

Conjoined Twins and Intentionality

To the Editor: Christopher Kaczor proposes that twins conjoined at the torso might be able to marry if, when one twin (say a brother) was having sexual intercourse with his wife, the other brother and his sister-in-law were “not necessarily intending to join themselves together in a sexual way,” so that their union would be “a foreseen side effect rather than something either one chooses.”¹

Even on the narrow view of intentionality, that proposal seems impossible. Since marriage requires the total and exclusive self-giving and receiving in the one-flesh union, it seems impossible for either twin in such a case to marry. In the example given, neither can give himself fully and exclusively to a wife, so it would seem neither could marry according to the natural-law criteria of marriage.

Kaczor’s attempt to apply the narrow account of intention is provocative in this example. The nature of sexual union does not allow a distinction of intentions in this case, because the two persons do not possess two reproductive systems and so are incapable of intending an individual act of sexual self-gift, whatever they might want to intend.

To extend this reasoning, such conjoined twin brothers, aside from any practical considerations, could also not be ordained priests, since what would disqualify them physically from marriage would also seemingly disqualify them from priesthood.

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¹ Christopher Kaczor, Notes and Abstracts: Philosophy and Theology, *National Catholic Bioethics Quarterly* 15.2 (Summer 2015): 401.

Prospective Medical–Moral Decision Making

To the Editor: Having read “Prospective Medical–Moral Decision Making” by Peter Cataldo and Elliott Bedford in the Spring 2015 *NCBQ* a number of times, I am surprised that the major premise of the article is based on a misinterpretation of what “in-the-moment decision making” means when Cataldo and Bedford critique the article by Deacon Daniel A. Gannon “Favor DNR/DNI Orders over POLST” (physician orders for life-sustaining treatment).¹ Cataldo and Bedford choose a reductionist interpretation when they claim that in-the-moment decision making would not include any future thinking or prognostication. In reality, Gannon’s DNR/DNI does, but recommends that the timing of decision making be the most appropriate, that is, when the facts are most clear for past, present, and future (most proximate), rather than remote (six months to five years) as with POLST, when details of a future situation cannot be known. In this way, POLST is like using a crystal ball.

The term “in-the-moment decision making” is explained well in a 2010 article by Rebecca Sudore and Terri Fried.² These authors emphasize that long-term ongoing discussions between providers, patients, and surrogates are a necessary part of the process, a recommendation with which we all can agree. In-the-moment decision making encourages these discussions for as long as needed to make the best decisions, especially at the time of a critical event when possible. POLST, in contrast, does not do this when it encourages patients to make final decisions prematurely, before the salient facts are known.

As an example, a discussion with a patient regarding his or her thoughts on ANH (assisted nutrition and hydration) is appropriate for the education of the patient, but any attempts to describe all of the possible scenarios months to years in advance is not possible, depends on baseless conjectures, and risks facilitator bias. Such a discussion in the moment, however, when it is pertinent to the patient's condition, is both feasible and realistic. For instance, ANH after a stroke—when recovery is possible, although uncertain, if appropriate care, including ANH, is given—is just good medical care, not extraordinary; details at this point in time give the patient understandable, adequate data to enable a personal, informed, appropriate decision. If such support were not given because of a remote decision made without true informed consent, a patient's chances of recovery would be reduced or eliminated (and death might represent euthanasia by omission). A prior decision, as with POLST, may not be what the patient would decide in the moment.

However, ANH in a terminally ill patient with an incurable brain tumor is a different story; the burden of ANH would seem greater than the benefit, and withholding ANH could be morally licit. We must remember that Catholic teaching is that the burden to be considered is the treatment, not the life itself or the quality of life. All of these considerations would be part of a discussion in the moment.

So how are DNR/DNI (do-not-resuscitate/do-not-intubate) orders alone different from POLST? POLST was created to provide emergency orders for medical care until a patient reached a point of care, when a physician could then evaluate the situation and make informed decisions with the patient or surrogate. POLST orders would be used by EMTs (emergency medical technicians) and nursing home personnel in the field. As Deacon Gannon points out, DNR and DNI are the only two possible interventions that would not allow time for in-the-moment discussion and decision making. All others, although serious and potentially acute, allow for thought and discussion after appropriate evaluation, are not emergencies, and are not

issues that need to be dealt with in the field.

POLST's part B, level-of-care orders, can become complex and confusing, not to mention time-consuming, for EMT personnel, and they are unnecessary, as EMTs are trained, and their charge is, to take care of the patient's needs and get them to the hospital as safely and comfortably as possible, not to make decisions which, other than DNR/DNI, may be ambiguous. My experience as a practicing physician and that of my colleagues has been that, other than DNR/DNI, decisions made at this time are not "panic" situations, as Cataldo and Bedford suggest,³ and good medical care allows time to make and even change decisions without harm.

