



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

AN EDUCATIONAL RESOURCE FOR PHYSICIANS



Part Five - Issues in Care for the Seriously Ill and Dying

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PRAYER RESOURCE

OPENING PRAYER

O God, creator and sustainer of all life, the death of each person recalls our human condition and the brevity of our lives on earth. Bring the light of your love and power to all who are dying and to those who love them and mourn their passing. Be with us as we minister to them and their families, that we may honor the sacredness of this passage into unending life. Amen.

READING

Out of the depths I cry to you, O Lord; Lord, hear my voice!
Let your ears be attentive to my voice in supplication.
If you, O Lord, mark iniquities, Lord, who can stand?
But with you is forgiveness, that you may be revered.
I trust in the Lord; my soul trusts in his word.
My soul waits for the Lord, more than sentinels wait for the dawn.
(Psalm 130)



Part Five - Issues in Care for the Seriously Ill and Dying

CASE STUDY

CASE #1: PAIN MANAGEMENT

A 68-year-old man with metastatic small-cell lung cancer has excruciating bone pain and was near death. He initially responded to a combination of radiation and chemotherapy and had a three-year remission. When his disease recurred four months ago, he chose a palliative approach. His pain from extensive bony metastases was initially well controlled with high-dose, around-the-clock opioids supplemented by radiation and nerve blocks. He prepared for death through talks with his family and clergy and he felt that he had no remaining “unfinished business.” At that time, he weighed 80 pounds, he was bed-bound, and his pain averaged eight points on a ten-point scale. He did not want to die but was willing to accept the risk for earlier death that might come from further increasing doses of opioids. After a palliative care consultation, his physician increased his total opioid doses by 25 percent per day until the pain was adequately controlled, or, if sedated, he appeared comfortable.

On the third day, the patient became very sleepy but arousable and appeared relatively free of pain. The physician shifted an equianalgesic amount of opioids from oral to transcutaneous administration because the patient was unable to reliably swallow. The patient became unresponsive but appeared comfortable, and he remained in that state until he died two days later. (Source: Unknown).

CASE QUESTIONS

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

Part Five - Issues in Care for the Seriously Ill and Dying

CASE RESPONSE

CASE #1: PAIN MANAGEMENT

1. What ethical issues do you see here?

- ✦ The administration of pain medications that might have hastened the patient's death

2. Which Directives apply to the case?

- ✦ Directive 61

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

- ✦ Directive 61, based on the principle of double effect, permits the administration of analgesics to relieve pain even if the unintended side effect is an earlier death for the patient.

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CASE STUDY

CASE #2: USE OF A FEEDING TUBE

M.L. was a 76-year-old female patient with history of COPD, atrial fibrillation, congestive heart failure, hypertension and type 2 diabetes. She was admitted to St. Bridget's Hospital after suffering a stroke that left her paralyzed on one side, unable to speak or swallow and without capacity. She could open her eyes, but it was unclear as to the degree of awareness she had of her surroundings. She did not indicate that she recognized her family.

Mrs. L. was widowed and lived with a daughter. Prior to the stroke, she had been able-bodied. She no longer drove or prepared meals but was able to perform self-care. She could feed herself and could navigate within her daughter's home independently.

Mrs. L's daughter was overwhelmed by the degree of her mother's impairment from the stroke. She knew she could no longer care for her, especially now that she was bedridden. In discussing nutritional support, Mrs. L's daughter declined a feeding tube. She did not think her mother would survive long-term and did not want to add to her mother's burden. Mrs. L's physician was unsure of how to proceed because she did not feel the stroke was necessarily terminal. The palliative care team was consulted to assist with the ethical and legal guidelines regarding artificial nutrition and hydration, specifically in someone without capacity and without an advance directive.

Mrs. L's vital signs were stable. Her blood pressure would trend upward at times but was controlled with medication. Her lab values were essentially normal. She failed a swallowing study that resulted in a recommendation to not take anything by mouth. The stroke team had weighed in with a guarded prognosis for recovery. There was no documentation stating the opinion that Mrs. L was going to die from this stroke. The attending physician was asked for her opinion regarding whether Mrs. L would die first from her medical condition or from the lack of food and water if she was not given nutrition and/or hydration.

The physician's opinion was that the patient would die first from lack of nutrition and hydration. Based on this assessment, the indication was to proceed with trial feedings through the use of a nasogastric feeding tube. If tolerated, Mrs. L would then be evaluated for placement of a more permanent gastric feeding tube.

This discussion was brought to Mrs. L's family and the daughter she lived with. They voiced their understanding and support to go forward with attempting to feed. A Dobhoff feeding tube was placed and tube feedings were started.

Within 24 hours Mrs. L showed new signs of having extended her stroke. She was no longer able to open her eyes. Her breathing was affected and she had less control of her oral secretions. It was thought that she had aspirated and was showing significant deterioration. Assessment for the more permanent feeding tube was placed on hold and the palliative care physician suggested observing Mrs. L for the next 24 to 48 hours.

