



Humanum

ISSUES IN FAMILY, CULTURE & SCIENCE

2014 - ISSUE ONE

Beginning and End of Life





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In Memoriam: Stratford Caldecott (1953-2014)

ADRIAN WALKER

It is with great sadness that we note the passing of this journal's Founding Editor, Stratford Caldecott, who died last month in Oxford, England after a three-year struggle with cancer. We shall remember him, not only as one of the most brilliant and original Catholic thinkers of our time, but also as one of the great contemporary champions of what John Paul II called the "culture of life."

Stratford was possessed of an extraordinarily versatile mind, which he applied with supple mastery to a vast range of topics that included--to take just a few examples at random--the theological implications of quantum mechanics and the spirituality of Tolkien, Islamic-Christian dialogue and the nature of economic rationality. Yet no matter how far afield he might range, his intellectual exploration was always guided by the same attitude of childlike wonder at God's inexhaustibly surprising gifts. This wonderment never degenerated into sentimental effusion, however, but found constant expression in a plain, candid, and robust lucidity informed by a gently self-deprecating humor. Stratford's style as a thinker was a model of *sobria ebrietas* that perfectly matched the central intuition around which his thought took shape--the intuition that the most realistic approach to the world is to welcome it as a gift "coming down from the Father of lights" (cf. Jas 1:17) who has fully revealed himself as love in Christ's voluntary self-gift on the Cross.

Stratford's capacity for wonder flowed naturally into an uncommon intellectual empathy. He had a rare talent for seeing things from other points of view, and he was always anxious to do justice to the objections and questions posed by his interlocutors. A passionate seeker of truth who loved and respected the same passion in others, Stratford was always prepared to acknowledge "seeds of the Word" wherever he might find them. At the same time, he never made a secret of his rich Catholic faith, or hid his conviction that Christ alone is the Way, the Truth, and the Life. Rather than regarding dialogue and evangelization as mutually exclusive activities, he understood them to be inseparable expressions of the same encompassing confidence in divine generosity: To seek the truth with his interlocutors was to be on the way to Christ, just

as to know Christ was to do justice to the (partial) truth they had recognized. In this sense, Stratford's work is a timely witness to the truth that, "in revealing the mystery of the Father and his love, Christ, the New Adam, revealed man to himself and manifested his most high calling" (*Gaudium et Spes*, 22).

Stratford's remarkable intellectual generosity lifted him beyond the sterile either-or between "Right" and "Left," "liberal" and "conservative" in the Church. Although he faithfully embraced the whole of Catholic teaching, he never trumpeted his own orthodoxy or abused it as a pretext for self-assertion. Indeed, his entire work was informed by the conviction that Catholic truth cannot be the jealously guarded possession of a party, much less of any self-anointed elect, but is a universal good that illuminates the entire human condition. It was only logical, then, that, in defending the Church's teaching about the good of human life, he should seek to situate it within the larger web of truths--truths about God, the natural world, and the just society--from which it remains inseparable. It is worth stressing that Stratford's thinking about these matters--like his thinking in general--was itself part of a larger web, a network of relationships spreading out organically from their natural center: his loving intellectual communion with his wife Léonie and--as his children grew up--with his three daughters as well.

Stratford believed that the fundamental note of reality is not stinginess or calculation, but generosity freely given and freely received. Created being, he felt, is a gift, indeed, a self-giving bestowed by, and imaging, God himself. In the same spirit, he saw the Church's teaching on the beginning and end of human life not as a collection of arbitrary rules, but as a mystagogical initiation into the sacred vision of triune generosity shining through human birth, reproduction, and death. Stratford's deepest contribution to the "culture of life," then, was not simply to produce an impressive array of arguments for magisterial doctrine concerning abortion, contraception, or gay marriage. It was to re-open our weary eyes to the wondering contemplation of the ever-fresh source from which every such argument must derive its power: the radiant generosity of being, itself a revelation of the God who is unreserved generosity in the eternal communion of the Father and the Son in the Holy Spirit.

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Is Brain Death the Death of a Human Being?

ROBERT SPAEMANN

Spaemann, Robert, “Is Brain Death the Death of a Human Person?” in *Love and the Dignity of Human Life: On Nature and Natural Law* (Grand Rapids: Wm. B. Eerdmans, 2012): 45–69. Reprinted by permission of the publisher; all rights reserved. This book is available at <http://www.eerdmans.com/Products/6693/love-and-the-dignity-of-human-life.aspx>.

I

Death and life are not primarily objects of science. Our primary access to the phenomenon of life is self-awareness and the perception of other humans and other living beings. Life is the being of the living (*vivere viventibus est esse*), says Aristotle. For a living being, not to live means ceasing to exist. Being, however, is never an object of natural science. It is in fact the *primum notum* of reason and as such secondarily an object of metaphysical reflection. Because life is the being of the living, then, life cannot be defined. According to the classical adage *ens et unum convertuntur*^[i] it holds true for every living organism that it is alive precisely as long as it possesses internal unity. Unlike the unity of atom and molecule, the unity of the living organism is constituted by an anti-entropic process of integration. Death is the end of this integration. With death, the reign of entropy begins — hence, the reign of “destructuring,” of decay. Decomposition can be stopped by means of chemical mummification, but this way of preserving a corpse merely holds its parts together in a purely external, spatial sense. Supporting the process of integration with the help of technical appliances, however, is very different. The organism preserved in this way would in fact die on its own if left unsupported, but since it is kept from dying, it is kept alive, and cannot be declared dead at the same time. In this sense Pope Pius XII declared that human life continues even when its vital functions manifest themselves with the help of artificial processes.

II

We cannot define life and death, because we cannot define being and non-being. We can, however, discern life and death by means of their physical signs. Holy Scripture, for example, regards breath as the basic phenomenon of life, and for this reason breath is often simply identified with life itself. The cessation of breathing and heartbeat, the “dimming of the eyes,” rigor mortis, etc. are the criteria by which, since time immemorial, humans have seen and felt that a fellow human being is dead. In European civilization it has been customary and prescribed by law for a long time to consult the physician at such times, who has to confirm the judgment of family members. This confirmation is not based on a different, scientific definition of death, but on more precise methods to identify the very phenomena

already noted by family members. A physician may still be able to discern slight breathing, which escapes a layperson. Besides, the physician could nowadays point out the person whose heart has stopped beating may very well still exist. Due to such sources of error in the perception of death, it is a reasonable traditional rule to let some time elapse between noting these phenomena and the funeral or cremation of the deceased. Similarly, consulting a physician serves the purpose of making sure that a human being is not prematurely declared dead, i.e., non-existent.

III

The 1968 Harvard Medical School declaration^[ii] fundamentally changed this correlation between medical science and normal interpersonal perception. Scrutinizing the existence of the symptoms of death as perceived by common sense, science no longer presupposes the “normal” understanding of life and death. It in fact invalidates normal human perception by declaring human beings dead who are still perceived as living. Something quite similar happened once before, in the 17th century, when Cartesian science denied what anyone can see, namely that animals are able to feel pain. These scientists conducted the most horrible experiments on animals and claimed that expressions of pain, obvious to anyone, were merely mechanical reactions.

This incapacitation of perception fortunately did not last. It is returning today in a different shape, however: namely by the introduction of a new definition of death, or rather the introduction of a definition of death in the first place, in order to be able to declare a human being dead sooner. By the same logic, it would also be possible to define pain in terms of the neurological processes which constitute its “infrastructure,” and consequently to define everyone as pain-free for whom these diagnostic findings cannot be confirmed. It is merely a matter of transforming the

explanation of pain into a definition, in order to be rid of it as pain. Just like pain, its foundation, life, is equally undefineable. The hypothesis that the total loss of all brain functions immediately and instantaneously brings about the death of a human being frequently eludes discussion in scientific debates by being transformed into a definition: if the death of a human being and the loss of all brain functions are by definition equated, any criticism of this hypothesis is naturally bound to go nowhere. What remains to be asked is whether what is defined in this way is really what all human beings have been used to call “death,” as when Thomas Aquinas, in proving the existence of a Prime Mover, a non-contingent Being, etc., concludes his proof with the words: “And this is what all mean when they say ‘God.’”

Is “brain death” what all mean when they say “death”? Not according to the Harvard Commission of 1968. The commission intended to provide a new definition of death, one that clearly expressed their main interest. This interest was no longer that of the dying, namely to avoid being declared dead prematurely, but rather that of other people interested in declaring a dying person dead as soon as possible. Two reasons are given in support of this third-party interest: (1) guaranteeing legal immunity for discontinuing life-prolonging measures that would constitute a financial and personal burden for family members and society alike, and (2) collecting vital organs for the purpose of saving the lives of other human beings through transplantation. These two interests are not the patient’s interests, since they aim at eliminating him as a subject of his own interests as soon as possible. Corpses are not subjects of interest anymore. The first of the two interests mentioned is incidentally bound to an erroneous premise and a correspondingly problematic practice of the judiciary. It presupposes that for every human being not declared dead, life-prolonging

measures are indicated always and without exception. When this premise is dropped, the interest in declaring death at an early point ceases to exist. What remains is the second interest, which is self-contradictory, insofar as it requires on the one hand the collection of live organs, for which reason the dying person needs to be kept alive artificially, while on the other hand it requires that the dying person be declared dead, so that the collection of those organs does not have to be considered an act of killing.

IV

The fact that a certain hypothesis regarding the death of a human being is in the interest of other people who would benefit from the verification of this hypothesis does not prove its falsity. It should cause us, however, to be extremely critical, and it requires setting the burden of proof for this hypothesis very high. This holds true all

the more so when the hypothesis is underhandedly immunized by being turned into a definition. Precisely because nominal definitions are neither true nor false, the question of whose interests they serve gains relevance. The strategy of immunization by definition thus has a counterproductive effect.

The legislation of my country allows for a physician's conflict of interests, insofar as, prior to a transplantation, death has to be determined by physicians who themselves are not involved in the transplantation. Unfortunately, however, transplantation physicians did have their share in drafting the Harvard Commission's criteria for the determination of death. It ought to be in the moral interest of transplantation physicians, regarding their own personal integrity, to have as little to do with the formulation of these criteria as with their application, even if this is not in the professional interest of transplantation medicine — although the professional interest of transplantation medicine, considered in itself, is a highly moral interest, the interest of saving the lives of human beings. It has to be ensured, however, that saving lives does not happen at the expense of the lives of other people.

It is a fact that since 1968, the consensus about the new definition of death has not been consolidated; to the contrary, objections against it have increased. Ralf Stoecker states in his 1999 habilitation thesis *Der Hirntod* ("Brain Death") that the switch-over from cardiac death to "brain death" is more contested today than thirty years ago.^[iii] The arguments against "brain death" are brought forward not only by philosophers, and, especially in my country, by leading jurists, but also by medical scientists, e.g., the American neurologist Alan Shewmon, prominent as a radical advocate of "brain death" still in 1985, until his own medical research convinced him of the opposite.

V

The observer of this discussion is bound to discover that it suffers from a marked asymmetry. The proponents of the new definition argue from a "position of strength." They feel that it is an unreasonable demand to waste more time with arguments, aware that they have the "normative power of the factual" on their side, i.e., an established medical practice which meanwhile has already become routine, as well as, for believers, the blessing of the Church (which, however, was categorically called into question by a public statement of the Cardinal Arch-bishop of Cologne). They do not even remotely make the same effort dealing with the arguments of their critics as vice versa. Consequently, for every unbiased observer the weight of the arguments has shifted more and more in favor of the skeptics. I myself have

to confess that the skeptics' arguments have meanwhile convinced me. Life and death are not the property of science, hence it is the duty of scientists to convince ordinary laypeople of their point of view. When scientists refuse to make this effort under the assumption that they can use arguments from authority instead, their case is indeed in a sorry state. In the following, I would like to make my own argument against the new definition of death. What this definition defines as death is not *quod omnes dicunt mortem*.^[iv]

VI

The proponents of the thesis that the loss of all brain functions is identical with the death of the human being divide into two separate subgroups. The first group distinguishes between the life of the human being and human life, i.e., the life of a person. According to this group, the term "human life" should only be used as long as mental processes of a specifically human nature can be discerned. When the organic basis of such processes ceases to exist, the human being is no longer a person, hence his or her organism is at other persons' disposal to use for their purposes. Consequently, a total loss of all brain functions is not even required at all. Sufficient is the failure of those brain areas that constitute the "hard-ware" for these mental acts. People in persistent vegetative state are thus considered dead as persons. Not only is this position incompatible with the doctrines of most high religions, in particular Judaism and Christianity, but it also contradicts the tenets of today's medical orthodoxy. A well-known proponent of this position is Australian bioethicist Peter Singer.

The second group starts from the assumption that we can only speak of the death of a human being when the human organism as whole has ceased to exist, i.e., when the integration process constituting the unity of the organism has come to an end. According to this second group, this process of integration is terminated with the total loss of all brain functions, since the brain is assumed to be the organ responsible for integration. Hence, according to the views of this group, the death of the brain is the death of the human being. If the underlying hypothesis is correct, the conclusion must be correct, and even the Church would have no reason to defy this conclusion. But obviously the hypothesis is not correct, and those who wish to adhere to the conclusion are consequently forced to draw closer to the unorthodox theory of the first group, i.e., the cortical death hypothesis.