Can DNR/DNI decisions be morally licit? Yes, by Catholic ethical and moral principles, if the burden of the treatment is considered greater than the benefit by the informed patient or surrogate (see directives 56 and 57 of the *ERDs*⁴). And yes, end-of-life decisions can be licit at some point for other care (such as ANH), based on the same principles, but emergency orders, made at a time remote from the event, are not needed and may mandate less care than a patient wants or needs in a particular situation. On page 54 of their article, Cataldo and Bedford state, "Moral certitude is necessary to act morally." I would ask, What gives you the best chance of moral certitude: in-the-moment or crystal-ball decision making months or years in advance?

It has been shown that patients who initially make decisions to forgo resuscitation or intubation will often change their minds, especially when presented with specific situations.⁵ The specific situation is what in-the-moment decision making is about.

Deacon Gannon makes it clear in his articles that the POLST paradigm is flawed, and this is supported by statements of the Catholic Bishops of both Wisconsin and Minnesota, which he cites.⁶ The major flaw is that POLST encourages providers to write potentially life-ending orders long before the facts of a situation are known. From a Catholic moral standpoint, such orders require a decision at the time the order is to be carried out, which takes into account the real burdens versus benefits, as opposed to orders written

months to years prior when such particulars are generalized and can only be surmised.

Cataldo and Bedford talk about fixing POLST, but this ignores the major flaw in the POLST paradigm. POLST has a number of other serious problems. To aid patients in their decision making, it uses facilitators who are often referred to as “health care providers” but who in reality may not be physicians and may have little or no medical background. They may not be skilled in understanding and explaining complex medical situations that would require physician input; some such explanations may indeed be difficult or even inaccurate when done by physicians, who are not omniscient. The facilitators may emphasize quality of life (living well) rather than sanctity of life. The facilitators may not understand or provide Catholic teaching on burden versus benefit, ordinary versus extraordinary, or proportionate versus disproportionate care. Negative aspects of care may be emphasized and positive ones not.

In some states, a signature on the form by the patient or surrogate is not required as evidence of informed consent. In some states, POLST can legally be used “across all venues,” which I suspect would be interpreted as in the emergency department and after admission to the hospital, making the current risk of continuing POLST orders without discussion with the patient or surrogate even greater. The National POLST paradigm says it “guides action of emergency medical personnel when made available” without defining whether “personnel” includes not just EMTs in the field but also physicians in the emergency room.⁷ POLST also “guides inpatient treatment decisions when made available,” which perpetuates its major flaw. In fact, this seems to give POLST the added power of being an advance directive, which it is not.

DNR/DNI orders as described by Deacon Gannon fulfill an appropriate need patients may have at a critical moment, as long as in-the-moment discussions occur for other issues when such discussions become possible and decisions become appropriate. The rest of the POLST prior orders, other than DNR/DNI, are inappropriate and unnecessary, as such decisions are not emergencies

for which there is no possibility of discussion. Medical care and Catholic ethics and morality value life, whereas the POLST paradigm risks devaluing it. It is understandable that a quick fix such as POLST is attractive to busy care practitioners, but we abrogate our responsibility if we do not eschew such an approach.

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¹ Peter J. Cataldo and Elliott Louis Bedford, “Prospective Medical–Moral Decision Making,” *National Catholic Bioethics Quarterly* 15.1 (Spring 2015): 53–61. See also Daniel A. Gannon, “Favor DNR/DNI Orders over POLST: A Compromise without Compromise?,” *Ethics & Medics* 39.10 (October 2014): 1–4; and Gannon, “POLST and Moral Human Acts: Neglect of Medical Circumstances,” *Ethics & Medics* 38.2 (February 2013): 1–2.

² Rebecca L. Sudore and Terri R. Fried, “Redefining the ‘Planning’ in Advance Care Planning: Preparing for End-of-Life Decision Making,” *Annals of Internal Medicine* 153.4 (August 17, 2010): 256–261.

³ Cataldo and Bedford, “Prospective Medical–Moral Decision Making,” 55.

⁴ US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009).

⁵ John E. Jesus et al., “Preferences for Resuscitation and Intubation among Patients with Do-Not-Resuscitate/Do-Not-Intubate Orders,” *Mayo Clinic Proceedings* 88.7 (July 2013): 658–665.

⁶ Catholic Bishops of Minnesota, “A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST),” 2013, Minnesota Catholic Conference, <http://www.mccc.org/>; and Catholic Bishops of Wisconsin, “Upholding the Dignity of Human Life,” July 2012, <http://www.wisconsin.catholic.org/>.

⁷ “POLST and Advance Directives,” National POLST, accessed November 20, 2015, <http://www.polst.org/advance-care-planning/polst-and-advance-directives/>.

Reply to Brother Breed on Embryo Adoption

To the Editor: Devoted readers of the *NCBQ* cannot fail to have noticed the pullulating claims in favor of embryo adoption made by authors of certain articles published in the *Quarterly* in recent years. First, there were efforts to interpret *Dignitas personae* (2008) as not rejecting the practice, despite the fact that the Instruction reinforces the reference in *Donum vitae* (1987) to the “absurd fate” of “spare” embryos by referring to such abandoned embryos as representing “a situation of injustice which in fact cannot be resolved” and for which “there seems to be no morally licit solution.”¹ Then, there was a recent article praising the virtuousness of embryo adoption, even comparing it to the Incarnation.² Now Brother Glenn Breed, MSA, asserts that we actually “offend God” and commit a “sin of omission” by *not* helping frozen embryos via adoption.³ In six short years, our having no morally licit solution for helping frozen embryos has morphed into our being morally obligated to adopt embryos under pain of sin!

