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■ Also in this issue: “Transgender Policies and Catholic Schools,” Jozef Zalot ■

DEACTIVATION OF PACEMAKERS AT THE END OF LIFE

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While there have been over fifty years of advances in the design and use of artificial pacemakers and implantable cardio-defibrillators, the consideration of their deactivation at the end of life has been undertaken only recently. The current discussion of pacemakers largely divides into two main camps: those who view deactivation as the moral equivalent of the withdrawal of other life-sustaining interventions, and those who hold deactivation as the equivalent of physician-assisted suicide.¹ Daniel Sulmasy affirms the latter position. He contends that, similar to a transplanted organ, the pacemaker establishes an organic unity with the human body. Hence its deactivation is equivalent to the removal or disabling of an organ.

On the contrary, the relationship of a pacemaker to the human body is not like that of a transplanted heart, but it is similar to other supportive mechanical devices, such as a ventilator or a dialysis machine. There are burdens associated with the presence of these devices. In the face of a terminal diagnosis, the deactivation of a cardio-pacemaker is morally similar to the withdrawal of other extraordinary measures currently accepted within the Catholic moral teachings.

Sulmasy on Deactivation

Sulmasy places all medical therapies into two broad categories: those that are *regulative* and attempt to “coax the body back towards its own homeostatic equilibrium,” and those that are *constitutive* and “take over a function that the body can no longer provide for itself.”² He distinguishes between interventions that *replace* a pathologically

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disordered function from those that *substitute* for a pathologically disordered function. Regulative therapies are never considered part of the self, since these inventions are distinct from the organism and extrinsic to its function. But replacement therapy, he contends, “participates in the organic unity of the patient as an organism” and becomes “a part of the patient” (71).

He offers six “signs” that are indicative of a replacement therapy: “(1) Its responsiveness changes in the organism or its environment, (2) properties such as growth and self-repair, (3) independence from external energy sources or supplies, (4) independence from external control by an expert, (5) immunologic compatibility, (6) physical integration into the patient’s body” (71–72).

According to this line of reasoning, a pacemaker shares these characteristics and becomes an intrinsic part of the human body, since it replaces a lost function in more or less the same manner that a patient’s body once provided it. Drawing upon his definition of killing as “an act in which an agent performs an action that creates a new, nontherapeutic, lethal pathophysiological state in a human being with the intention of thereby causing that human being’s death,” he concludes that the discontinuation of replacement therapies (e.g., pacemakers) is an act of killing (70).

But do pacemakers fit the criteria Sulmasy has set for a replacement therapy? The device is not a “replacement” for the heart, since a functioning heart is still needed to pump the blood through the body. Nor does it fully replace the heart’s electrical function, since a patient’s heart will continue to beat, albeit poorly, without a pacemaker. The preprogrammed set of regularly spaced electrical impulses merely “substitutes” for the patient’s irregular cardiac impulses.

It follows that a pacemaker is replacement therapy that uses an assistive device to provide a supportive intervention similar to that of mechanical ventilation. Mechanical respiration provides a conduit to deliver oxygen to the alveoli, but it does not exchange the blood gases within the bloodstream. Therefore, it does not replace the function of a patient’s lungs. Both pacemakers and ventilators help to support poorly functioning physiology by providing assistance through mechanical means, but they are not replacements of the organs themselves.

Additionally, a pacemaker does not become a part of the patient like a transplanted organ. It does not respond to changes in the organism or environment, as is evident

when a patient is clinically brain-dead but the device continues to function. It does not grow, nor does it self-repair; when the device malfunctions or when the leads are pulled out, it must be repaired through an external intervention. Although the device is implanted within the body, it is powered by an external energy source.

Likewise, the pacemaker is not independent of external control, since adjustments to its discharge rate must be made externally by a trained technician. A pacemaker is not immunologically compatible with the human body because it is biologically similar to it; instead it is a nonbiological, artificially manufactured device. Finally, it never becomes a fully integrated and intrinsic part of the body like a transplanted organ, which at the time of death ceases to function and joins in the disintegration of the body unity. The pacemaker will continue to function and degrade independent of the body.

