



TEACHINGS OF THE CATHOLIC CHURCH

*Caring for People
at the End of Life*



TEACHINGS OF THE CATHOLIC CHURCH ON CARING FOR PEOPLE AT THE END OF LIFE

The Catholic Health Association has developed this guide in collaboration with physicians, nurses, theologians and ethicists within Catholic health care. It is based on frequently asked questions to help patients, families and clinicians think about end-of-life decisions regarding medical treatments and care. Although the guide reflects the perspective of Catholic tradition, the information is helpful to people from any religious tradition.

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INTRODUCTION

Modern medical technology has saved countless lives, but it can also make end-of-life decisions more complicated. The very success of technology has heightened the expectation that it will always benefit the patient. Unfortunately, this heightened expectation can lead patients, family members and health care professionals to pursue treatments beyond the point where there is a reasonable hope for benefit.

Patients and their families may fear an impersonal prolonging of the dying process in an intensive care unit, surrounded by tubes, wires and machines. At the same time, they may also fear that refusing such treatment will make them seem to be “hopeless” cases or that they are giving up or that others will not respond to their needs and that they will be abandoned by health care workers. Family members may even feel that not doing everything possible means they are abandoning their loved one, even though this is not the case. Competing concerns about continuing or refusing treatment can greatly complicate end-of-life decisions, making them seem almost impossible to make.

There is a long tradition in Catholic moral teaching that is as relevant today as when it was developed over 500 years ago. It speaks of “reasonable” care in terms of the benefits treatments have that are proportionate to the burdens the treatments impose on the patient. The tradition does not prescribe hard-and-fast rules regarding specific medical procedures, but urges that prudent decisions be made regarding the benefits and burdens of the medical treatments for the patient. The tradition offers a middle ground between two extremes: the extreme of intending the death of a patient by euthanasia or assisted suicide, and the other extreme of continuing non-beneficial or excessively burdensome treatments, often against the patient’s wishes.

What is the Catholic Church’s teaching about end-of-life decisions?

Catholics believe that human life is a gift from God, a sacred gift that no one may dispose of at will. All persons, regardless of their medical condition, possess inherent dignity and are worthy of respect, protection and care. Respect for human dignity and human life demands that we will take reasonable care of our lives.

Such respect, however, does not mean that we must do everything possible to prolong physical life, especially when death is inevitable or when treatments would be too burdensome for the patient.

The Ethical and Religious Directives for Catholic Health Care Services (ERDs), a document issued by the United States Conference of Catholic Bishops (USCCB) that guides the practice of Catholic hospitals, long-term care

facilities and other Catholic health care organizations, summarizes the Catholic tradition when it advises against the two extremes of:

1. Intentionally causing death by means of euthanasia, including physician-assisted suicide.
2. Continuing useless or burdensome medical interventions, even when the patient legitimately wishes to forgo such treatments.

This understanding of burden and benefit is the basis for what the Catholic moral tradition has called the distinction between “ordinary” or proportionate means and “extraordinary” or disproportionate means. “Ordinary means” is not the same as the customary or normal care we usually think of in medicine, or extraordinary treatments that involve rare, advanced or experimental procedures. In the Catholic tradition, what distinguishes

*Death is swallowed
up in victory. Where,
O death, is your
victory? Where, O
death, is your sting?*

1 CORINTHIANS 15:55 NEW AMERICAN BIBLE

“ordinary” from “extraordinary” tradition is not whether the treatment is “ordinary” in the sense of being normal or frequently used, but rather whether the treatment is beneficial (ordinary) or excessively burdensome (extraordinary) to the patient.

How has this teaching developed over the years?

The Church’s teaching regarding end-of-life care is not new. The understanding that human life is a sacred gift from God is a fundamental belief that is grounded in the Bible. The opening chapters of Genesis explain that God formed Adam out of dust “and blew into his nostrils the breath of life” (Gn 2:7). Later in the Old Testament, Job professes that it is God who gave him life (Jb 10:11-12). In the New Testament, the First Letter to Timothy is even more explicit, speaking of God “who gives life to all things” (1 Tm 6:13).

Catholic moral reflection on this biblical teaching accepts the fact that although one has a duty to preserve life, this duty is not absolute. What would become the distinction between “ordinary” and “extraordinary” means was formulated in the 16th century. Following the teaching of the 13th century Doctor of the Church, St. Thomas Aquinas, theologians at the time argued that no one is required to use all means at one’s disposal to preserve life but only what is reasonable, taking

into consideration the patient’s circumstances.