VII

The hypothesis of at least extensional identity of the total loss of brain functions and the death of the human being is incorrect for several reasons. First of all, it contradicts all appearances, i.e., normal human perception, similar to the Cartesian denial of pain in animals. A German anesthesiologist speaks for many others when she writes that “Brain- dead people are not dead but dying,” and that even after thirty years in the profession she could not convince her- self of the opposite of what everybody can see. One of the most well-known German neurologists, Prof. Dichgans, head of the Neurologische Universitätsklinik in Tübingen, told me recently that he personally was not prepared to diagnose death based on standard neurological criteria, and therefore did not participate in the determination of death. German intensive care physician Peschke reports that, according to his investigations, nurses in transplantation units are prepared neither to donate their own organs nor to receive donated organs. What they see on a daily basis makes it

impossible for them to become part of this practice themselves. One of these nurses writes: “When you stand right there, and an arm comes up and touches your body or reaches around your body — this is terrifying.” And the fact that the allegedly dead person is usually given anesthesia, so that the arm stays down, does not contribute to putting less trust in one’s own senses. Does one anesthetize corpses? This is merely a suppression of vegetative responses, the argument goes. Yet a body capable of vegetative responses requiring complicated coordination of muscle activity is obviously not in that state of disintegration which would entitle us to say that it is not alive, i.e., that it does not exist anymore.

VIII

Here the reasons of common sense converge with those advanced by medical science. Thus it was already pointed out by Dr. Paul Byrne in 1979 that it is unjustified to equate the irreversible loss of all brain functions with “brain death,” i.e., with the end of the existence of the brain.[v] We do not equate the cessation of heartbeat with the destruction of the heart, because we know today that in some cases this loss of function is reversible. But it is only reversible because the heart precisely does not cease to exist when it ceases to function. And only because the cessation of breathing was not equated with the “death of the lung” did it become possible to utilize mechanical ventilators to restart those functions.

Based on considerations of this kind, Dr. Peter Safar and others began to work on the resuscitation of brain function in brains considered dead by standard criteria. The reply by some that the loss of function in these “resuscitated” brains had not yet

become irreversible makes for a circular argument. Irreversibility is obviously not an empirical criterion, since it can always be determined only retrospectively. It is precisely because we assume that the brain still exists that we try to resuscitate its function.

Similarly circular is the reasoning behind the question as to what constitutes “total loss of brain function.” The proponents of “brain death” reject the substitution of this term by “loss of all brain functions” on the grounds that this would also pertain to “peripheral brain functions” which can survive the death of the brain as a whole. What are such “peripheral functions”? The Minnesota criteria for this are different from the British criteria, and some authors already declare brain stem activity peripheral when the cortex has ceased functioning. Anything can apparently be regarded as peripheral which is not identical with the integrative function of the brain for the organism as a whole. But the question has precisely been to prove just this integrative functional. So Paul Byrne’s words are arguably still valid: “There is no limit to what real functions may be declared peripheral when the only non-peripheral function is imaginary.”[vi]

IX

Is it justified to call the somatically integrative function of the brain “imaginary”? Among the authors who claim this and give reasons for their views, maybe the most important one is Alan Shewmon. A summary of his empirical research and theoretical considerations can be found in his essay “The Brain and Somatic Integration: Insights into the Standard Biological Rationale for Equating ‘Brain Death’ with Death.”[vii] Here I will only present the abstract of this

essay, which of course contains neither empirical evidence nor theoretical arguments, only the theses.

The mainstream rationale for equating “brain death” (BD) with death is that the brain confers integrative unity upon the body, transforming it from a mere collection of organs and tissues to an organism as a whole. In support of this conclusion, the impressive list of the brain’s myriad integrative functions is often cited. Upon closer examination and after operational definition of terms, however, one discovers that most integrative functions of the brain are actually not somatically integrating, and, conversely, most integrative functions of the body are not brain mediated. With respect to organism-level vitality, the brain’s role is more modulatory than constitutive, enhancing the quality and survival potential of a presupposed living

organ-ism. Integrative unity of a complex organism is an inherently nonlocalizable, holistic feature involving the mutual interaction among all the parts, not a top-down coordination imposed by one part upon a passive multiplicity of other parts. Loss of somatic integrative unity is not a physiologically tenable rationale for equating BD with death of the organism as a whole.[viii]

From the actual text of Dr. Shewmon's essay I will only quote a short paragraph:

Integration does not necessarily require an integrator, as plants and embryos clearly demonstrate. What is of the essence of integrative unity is neither localized nor replaceable — namely the anti-entropic mutual interaction of all the cells and tissues of the body, mediated in mammals by circulating oxygenated blood. To assert this non-encephalic essence of organism life is far from a regression to the simplistic traditional cardio-pulmonary criterion or to an ancient cardiocentric notion of vitality. If anything, the idea that the non-brain body is a mere “collection of organs” in a bag of skin seems to entail a throwback to a primitive atomism that should find no place in the dynamical-systems-enlightened biology of the 1990s and twenty-first century.[ix]

X

A nonmedical person, trained in the theory of science and wishing to form an objective opinion about the status quaestionis, must strive to evaluate the arguments brought forth in the debate. Where results of empirical research are concerned which he or she has no way of verifying independently, it is necessary to confront them with the counter-arguments. Insofar as these counter-arguments are of an empirical nature as well and challenge the accuracy of the presented research results, he or she ought to abstain from judgment until further empirical verification. As far as a theoretical interpretation of the results is concerned, however, he or she is qualified to verify and evaluate it. Regarding the findings presented by Dr. Shewmon, I am not aware of any criticism targeting the core of his argumentation. I conclude from two facts that such criticism indeed does not exist:

(1) When Shewmon presented his research results at the Third International Symposium on Coma and Death in 2000[x] which was attended largely by neurologists and bioethicists, there was surprisingly broad acceptance. What ensued was a shift of the domain of the debate from the medical to the philosophical arena, with the defenders of “brain death” appealing exclusively to consciousness-based concepts of personhood rather than the previously standard medical rationale of bodily integrity.

(2) In 2002, the National Catholic Bioethics Quarterly published an article by editor-in-chief Edward J. Furton which

was dedicated exclusively to the debate with Alan Shewmon.^[xi] In this article, Dr. Shewmon's empirical research results are not disputed, nor is any reference made to literature which would justify such doubts. From this I conclude that indeed there is no such literature.

All the more interesting is Furton's argument itself, which defends the equation of "brain death" with death against Shewmon. I will conclude my own remarks with a critical report about this article, beginning with a summary.

Furton's primarily philosophical arguments in favor of "brain death" convinced me more than anything else of the opposite of his position. The reason is that Furton is only able to sustain his thesis of "brain death" as the death of the human being by distinguishing between the death of the human being as a person and the death of the human being as a living being. He writes: "Although the difference between the death of the person and the decay of the body had long been obvious, it is only in our time that the difference between the life of the person and the life of the body has become apparent."^[xii] This, now, is exactly the position of Peter Singer, and it is incompatible with the belief of most religions, and certainly with that of Christianity. If Church authorities cautiously accepted the premise of "brain death," this was always done under the premise that the brain is responsible for somatic integration, the loss of the brain functions thus being identical with the death of the organism. It is beyond the scope of religious authority to judge the validity of this premise. When the premise becomes doubtful, the conclusion ceases to apply.

Furton would like to hold on to the conclusion, even though he abandons the premise under the impression of Alan Shewmon's arguments. His appeal to papal authority is, therefore, unjustified, and it is surprising that he makes such excessive use of the argument from authority in his debate with Shewmon. Just because the Pope bases his own equally hypothetical conclusion on a scientific hypothesis does not mean that this hypothesis is thereby withdrawn from further scientific discourse.

If it were otherwise the Ptolemaic worldview would have been dogmatized forever, just because the Church drew conclusions with religious and practical relevance from it while it was generally accepted. At the same time

Furton himself concedes in his essay that "the determination of death does not fall under the expertise of the Church, but belongs to the physician who is trained in this

field.”^[xiii] (I would like to render this more precisely: the physician is qualified to determine the existence of pre- defined criteria for death. The discourse about these criteria themselves falls into the domain of philosophers and philosophizing theologians after they have received the necessary empirical information from the medical profession.) Furton bases his argument on the Aristotelian- Thomistic doctrine of the soul in connection with the teaching of the Church, dogmatized after the Council of Vienne 1311-1312, according to which the human soul is only one, from which follows that the anima intellectiva is at the same time the forma corporis.^[xiv] From this doctrine, however, Furton draws a conclusion which is diametrically opposed to the intention of St. Thomas as well as the Council of Vienne.

Thomas assumes that the human being initially possesses a vegetative and then an animal soul, and that the spiritual soul is created only on the fortieth day of pregnancy, and not in parallel with the other two souls but in their stead, so that it is now the spiritual soul that simultaneously fulfills the vegetative and sensorimotor functions. This is

drastically different from Aristotle, for whom nous, reason, is not part of the human soul, but is *thyrathen*, entering the human being from outside. St. Thomas, by the way, excludes Jesus Christ explicitly from successive animation: that the Incarnation occurs at the moment of his conception presupposes that Jesus’ soul must have been a human soul in the full sense from the very beginning. The Church, herein following science, has given up the idea of successive animation long ago and regards not only Jesus, but any human being as a person from the moment of conception, with his or her soul being an anima intellectiva — even though the newborn infant is not yet capable of intellectual acts. This inability is due to the lack of sufficiently developed somatic “infrastructure.” Similarly, a pianist “cannot” play the piano when there is no piano available. Just as the pianist nonetheless remains a pianist, the soul of the human being is an anima intellectiva even when it is factually unable to think. The being of man is not thinking but living: *vivere viventibus est esse*.

Furton’s way of thinking is radically nominalistic. For him, a personal soul exists only as long as an individual is capable of specifically personal acts. For Furton, then, the reality of the human soul is not found in allowing man to exist as a living being; the soul is not the forma corporis but the form of the brain and only indirectly the form of the body. “The soul is . . . what enlivens a material organ, namely the brain, and from there enlivens the rest of the human body.”^[xv] (This view was rejected already in 1959 by the Würzburg-based neurologist Prof. Joachim Gerlach, for whom the error in the

equation of “brain death” and the death of the individual consists in “regarding the brain as the seat of the soul.” Similarly, Paul Byrne wrote already in 1979: “‘Brain function’ is so defined as to take the place of the immaterial principle or soul of man.”)[xvi] Furton identifies that which Thomas calls intellectus with factual intellectual consciousness. He does not conclude from the obvious continued existence of a living human organism that the personal soul, which is the form of the human body, is still alive, but contrariwise: if a human being is not capable of intellectual acts anymore, the soul has left him and he is, as a person, dead. The fact that the organism as a whole is obviously still living doesn’t play any role. Without actual brain function, the human organism is nothing other than a severed organ, which also still shows expression of life. This position is consequent to, and largely coincides with, that of Peter Singer and Derek Parfit, for whom persons exist only as long as they are capable of personal acts: hence sleeping people, e.g., are not persons.

XI

Under the weight of the arguments of Shewmon and others, the group of medically and theologically “orthodox” defenders of “brain death” is apparently disintegrating. In the light of the untenability of the thesis of the integrative function of the brain, the identification of “brain death” and the death of the human being can only be held up if the personality of man is disconnected from being a human in the biological sense, which is what Singer, Parfit, and Furton are doing. To do this under reference to the doctrine of St. Thomas is absurd indeed. Furton avails himself of an equivocation in the term intellectus when he claims that being a human consists in the connection of intellect and matter, as though Thomas understood “intellect” in terms of actual thinking rather than the capacity to think. This capacity belongs to the human soul, and this soul is *forma corporis* as long as the disposition of the body’s matter permits it. Instead of concluding: where there is no longer any thinking, the *forma corporis* of the human being has

disappeared, we can thus only conclude: as long as the body of the human being is not dead, the personal soul is also still present. Only the second conclusion is compatible with Catholic doctrine as well as the tradition of European philosophy. Furton’s adventurous conclusion, to declare a human being dead when his or her specifically human attributes do not manifest themselves anymore, is contrary to all immediate perception. Even Peter Singer and Derek Parfit are still closer to the phenomena when they do declare the person expired, but do not already for this reason consider the human being dead.

I conclude with the words of three German jurists who wrote after immersing themselves in the medical literature: “To be correct, the ‘brain death’ criterion is only suited to prove the irreversibility of the process of dying and to thus set an end to the physician’s duty of treatment as an attempt to delay death. In this sense of a treatment limitation, the ‘brain death’ criterion is nowadays likely to find general agreement” (Prof. Dr. Ralph Weber, Rostock).

“The brain dead patient is a dying human being, still living in the sense of the Basic Constitutional Law [of the Federal Republic of Germany, ESSJ Art 2, II, 1 99]. There is no permissible way to justify under constitutional law why the failure of the brain would end human life in the sense of the Basic Constitutional Law. Accordingly, brain dead patients have to be correctly regarded as dying, hence living people in the state of irreversible brain failure” (Prof. Dr. Wolfram Höfeing, Bonn).