Unlike a transplanted heart, a pacemaker is not a curative intervention, nor is it a completed therapy as some would contend. The condition that warranted its placement is still present. The pacemaker is an assistive mechanical device that alleviates, but does not remove, the underlying pathology. Its deactivation would not be, as Sulmasy claims, the introduction of “a new lethal pathophysiological state,” but would be the discontinuation of “a treatment that is merely substituting for a preexisting lethal pathophysiological lack of function” (72).

Potential Burdens of a Pacemaker

In the course of its operation, a pacemaker must be replaced every five to ten years due to the expiration of the battery. Prior to this time, the wire leads that deliver the electrical impulses from the device to the heart wall may degrade or become dislodged. Also a pacemaker may at any time be subject to mechanical failure or product recall like any other manufactured product. In each of these cases, an incision must be made in the patient. For this reason, the initial implantation of a pacemaker is not indicated for a person with a terminal diagnosis. If the implantation of a cardio-pacemaker is ethically withheld in such a circumstance, it logically follows that a patient with a pacemaker may ethically forgo the replacement or repair of the device at the end of life in order to avoid the same burden.

The pacemaker also may present significant indirect burdens to terminally ill patients. “These include: (1) the prolongation of a life of suffering, without hope of relief; (2) interference with death that would occur in the natural course of events without the pacemaker; (3) the expense and expenditures of funds, resources, and facilities [to provide what can be considered futile care]; and (4) the emotional burdens that a prolonged illness would have on family and friends.”³

The consideration of pacemaker withdrawal is especially important when the terminal diagnosis is particularly debilitating, like in Huntington’s disease or Parkinson’s disease, or when intractable pain is present, such as in bone cancer. In these instances, to insist that a pacemaker must

be kept operational because it is similar to a transplanted organ—or is ordinary or proportionate care—would be equivalent to saying the person must be kept artificially alive so that a more painful condition can eventually take his or her life. The pacemaker would then “become a sort of technological cage from which patients could never escape” and could “transform technological opportunities into unconditionally binding moral imperatives.”⁴

The most likely effect of deactivation is bradycardia, whose symptoms include fatigue, dizziness, and dyspnea.⁵ These end-of-life symptoms can be managed with good palliative care without the attendant risk of prolonging or interfering with the dying process. One effect that is not likely to occur, even in patients who are dependent on pacemakers, is a quick and sudden death. This reinforces the ultimate intention of pacemaker deactivation: not the death of the patient, but the avoidance of prolonging the dying process.

This also indicates that deactivation is not the proximate cause of the patient’s death. The cause is the underlying disease, which the pacemaker does not address or cure. The intention of avoiding additional burdens or interfering with the dying process is similar to the licit withdrawal of other interventions at the end of life, such as mechanical ventilation, dialysis, invasive diagnostics, and aggressive therapeutic measures.

As medical technology advances, and new therapies and interventions bring relief to what was once thought insurmountable, it is important to remember a basic truth regarding the human condition: death is not a pathology; it is the natural end of our earthly existence. Anyone who wages a battle against death eventually loses. Ultimately, we cannot save ourselves, let alone anyone else, from death, but the victory has already been won for us. With humility and faith, we must recognize that there comes a time to give up the well-fought fight, while remembering, as the anonymous twelfth-century saying puts it, that we are “to cure sometimes; to relieve often; to give comfort always.”

Endnotes

1. Rachel Lampert et al., “HRS Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices (CIEDs) in Patients Nearing End of Life or Requesting Withdrawal of Therapy,” *Heart Rhythm* 7.7 (July 2010): 1008–1025, doi: 10.1016/j.hrthm.2010.04.033; and G. Neal Kay and Gregory T. Bittner, “Should Implantable Cardioverter-Defibrillators and Permanent Pacemakers in Patients with Terminal Illness Be Deactivated?,” *Circulation: Arrhythmia and Electrophysiology* 2.3 (June 2009): 336–339, doi: 10.1161/circep.108.821975.
2. Daniel P. Sulmasy, “Within You / Without You: Biotechnology, Ontology, and Ethics,” *Journal of General Internal Medicine* 23 suppl 1 (January 2008): 70, doi: 10.1007/s11606-007-0326-x. Subsequent references are given as in-text citations.
3. Edmund D. Pellegrino, “Decisions to Withdraw Life-Sustaining Treatment: A Moral Algorithm,” *JAMA* 283.8 (February 23, 2000): 1067, doi: 10.1001/jama.283.8.1065.
4. Massimo Reichlin, “On the Ethics of Withholding and Withdrawing Medical Treatment,” *Multidisciplinary Respiratory Medicine* 9 (2014): 4, doi: 10.1186/2049-6958-9-39.
5. Ron Hamel, “Implantable Cardiac Devices at Life’s End: Is Deactivation Morally Licit?,” *Health Care Ethics USA* 18.3 (Summer 2010): 3.