Is this sin of omission committed only by women of child-bearing age or does it extend to husbands as well? Will the moral obligation to adopt embryos remain until all the stored embryos are transferred, or may married couples procreate at least some embryos together? Is it also a sin of omission to not rescue each baby about to be aborted, given that abortion is, at least statistically, a far greater evil in contemporary society? Or is Breed just referring to some kind of so-called corporate sin?

Few would disagree with Breed that the object and end of embryo adoption are good. Unfortunately, he addresses neither the *circumstances* of embryo adoption, which constitute the third component of moral acts, nor the *consequences* of embryo adoption, including the risk of being implicated in the immorality of the in vitro fertilization (IVF) industry and thereby giving scandal.⁴ He does not even mention *Dignitas personae*, the most recent bioethical Instruction; rather, he quotes only *Donum vitae*, including a sentence from I.3, which is a section clearly referring to

medical treatment carried out on embryos, as legitimizing embryo adoption. His second quotation, from *Donum vitae* I.5, about not deliberately exposing in vitro embryos to death, is also used to justify embryo adoption, despite the fact that the very next sentence says that embryos not transferred into the body of the mother have no “means of survival which can be licitly pursued.”⁵

Both *Donum vitae* and *Dignitas personae* invoke the personal order for addressing controverted issues in bioethics. Unfortunately, Breed unwittingly reinforces the depersonalization of the woman’s body when he refers to frozen embryos being “in desperate need of a mother’s womb” (my emphasis) and to their need for a maternal “environment” or “home.”⁶ The human body expresses the *person*, and total bodily unions, as in marriage, are radically exclusive. The marital act with its inherent procreative power has undergone a great sundering in modern society, suggesting the activity of the diabolic (Gr. *diaballein*, to hurl between or divide) and reflecting the fundamental sundering of body and person. Contraception divides union from procreation; IVF divides procreation from union. Both treat the body of a person as an object, not a subject.

Embryo adoption attempts to unite that which has been divided by IVF, namely, procreation and pregnancy. Yet this union occurs between *the wrong subjects*. The dignity of persons is grounded in their incommunicability. This is why a relationship in which a person is reduced to a thing or one person is facilely substituted for another person undermines the dignity of persons. This is particularly true of relationships involving the total gift of the person through the gift of the entire body. Charity between persons is paradoxically limitless and limited. One may lay down one’s life for a neighbor but may not give one’s body to a neighbor. *Who* the person is matters as much as *what* he or she needs or can do. There is a prescient wisdom in the Church’s bioethical Instructions that human love involving union through the total gift of the body must express the dignity of persons, which means the incommunicability and thus non-substitutability of such interpersonal relations.

I would also note in passing that Breed neglects to make any reference to original sin when repeatedly citing the innocence of embryos as a reason for rescue. It is a doctrine of faith that no human person, with the exception of the Blessed Mother, has entered this vale of tears innocent and that all, including the Blessed Mother, have need of redemption. The real tragedy of frozen embryos is not their precarious natural survival or their being “enslaved in a test tube in liquid nitrogen,” but the uncertainty of their achieving the real end of human existence, which is the supernatural beatific vision of God.⁷ Embryo adoption distracts from the imperative of stopping the ongoing genesis of innumerable souls consigned to an absurd fate in this life and an uncertain fate in the next.

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¹ Edward J. Furton, “Embryo Adoption Reconsidered,” *National Catholic Bioethics Quarterly* 10.2 (Summer 2010): 329–347; and Ryan C. Mayer, “Is Embryo Adoption a Form of Surrogacy?,” *National Catholic Bioethics Quarterly* 11.2 (Summer 2011): 249–256. See Congregation for the Doctrine of the Faith, *Donum vitae* (February 22, 1987), I.5; and CDF, *Dignitas personae* (September 8, 2008), I.19.

² Elizabeth B. Rex, “IVF, Embryo Transfer, and Embryo Adoption,” *National Catholic Bioethics Quarterly* 14.2 (Summer 2014): 227–234.

³ Glenn Breed, “The Only Moral Option Is Embryo Adoption,” *National Catholic Bioethics Quarterly* 14.3 (Autumn 2014): 441–447.

⁴ Austin Fagothey, *Right and Reason: Ethics in Theory and Practice*, 2nd ed. (1959; Rockford, IL: Tan Books, 2000), 151; and Ronald Fabbro, “Stem Cell Research, Cloning, and Catholic Moral Theology,” *Linacre Quarterly* 72.4 (November 2005): 302.

⁵ CDF, *Donum vitae*, I.5.

⁶ Breed, “The Only Moral Option,” 446–447.

⁷ *Ibid.*, 446.