure freedom of discussion and objectivity of their judgments, their ability to make suggestions on behalf of patients and staff, to advise governing boards on the ethics of proposed and current clinical practices, and to assist with the professional development of staff in relation to ethics and Catholic teaching.

7.28 Consultation with clinical ethicists should be at the invitation of a patient, the patient's representative(s) or a clinician. Referral of particular cases to ethics committees should respect patient privacy and professional privilege and not identify particular patients. Advice given by ethics committees in response to particular cases should be in terms of general protocols applicable to like cases and in terms of the ethical principles relevant to them.

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1. Although it is sometimes contested, we note the authority of European human rights decisions in support of the principle that institutions may hold ethical positions. Cf. Resolution 176 of 2010 of the Parliamentary Assembly of the Council of Europe, also various decisions of the European Court of Human Rights.

2. Freedom of Conscience as a fundamental human right, see *UNDHR*, Art. 18; *European Convention on Human Rights* (1950), Art. 9.1; *Charter of Fundamental Rights of the European Union*, (2009) Art. 10; Bunreacht na hÉireann (1937), Art. 44.2.1. *Evangelium Vitae*, 74 states: 'To refuse to take part in committing an injustice is not only a moral duty; it is also a basic human right … What is at stake therefore is an essential right which, precisely as such, should be acknowledged and protected by civil law. In this sense, the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-care personnel, and directors of hospitals, clinics and convalescent facilities. Those who have recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane.'

3. *Council Directive 2000/78/EC of 27 November 2000,* Art. 4.2.

4. Peter J. Cataldo, ‘Models of Health Care Collaboration’ in Edward J. Furton, Peter J. Cataldo and Albert S. Moraczewski, eds, *Catholic Health Care Ethics: A Manual for Practioners*, 2nd ed., Philadephia: The National Catholic Bioethics Center, 2009, 271-273

5. *Evangelium Vitae*, 74

6. See Pope St John Paul II, *Laborem Exercens* (1981), 9, 20

7. See C. Russell and D. O’Neill, ‘Ethicists and clinicians: the case for collaboration in the teaching of medical ethics,’ in *Irish Medical Journal*, January 2006.

8. Cf. New *Charter for Health Care Workers*, 140

8. Cooperation with Others

Introduction

8.1 For Catholic healthcare practitioners, institutions and organisations, collaboration with others and the sharing of resources provides an opportunity to extend their mission, to witness to their ethical commitments, and to promote the common good and a responsible stewardship of limited resources. At the same time, cooperative arrangements may pose challenges for the identity and mission of Catholic healthcare if the arrangements involve cooperation with those who endorse procedures or treatments which Catholic teaching holds to be wrong. As a result, Catholic healthcare organisations, and the individuals working within them, may face difficult decisions about the extent to which they should be involved in cooperative relationships with certain individuals, funding bodies, or governments.[1]

8.2 The executives and governing boards of Catholic healthcare facilities are answerable to the trustees where ethos is concerned. This includes a responsibility for ensuring that decisions about cooperation are made with due regard for the tradition of Catholic healthcare. Because of the complexity of these issues, the advice of Catholic ethicists should normally be sought before any such cooperative arrangement is considered. In the case of a significant alienation of property or substantial institutional cooperation, the appropriate permission or guidance of the Diocesan Bishop should be sought.

Respect for the Rule of Law

8.3 Every society depends for its coherent functioning and for the attainment and preservation of the common good, on the observance of the rule of law. 'The common good presupposes respect for the person as such. In the name of the common good, public authorities are bound to respect the fundamental and inalienable rights of the human person.'[2] As a basic principle, the presumption is always in favour of the law. In other words, in the event of any conflict between personal preference and the rule of law, the law must be obeyed. If a particular law conflicts with the fundamental and inalienable rights of the human person, however, it conflicts with the common good and with reason and does not command obedience.

Healthcare practitioners, in so far as they are engaged on a daily basis in matters of life and death, are sometimes challenged at the level of personal conscience by the fact that public policy gives rise to laws which, by seeking to enhance the autonomy of individuals or to vindicate lesser rights, permit or even require actions which conflict with the fundamental human rights.