TRANSGENDER POLICIES AND CATHOLIC SCHOOLS

Jozef Zalot



Over the past few years The National Catholic Bioethics Center (NCBC) has received numerous inquiries from Catholic school principals and superintendents asking for guidance on how they can (1) respond to gender ideology in their schools and (2) address the particular challenges that arise when a student (or parent) announces that he or she is transgender. In the absence of specific, practical guidance on these issues from the US bishops or the Church universal,¹ these administrators are confused and often at a loss for what they should—and should not—do. The NCBC reviewed various Catholic school policies concerning transgenderism to identify best practices. The following list is neither complete nor exhaustive. Instead it is presented as a guide or framework for other schools to use in drafting their own policies in response to this powerful, but erroneous, social trend.

Policy Elements regarding Mission and Curriculum

Catholic schools perform an essential ecclesial ministry, the purpose of which is evangelization leading to salvation.² Due to the nature and profound responsibility of this ministry, Catholic schools must faithfully impart the truth of Jesus Christ and his Church in all they teach and do.

Catholic education focuses on the integral development of the human person: mind, body, and spirit. Specifically with regard to gender ideology and transgenderism, Catholic schools have a duty to teach their students truth about the human person (anthropology) and human sexuality. They also have a duty to counter any ideology or cultural trend that denies this truth. Essential points to be included in any Catholic school curriculum include the following: (1) Human beings are created male and female (Gen. 1:27). Human biology demonstrates that sex is determined at conception (XX/XY chromosomes), and it is objectively observed (genitalia) even before a child's birth. These teachings, which are based in demonstrable biological truth, expose the illogic of gender ideology's foundational claim that sex is assigned at birth. (2) The human person is a body-soul union, and the body—created male or female—is a constitutive aspect of the human person.³ These teachings

counter gender ideology's inherent dualism, the notion that there is a "self" separate from the body, or that "I am not my body."⁴ (3) Sexual difference is willed by God as part of the divine plan. The complementarity that results from this differentiation is ordered to the human good, particularly to marriage and family life.⁵ These teachings counter, and ultimately refute, gender ideology's insistence that there is no difference between men and women. They also counter and refute the cultural norm that biological parenthood is irrelevant for the engenderment, gestation, and raising of children. (4) Humans are called to accept their sexual identity, manifested through the body, as a fixed and unchanging element of self.⁶ This teaching once again counters, and ultimately refutes, the notion that sex and gender are "fluid" and that one can redefine—and thus "transition"—one's gender as one wishes.⁷

In addition to these essential curricular points, Catholic schools should be prepared to offer students, faculty, staff, administrators, and parents additional educational resources that address the realities of gender ideology and transgenderism. These resources should (1) clarify gender dysphoria and describe the medically accepted interventions for it (gender-affirming therapy, puberty-blocking and cross-sex hormones, and sex reassignment surgeries), (2) expose the tactics employed by gender advocates to justify and impose their ideology, and (3) explain the public policy challenges posed by gender ideology, including but not limited to access to bathrooms and the consequences of redefining *sex* in both federal and state law. Finally and perhaps most importantly, these resources should demonstrate how the Catholic Church responds to gender ideology and transgenderism through the writings of Pope Francis, Pope Benedict XVI, and other sources.⁸

Policy Elements Regarding Students

Admission and Retention: (1) A student diagnosed with gender dysphoria should not be denied admission to a Catholic school as long as the student and his or her parents agree that the child will abide by the expectations and standards of conduct set by the school. (2) The student and his or her parents must agree that while enrolled in the school he or she will respect Catholic teaching concerning faith and morals, particularly those that address human sexuality. (3) Respectful, critical questioning of Catholic teaching in the classroom is encouraged as long as its intent is to help the student progress toward greater awareness and understanding. Open hostility toward, or defiance of, Church teaching indicates that a student is not a proper fit for the school. The student code of conduct should address this possibility, and it should be signed by the student and parents at the beginning of each school year.