“It is impossible to adhere to the concept of ‘brain death’ any further. . . There is no dogmatic return to the days before the challenges to the concept of ‘brain death’” (Dr. Stephan Rixen, Berlin).

XII

After all that has been said, for anybody who is still doubtful, the principle applies, according to Hans Jonas, in dubio pro vita.[xvii] Pius XII himself declared that, in case of insoluble doubt, one can resort to presumptions of law and of fact. In general, it will be necessary to presume that life remains.[xviii]

Robert Spaemann is a preeminent German philosopher.

[i] “Being and unity are convertible”.

[ii] “A Definition of Irreversible Coma. Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death,” *Journal of the American Medical Association* 205 (1968): 337-340.

[iii] R. Stoecker, *Der Hirntod. Ein medizinethisches Problem und seine moralphilosophische Transformation* (Freiburg/München: Verlag Karl Alber, 1999), p. 37.

[iv] “What all mean when they say ‘death’.”

[v] Paul A. Byrne, Sean O’Reilly, Paul M. Quay, “Brain Death — An Opposing Viewpoint,” *Journal of the American Medical Association* 242 (1979): 1985-1990.

[vi] Paul A. Byrne and Walt F. Weaver, “‘Brain Death’ Is Not Death,” Fourth International Symposium on Coma and Death, Havana, Cuba, March 9-12, 2004.

[vii] A. Shewmon, “The Brain and Somatic Integration: Insights into the Standard Biological Rationale for Equating ‘Brain Death’ with Death,” *Journal of Medicine and Philosophy* 26 (2001): 457-478.

[viii] *Ibid.*, p. 457.

[ix] *Ibid.*, p. 473.

[x] D. A. Shewmon, “Seeing Is Believing: Videos of Life 13 Years after ‘Brain Death,’ and Consciousness Despite Congenital Absence of Cortex,” Third International Symposium on Coma and Death, Havana, Cuba, February 22-25, 2000.

[xi] . E. J. Furton, “Brain Death, the Soul and Organic Life,” *National Catholic Bioethics Quarterly* 2, no. 3 (Autumn 2002): 455-470.

[xii] *Ibid.*, p. 467.

[xiii] *Ibid.*, p. 463.□14. “Intellectual soul” and “form of the body.”

[xiv] “Intellectual soul” and “form of the body.”

[xv] *Ibid.*, p. 470.□

[xvi] Cf. Byrne, “Brain Death — An Opposing View Point.”

[xvii] “When in doubt, favor life.”

[xviii] Pius XII, To an International Congress of Anesthesiologists, Nov. 24, 1957, in *The Pope Speaks* 4, no. 4 (1958): 393-398.

Stratford Caldecott: The Glory of God....a Man Fully Alive

DAVID L. SCHINDLER

Eulogy for Stratford Caldecott

St. Aloysius Church

The Oxford Oratory

Oxford, England

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Feast of St. Ignatius of Loyola

Stratford Caldecott was a man fitted for our time. We must submit to providence about why he has left us so soon. We come to mourn his passing, but also to recall his life. What did he have to say to us?

There are likely few here today who have not been surprised, even initially unsettled, by some reflection of Strat. Why is he interested in this? Or in taking that particular aspect of experience or cultural-religious argument so seriously? It doesn't fall into customary categories—certainly social-political categories, but sometimes even the categories to which we are most accustomed as members of the Church in our relations with the world. His gift to us, however, lies just here, in his constantly calling us to look more deeply and more comprehensively at the meaning of things, of life and the state of culture. His gift to us, in other words, lies in his catholicity—an often misunderstood but nevertheless essential term.

What Strat meant by this term, and how he embodied it, are indicated in the readings from today's liturgy (the feast of St. Ignatius of Loyola):

Whatever you do, do everything for the glory of God. Avoid giving offense, whether to the Jews or Greeks or Church of God, just as I try to please every one in every way, not seeking my own benefit but that of the many, that they may be saved (σώζω: save from death, keep alive, preserve) (1Cor 10:31-11:1).

It is the indissolubility of the “everything” and the “giving glory to God” expressed in this text that is just the point for Strat. It is the penetration into the center, the heart of the divine logos incarnate in Jesus Christ, that both impelled his dialogue with what may have appeared to us at times peripheral, and enabled his generous embrace of things—of all things and of each thing in its integrity. “In the beautiful logos,” writes Strat, “all things cohere. In the Word of words, all threads of meaning are drawn together, and the notes and noises of our lives add up to parts of a symphony” (*The Radiance of Being*, 5).

Here, then, is the center from which Strat never strayed. Here, in the trinitarian God, we find the original generosity—the giving and gift and gratitude—the traces of which he found hidden everywhere, a generosity that he saw struggling to come to expression in every human endeavor, even when otherwise broken. It is his recognition of this generous unity that prompted him to attend to things so various: to ponder the non-mechanistic natural order as indicated in quantum physics; to work toward an integrated social-economic order; to dialogue with other religions, uncovering their deep dimensions of the transcendent and the mystical; to recuperate the symbolic character of nature and language; to defend the integrity of the Church’s sacramental liturgical tradition, in its implications also for a cosmic liturgy; to affirm a theological order in the human body—the order of generous love expressed in the distinction between a man and a woman that is ever fruitful.

The depth in this breadth of Strat’s sensibilities and abilities can be missed only if we fail to see the center that brings unity to it all. He engaged it all with a childlike innocence and humility, as well as with a courage that was as fearless as it was gentle and patient—and always ready of wit.

This catholic spirit took in Strat the concrete form of community, above all in two senses. First of all, with Benedict XVI, he believed that an authentic human culture is possible only on the basis of our willingness to search for God and our readiness to listen to him. Strat’s inquiries grew out of a life of prayer and worship. His inquiries were also tied to, and grew organically out of, his lifetime of fidelity to his wife, Leonie, a fidelity that has borne abundant fruit in their dear children, Tessa, Sophie, and Rosie—and now also grand-daughter Evangeline. Leonie was Strat’s best friend, and his closest collaborator in all of his work. Her distinct voice is ever present in the symphony he and she together orchestrated to the world.

What Strat has to teach us, then, is simple and radical (i.e., going to the roots): not a new program but a way of life. After the manner of St. Francis—and of St. Ignatius,

whose feast the Church celebrates today, and who was one of the original and most important missionaries to modern culture in its global reality—Strat instructs us in the meaning of Catholic wholeness, now in the face of the fragmentations and reductions of modern intellectual and academic life, and of the social-political ideologies of the Right and the Left. He stands as a contrasting witness to the abstract catholicity of our electronic age, which in a technical sense can reach everywhere, but at the expense of never being anywhere, or truly indwelling any reality, in particular. Strat witnesses instead to the concrete catholicity rooted in community—with the God in whom we live and move and have our being, and as expressed in the marital state the measure of which is the free-intelligent act that says forever.

And so, we come to mourn your passing from us, Strat, and to thank you—and Almighty God—for your life. We salute you and we bid you farewell, dear friend. May you rest eternally in the peaceful joy of the trinitarian God, in the company of Mary and all the saints, surrounded by the beauty of all of God’s creation.

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Aspects of Beauty: The Medical Care of Terminally Ill Newborns

ELVIRA PARRAVICINI, M.D.

This title sounds really contradictory. What kind of beauty can there be in a situation near death, especially when babies are involved? And yet, there is some truth to it. With this talk I would like to share my experience of beauty, precisely in situations where it seems impossible to find.

I believe that the moment a baby is born is the time where it is evident that we are made for happiness. What fills me with wonder is entering the delivery room, and there you count the people: a mom, a dad, a nurse, a doctor, a midwife... there you count five persons and, after a while, you count six, for at a certain point there is one more person. It was not there before, and now... there it is. And this little new person arouses surprise, wonder, and enthusiasm in all those around him or her, only and exclusively because he or she is.

The baby does not impose itself because of its physical appearance (blonde or tall or whatever) or because of moral characteristics (coherent or generous), or because of its abilities (intelligent, great in organizing). The baby imposes itself because it simply is. All the surprise and wonder around the new baby are nothing else than the manifestation of hope, an expectation of happiness. I believe that the birth of a baby is not primarily a biological mechanism. It is an event that arouses a limitless promise.

It is within this context that, during med school, I decided to become a neonatologist. The intuition I had was this: I had this strong desire to support with my medical knowledge this promise of happiness for infants who have medical problems. I wanted to heal these babies and send them home with mom and dad, healthy and happy. In short, I wanted to become a neonatologist because I wanted to save babies.

I work at Morgan Stanley Children's Hospital of New York Presbyterian, associated with Columbia University. We have about seventy beds for neonatal intensive care, and we take care of infants born in our hospital or coming from other hospitals in the

state of New York or other states.

The vast majority of infants we take care of go home healthy and happy with their parents. But this is not always possible. There are a few conditions, congenital or associated with prematurity or with other diseases, that are defined as “life-limiting,” that is, they are not susceptible of medical or surgical care. The infants affected with such diseases have a very short life.

For some reason, I found myself at a certain point taking care of these kinds of infants. But how did it happen? It was not my idea, but I was somehow called there by things happening in reality.

In fact, as I said before, I wanted to be a neonatologist to save babies’ lives, and I would never have imagined that I would end up taking care of babies who are not expected to live at all, but supposed to die.

Anyway, in short, this is the story.

Introducing Elvira

As a neonatologist I always loved to be involved in the prenatal care of infants, to give a proposal to parents about the plan of treatment for their babies once they had been born. Unfortunately prenatal diagnosis is more and more focused on the identification of fetal malformation, in order to eliminate infants with any kind of problem. As a physician and a neonatologist I am rather interested in the medical treatment of each one of my little patients, before or after the delivery. I believe that any medical condition can be treated, whether the estimated length of life is ninety years or seven minutes. Therefore, as I had been participating in the meetings for prenatal diagnosis in my hospital, at a certain point I stopped going to these meetings. It was just too painful – the proposal was termination of pregnancy all the time; there was no space for me as neonatologist, and I felt quite useless and impotent.

I had not been attending those meetings for about two years, when, one day, the chief of prenatal diagnosis met me in a corridor and asked me, Elvira, why are you no longer coming to our meetings? They are so good, we learn so many things... and she was sincere. Right there I remember, I told myself, reality is calling me, through the voice of this doctor. Therefore I told myself, okay, I can go back. These babies suffer; I can suffer with them. I can do this.

The following week I went to the weekly meeting and – surprise! – the OB fellow

presented the cases of two women expecting babies with Trisomy 18, a life-limiting condition, but these women did not want to terminate the pregnancy. There was a discussion. What do we do now? Who is going to take care of these babies? And so on. ... So I raised my hand.

I said, I can take care of them: we can do “comfort care.” To tell the truth, at that moment, I had no idea what “comfort care” meant in any detail, but I said it because I wanted to affirm that there was a way to take care of them. Of one thing I was certain, that I was their doctor, and those babies needed me.

Of course, everybody felt relieved by my proposal. Little by little, over the next weeks or months, they started referring to me all the moms who either did not want to abort their babies or those who maybe would have aborted, but the pregnancy was too advanced.

Before entering into the specifics of comfort care, I want to share with you a very important step in my knowledge of what it means to be a physician, because exactly this point was what helped me in developing the comfort care program. As I said in the beginning, I became a neonatologist to save babies’ lives. But, here I was faced with a question, dealing with these babies whose life is so short. What does it mean to save a life?

It means I cannot give up my desire to save each one of them.

Learning from Reality

In my quite long career, I have learned practically everything from my patients. Therefore I would like to tell you the story of a little baby, Maria Ximena. By taking care of her, I made the following step; that is, I really understood what it means to be a physician, and what it means to save the life of my patients in any condition.

Maria Ximena was born very premature and very sick, in my hospital. During her resuscitation, it was quite dramatic because she is not just one of my patients, she is also the daughter of some good friends of mine. And so I tried all kinds of life support, modes of ventilation – everything – to save her life.

In those dramatic moments I realized that all my medical knowledge, my experience, my expertise, nothing of all this would have kept her alive unless the One who gives her life decided that it should. That is, during her resuscitation, I suddenly understood that while I had to give all of myself, with all my professional knowledge, her life

remained in the hands of Another.

In those six hours, without leaving her bedside even for a minute, I understood: to be a physician means using all the expertise, medical knowledge, experience in order to serve the Other who gives life to the patient. And how does this Other let me know about his plan for my patient? Very simply. Through the patient himself. For this reason I am called to be extremely attentive to the clinical signs of my patient, and also to be affectively or emotionally involved in order to perceive any small sign that might lead me toward an appropriate treatment. This experience became fundamental to my understanding of my profession as physician.

In fact, going back to comfort care, this little girl's story clarified what it means to save the life of my patients, even in cases when life is really very short. It is the same thing. When patients' lives are very limited in length, I also need to be very attentive and affectively involved in order to perceive which direction their life is taking, and to serve the One who gives life to them and decides how long or how short it is – whether months, weeks, days, or just a few minutes.

