



Understanding and Applying the *Ethical and Religious Directives for Catholic Health Care Services:*

AN EDUCATIONAL RESOURCE FOR PHYSICIANS



*Part Two - The Pastoral and Spiritual Responsibility of Catholic Health Care*

# *Part Two - The Pastoral and Spiritual Responsibility of Catholic Health Care*

## **PRAYER RESOURCE**

### **OPENING PRAYER**

O God, who calls us to promote health and relieve human suffering, be with us as we live out our calling to be a healing presence in the world. Help us to be living signs of your grace and compassion. We pray in your Holy Name. Amen.

### **READING**

A leper came to Jesus and, kneeling down, begged him and said, “If you wish, you can make me clean.” Moved with pity, he stretched out his hand, touched him and said to him, “I will do it. Be made clean.” The leprosy left him immediately, and he was made clean. Then, warning him sternly, he dismissed him at once. Then he said to him, “See that you tell no one anything, but go, show yourself to the priest and offer for your cleansing what Moses prescribed; that will be proof for them.” The man went away and began to publicize the whole matter. He spread the report abroad so that it was impossible for Jesus to enter a town openly. He remained outside in deserted places, and people kept coming to him from everywhere. (Mark 1:40-45)



# *Part Two - The Pastoral and Spiritual Responsibility of Catholic Health Care*

## **CASE STUDY**

### **CASE #1: A POOR PROGNOSIS AND ASKING “WHY?”**

Terry was a 24-year-old mother of a toddler when she was first admitted to the hospital five years ago to have a growth on her right kidney removed, a growth her doctor had assured her was benign. After the biopsy showed the tumor to be cancerous, her doctor told her that such a cancer at her age was very rare and added, “It’s also difficult to cure.” An oncologist subsequently told her that, even though the surgeon had removed all of the visible tumor, this type of cancer often reappears within a year. Terry and her husband rejected this gloomy prognosis and found an oncologist who talked about occasional complete remissions and recommended a course of chemotherapy. After the course of therapy was completed, he told the couple that they could now get on with their lives. This is what the couple did, having a second son shortly thereafter and very recently adopting a baby girl.

Weeks ago, Terry developed a raspy cough and occasionally spit up streaks of blood in her phlegm. At first her primary care physician thought she had a bad chest infection and gave her an antibiotic. But the condition continued. A chest X-ray showed multiple shadows in her lungs. The cancer had returned. A lymph node biopsy removed any doubt, and a three-week course of radiation therapy to her chest did not halt the progression of the disease. The cancer moved quickly, spreading to her sinuses. Soon thereafter painful spots appeared on her shoulder and hip.

One morning, on attempting to get out of bed, she felt something give way on the right side of her pelvis, and she collapsed in excruciating pain. At the ER, the admitting doctor wrote in her chart: “No fractures are evident today; however this patient obviously has very rapidly progressive renal cell carcinoma with several known foci of metastatic involvement to the skeletal areas and attendant secondary problems with extreme pain, malnutrition, weakness, fatigue, and severe depression. Unfortunately, her prognosis with all of this is quite horrible, and therapy is only palliative.” The physician inserted a Portacath directly into Terry’s bloodstream and ordered high doses of Decadron and a constant infusion of narcotic.



As a second physician is now explaining to Terry and her husband possible courses of treatment and palliative care, she turns to him and asks, “How can this be happening to me now? Why did God let us adopt Sally if he knew this was going to happen? Is she now going to lose two mothers? Why is God doing this to me?” (Adapted from Ira Byock’s Dying Well).

## **CASE QUESTIONS**

- 1. What ethical issues do you see here?**
- 2. Which Directive(s) apply to the case?**
- 3. How might the Directive(s) help address the case?**

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## CASE RESPONSE

### CASE #1: A POOR PROGNOSIS AND ASKING “WHY?”

#### 1. What ethical issues do you see here?

- ✦ The issue here is not so much an ethical issue as it is one of how to address the psychological, emotional, spiritual situation of the patient and whose responsibility it is. Is it the physician’s responsibility to respond? Or someone from pastoral care or social work? Even if it is more the responsibility of pastoral care or social work, can the physician ignore the patient’s questions? If not, what might the physician say in such a situation?
- ✦ It is also important to note that the time at which a diagnosis/prognosis is given is an important time to involve pastoral care — the ability for the patient to receive the prognosis and maintain appropriate hope in God can be assisted through spiritual care.

#### 2. Which Directive(s) apply to the case?

- ✦ In this situation, it is the Introduction to Part Two that is most relevant. One statement in particular is most apropos to this case: “The medical expertise offered through Catholic health care is combined with other forms of care to promote

health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person.”

- ✦ Directives 10 and 11 might also have some bearing on the case.