Conduct and Expectations: (1) Students will conduct themselves in accord with their biological sex at all times, both on campus and when representing the school at off-campus events. (2) Students will abide by the dress code that corresponds with their biological sex. No administrator may waive this requirement. (3) Students will participate in competitive athletics in accord with their biological sex.

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No administrator may waive this requirement. (4) Students will use bathrooms and locker rooms that correspond with their biological sex. Students who have been clinically diagnosed with gender dysphoria may request the use of a single-person, unisex facility. Such requests will be assessed by the appropriate school administrator on an individual basis. (5) Students may bring only an opposite-sex date to school-sponsored functions, especially dances and prom.

Names, Pronouns, and Records: (1) Students will be addressed at all times by their legal name and referred to with pronouns in accord with their biological sex. (A nickname may be permissible in some circumstances.) Addressing students by a preferred name (even when the name is gender-neutral) or referring to them by a preferred pronoun is not acceptable. Doing so conveys a falsehood (the child *is* the “wrong” sex) and signals that the school accepts gender ideology as well as the student’s false notion of self. Furthermore, using preferred names and pronouns could confuse other students and act as a source of scandal.⁹ (2) Student schedules, identification cards, class lists, correspondences (including college recommendation letters), and permanent records will reflect the student’s legal name and biological sex at birth.

Counseling and Health Services: (1) Catholic schools will make appropriate counseling available to students diagnosed with gender dysphoria to address behavioral health issues. If feasible they also will provide access to a licensed mental health provider who understands and adheres to Catholic teaching. Catholic schools will not provide or refer students for gender-affirming psychotherapy. (2) Catholic schools will not allow, or otherwise cooperate in, the administration of puberty-blocking or cross-sex hormones on school property.

Policy Elements Regarding Employees

School employees (faculty, staff, and administrators) are the ministers of Catholic education. As such, they are

expected to live virtuous lives guided by gospel values and the teaching of the Church. (1) Employees will conduct themselves in accord with their biological sex at all times, both on campus and when representing the school at off-campus events. (2) Employees will be addressed at all times by the title (Ms., Mrs., Mr.), and referred to by pronouns, in accord with their biological sex at birth. (3) Schools should establish policies to address situations where an employee publicly promotes gender ideology, transgenderism, or any other belief that is contrary to the teachings of the Catholic Church. Open hostility toward, or defiance of, these teachings indicates that the employee is not a proper fit for the school. Such policy should be expressed within the code of conduct that each employee signs in conjunction with his or her employment contract.

Endnotes

1. For a philosophical framework, see Congregation for Christian Education, *Male and Female He Created Them: Towards a Path of Dialogue on the Question of Gender Theory in Education* (February 2, 2019).
2. Denise Donohue and Dan Guernsey, *Human Sexuality Policies for Catholic Schools* (Manassas, VA: Cardinal Newman Society, 2016), 1–2.
3. *Catechism*, nn. 364, 365.
4. National Catholic Bioethics Center, “Brief Statement on Transgenderism,” *National Catholic Bioethics Center Quarterly* 16.4 (Winter 2016): 600–601. See also John A. Di Camillo, “Gender Transitioning and Catholic Health Care,” *National Catholic Bioethics Quarterly* 17.2 (Summer 2017), 219–220.
5. *Catechism*, nn. 369, 2333.
6. *Ibid.*, nn. 2333 and 2393; and Francis, *Laudato si* (May 24, 2015) n. 155.
7. There are currently at least 112 genders. See Dude Asks, “How Many Genders Are There in 2019?,” accessed July 17, 2019, <https://dudeasks.com/>.
8. Francis, *Amoris laetitia* (March 19, 2016), n. 56; Francis, *Laudato si*, n. 155; Benedict XVI, Address to the Roman Curia (December 21, 2012); and United States Conference of Catholic Bishops, “‘Gender Theory’/‘Gender Ideology’—Select Teaching Resources,” updated February 1, 2017, <http://www.usccb.org/>.
9. *Catechism*, nn. 2284, 2285.