Since that day in 2006, when I raised my hand proposing comfort care for those two babies, I developed a methodology to define the Comfort Care Treatment, by following this point exactly. Comfort care is not a matter of “trying to be kind to the patient, and not doing anything medical because there is nothing we can do.” It is not true at all that there is nothing we can do; rather, taking care of these patients is sometimes more complicated and time-consuming than with others. With these patients we need to override policies and guidelines. We need to be creative, using all our medical knowledge and our humanity.

By the way, comfort care should be part of the treatment of any patient, because each patient wants to feel comfortable. The difference is that, in these cases, because there is no recovery possible, the patient's comfort becomes the main goal of the treatment.

Comfort care management can include medical treatment and surgical procedures, with the goal of making the patient comfortable. I will give you an example. A couple of years ago we took care of a little girl, born with very severe anomalies of her head and face, and the only intact part of her face was her mouth. She was struggling to breathe and feed. She felt suffocated while attempting to eat. Therefore, with the support of her parents, we inserted a gastric tube, enabling her to breathe comfortably with her mouth, and to be fed via her G-tube. She lived four months, and in those four months she was really comfortable.

So then what is comfort care? It is both a medical and a nursing treatment. The principles of comfort care include the satisfaction of some basic needs, so that in order to be comfortable a newborn needs to be welcomed, and to be kept clean and warm. He or she should not be thirsty or hungry, and should not suffer pain.

Therefore, we do medical rounds on these patients and, as we go around, we ask the nursing and medical team, how can we help this baby to be comfortable? This list of needs to be fulfilled seems nothing, too simple; however, this is not the case, because it requires the overriding of policies, rules, and schemes in the neonatal intensive care or in the nursery. And you will see this as I am going through some details.

In fact over the course of the past few years I have taken care of more than a hundred newborns and their families. I lived with them beautiful stories, which also helped me understand many things from a medical point of view. Moreover, I could see so clearly the victory of beauty and truth over limits, lies, and death. I saved a lot of pictures given to me by parents. The predominant feeling portrayed in these pictures is always the joy, the joy to have your child with you now.

I would like to share a few of these stories.

Competing in Love

A few years ago I met an American family, which had been for years on mission in Brazil. Their third baby was diagnosed with a lot of problems before birth, and so they moved back to the US to provide adequate care for this baby once she was born. I met them in my hospital at the beginning of the third trimester, just after the baby had been diagnosed with a life-limiting disease. They told me: Doctor, we will carry our baby as she is, and the most important thing, after she is born, is that we would like to spend the most possible time with her. I explained to them comfort care treatment and, yes, I assured them that they would be able to spend time with their baby in our unit.

I was expecting to see them in a couple of months, at the term of pregnancy. However, after a couple of weeks, I was on call at night and I was called to the emergency room. They told me that a woman had just delivered a premature baby, and this baby seemed to have a very serious disease. I went there and recognized them. I could not believe that it happened exactly the night I was on call. They were happy, too, that I was around.

The little baby was indeed little, a girl of about two pounds, but she was alive and

quite active. Because she was so tiny I was worried that she might get cold, but I did not want to place her in an incubator, because this would not enable the parents to stay with her. So I proposed kangaroo care: skin-to-skin contact. Mom and dad alternated in holding her on their chest for the twelve hours of her life. Grandparents came with the other siblings, and those twelve hours were a big celebration! I can say that, together with sorrow, the prevalent feeling was one of joy, the joy of having your baby with you now.

In fact, when I went to greet them at discharge, after the baby had passed, I told them something like, I am sorry for your baby. They told me, Doctor, don't say, I am sorry, we were happy – yes, they used the word happy – to stay with our baby for those twelve hours. And we are very grateful that you allowed us to spend those hours with our daughter.

Another important need a baby has is to be fed and nourished. These babies are often quite sick, so occasionally they can be fed at the breast or with a bottle, but often they have no strength to suck, therefore we give them some milk with a little syringe, or by placing a little tube in their stomach.

I took care of a little baby boy, the second of twins, who was born with a very severe cardiac condition that could not be operated on. He lived a beautiful life of fifteen days. He was kangarooed and fed with a syringe by mom and dad. When I met the parents during pregnancy I offered them, not options, but my proposal. I proposed myself as the doctor of their baby, saying something like this: I am a neonatologist and I am here to take care of your baby. If medical treatment is not going to be good enough to save the life of your baby, we will make his or her life the most beautiful possible. I believe that any other proposal is not adequate; it does not address the patient and the parents' ultimate needs, which is to be able to love their baby. And it does not address the need of the physician as well, because as physicians, we need to care for our patients and not just eliminate the problem.

So, when I talk to parents, even before telling them what is going on with their baby, I ask them, is it a boy or a girl? Do you have a name for your baby? By doing so I want to communicate how much I care for their baby, and I see very often what I call an "affective competition." For a parent it is impossible to tolerate the possibility that there is someone else who loves their baby more than they, therefore my proposal helps them to be free to love their babies.

My proposal is reasonable, based on the fact that we all share the same heart. Loving

their children is an original need for parents, just as helping the one who asks for help is a primary need for the physician. In that sense termination of pregnancy is not a real medical option. It is really true that we all have the same heart. In fact beauty attracts and moves people.

A good example of this is that, within a few years of developing comfort care on my own, one by one several nurses and social workers have asked to assist me in this project. In this way we established the comfort care team, some ten people working with these babies and their families. They are nurses, social workers, a child life specialist, ministers from chaplaincy, etc. They help me taking care of infants during their hospitalization, but also training other nurses and medical personnel in comfort care management.

We set aside a “comfort care room,” a private room in the intensive care unit that allows privacy to parents who want to spend time with their infants suffering from terminal conditions. There is a beautiful rocking crib, a bath-tub for the first bath, and beautiful outfits and blankets that we received as donations.

As I mentioned before, aside from nurses and myself, there are other professionals helping. Child life offers activities for siblings, helping them face the drama that is unfolding in their family. They also are able to reproduce tridimensional casts of the hands or feet of the baby as a way of remembering this little child whose life is so short.

We are well aware of the fact that nothing that we do can fill up the emptiness left by the loss of a child, but all these activities allow us to stay with the parents in these dramatic moments. It is impossible for a parent to face the death of their child alone. So, through all these activities, we very simply stay with them.

Alejandra's Story

Another interesting point relates to the fact that, as we want to assure comfort to our little patients, we don't want to prolong or shorten the length of that life. There is a risk that comfort care might become a shortcut for euthanasia. Life is given, and the length of life of these children cannot be determined by the parents or by the doctors. And so we work to keep our babies comfortable. Nevertheless, we can have surprises. I would like to tell you a story that is very significant in this sense.

Alejandra's story could be entitled, “When reality surprises us.” Alejandra was born very small, less than two pounds, and she became sick with a very severe infection

that destroyed her intestine completely. Back from the OR, the surgeon told the family and myself (I was her doctor): There is nothing we can do, let her die. Pull the tube.

The parents were desperate and begged me, do not stop life support, at least for some time. I followed their desire, not because I thought she would have recovered, but to make them happy, just for few hours or for a day. Also, I thought, she is premature, and I know that premature infants, even if they are healthy, need a minimum of life support because of the immaturity of their lungs. Therefore I proposed to the parents a modified comfort care treatment which included minimum life support, minimum nutrition, one antibiotic because she had an infection, and morphine around the clock. And we observed her hour by hour, day by day. I was sincerely convinced that her life would have been quite short.

However, Alejandra was surrounded by people who loved her very much – first of all her parents, then some nurses very devoted to her, and I put myself on the list as well. All these people observed very attentively each clinical sign, and nothing was taken for granted. Weeks passed by, the wound started healing a little bit, and Alejandra started moving and breathing on her own, until one day – incredibly – I had to tell the parents that I wanted to pull the tube, not because she was dying, but because she was able to breathe on her own.

After a few months, she went home. Now, at five months, her weight went from two to eight pounds. Her intestine was very short, only a few inches, she needed parenteral nutrition through a central venous access, and could only drink a small amount of milk, but she was alive. Currently she is six years old, and she goes to school with her feeding tube for a slow infusion of milk in her still very short intestine. She receives parenteral nutrition a few times a week, with the hope of weaning this artificial nutrition over the next three to four years. But she is a very bright and happy girl.

By taking care of Alejandra, I realized with even more clarity that being a physician means being in dialogue with the Mystery, who talks to us through reality, the reality of our patients.

I like to tell parents, as I discuss with them my plan of care for their baby, that, in order to understand what to do in terms of a medical plan, I need to follow their baby. I tell them, I follow your baby, and your baby will let us know what we need to do medically. It is amazing how the parents are very much at peace with this plan, and they are even proud that their babies are guiding the physician.

Learning from Baby

In this sense, taking care of each patient is always a drama, because I need to follow Another; but, exactly because I follow this Other, there is no right or wrong decision. Of course, I experience powerlessness quite often because, as it was so clear with Alejandra, each patient's clinical course is a sort of mystery. Now it is very clear what happened to her; now we know. But during those months while she was sick, we did not know what to expect. But this sense of powerlessness is good. It opens a space for the Mystery to come, and each time he comes and clarifies.

In front of these infants with such a short life, a question arises for me every time. Why is their life so short? I feel that this is an ultimate injustice. I really enjoy my life, because life is beautiful. We are free, we can enjoy the beauty of nature, we can love and be loved. They are missing all of this.

This question is always open for me, but I began to understand the answer to it a little bit more by taking care of some of my patients who were Siamese twins. Their teenager parents looked like typical teens, with tattoos and piercing all over. After the diagnosis was made, it was strongly suggested to them that they should terminate the pregnancy, but they refused, saying, "These are our babies." So they continued the pregnancy. We consulted cardiologists and cardiosurgeons, but unfortunately the babies could not be operated on, because they shared a single heart with severe anomalies, and they also had to be delivered prematurely because mom had very high blood pressure.

The day of their birth, just before the caesarean section, I was very sad. In the delivery room, many people were commenting about the fact that this mom was crazy to bring the babies to term. They were saying, "She is going to get a cesarean section. This wound will mark all her life; she will have possibly problems having other children; she should have terminated the pregnancy." Also there were some young physicians in training ready with their camera to take pictures of the "rare case"; and, in the very end, it seemed to me that no one was welcoming these babies.

Finally, here they are, two beautiful little girls, embracing each other because they have been united by the chest their entire life. The father asks me if he could hold them. Of course, I say. The babies were just gasping a little bit, the heart was going very slow, and the father kept reassuring them, "Don't worry, daddy is here." I told myself, this boy, a typical teenager, probably gets bad grades at school, but he is a great father!

Suddenly I looked around and what did I see? The atmosphere in the delivery room

was completely changed, I saw tears, people embracing this young father; the cameras were no longer around. The people were the same, but completely changed.

What had happened? It was a moment of beauty, because beauty is the splendor of truth and the truth is that these babies are. They are, they exist, and the only possible explanation for their existence is that a Mystery called them to life. This is beauty and truth. And this is witnessed by the fact that everybody changed, everybody was moved. This is another proof of the fact that we all share the same heart, despite our ideologies or preconceptions.

Therefore, going back to my question, why is their life so short? Of one thing I am completely certain: their life is the sign of Another who wanted them, who called them to life, even if it is very short. In the shortness of their life I continue to see a sort of injustice, and this remains a tremendous puzzle. However, I see also the signs of something new, unexpected, beautiful. In their short appearance in that delivery room, for a just few minutes, I saw the victory of beauty and truth over lies and death. The change in those people is the witness of this victory.

In conclusion, I would like to say that my job as neonatologist is to affirm that each one of these babies is not the sum of their chromosomes, whether normal or abnormal. They are not defined by the cultural hegemony of this society that considers them useless or even dangerous. They are a relationship with the Mystery.

How can I say this? Because they are, they exist. The Mystery called them to life. And, by creating them, the mystery opens a great promise for happiness. It is possible to taste this happiness in advance when we look, when we really look at reality in its truth.

Like a mom who embroidered a frame and put it at the bedside of her baby. In the frame you can read, You are loved. This mom looked at her baby, and said the only true thing it is possible to say: You are loved.

This is the BEAUTY that I see, and I have shared it with you.

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Conversations With a Hospital Chaplain

JONAH LYNCH, F.S.C.B.

The summer of 2002 in Attleboro, Massachusetts was hot and sticky. I was a young seminarian and had been sent to spend July and August with three missionaries of the Fraternity of St. Charles. In particular, I was to corner one of them, Fr. Vincent Nagle, and collect and transcribe his stories of work as a hospital chaplain in preparation for a book, entitled, *Life Promises Life*.

He was always on call. Often his beeper rang at the deepest hours of the night and he stumbled out of bed and into his car to administer the sacraments moments before someone died. During the day, many hours were spent praying with the sick, meeting their families and doing battle with the wide range of forms desperation can take: quiet bottomless sadness, anger at God, laying of blame—worse still, the dramatically useless attempt to defeat death through ever more sophisticated technologies. Fr. Nagle knew that medical science has great value in treating illness, but it cannot sidestep the mysterious doorway all of us have to pass through. Each of us must die.