#### 3. How might the Directive(s) help address the case?

- ✦ The Directives can heighten awareness of the importance of dealing with patients’ spiritual needs in addition to their physical needs and of the existence of a resource trained to do just that, namely, pastoral care.
- ✦ The Introduction to Part Two can also remind the physician that he or she, in taking a more holistic approach to the patient’s care, may need to deal to some extent with the patient’s spiritual concerns.

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## **CASE STUDY**

### **CASE #2: RELIGIOUS BELIEFS AND NON-BENEFICIAL TREATMENT**

Mr. Z is a 79-year-old African-American man with a history of diabetes and heart disease. He has been in and out of St. John's Hospital for the last eight months. On his last admission it was discovered that he had an infected left hip that required the removal of the hardware from his previous hip replacement surgery and aggressive antibiotic treatment to stem the infection that had developed. After being home for nearly four weeks, Mr. Z was brought back to the hospital by his son because of a high fever and intense, diffuse pain. It was discovered that the infection had reoccurred and that his leg, on the same side as the hip complications, was gangrenous. Based on Mr. Z's instructions, nothing aggressive (e.g., amputation) was to be done to the leg. However, he did consent to further antibiotic treatment and to relatively high doses of morphine for the pain. As time went by, the infection proved resistant to the medications and Mr. Z's pain increased. His attending physician was alerted to this but was hesitant to increase the dosage of morphine fearing that it may actually "cause his death" and that Mr. Z could become "addicted to the medications." Mr. Z's primary nurse caregiver was uncomfortable with the physician's opinion and sought a palliative care consult to discuss pain management options.

Shortly after Mr. Z's pain was better controlled, he had a stroke that left him unconscious and he subsequently developed pneumonia and septicemia. When asked by the attending physician about the future course of treatment, the son, who was previously estranged from Mr. Z but was recently designated his durable power of attorney for health care, stated that he wanted "everything done to keep his father alive," including, if necessary, amputating the gangrenous leg with partial pelvic removal, starting mechanical ventilation, and inserting a feeding tube. The attending physician was dismayed and told the son that not only was this against his father's wishes but that she would not honor the son's request because it was "tantamount to torture." The son did not relent, however, and insisted that everything be done because the matter was "in God's hands" and that a "miracle could still happen. My father needs to be kept alive with everything so that God can perform a miracle. My father

was faithful. God will rescue him.” He also perceived that stopping treatment was against the teachings of the Catholic Church to which he belonged. Furthermore, he threatened to bring suit against the physician and the hospital if his request was not honored and suggested that the real reason the physician wanted to “kill his father” was racial bias. The physician, as well as the nursing staff, were highly stressed and exasperated. They fully believed that they were doing harm to Mr. Z. (Courtesy of Dr. Michael Panicola, SSM Health Care, St. Louis, Mo.).

## **CASE QUESTIONS**

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## CASE RESPONSE

### CASE #2: RELIGIOUS BELIEFS AND NON-BENEFICIAL TREATMENT

#### 1. What ethical issues do you see here?

- ✦ Respect for human dignity
- ✦ Informed consent
- ✦ Patient self-determination
- ✦ Pain relief
- ✦ Withdrawal of life-sustaining treatment
- ✦ Non-beneficial treatment
- ✦ Do no harm

#### 2. Which Directive(s) apply to the case?

- ✦ There are a good number of Directives that apply to this case from other parts of the Directives, especially from Part Three and Part Five, for example, Directives 26, 27, 32, 33, 37, 56, 57, 59, and 61.
- ✦ Again, here it is primarily the emphasis on the importance of pastoral care that is critical.

#### 3. How might the Directive(s) help address the case?

- ✦ Pastoral care could have been of assistance to the patient's son especially with regard to his appeal to a miracle and his claim that stopping treatment was against his Catholic faith. Pastoral care might also have been of assistance in helping the son understand why he was demanding that everything be done.
- ✦ The presence of Part Two should remind clinicians that "the care offered... embraces the physical, psychological, social, and spiritual dimensions of the human person." How were and are the patient's spiritual needs being addressed? Specific Directives in Part Two should remind clinicians that, for a Catholic patient, the sacraments are an important part of their care.



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## **SELECTED READINGS AND MEDIA**

Fitchett, George, Peter M. Meyer and Laurel Arthur Burton, "Spiritual Care in the Hospital: Who Requests It? Who Needs It?" *Journal of Pastoral Care* (Summer 2000): 173-186.

Lichter, David and Mary Lou O'Gorman, "Establishing a Chaplain's Value," *Health Progress* 90, no. 3 (May-June):30-33.

John Paul II, "On the Christian Meaning of Human Suffering," (February 11, 1984)