The Universal Declaration of Human Rights recognises a fundamental right to freedom of conscience and, in the same article, to freedom of religion, which includes not only belief and worship, but observance.[3] Even in circumstances where the fundamental human rights are not at stake, the right of the healthcare practitioner to freedom of religion and personal conscience may be undermined by laws which require that he or she should perform a service for another person which though lawful, conflicts with his firmly held belief as to what is true and good.

We recognise that it may sometimes be very difficult for healthcare practitioners to operate within a publicly funded healthcare system while, at the same time acting consistently according to a mature judgement of personal conscience.[4]

IDENTIFYING ISSUES OF COOPERATION

8.4 The Church has a long-standing tradition of ethical reflection on the conditions under which cooperation with others is legitimate. Although different theologians have articulated this tradition in slightly different ways, their formulations have the common aim of explaining why, on some occasions at least, it may be permissible to cooperate with those whom one believes to be acting wrongly, but whose wrongful intention one does not share.

8.5 In the context of healthcare provision, questions of cooperation concern the extent to which individual practitioners, and those responsible for the identity and mission of a Catholic facility or service, may or should do something which facilitates conduct by another party which is not in accord with Catholic teaching or indeed with reason or sound ethical principles. Thus, for example, a question of whether it would be permissible to cooperate with others arises when one facility provides goods or services to another facility which then uses them to an unethical end.

8.6 One can, in practice, facilitate another's conduct either by a positive action or by a decision to refrain from doing something one could do to influence or prevent the other's conduct (e.g. by 'turning a blind eye' to a colleague's unethical practices that one ought to report to the appropriate authority). Some key questions here are: Is it one's intention to assist the other's wrongdoing, or is this assistance merely a side-effect of one's action? Does one's cooperation amount to an endorsement of the other's wrongdoing? How will one's participation be perceived or interpreted by the colleague or by others?

8.7 When morally evaluating actions which assist another's wrongdoing, it is essential firstly that one is able to distinguish one's own potentially cooperative action from the action of the other party. The object of one's own action - what he or she is doing - must not be unethical or wrong in itself, and must be distinct from what the other person is doing. The key question here is: 'What is the precise nature of my cooperative action or omission', or 'what is the intrinsic moral meaning of my proposed course of action?'

8.8 Having distinguished one's own action from that of the other party, one must then examine the way in which these actions are nonetheless cooperatively linked.

FORMAL COOPERATION IN WRONGDOING

8.9 On the basis of reflection on questions like these, the Church has come to distinguish between 'formal' and 'material' cooperation. Cooperation is *formal* if the intended 'object'(purpose) or 'end' (including the chosen means) of one's action is precisely to contribute to the other's wrongful conduct, or if one otherwise shares in the other party's 'bad will'. For example, if a Catholic facility refers patients to another facility *intending* that they undergo abortions there rather than on its own premises, such a referral would involve formal cooperation in abortion. Likewise, if a Catholic institution entered into a contractual arrangement with another party, with the intention of providing some services prohibited by Catholic teaching, such a contract would involve formal cooperation in the wrongdoing that is involved in providing those services. Formal cooperation in wrongdoing is never morally permissible.

8.10 Care must be taken to ensure that arrangements which are claimed to distance a Catholic provider from the provision of prohibited services do not implicitly involve *formal* cooperation. Sometimes there is no reasonable explanation for one's cooperation other than that one intends or endorses the other's wrongdoing.

MATERIAL COOPERATION IN WRONGDOING

8.11 *Material* cooperation in another's wrongdoing occurs when, although one's cooperative action is not unethical in itself, and although one does not intend to assist the wrongdoing of others, one's own behaviour does (foreseeably) have that side-effect. For example, if a nurse assisting in theatre becomes aware that the surgeon is carrying out a procedure with which she could not in conscience cooperate formally, she or he may not be in a position to cease her or his involvement, without placing the patient at grave risk. Likewise, if a medical practitioner gives a patient advice or information on the basis of which the patient makes decisions not in accord with Catholic teaching, this may involve material, rather than formal, cooperation.

8.12 For cooperation to be merely material, the cooperative action must not be wrong in itself and must not intend to aid the wrongdoing of the other party. However, the fact that cooperation is material, rather than formal, does not in and of itself mean that it is permissible. There must always be serious reasons to justify even material cooperation in someone else's wrongdoing.