Fr. Nagle's pockets were always stuffed with cheap plastic rosaries. "Made in China—they cost 9 cents if I buy them in quantity! I like these ones because they have a Crucifix at the end," he explained to me. He gave them out to anyone and everyone, not so much for them to pray the Rosary, which many had long forgotten or never knew, but in order to be able to look at an image of Christ, however crude. Vincent often taped the Rosary to the patient's bed in such a way that they could see the tiny figure of Christ a few inches away; see His arms outstretched in an embrace of the whole world, holding nothing back; His body lacerated with the same pain the dying women and men felt in that hospital; His resurrection the one medicine capable of doing battle with death itself. As Vincent says in the title chapter of his book, "Life promises life: it's a promise of more, especially in a person we love. It doesn't fit that everything visible and experiential about a person then die! It isn't what was being led up to." The promise life contains is a promise only Christ can keep.

When we began our interviews in an air-conditioned room of the parish, he hurled his favorite prayer, "...create in me the heart of a child..." at the inevitable pride which a

microphone arouses. When with halting speech he began to describe the extraordinary encounter on a far-off night in Saudi Arabia that he mentions in the book, he was interrupted by gentle, grateful tears. He said little, afraid to cheapen the facts with too many words and aware of the discomfort others feel in front of unverifiable and intensely personal experiences. But his voice and his tears were verification enough.

A few days later, pressed for time between the hospital, the prison, and many other engagements, Fr. Nagle decided to record the interviews in the car. On our way to visit one of the prison inmates, we drove past a cripple struggling down the sidewalk under the midday sun. Vincent secretly blessed him with a firm, quiet gesture and a mumbled prayer, seamlessly interrupting and then returning to the topic we were discussing. I was moved beyond words.

In our conversations and encounters with the suffering men and women of Attleboro, I learned to appreciate this affectionate outpouring of grace undeserved and often unasked for. In that freedom and freely given love, it was possible to intuit that indeed life promises life, and that love is indeed stronger than death. Sometimes a powerful echo of these truths, accepted and embraced, filled the sick and dying and their families and friends with a holy light, even in their sorrow.

Other times a confession did not come; some patients faded out of consciousness before the proffered arms were visibly accepted. Here is mystery. It was not Fr. Nagle's business to judge what comes after, but only to stand on the threshold, patiently offering his hands together with Christ's outstretched arms, holding nothing back. On that frontier battleground, he was sentinel, fellow soldier, and medic, bearing the one hope capable of healing our common mortal illness.

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Embracing "Slow Medicine" as Compassionate Care for the Elderly

COLET C. BOSTICK

McCullough, M.D. Denis, *My Mother, Your Mother: Embracing "Slow Medicine," the Compassionate Approach to Caring for your Aging Loved Ones* (New York: Harper Collins Publishers, 2008).

My Mother, Your Mother is an excellent common-sense book that addresses the inevitable decline and aging of one's parents. It is both a sobering and encouraging read, especially if one is fortunate enough to absorb its advice early on in the aging process.

The project proposed by McCullough, a geriatrician and the son of a nonagenarian, is to combat the present healthcare system of emergency room medicine with a more tempered approach of "slow medicine." As a specialist to the elderly and caretaker of an aged mother, the author has seen first-hand, repeatedly, that modern-day Americans do not treat advanced age as a stage of life with its own predictable ebbs and flows; as a result, those who are fortunate enough to live into their eighties and beyond endure "crisis cycles of hospital-rehabilitation-nursing home stays [which] are often repeated many times over." (Pg. 10).

"Slow Medicine" is not the systemization of yet another process, but the recognition of and insistence on the need for relationship. McCullough strives to be a gentle soul, but the core of his message is rather blunt: your parent is at some point going to die; prepare yourself, and plan to walk with your mother or father on this bittersweet path. (The reader is forced to endure repeated metaphors of life's journey and autumn leaves and climbing the last mountain of life; the main message is, however, a sound one.)

McCullough presents this journey as a series of seven Stations—an image which can be interpreted spiritually (the stations of the cross, the seven Sufi stations of

enlightenment) or metaphorically (train stops on the journey to the final destination), depending upon one's perspective. These stages are: Stability (“Everything is just fine, dear’—Mom”), Compromise (“Mom’s having a little problem’—Dad”), Crisis (“I can’t believe she’s in the hospital’—Sister”), Recovery (“She’ll be with us for awhile’—Rehabilitation Nurse”), Decline (“We can’t expect much more’—Visiting Nurse”), Prelude to Dying (“I sense a change in her spirit’—Nurse in long-term care”), Death (“You’d better come now’—Hospice nurse”), and Grieving/Legacy (“We did the right things’—Brother”).

The heart of McCullough’s message is the inviolable dignity not only of elders, but of the family that surrounds them. He is encouraging adult children to reacquaint themselves with their parents--to go back to the nest and not only rediscover, but intimately care for the ones they have most likely left behind. The answer may not be for mother to move back in with her children; however, children must familiarize themselves with the way mother lives in a day-to-day fashion, whom she relies upon as friends and intimates, how she views life and what awaits her after, what she wants for herself and why. As a geriatrician, McCullough is able to provide the reader with the red flags of breakdown that occur at various stages of aging, how to address setbacks, and how to advocate for the aging in a system which values efficiency over quality of life. Throughout the book he pleads for thoughtful deliberation and patience in considering options for one’s parents, as a restive society and a faceless medical bureaucracy pressure the elderly into nursing homes.

McCullough’s main objective—one he is hoping the reader and, eventually, the medical community at large will share—is to provide the elder with a fruitful end of life and a peaceful death at the heart of a loving family community. His book is an invaluable guide for adult children who wish to face their parents’ end, and eventually their own end, with empathy and peace.

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Awakening to Persons: the Ethics of Abortion

ERIK VAN VERSEDAAL

Kaczor, Christopher, *The Ethics of Abortion: Women's Rights, Human Life, and the Question of Justice* (Routledge, 2011).

Christopher Kaczor sets out in this work to present a methodical case against abortion from a strictly philosophical perspective. He proceeds by patiently engaging those pro-choice authors whose arguments have proven to be among the most persuasive in the abortion debate. His express aim is to attend to each of these dominant opinions and judgments thoroughly until their own self-contradictions or dire implications come to the surface, at which point their provisional reasonableness is radically undermined. He is explicit about the scope of his approach to the issue of abortion; the primary question that guides his study is simply whether abortion is morally legitimate. By appealing solely to reason rather than to revealed truths or theological reflection, and by restricting the range of his arguments to philosophy rather than including data or paradigms from, say, sociology, Kaczor admirably seeks to enter into conversation with those whose commitments are otherwise different from his own.

Acknowledging the kind of suffering that can lead to, accompany, and follow upon abortion, as well as the intimate nature of this event for those directly involved, from the outset the author distinguishes culpability from the morality of the act itself. There can be many factors that mitigate an individual's culpability, but Kaczor rightly points to the concreteness of the action as having inevitable consequences for the agent's very being. One's destruction of anything inviolable is, in this sense, immediately a self-wounding or self-disfigurement. With this in mind, Kaczor clarifies the decisive problem around which the abortion debate revolves—whether abortion is good or not—without undermining a concern for those whose suffering or fear leads them to take this measure, and without letting his rhetoric ever devolve into denunciation. Indeed, his understanding of morality allows him to place this work at the service of the well-being of all who may in some way participate in an abortion. Since he is asking about the morality of the act itself, he also does not base his claims

on the physical or psychological well-being of women who do or do not have an abortion, even if he does give attention to this at places in the book. He is interested rather in the flourishing of human persons, their moral and ontological well-being, which comes with enacting and being conformed to the good, even and perhaps especially under extremely adverse conditions and challenges to this enactment.

Focusing on the act of abortion itself, rather than on the intentionality of the agent or on extenuating circumstances surrounding the act, Kaczor is also able to direct his inquiry to the primary standard according to which the morality of abortion must be judged: personhood. In what does personhood consist and what qualifies a human being as a person? How is personhood recognized and what kind of response is called for by the reality of the person? As this work helps to show, the most important contributions from both sides of the debate have all had to grapple with such fundamental questions. Provided that the killing of an innocent person is always evil, and provided that a human being is in all cases a person, then no other principles or conditions could ever be invoked to justify a 'direct' abortion. Kaczor often points out that virtually all involved in the debate acknowledge the genetic humanity of the conceptus. He cites no less staunch an advocate for abortion (and infanticide) than Peter Singer, who plainly admits that "there is no doubt that from the first moments of its existence an embryo conceived from human sperm and egg is a human being" (cited on p.7). The relevant issue is, therefore, at what point and in what respect a human being is a person. In the first several chapters Kaczor examines and rebuts opinions that personhood begins after birth (Chapter 2), at birth (Chapter 3), and during pregnancy (Chapter 4), before offering a case for conception as the beginning of personhood (Chapter 5).

In the course of his inquiry, Kaczor trenchantly marks the consistency between many significant arguments for abortion and would-be justifications of infanticide. First, there are those who overtly mount a defense of infanticide, since the moral permissibility of abortion, at least in certain cases, would be secured were it proven legitimate to kill a child after birth. The whole basis for such a drastic standpoint rests on a distinction between the human being and the human person, or else a fast juxtaposition of 'potential' and 'actual' human personhood. These dichotomies are inflected in numerous variations among those who defend the validity of abortion, but the common claim is that the attainment of personhood confers on the human being immunity from unjust killing, a 'right to life.'

As noted above, the humanity of the conceived zygote is biologically incontrovertible.

How then are we to determine personhood? Proposals for identifiable markers of personhood that are common both to those who defend infanticide and to more moderate theorists of the pro-choice position include such human attributes and activities as self-awareness, discursive reasoning, intentional desire, concept-formation, communication, moral agency, future planning, sentience (the capacity for pleasure and pain), and physical movement, among others. Many of these would disqualify the newborn infant or even the young child. Depending on what combination of markers a given theorist posits as definitive, he may also run into difficulties when accounting for the personal dignity of the unconscious, the mentally disabled, the comatose, the emotionally disturbed, those with brain injuries, and even (as Kaczor himself enjoys pointing out) angelic or divine persons. Reliance on these emergent capacities for a standard of personhood leads to the difficulty of needing to determine gradations of personhood in a single individual, such that we can be confident that a point is eventually reached at which the human definitively possesses dignity and a right to life. Another chief problem raised by such criteria is that they force us to ask about degrees of personhood from one individual to another. If human persons each exercise these properties or capacities differently, then none share the same moral (or ontological) status. Similarly, these criteria fall prey to the ‘episodic problem,’ which indicates the possibility of transition from and back to personhood. In short, Kaczor exposes the vertiginous contortions to which defenders of abortion are forced to resort when attempting to deny that some human beings are not persons. His scrutiny of these divergent proposals serves as its own compendium of pro-choice stances, and sheds light on presuppositions they inevitably share despite their apparent disagreements.

At the heart of the book - the fifth chapter, entitled “Does Human Personhood Begin at Conception?” - Kaczor makes a crucial distinction between two competing accounts of personhood. The first he refers to as the “performative account,” a term which describes all those perspectives that grant personhood to humans based on a particular activity that they manifestly exercise. The other, the “endowment account,” speaks of personhood as an intrinsic character that is constitutive of all humans whatsoever by virtue of their very existence. The endowment account is comprehensive enough to justify the personhood of all those in whom human maturation is disrupted in one way or another. While the author seldom makes it explicit, the endowment account understands personhood ontologically. From this standpoint, all appearances that offer evidence of a given being’s humanity, however basic, express personhood, since being a person orders the human from his substantial ground. By contrast, we could speak of personhood on the ‘performative

account' as itself merely accidental, rather than that which is recognizable and worthy of reverence in all accidents of the human being. The performative account is incapable of providing a sure foundation for the protection of all innocent human beings from mistreatment and violence, since it would lead to the aforementioned problems of gradations and episodicity.

The pivotal point for Kaczor is that even if the 'performance' of an individual falls short of this flourishing in some way, the human is never potentially a rational being, but always already an actual person. What this means is that the rationality and freedom that characterize the fully-defined ('perfected') human being already shape the body from the roots of its organic life and in its most incipient state, even if the individual's capacity for intellectual or voluntary activity is somehow impeded or fails to fully develop. It is from this hylomorphic vantage-point that Kaczor offers clarifications in response to such objections against constitutive personhood as the vast developmental changes from embryo to adult, or the seemingly vexing problems presented by "twinning" and "fusion" of embryonic persons (Chapter 6).

Kaczor's method could be favorably regarded as a pedagogy in 'seeing' or 'awakening to' the reality of persons. "Awakening to reality" (Erwachen zur Wirklichkeit) is a metaphor coined by the German philosopher Robert Spaemann to describe the beginnings of the ethical life as a response to the goodness of a world of fellow beings. I find the term applicable to the maieutics through which Kaczor leads his readers in *The Ethics of Abortion*, which is to culminate in the acceptance that the personhood of all human beings can be known. Once one is 'awake' to this reality, the convicting evidence of the person shows itself radiantly, and calls forth a fitting response.