In the 18th century, St. Alphonsus Liguori, who was one of the most influential moral theologians of his time, explained the meaning of “reasonable” in Book III of his work entitled *Moral Theology*:

“There is no obligation to use an uncommon or costly medicine; there is no need to change one’s place of residence to move to a healthier climate; no one is held to employ a difficult means such as an amputation in order to preserve life; abhorrence of a treatment can render it extraordinary, in the moral sense.”

In the 20th century, the Catholic tradition continued to develop through the writings of Pope Pius XII. In a famous address in 1957, he stated:

“Normally one is held to use only ordinary means — according to circumstances of persons, places, times, and culture — that is to say, means that do not involve any grave burden for oneself or another. A stricter obligation would be too burdensome for most people and would render the attainment of the higher, more important good too difficult.”

Pope Pius’s words are echoed in the Vatican’s 1980 document entitled “Declaration on Euthanasia” and in St. John Paul II’s encyclical, *The Gospel of Life*. Part IV of the



Declaration explains that “one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition.”

Similarly, St. John Paul II’s encyclical states: “Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death” (§ 65).

Since the tradition is over 500 years old, how can it have anything to say about contemporary decisions involving today’s complicated medical technology? Haven’t things changed too much?

Although the diseases we face and the treatments available to us have changed, Catholic teaching regarding care at the end of life has remained remarkably durable throughout the ages.

The reason for this durability is that the tradition does not speak about specific technological remedies or interventions as being “ordinary” or “extraordinary,” but rather asks whether a given medical treatment is burdensome or beneficial to the patient. As Pope Pius XII explained, the distinction offers guidance that is dependent upon “circumstances of persons, places, times, and culture.”

What does it mean when Catholic teaching states that two extremes must be avoided in end-of-life decisions?

The Catholic moral tradition recognizes that virtuous behavior entails a balance or proportion that can be harmed by two extremes, shortcoming or excess, each of which is a vice. In the case of decisions at the end of life, the two extremes are euthanasia or assisted suicide on the one hand — that is, intentionally causing death — and, on the other hand, what many health care professionals call medical “vitalism” — that is, attempts to preserve the patient’s physical life in and of itself without consideration of any reasonable hope for benefit, even when the patient would not want to continue the treatment.

At the beginning of an illness a variety of medical interventions are appropriate. However, there may come a time with serious advanced illness when continued attempts at a cure are no longer of benefit to the patient. This acknowledgment is not abandoning the patient but rather acknowledging the human condition and the limits of medicine. St. John Paul II, in his encyclical, *The Gospel of Life*, explained:

“Euthanasia must be distinguished from the decision to forego so-called ‘aggressive medical treatment,’ in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family” (§ 65).

What does the Catholic tradition mean by benefit? Isn’t living longer in itself a benefit?

The Catholic moral tradition has not been very specific in its description of benefit. However, it is clear in the tradition that simply prolonging physical life, especially when the means to accomplish prolonging life are “precarious and burdensome,” is not required. According to the Catholic moral tradition, for any medical procedure to be considered ordinary means, it must be worthwhile — in quality and duration, and in the sense of being proportional to the effort expended in using the means. Moral theologians in the 20th century often spoke of “hope for success” in assessing ordinary means.

**What about the idea of burden?
How do I know if a medical
treatment is too burdensome?**

The Catholic moral tradition has been clearer in its account of burden. Since the 18th century, the tradition has described four aspects of burden:

Great Cost or Means

Catholic moralists explain that no one is obliged to spend a great amount of money to preserve one's life. Catholic Church teaching accepts the fact that a person may decide not to impose excessive expense on oneself, one's family or the community.

Grave Effort

The duty to preserve life, furthermore, does not mean that a patient must exert an extraordinarily great amount of effort. For example, someone

living in the Midwest would not be obligated to move to Palm Springs, California, because it would be a healthier environment, considering the person's respiratory disease.

Excessive Pain

The fact that a treatment may cause an unreasonable amount of pain for an individual can render the treatment excessively burdensome.

Severe Dread or Repugnance

Finally, intense fear or strong repugnance can make a treatment that most would consider to be ordinary means excessively burdensome and therefore extraordinary means for that particular patient. The 17th century Jesuit moral theologian, Leonard Lessius, explained: "No one is held to accept a cure which one abhors no less than the disease itself or death."