DETERMINING WHETHER MATERIAL COOPERATION IS JUSTIFIED

8.13 In reaching a judgment on the question of whether material cooperation can be justified, the Principle of Proportionality will be of help. According to this principle, one's own cooperative act must not only not be wrong in itself, but the good which can reasonably be expected to flow from one's cooperation must be greater than the harm that will flow from it. One should consider carefully and objectively how important is the good one is pursuing and whether there are other ways of pursuing it; how serious are the evils to which one's cooperation would contribute, and the necessity and proximity of one's contribution to the success of the other's action; the foreseeable benefits and harms that would result from cooperating and from not cooperating, including any injustice one's cooperation would occasion.

8.14 Where there are foreseeable harms from material cooperation, Catholic healthcare facilities and professionals should always try to minimise those harms. The graver the foreseeable harms of cooperation, the more significant the morally permissible and expected benefits of the cooperation, or the expected harms of non-cooperation must be, if such cooperation is to be justified. While the expected benefits of material cooperation are often easy to identify, the harmful effects may be less apparent and so are noted below.

HARMFUL EFFECTS OF MATERIAL COOPERATION

8.15 The principal ill-effect of material cooperation in wrongdoing is that it facilitates someone else's wrongful conduct.[5] Catholic healthcare facilities and professionals should be reluctant to assist others, even materially, in any conduct which is contrary to sound ethics and the Christian gospel. Where possible, one should try to avoid or minimise this harm by persuading the other party not to engage in the wrongful activity, for example by proposing alternative options or, at least, suggesting taking time for further thought.

8.16 Another potential ill-effect of material cooperation in wrongdoing is on the cooperating person or facility itself. Despite not sharing the wrongful object(s) or bad will of the person with whom one is cooperating materially, there is a danger that one may become less sensitive to the wrongdoing, and may unjustifiably place such things as a desire to work well as a team, or a desire to succeed in one's joint projects, ahead of a concern for sound ethics and moral teaching. The normal way to minimise this risk is to examine one's own objects and motives carefully, to recommit oneself to the highest ethical standards, and to discourage the wrongful practice with which a person or group find themselves cooperating.

SCANDAL

8.17 The possibility of 'scandal'–both in the ordinary sense of that which causes people shock or dismay and especially in the theological sense of that which leads others to act wrongly[6]– is another harm that may result from cooperation. At times, the true nature of one's material cooperation may not be apparent to all, particularly to people outside the Catholic institution. As far as practicable, one should try to minimise scandal by explaining clearly to staff, patients, and the wider public the reasons for one's cooperation and why the proposed cooperation is permissible according to Catholic principles. Secrecy about legitimate cooperation is inappropriate. It may undermine the integrity of the institution and increase the risk of scandal if the cooperation becomes known and it is perceived that the institution tried to hide the practice. The diocesan bishop has the ultimate responsibility for judgments about such scandal in the context of the local church.

8.18 Material cooperation may also compromise one's ability to witness to certain values or principles. Catholic facilities and their professionals share in the Church's 'prophetic' calling to witness to the truth of the Gospel, and so they will be wary of doing anything which might compromise the mission of the facility or the Church more broadly. The reasons which would justify cooperation by institutions sponsored by the Church are usually required to be more stringent than they need to be in the case of individuals, since institutions have a higher public profile and a correspondingly greater prophetic responsibility. The best way to avoid compromising that witness is for the facility or individual to explain their basic commitments clearly and publicly, and to testify to them in ways which help to ensure there is no misunderstanding that they have lessened their commitment to those values.

CONSCIENTIOUS OBJECTION AND REFERRAL

8.19 The widely held presumption that healthcare personnel, who are unwilling on grounds of conscientious objection to provide a particular service, should be required to refer the patient to another healthcare professional who would not have the same conscientious objection is really only a way of pretending to respect freedom of conscience while actually requiring one person to cooperate in what he or she sincerely believes is the wrong-doing of another. Such a presumption is at variance with the right to conscientious objection.