One of the lacunae of this work, however, occurs precisely with respect to Kaczor's use of the term person. While he makes clear that his approach does not first concern the legality of abortion but its morality, he is still willing to speak of this morality in terms of the rights of persons. To be sure, he thinks of the right to life as inalienable, and he ultimately grants that persons possess rights and dignity in view of their always-actual rational nature and their intrinsic directedness towards flourishing. At the same time, he never spells out the relationship between the person's metaphysical constitution and her belonging to a 'moral community.' It would be worthwhile for him to consider further the long-term dangers and possible misuses of rights-language, even if it can serve as a premise that he can expect his intended interlocutors to share with him. The ambiguity in his understanding of the person comes out in occasional appeals to egalitarian convictions as support for his claims. On what basis, it might be asked, ought we agree that all men are created equal? In

the end, we must do more than allude to the practical debacles that would result from failing to assent to this truth, for it is a metaphysical and theological claim that requires profound justification.

The most serious objection to be raised against Kaczor's work concerns his speculative argument in the final chapter of the book, which asks if artificial wombs could end the abortion debate. In brief, Kaczor argues here that, were artificial wombs invented, this technology could satisfy both pro-choice and pro-life concerns. An artificial womb would allow for the extraction of a child, and so effectively terminate the mother's pregnancy, without ending the child's life. Pro-lifers might object to the artificiality of this procedure, its unnaturality, but he deconstructs several attempts to contest its morality. Kaczor himself regards his approach here as "exploratory" rather than demonstrative. The point of this hypothetical exercise is, I take it, to establish a common ground or aim for all those engaged in the debate. The basic problem that Kaczor does not sufficiently consider (even if he gives it a nod) is the meaning of maternity and gestation in the womb, and their relation to personhood. Even if the instrument of an artificial womb is medically useful, and in extreme cases may save children from death, the question of what it means for a child to grow in such conditions, in isolation from his or her biological mother, must still be contemplated before it is proposed as a viable alternative to abortion. In other words, either ethics is too narrow to deal with this issue, or else the weight of the matter demands a more capacious notion of ethical judgment than is given here.

While the argument against abortion can be sustained by reason alone, religion is not irrelevant to illuminating these natural truths. In the first place, it should be affirmed, in support of Kaczor's accomplishments here, that no appeal to revelation is necessary to substantiate the claim of the fetal child's personhood. It is also the case, however, that the deepest significance of human life and its beginning cannot be contemplated independent of knowledge of its Creator, who is knowable by reason and hence is not beyond the purview of a philosophical treatise. Furthermore, it should also be held that knowledge of the Creator as he reveals himself, as a Trinity of persons, will guide and further inform our understanding of creatures and hence of created personhood. If a false ontology blinds people to the reality of persons, this is due both to a deficient exercise of reason and to the effects of sin. It is the light of the personal Logos of the Father, embodied in Jesus Christ, that heals the wounds of sin, restores to fallen man a vision of the good, and enables him to know the mysteries of divine love. So it is that communion with the Trinitarian God in Christ most fully 'awakens' one to persons, as well as to the ultimate foundation for creaturely dependence and vulnerability, the

goodness of begetting and parenthood, and the inviolability of the enwombed child.

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Lamenting The Failure of Long-Term Care

KATHLEEN CRANE VIDMAR

Kane, Robert L. and West, Joan C., *It Shouldn't Be This Way: The Failure of Long-Term Care* (Vanderbilt University Press, 2005).

“Packing up our mother’s few remaining possessions, we felt that her life should mean more than these fragments,” say brother and sister co-authors Robert Kane and Joan West. Their mother, Ruth Kane, suffered a stroke at age 84, and lived the final three years of her life in various long-term care settings. Robert Kane, a geriatric physician and researcher, and West, an elementary school teacher, recount the final years of their mother’s life, and in the process of telling their story, attempt to offer practical guidance to others who are navigating the world of long-term care for the first time.

As it happens, Kane and West wrote this book for people like me. Shortly after I was asked to review their work, my own mother suffered a severe hemorrhagic stroke to her right brain. Only 59 years old, my vibrant, energetic mother was rendered utterly dependent, losing all sensation and mobility on the left side of her body from her shoulder down. After cranial surgery and a brief stay in the hospital, she has lived the last two months in a Transitional Care Unit. Happily, my mother is recovering beautifully from her stroke. She is regaining sensory and motor function, and will be leaving the world of long-term care and returning home as I write this review.

My personal experience lead me to read Kane and West’s book with great interest. The book promised to be part memoir, part practical guide, as the siblings recounted each step of their mother’s journey. From the event of her stroke, through relocation, rehabilitation, assisted living, and their mother’s final days in a Nursing Home, the authors outline their experience navigating through a matrix of insurance rules, hidden costs, and federal regulations.

They describe an environment where poor communication and caregiving without compassion are commonplace. Most significantly, they reveal a care system ordered

toward metrics and profit rather than what was best for their mother, a system that seems utterly incapable of appreciating the profundity of what it means to care for those among us who are facing their own mortality.

At the end of each chapter, Cane and West offer practical advice on traversing what they describe as a tragically broken system. These sections of the book are a crash course in what my mother calls “personal advocacy,” understanding your rights and how to assert them over and against a care system that could quite literally “care less.” The final chapter of the book calls for reform, demanding the dramatic reorganization of Medicare and Medicaid, and changes in the communication and funding structures in hospitals, insurance companies, and long-term care facilities. The authors advocate for higher wages for those caregivers who work in closest proximity to patients, and end by calling for the formation of a coalition of interested medical practitioners and laymen to lobby Congress.

For me, *It Shouldn't Be This Way* provided a technical introduction to the world in which my mother was now living. For someone unversed in hospital jargon, unaware of the inner-workings of insurance companies and federal programs, and generally naïve to the pitfalls of the long-term care scene, this book could prove to be very helpful.

But I wanted more.

Cane and West do not promise anything more than a secular, technical analysis of the state of long-term care in the United States, and they deliver their conclusions in these terms. In the end, they advocate for the creation of a system that more justly adjudicates between the rights of the person over and against the rights of the institutions. In doing so, they betray a foundational belief that this kind of procedural response will have the power to resolve the tragedy of their experience.

With all due respect, I doubt it.

Our long term care system does not exist in isolation—its problems are the fruit of underlying cultural problems that are born out in the authors' experience, and the result is heart-rending. As I reflect on my own experience with my mother, I wanted someone to speak into my experience on this plane.

I wanted Cane and West and to talk about what it meant to them that their family was scattered across the country. After their father's death, their mother moved out of their family home in New York and took off for Florida with a new lover. With the

locus of their family life gone, Cane and West did what most everyone in the US does—they moved to the places that were most advantageous to their careers. Their mother did not have strong connections to her community in Florida, and much of the difficulties in the early days after her stroke were clearly exacerbated because none of them were rooted in a place. (I mean “place” with all of the force that an Aristotelian/Wendell Berry-ian context can provide!)

I wanted the authors to tell me more about their mother’s extreme aversion to medical care, her great fear of becoming disabled, and her wish to be euthanized if she were ever to become so. In her view of the world, she did not believe that her life would be worth living if she were dependent; clearly, the knowledge of her adamant perspective on this matter was a cause of great grief for her children throughout the ordeal. Ruth was not a religious woman. Indeed, through the lens of a secular worldview, old age, decline, and death are an absurdity. If Ruth had been grounded in a perspective of the human person founded in our ability to give and receive love (as opposed to an identity rooted in our ability to exercise control), how might her perspective on her own life have been different?

Much more could be said here, but my central question is not so much directed to the authors, as to all of us. In the United States, to have a right, one must be able to claim it. The majority of the advice given by Cane and West is about just this—self-advocacy in the form of claiming rights within the context of our long-term care system. My question is this: what does it mean that within the socio-political cultural context of the United States, our conception of “rights” carries forward an inherent vulnerability for anyone who is unable to claim these rights for themselves. So long as our paradigm of human interaction is conceived in this manner, we will always have reasons to say, “It shouldn’t be this way.”

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The "Gift" That Kills? On the Ethics of Organ Transplantation

MATTHEW AND MICHELLE KUHNER

Jensen, Steven J., Editor, *The Ethics of Organ Transplantation* (Washington, DC: Catholic University of America Press, 2011).

In his 1995 encyclical, *Evangelium Vitae*, St. John Paul II stated that “the donation of organs, performed in an ethically acceptable manner, with a view to offering a chance of health and even of life itself to the sick who sometimes have no other hope,” is a “particularly praiseworthy example” of the everyday heroism that builds up the culture of life (§86). Unfortunately, the nobility of such a gesture is threatened in our contemporary setting by many ethically questionable practices, some of which have become deeply imbedded in the wider implementation of organ transplantation. *The Ethics of Organ Transplantation*, edited by Dr. Steven Jensen, treats these practices head-on, providing a thought-provoking contribution to the ongoing discussion of this topic.

The book consists of 14 essays that were originally papers given at a University of St. Thomas (Houston, TX) conference in 2009. The published text clearly bears the stamp of a multi-disciplinary approach, insofar as the authors range from bio-ethicists and medical doctors to psychiatrists, theologians and lawyers. The book is divided into five thematic parts, each of which considers the most pressing questions in the present debate (Brain Death, Donation After Cardiac Arrest, The Dead Donor Rule, Gift or Conscriptio?, Corollaries and History). It may be helpful to note that the conference was not focused upon a Catholic approach to organ transplantation, even though a good number of the essays take up the question directly.

The Ethics of Organ Transplantation concerns itself with both living organ transplantation –the transplantation of a non-vital organ (e.g., a kidney) from a healthy donor –as well as the transplantation of vital organs after death. While these

are obviously both instances of transplantation, it is helpful to distinguish them at the outset insofar as each has come to carry its own set of attendant ethical questions and problems.

Several authors deal with living organ transplantation alone. Those who do so – Romanus Cessario, O.P., Thomas L. Cook, and Janet Smith – write from a distinctly Catholic perspective, and this is no accident: a very spirited intra-ecclesial debate has taken place over the last 75 years regarding the ethics of living organ transplantation. The presently ubiquitous intuition that living organ transplantation can be an ethically responsible form of charity and self-gift was not always shared by the majority of Catholic theologians and ethicists. Many Catholic thinkers of the 1940’s and 1950’s found it difficult to accept living organ transplantation – a potential possibility of science that came to reality in 1954 – as ethically permissible. Our three authors revisit the arguments, pronouncements, and developments that eventually brought us to the position indicated in the Catechism: “Organ transplants are in conformity with the moral law if the physical and psychological dangers and risks to the donor are proportionate to the good sought for the recipient” (§2296).

The majority of the text deals with the issues that crystallize around the transplantation of vital organs after death, as well as the foggy borderline that traverses living and dead organ transplantation (e.g., a person who is already dying but wishes to donate their vital organs prior to the occurrence of natural death). Presently, a person must be declared dead in order to donate his vital organs. This so-called ‘dead donor rule’ is intended to go a long way in preserving the “first, do no harm” aspect of the Hippocratic Oath by ensuring that the physician’s act of transplantation does not kill—and thus harm—the donor. Yet it is precisely here that a conundrum surfaces: as soon as the donor dies, the organs—the vital organs especially—begin to deteriorate quite rapidly—often too rapidly for successful transplant. This obviously poses a problem for advocates of vital organ transplantation, who wish to procure the organs prior to their deterioration. Instead of opposing the ‘dead donor rule’ directly, some of these advocates have sought a way around the conundrum by attempting to modify the definition of death. The neurological criteria for death—so-called ‘brain death’—arose (in part) from this situation: the ‘death’ of the brain will sometimes occur before the organs begin to seriously deteriorate, so there is a longer window for a successful transplant. Any follower of the ‘brain death’ controversy and debate will benefit from the four essays addressing it in our text. Most notably, D. Alan Shewmon, the most well-known critic of the ‘brain death’ criterion, makes a contribution, as well as Jason T. Eberl, who

wishes to defend the 'brain death' criterion on Aristotelian-Thomistic grounds. The reasonable question that Shewmon and others ask is whether the 'death' of the brain, so to speak (or the prognostic assessment of the cessation of brain function) is the actual death of the organism.

The neurological criterion for death is not the only controversial point of intersection between organ transplantation and the medical prognosis of death. Christopher Kaczor and L. M. Whetstine discuss Donation after Cardiac Death (DCD), a practice that relies upon the older cardiopulmonary prognosis of death. Such a prognosis posits that a patient is dead when there has been an "irreversible cessation of circulatory functions" (see The Uniform Determination of Death Act). The pressing question that lies at the heart of the issue concerns the precise meaning of 'irreversible': when precisely is the point of irreversibility? Or, as put by Whetstine, "[W]hen, in the resuscitation process, does the patient transition to a donor?" (119). Advocates of DCD generally opt for a minimalist interpretation, wherein the patient is declared dead if he or she does not respond to CPR and does not autoresuscitate for two to five minutes. This will, of course, help preserve the viability of the organs for transplant. But since there is medical doubt about the sufficiency of the minimalist interpretation for a thorough prognosis of death, it is difficult to see how DCD practiced in this manner can fully respect the 'dead donor rule.'