Who determines what is ordinary means and what is extraordinary means?

The Vatican's *Declaration on Euthanasia* explains that in making a judgment regarding end-of-life decisions, one must "take into account the state of the sick person and his or her physical and moral resources." It is for this reason that the U.S. bishops' *Ethical and Religious Directives* maintain that:

"The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless contrary to Catholic moral teaching"
(Directive 59).

The right to make an ethical decision regarding what would be an ordinary means or an extraordinary means belongs to the patient or his or her surrogate. However, for Catholics such decisions should be made taking into consideration the Catholic moral tradition on end-of-life care.

For a discussion of surrogate decision making, see the CHA Guide on Advance Directives entitled *Sharing Your Health Care Wishes* at www.chausa.org/ethics.

Is there an ethical difference between not beginning medical treatment and discontinuing treatment once it has begun?

Although there may be emotional or psychological elements that make withdrawal of treatment more difficult than not initiating such treatment, there is no ethical distinction between refusing treatment and discontinuing treatment.

Appropriate ethical reasons for not initiating a given treatment are also justification for withdrawing the same treatment. In his encyclical, *The Gospel of Life*, St. John Paul II explained that one may discontinue "medical procedures which no longer correspond to the real situation of the patient, either because they are now disproportionate to any expected results or because they impose an excessive burden on the patient and family" (§ 65).

What does the Catholic moral tradition say about pain relief? What if the use of pain medications raises the possibility of shortening the patient's life?

Since the Catholic Church speaks of the redemptive value of suffering, some Catholics believe that they must accept pain in order to unite their suffering with that of Christ. This is not the Church's moral teaching. The ERDs explain that "patients should be kept as free of pain as possible so that they may die comfortably and with 9

dignity” (Directive 61). Furthermore, in his encyclical, *The Gospel of Life*, St. John Paul II reaffirmed the teaching of Pope Pius XII and stated that it is proper “to relieve pain by narcotics, even when the result is decreased consciousness and a shortening of life” (§ 65).

What is ethically required concerning giving food and water at the end of life?

The purpose of food and water is to help the body sustain life. When the body is no longer able to process food and water or when their use becomes too burdensome for the patient, using artificial nutrition and hydration becomes a disproportionate way to preserve life and is therefore morally optional. In such circumstances,

we are not “starving” the patient. Rather we realize that food and liquids are no longer fulfilling their purpose of nourishing the patient and may be causing additional pain.

Directive 58 of the ERDs emphasizes the general moral obligation to provide nutrition and hydration, even when administered medically, but it also explains that one can reject these measures “when they cannot reasonably be expected to prolong life or when they would be excessively burdensome to the patient.”

When it is determined that medically assisted nutrition and hydration are not beneficial, our duty to care for the patient in other important ways remains, such as providing pain relief and caring for spiritual needs and healing.



If patients are able to make their own decisions about treatments and express them to others, their free and informed decision should be honored.

What if family members disagree on treatment options?

If patients are able to make their own decisions about treatments and express them to others, their free and informed decision should be honored.

Difficulties often arise when patients can no longer speak for themselves and family members disagree on the appropriate treatment. It is important for people to discuss their end-of-life care with their families prior to becoming incapacitated. These important conversations should include the discussion of the person's values and faith commitments as well as treatment options.

Often these discussions are postponed until it is too late and the patient can no longer express these wishes on his or her own. When this happens, family members do not know the wishes of their loved one and are unable to carry them out.

It is important to discuss your decisions with your physician, surrogate and family members to help all understand the health care options in relation to your particular illness, values and faith commitments. As the *Ethical and Religious Directives* explain, "Neither the healthcare professional nor the patient acts independently of the other; both participate in the healing process."

FOR MORE INFORMATION

This is one of a series of publications from the Catholic Health Association to help patients, families and caregivers with decisions about end-of-life care. We invite you to view the accompanying guides,

Sharing Your Health Care Wishes and *Living Well with Serious Illness*, for additional assistance. These and other resources are available to order or download at www.chausa.org/store.





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The mission of Catholic Health Association of the United States (CHA) is to advance the Catholic health ministry of the United States in caring for people and communities.

Catholic health care is a ministry of the Catholic Church continuing Jesus' mission of love and healing in the world today. Composed of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation.

At the national level, these organizations join together in the Catholic Health Association of the United States.

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