The ethos of a healthcare institute has the character of an 'institutional conscience'. It contributes to the formation of policy and the making of judgements in a manner which is consistent with reason. The ethos of the institution guides the institution in identifying both its operational priorities and the activities in which it cannot participate with integrity (see also 7.1 & 7.3 above).

CASE STUDY

8.20 These principles may be illustrated by reflection on the following case of 'institutional cooperation', viz. when a Catholic facility's pathology service realises that on occasion the information it provides to its clients may be used by them to make decisions not in accord with Catholic teaching (e.g. information about a chromosomal abnormality which is used as the basis for a decision to seek an abortion). Because institutional cooperation is more complex than cooperation by individuals the discussion of this case can only be in general terms, which would need further specification depending on the precise circumstances. In this scenario, the relationships of clients to the Catholic facility may vary from their being patients in the Catholic facility to their being patients in another facility. Lastly, the contractual arrangements involved may be either between facilities or between individuals and facilities.

As in all cases of cooperation, moral evaluation proceeds in two stages: first, it must be established that the cooperation would not be formal; secondly, if the cooperation would be merely material, then the grounds for its justification must be seriously and honestly examined.

In establishing that the cooperation would not be formal at least four matters need to be clarified.

- First, the overall *purpose* of one's own service must be morally upright (e.g. to provide information to patients and their doctors that allow them to make informed and ethically sound decisions). When considering whether to provide pathology services for another facility, the nature of the procedures and treatments for which the services are to be provided will be crucial to determining whether a Catholic facility should be providing such a service.

- Secondly, the *tests* carried out by the Catholic facility must be medically appropriate and ethical in themselves (e.g. not tests which unjustly risk the life or health of the unborn).

- Thirdly, the Catholic facility must not conduct the test with a view to, or as a preliminary to, the immoral procedure (e.g. selective abortion), but simply for the purpose of a sound diagnosis relevant to an ethically sound treatment option.

- Fourthly, any immoral *use* to which the results of the test might be put must not be the object of the Catholic service (e.g. to profit from the provision of the prohibited services by others).

In determining whether material cooperation by a pathology service would be morally justified in a case like this, a number of issues need to be addressed:

- First, the morally permissible benefits (and prospective harms) of providing the service must be preferable to the benefits (and prospective harms) of not providing the service at all. For example, if a Catholic facility is the sole provider of pathology services in an isolated town, the non-provision of any services to other providers might seriously delay pathology results for all their patients.
- Secondly, the prospective harms of providing the service (including the likelihood of scandal to staff, patients and others) must be minimised.
- Thirdly, there should be no weakening of witness to Catholic moral teachings, and new ways of affirming Catholic witness should be found.
- Finally, strategies for staff formation and education, and for the communication of facility policies will usually be required in addressing these issues.

8.21 It is possible that in some situations the very nature of the proposed project is such that grave scandal is unavoidable. In such cases, the gravity of this consequence must be taken into account in assessing whether material cooperation would be justified. Likewise, the frequency with which contractual arrangements may involve material cooperation is obviously relevant to whether it is prudent to enter into those arrangements in the first place. Although cooperative relationships between facilities may distance the Catholic facility from prohibited procedures in the other facility, this distance may also limit the Catholic facility's ability to witness to its convictions and to prevent scandal occurring. Great prudence is necessary in the resolution of these difficult cases, and expert advice should always be sought.

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1. NCBC Ethicists, 'Cooperationg with Non-Catholic Partners,' in Edward J. Furton, Peter J. Cataldo and Albert S. Moraczewski, eds, *Catholic Health Care Ethics: A Manual for Practioners*, 2nd ed, Philadephia: The National Catholic Bioethics Center, 2009, 265-273.
2. *Catechism of the Catholic Church*, 1907.
3. See *UNDHR*, Article 18. 'Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom,

either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance'. See also *Gaudium et Spes*, 16

4. Donal Murray, *Morality, Conscience and Healthcare*, Dublin: Veritas, 2014; See also A.M. Mealy, 'The Bioethical Conscience,' in R. John Elford and D. Gareth Jones, eds. *A Tangled Web: Machine and Theology in Dialogue,* Oxford: Peter Lang, 2009, 73-85

5. *Evangelium Vitae*, 74

6. *Catechism of the Catholic Church*, 2284

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