A perhaps obvious but less travelled path out of the conundrum is to propose the abolishment of the 'dead donor rule' as such. Such is the argument of Thomas Cochrane in the text. He suggests that the rule presently inhibits dying patients from exercising their liberty by denying them the right to donate their vital organs prior to natural death. Interestingly, he cites the abuse of the dead donor rule as a reason to abolish it altogether. In other words, if advocates for organ transplantation are constantly pushing the limits regarding the definition of death, then the dead donor rule has effectively lost its meaning. Cochrane's proposal is to come to overt terms with what has been covertly attempted, namely, to find a way around the dead donor rule. The problem is, of course, that the abolishment of the dead donor rule entails the establishment of a kind of suicide, in which the patient willingly (and supposedly generously) consents to be killed by the doctor in the process of harvesting his vital organs for donation.

Beyond delving into each of these particular aspects of organ transplantation, perhaps the greatest strength of the text is its (albeit implicit) presentation of the differing anthropologies present in the varying positions on the issue. While perhaps not intending to do so, this collection of essays enables the discerning reader to notice that

a particular position regarding the ethics of organ transplantation harbors a definite anthropology, a certain understanding of what the humanum is. Returning to the statement of St. John Paul II at the beginning of this review, it is clear that the late Pope considers organ transplantation to be a possible element of a sincere gift of self, such that it will participate in the building up of the culture of life. Yet, interestingly, Thomas Cochrane speaks of his understanding of organ transplantation in terms of donation as well. Both claim that their divergent understandings of organ transplantation have the character of self-giving –but can they both be authentic? Is my body a possession (or a collection of possessions) which I may rightfully dispose of as I see fit, even if this takes the form of an act of suicide? Or is my body first given –as one pole of a body-soul unity –such that I do not have the rightful authority to intentionally take my life (even if it were to benefit another)? The essays of Witold Kania, Steven J. Jensen, and Thomas Hurley are of particular help to the reader in identifying these implicit anthropologies and working through their different aspects.

The Ethics of Organ Transplantation offers an informative and multi-faceted approach to the status quaestionis of organ transplantation and donorship. Either through a positive articulation or through presenting a negative foil, these essays will help the reader to think through the Church’s teaching on the matter. As a whole, ecclesial guidance and the unfortunate outcomes of the culture of death make one thing amply clear: whether in vital or non-vital organ donation, a giving of self that does not respect our origin and our nature will undoubtedly shatter the very nobility of the gift through the triumph of parts over persons.

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Defending the Defenseless: A Case Against Abortion

SIOBHÁN MALONEY

Beckwith, Francis , *Defending Life: a Moral and Legal Case Against Abortion Choice* (New York: Cambridge University Press, 2008).

Francis Beckwith's book is heralded as the "most comprehensive defense of the pro-life position, morally, legally and politically, that has ever been published." Perhaps the word comprehensive is the best that can be found to describe the task undertaken in this book. Associate Professor of Philosophy and Jurisprudence at Baylor University, Beckwith here gives an incredibly thorough presentation of the questions at stake in the legal and moral debate over abortion. He himself describes the purpose of the book as providing " a thorough defense of the pro-life position on abortion and its grounding in a particular view of the human person, a view I will argue is the most rational and coherent one that is at the same time consistent with our deeply held intuitions on human equality." (Intro, pg. xi) In order to accomplish this goal, he utilizes everything from a detailed overview of the history of the Roe v. Wade court case, and those following it, to an explanation and critique of virtually every argument of the opposing side.

Some of the most valuable sections of Beckwith's book are those in which he engages the "deeper questions," uncovering the inner logic (or lack of it) at work in the legal decisions and popular arguments in support of abortion. While it is easy to get lost in the details of specific debates, situations and actions in the midst of such an emotionally charged topic as abortion, Beckwith takes us the crucial step further into examining the heart of the issue. His first chapter is devoted to a critical examination of the problem of moral relativism, and how it affects our mode of reasoning about moral questions in general. Again in Chapter Three, he gives us a thorough account of why it is impossible to avoid the question of what it means to be a human person, a subject of moral rights, even when one claims not to have attempted to answer such a philosophical question. Beckwith rightly asserts that everyone who takes a stand on anything is operating on some implied conviction of what it means to be human,

what a person is, etc. In his explanation of this fact, he also presents a clear, straightforward account of a traditional metaphysics, describing the crucial distinctions of accident and substance, what it means that things have natures, what constitutes an organism, etc. He brings all of these important distinctions to bear in demonstrating that virtually every argument in favor of abortion has ignored or misunderstood some or all of these principles. For example, he shows how many arguments which deny personhood to the unborn do so out of a mistaken reliance on accidental qualities as the criteria of personhood, such as viability, sentience, consciousness, physical appearance, or other characteristics, and confusing them with essential qualities, i.e., those things that make something to be what it is.

The remaining chapters of the book are largely devoted to a critical analysis and refutation of the variety of arguments for abortion, loosely organized around two different stances: those that argue for abortion on the grounds of the unborn not being a person (even if recognized as a human being,) and therefore, not a subject of rights, and those who grant the unborn personhood, but, for a variety of reasons, still maintain they have a lesser degree of value/rights than fully-born persons.

Because of his engagement with so many interlocutors over the fine points of their arguments and their individual examples, it can be hard at times to follow him through his plethora of debated points. The structure and method he employs can be confusing, and the basic truths he's trying to convey at times become lost in the minutiae of answering every last objection and analogy offered against him. This structure even causes him to repeat, verbatim, several pages of his argument from chapter three to reinforce his point in chapter six!

It is clear throughout these chapters that Beckwith is very well-versed and equipped in his understanding of the opposition's arguments and logic, and very practiced in debate on this topic. However, I was disappointed by a lack of unity and integration at times between the chapters devoted to answering specific thinker's positions and his reflections on the deeper questions at stake in the debate. It seemed oftentimes that he failed to bring to bear upon the popular arguments the very conclusions concerning anthropology and metaphysics that he himself enunciated in other chapters. Thus, in answer to certain arguments that affirm abortion on the principle that human life is only potentially present, or not present until sentience, etc. he wants to argue that the value of a human person is not dependent on qualities they possess, or their benefits or usefulness to society. But this truth, (namely, that every person has an intrinsic value by virtue merely of being human,) is precisely what is being denied and

challenged in such positions, a fact he himself acknowledges in other places.

Similarly, he critiques those who argue for abortion on the grounds of the inviolable autonomy of the human body by appealing to the natural dependence of the child, the nature of pregnancy as a good according to the nature of the human person, and the woman's responsibility in bringing that child into being, and therefore causing it to be dependent on her. What he fails to address head on, however, is the very fact that this recognition of pregnancy as a natural good has become incomprehensible to a society with a dualistic/Cartesian approach to the body, and an anthropology of the autonomous individual.

It is frightening to realize that in a world of assisted suicide, IVF, and genetic selection, it is becoming impossible to find the grounds to argue from the basic established principles Beckwith felt he could employ when this book was written only eight years ago. Thus, such appeals as: "No one disputes that the homeless are intrinsically valuable, even though they are, for the most part, unwanted..." (pg.99), or that of the wrongness of taking a ten year olds' kidneys to save a person who is curing AIDs (pg. xii), are becoming increasingly hard to maintain with the logic of a society that does ground the value of persons oftentimes in their utility, or desirability for the strong, the intelligent, and the successful. Beckwith sometimes touches on this, but in other places assumes in his arguments that his readers are willing to accept a definition of the value of life that is becoming virtually incomprehensible to modern society.

I would recommend this book to those interested in understanding the details of *Roe v. Wade*, those in pro-life work and ministry who find themselves often confronted by the details of the arguments refuted here, and to anyone interested in understanding and thinking more deeply through the implications of our current legal battle over abortion. It is a very good summary, and comprehensive approach to the many-faceted components of the debate.

In the end, this book is most valuable for its insistence on asking the deeper questions within the abortion debate: Who has rights? Human persons? But, then, what makes you a person? Is it biology? The capacity to feel pain? Being human? Or certain apparent characteristics, determined by whom? These questions are foundational to the debate, and it is doubtful whether they can be answered apart from theological resources. In the end, are compelling, rational arguments, like those Beckwith ably provides, enough? Is logic and reason enough? Do we even still take them seriously? Can we speak about morality in purely rational terms, with no appeal to the spiritual? In speaking of rights, is it possible to avoid the question of Who the source of these

rights is? Can one truly affirm the inviolable dignity and personhood of the unborn apart from the truth that man is made in the image of a Triune God, made from and for and towards the other, made to love and to be loved?

These are some of the questions I pondered in reading this book. In a society that conceives of the person as the independent, self-made individual, I think we will need more than logic to move and open our hearts of stone to the needs and inviolable dignity of the other... especially the youngest, most vulnerable. And I think this “more” requires an openness to the Other without Whom our very existence and meaning cannot be comprehended.

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The Vocation of the Hospice Nurse: A "Midwife for Souls"

KRISTINE CRANLEY

Kalina, Kathy, *Midwife for Souls: Spiritual Care for the Dying* (Boston: Pauline Books & Media, 2007).

“We are eyewitnesses to the infinite value of the last days. We see the miraculous spiritual growth and reconciliations, the heroism, humor, and unconditional love of the dying. We feel the graces that flow and, if we’re attentive, we see the eyes of Jesus. Even if the whole world insists that killing can be an act of mercy and compassion, hospice midwives must stand firmly and boldly in the defense of life, from womb to tomb. It’s nothing less than our duty to speak the truth we’ve been blessed with.” - *Midwife of Souls*, p. 75

It is precisely this eyewitness account of the infinite value of the last days which seasoned nurse and hospice care practitioner Kathy Kalina offers to her readers in her book *Midwife for Souls: Spiritual Care for the Dying*. Comprised mainly of stories from her own experience with the dying, this work grants a rich and privileged perspective into the mysterious beauty of the last days of life. Although written primarily as a guide for hospice workers and those who live with the terminally ill, the vignettes contained therein testify powerfully to all readers about the inviolable sacredness of the soul’s final journey to God, and offer practical wisdom on how to accompany a loved one during the last days of this pilgrimage.

The author begins by sharing her original reluctance to become involved with hospice care, rooted in her distasteful experiences of hospital practices regarding death. In her time as a nurse she had seen numerous patients who, though clearly past the point of being able to be cured, were made to endure painful and unnecessarily prolonged treatment. Believing there must be a better way in which to accompany the dying she came to appreciate the contrast she found in hospice which, in focusing on the control of symptoms rather than the cure of the disease, offers the patient the opportunity to die in the peace of their own home surrounded by their family. She states that “care

for the dying has traditionally been a function of the family with generous community support.” However, because the geographical scattering of families and communities has resulted in a general ignorance about how to care for the terminally ill, she believes that “the hospice team can fill these gaps, acting as a substitute for family wisdom and community support, giving families the courage to care for their loved ones at home.”

In order to articulate the nature of a hospice worker’s task, Kalina returns over and over to the analogy which she sets forth in the title of her work: namely, that the hospice nurse acts as a ‘midwife’ of the soul in its transition from life on earth to eternal life. She points out that the word ‘hospice’ means “a place of rest for weary pilgrims” and seeks to enlighten her readers about the arduous spiritual work that takes place in souls preparing to meet God. She insists that the hospice care worker must be concerned the whole truth of the person, understood as a body and soul unity who exists in relation with others, and is ultimately called to communion with God. “In midwifery for souls, the goal is a comfortable body, a peaceful passage and a triumphant soul”. To this end she educates the prospective hospice care worker on the physical, emotional, relational and spiritual needs of the dying patient.

Regarding the physical needs, she focuses primarily on the role of the hospice midwife as ‘comfort expert.’ She tells us she always starts there because “trying to work on anything else before the patient has reached some level of comfort is futile.” Additionally, she helps the ‘midwife of souls’ to recognize some of the physical signs of the imminence of death in order that she might assist in preparing the family for their final farewells.

In contrast to the common practice which counsels those who work with the terminally ill not to allow themselves to become emotionally attached to their patients, Kalina insists on the need for the hospice nurse to allow herself to bond with the patient. When an emotional connection is formed between the caregiver and receiver, it enables the hospice worker to accompany and support her charge in their emotional needs. She finds that patients often have a longing to tell their story and to speak of their faith and their fears. To this end she offers several leading questions which help facilitate conversations, such as, “How long have you been sick?”, “Are you afraid?”, “What do you think will happen after you die” or “Do you believe in God”? In the face of a patient’s anxiety, she is able to share from her own treasury of experiences in order to assuage their fears about death. “I share what I’ve seen with my own eyes. I tell them about patients who saw angels and loved ones already on the other side. I tell them about patients who die with an expression of radiant joy, who

obviously are seeing something beautiful at the moment of death. And then, with their permission, I pray with them.”

An integral part of caring for the whole person involves recognizing that the patient is not an isolated individual but rather one who exists in relationship. Kalina insists that the family is ‘the basic unit of care’ and stresses to all hospice workers the necessity of working closely with the family and listening to their needs and concerns. She testifies that when the family is able to participate in the physical care it can bring relational healing and help reconcile them to their loved one’s death. The importance of the intimate relational dynamics which occur during this time, even when a patient is seemingly unconscious, is demonstrated in some of the remarkable stories the author shares of patients refusing to die until certain family members are present, or until they receive permission to die from their loved ones.

Above all, Kalina stresses the importance of the spiritual care for the dying. She encourages her ‘midwife of souls’ to assist in getting clergy involved and to look for opportunities to pray with the patient. In the appendix she includes some prayers and scriptures that can be helpful in bringing spiritual comfort to those who are dying. She remarks that the physical signs of approaching death are accompanied by spiritual signs such as desire for silence, detaching from relationships, and a spiritual restlessness which, when it passes, is usually followed by a new peacefulness and resignation. In addition she notices what she speaks of as a ‘heightened spiritual awareness’ at the approach of death, marked by patients staring intently at some point in the air and speaking of seeing angels or loved ones, or even at times menacing presences which have come to try to rob them of their confidence in God’s love. In the intense vulnerability of the dying process, she is convinced that patients “want to believe in a loving and forgiving God, and as a Christian midwife for souls it would be irresponsible not to gently share my faith with them when presented with the opportunity.” She has found that when patients bond with their hospice nurse, they let her in on the process of reviewing the joys and regrets of their life. When allowed into the sacred space of this ‘life review,’ those at the bedside of the dying can be a catalyst for encouraging them to reconcile and forgive past injuries in order for a peaceful death to occur. Finally she speaks of the need for the hospice midwife to attend to her own spiritual needs through prayer, personal formation, and fellowship with other believers in order to better be an instrument of grace to those whom she severs.

Via the witness of her own experience at the bedside of the dying, the author argues

passionately against the practice of assisted suicide and euthanasia. She insists, “If a patient takes an unusual amount of time to die, there is always a reason. Even if you can’t figure it out, there’s important work going on. That’s why euthanasia is such a tragedy, aside from the fact that it’s murder. It robs the patient, and the family, of the time they need to resolve vital issues, even if they can’t see any purpose to the delay.” In her work she finds that suicide requests usually come only when a patient is suffering from uncontrolled pain, coupled with a sense of being burdensome or unloved. Hospice seeks to address both of these concerns in order that the patient and family may receive all the blessings of reconciliation and growth in spiritual maturity which God has prepared for them in this final time. In accord with her theme, she likens suicide requests to a woman in labor who tells her midwife she wants to give up and go home before the child is born. She asserts that the midwife of soul’s job is to dissuade patients from giving up the fight and encourage them to push through to the end, while likewise assuring family members tempted to hasten their loved one’s death that “killing her would rob her of the time she needed to put her house in order.”

Additionally, she addresses the crucial distinction between the withdrawal of food and water for the purpose of hastening death, and the point when food and water can no longer be processed by the body. In a footnote on page 12 she clarifies, “[I]n the active dying process, the body’s systems are failing and eventually lose the ability to process or to utilize food and fluids. In this case the patient will take in by mouth only what the body needs. Tube feedings and IV fluids strain marginally functioning systems and cause discomfort. This is not to be confused with removing food and fluids from an unconscious patient—whose body is able to utilize nutrients—in order to cause death.” While some hospice programs have been known to intentionally render the patient perpetually unconscious through medication and consequently allow them to starve to death through being unable to wake up in order to take food, Kalina in contrast argues forcefully for a hospice care in which “death is neither hastened nor prolonged,” in conformity with the full truth and dignity of the human person.

Finally, Kathy Kalina concludes her work with a word on the mystery of suffering, which is inextricably linked to the end of life issues to which she is speaking. The foundation of her rejection of what she calls the “false kindness without love” which seeks to kill the sufferer, is the conviction that suffering in union with the Crucified Lord is “infused with the ‘salvific power of Christ’s own Cross, offered to humanity in Christ’”. Going back to her midwife motif she writes, “Working in labor and delivery would be very depressing if you never saw a baby. Hospice midwives must see the

baby, the soul, safely delivered to God, with their spiritual eyes.”The revised edition of this book includes an additional section of stories which testify gloriously to the “spiritual productivity of suffering,” in which she has seen her patients “lifted by that grace to spiritual maturity, even greatness which inspires those around him or her.” Likewise, it is faith in the fruitfulness of suffering love that enables her to repeatedly embrace the compassionate grief intrinsic to her work. She explains, “It took me years to discover the truth; the only way to protect yourself from the pain of compassion is to never love. For a midwife of souls, that just isn’t an option.”She has come to believe that offering the gift of one’s presence at the bedside of the dying in imitation of the loving Mater Dolorosa in attendance at Her Son’s death can be a manifestation of what John Paul II in *Savifici Doloris* speaks of as the “gift of self,” through which one “finds himself” as he grows toward the fullness of his humanity. “Did you know that a heart can get stronger in all the broken places?” she writes. “I used to think it took a strong heart to do difficult things. Now I know that doing difficult things is how you get one.”

In summary, I believe the stories which Kathy Kalina shares in *Midwife for Souls : Spiritual Care for the Dying* do exactly what she intends them to do: namely, offer encouragement and practical advice for all who live and work with the terminally ill. She is explicit that she is offering her readers practical wisdom for hospice work that is unabashedly informed by her Catholic faith, and which prioritizes the care of the soul in its attentiveness to the needs of the whole person. Her simple and narrative style is not intended as a theological or ethical treatise on the end of life issues, and yet the experiences of the dying which she recounts speak for themselves of the marvelous dignity of the human person. Whether it be John who beyond all odds waited weeks for his mother to arrive before he died, Mary who passed peacefully moments after she was finally able to forgive her ex-husband, or four-year-old Brice telling Jesus that he wanted to bring his puzzles and his grandmother along when he went, each show forth the relational reality of the human person, created with free will and called to union with God. Additionally, the author’s sensitive and maternal approach to addressing the needs of the dying offer a helpful example and encouragement for all who find themselves timid before the unfamiliar challenge of facing the death of a terminally ill loved one. Finally, as one who must likewise make this same journey common to all who share the mortal condition, I am grateful for, and deeply comforted by, the numerous stories Kathy Kalina shares in *Midwife of Souls* of the merciful tenderness and nearness of God to the one preparing to meet Him. “Since we are surrounded by so great a cloud of witnesses, let us rid ourselves of every burden and sin that clings to us and persevere in running the race that lies before us while

keeping our eyes fixed on Jesus, the leader and perfecter of faith [who] for the sake of the joy that lay before him ... endured the cross despising its shame, and has taken his seat at the right hand of the throne of God ... in order that you may not grow weary and lose heart.” Hebrews 12:1-3

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Blurring the Line Between Life and Death In Organ Donation

BENJAMIN PETTY

Teresi, Dick, *The Undead: Organ Harvesting, the Ice-Water Test, Beating-Heart Cadavers—How Medicine Is Blurring the Line Between Life and Death* (New York: Pantheon, 2012).

The saying goes that nothing is for certain except death and taxes. Dick Teresi invites us to consider that perhaps we aren't even that certain about death. Of course we all will die, but when we try to pinpoint the moment of death, things get very complicated. Just how complicated is the subject of this book.

In 1968, a group of Harvard scientists published a paper laying out criteria to determine whether a patient is sufficiently unresponsive to be able to declare that an irreversible “loss of personhood” has occurred. This committee began what Teresi refers to as the “brain-death revolution” that reversed millennia of traditional and nearly universal agreement that a body isn't truly dead until it begins to decay. Given the growing demand for organ donors in the now \$5 billion a year transplant enterprise there is pressure to declare potential donor candidates dead earlier and earlier. Teresi suggests that the Harvard Study and its rapid acceptance may have been anticipating this demand.

Overtaking traditional consensus isn't news to anybody alive today, but what is surprising is the lack of good scientific practice in doing so. The original Harvard report cited no studies to support its new criteria. Later studies even falsified their basis. The report switched the debate from biology to philosophy, essentially saying, “We want to redefine death, and here are some suggested criteria for our new definition.” The Harvard report ended up becoming the basis for the 1981 Uniform Determination of Death Act which codified death as the irreversible cessation of the entire brain, but left the medical profession free to formulate how that is determined and gave them immunity from criminal and civil prosecution so long as they act in good faith.

Teresi examines the criteria: being unreceptive and unresponsive, lacking movement or breathing, lacking reflexes, and having a flat electroencephalogram (EEG). Practically, this means just a few simple tests conducted within five minutes at a patient's bedside: swabbing the eyes to cause a blink, provoking a gag reflex or cough, pouring cold water into the ears, verifying the eyes do not track and then seeing if the patient gasps when disconnected from her respirator. None of the tests by themselves are sufficient upon to review to verify that the person has died.

He compiles an impressive array of falsifying examples that demonstrate that "brain death" maybe a very good predictor of imminent death, but it is by no means an ironclad indicator that an irreversible "loss of personhood" has occurred. These examples range from the beating heart corpses awaiting organ harvest to people in a persistent vegetative state to those having a near death experience, but all of them reveal the tenacious persistence of human life in spite of a loss of measurable brain activity. There exists the very real possibility that many people's organs are being harvested while they are in fact possessed of some form of consciousness.

Teresi shows how this shift in one part of medicine impacts not only the rest of the art as a whole but also has significant social and legal repercussions. Some of these include doctors who stop treating patients for the sake of saving their organs, hospitals that won't release bodies to the families until they consent to organ donation, the warehousing of ICU patients, and the complications of carrying out a criminal death sentence.

The final chapter is a look at different philosophical questions in the scientific community which shape the discussion of what death and personhood actually mean. He concludes by clarifying that he is not against organ donation but is simply asking the obvious questions which come from looking at the way it is currently carried out.

By the end it becomes clear why the first chapter is chiefly a reminder that we all will die and there is nothing we can do about it. For all its magnificent accomplishments modern medicine has yet to prevent the eventual death of anyone. In fact, though it has increased the length of time an average person may live (life expectancy) it has been unable even to increase the length of time it is possible for a human being to live (life span). In our rush to preserve life we may have forgotten that it does in one way or another end. *Memento mori*.

For Teresi, appealing to the brain death criteria is a convenient way for doctors to justify making use of someone who is so close to death that she is otherwise useless. In

a sense it avoids the messiness and mystery of human death by bringing it about through organ donation. Teresi shows us that waving the brain death wand doesn't make the person go away, and that we ought to think more about how to die well than to avoid death.

As a long time science writer and journalist and aware that he, too, is approaching his own death, he is well-suited to issue this call. He takes seriously his obligation to maintain journalistic objectivity but his tone is approachable and full of winsome humor. He doesn't present the other side strongly, mainly because it already has such broad support. He claims to be making no moral judgments but finds himself constantly pointing out where the emperor of organ donation is lacking some critical garments. His writer's attention to the semantic battles in brain death reveals their underlying philosophical concerns.

His book's greatest accomplishment is to show how this shift in the determination of death has nothing to do with biology or scientific advancement but is at root a philosophical judgment that is potentially driven by the economics of organ donation. He could do more, however, to make explicit the Cartesian dualism informing this judgment. Despite its theoretical limitations, the book is worth reading. Teresi writes with the skill of a seasoned journalist, powerfully demonstrating his thesis through a wealth of interviews and compelling stories. The Undead might not lay out a thoroughly philosophical critique of medicine's morbid interventions, but it will put the reader on alert viscerally. After contemplating Teresi's vivid and disturbing examples, it is not difficult to see how we should appreciate the mind-body integration now—before our organs are removed.

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Caring for Aging Parents in a Catholic Way

PRAVIN THEVATHASAN

Dodds, Monica, *A Catholic Guide to Caring for Your Aging Parent* (Loyola Press, 2006).

Monica Dodds had a great deal of experience working with elderly people and their families in the Seattle region. She was a case manager for homebound elderly and a program coordinator of a senior center. In this highly readable work, she proposes that care giving can be a time of grace.

The work is largely aimed at the increasing number of people who are called to become caregivers for their aging parents. The author's personal experience shows as she tackles medical, financial and legal problems associated with looking after elderly parents. The book is easy to read and is ideal for tired caregivers.

The chapter on mental health is excellent, providing a wealth of practical advice. She covers important topics including depression and dementia. The chapter on emotional and social health is also filled with good, sensible practical advice. Anyone who describes the encyclical on the Gospel of Life by Pope John Paul as "a stunningly beautiful document" must have been a solid Catholic and this shows in her discussion of Catholic spirituality. Practical as always, she discusses how to prepare the elderly for confession and how to deal with a parent who wishes to receive Holy Communion but who has swallowing difficulties. The chapter on how to deal with the many emotions that come with caring, including anger, guilt and exhaustion are especially helpful. The practical note goes all the way to the last chapter on the Church and dying.

This reviewer was able to read the book quickly. But it is best to hold onto it and read it over several weeks and months. The book would certainly be of benefit for caregivers of aging parents. But it is of equal value for professional caregivers, health workers and caregivers of people with disabilities in general.

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