Within two days Mrs. L was thought to be imminently dying. She was unresponsive and with worsening respiratory status. She was congested and breathing with some difficulty. The family was updated by both the primary and palliative care physicians. Direction of care became solely that of comfort.

Because it was thought that Mrs. L was now imminently dying and because her stroke had further impaired her ability to protect her airway, tube feedings were stopped and the nasogastric feeding tube was removed. Medicines were provided in low doses to calm her breathing and reduce the amount of excessive secretions. A lubricating solution and ointment were kept at the bedside to keep her mouth and lips moist. A private room was provided where family could be present. About 36 hours later Mrs. L died with symptoms controlled and in what appeared to be a peaceful manner. (Courtesy of St. John Medical Center, Tulsa, OK).

CASE QUESTIONS

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

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CASE RESPONSE

CASE #2: USE OF A FEEDING TUBE

1. What ethical issues do you see here?

✦ The use of medically administered nutrition and hydration

✧ Was the daughter's initial refusal morally acceptable?

No, from the information given, it was clear that the mother's condition was not terminal at the time. Medically assisted nutrition and hydration were ordinary care initially.

✧ Was the placement of the NG tube morally required?

Yes, because the mother was not judged to be terminal and would have died first of malnutrition or dehydration rather than from her underlying condition.

✧ Was stopping tube feeding after the patient's condition worsened morally permissible?

Yes, due to the imminence of death and the increased burdensomeness of the treatment.

2. Which Directives apply to the case?

✦ Directives 56, 57, and 58

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

✦ Directives 56 and 57 define what is to be considered ordinary and extraordinary means. Was tube feeding ordinary or extraordinary in the various contexts in the case?

✦ Directive 58 speaks directly to feeding of patients, even artificially. It distinguishes between non-dying and imminently dying patients and excessive burdensomeness with regard to the use of feeding tubes.

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CASE STUDY

CASE #3: ADVANCED CARDIAC LIFE SUPPORT

Mr. Kind is a 71-year-old man with multi-system organ failure. Presently, his kidneys are not functioning appropriately. However, his underlying problem is non-small cell lung cancer with metastases to the liver. He has been unconscious in this most recent hospitalization for more than five days. Fluid is accumulating around his heart and within the last 24 hours he was placed on mechanical ventilation. This is the third hospitalization at All Saints Hospital for Mr. Kind. His first resulted in physician requests to make him a “no code” and to limit the extent of aggressive technological interventions and instead focus solely on comfort care. Mr. Kind’s three daughters, all of whom are single and have quit work to live with and care for their father, refuse to believe that their father is dying and think that if only appropriate medical interventions are given he will go home and live peacefully for some months, if not years.

After Mr. Kind’s daughters took him home following his first hospitalization, Mr. Kind seemed to stabilize for a short period of time, but then was hospitalized again with similar complications. Physicians and hospital staff took the same course of action and again requested a DNR order and minimal technological and intensive care use, only to have all of these requests denied by the daughters. The daughters have learned how to provide excellent home care and despite their father’s limited mobility, he is free from infection, bedsores, and any other medical difficulties.

The third and most recent hospitalization was caused by an increase in respiratory difficulty and an increasing lethargy and unresponsiveness. Again, physicians are requesting that Mr. Kind be made a “no code” and that he be removed from the intensive care unit and be given only comfort measures. The daughters believe these requests are financially motivated and are disrespectful to the dignity of their father. They even said that if their father were not resuscitated upon arresting, they would bring a wrongful death suit against the hospital as well as the participating physicians and nurses. Periodically, they invoke their Catholic faith

in support of their requests, but are unable to elaborate on the elements of their faith that would require such a course of action. (Courtesy of Dr. Michael Panicola, SSM Health Care, St. Louis, Mo.).

CASE QUESTIONS

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

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CASE RESPONSE

CASE #3: ADVANCED CARDIAC LIFE SUPPORT

1. What ethical issues do you see here?

- ✦ Non-beneficial treatment — was the DNR recommendation appropriate at the initial visit to the hospital? The second?
- ✦ Ordinary versus extraordinary treatment
- ✦ Appropriate decision-makers for a patient without decision-making capacity
- ✦ Respect for human dignity/patient best interests

2. Which Directives apply to the case?

- ✦ Directives 56 and 57

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

- ✦ Directives 56 and 57 are obviously directly applicable. Is the patient's treatment ordinary or extraordinary and why?
- ✦ Earlier discussion of stewardship of resources is relevant (Part One).

- ✦ Directive 28 is important. It speaks to the need for adequate moral information. The daughters in this case seem to have misinformation about the Church's teaching.
- ✦ Part Two might also be applicable in two ways: (1) a role for pastoral care in working with the daughters; (2) administration of the sacrament of the Anointing of the Sick.

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SELECTED READINGS AND MEDIA

_____, "Special Section: Palliative Care," *Health Progress* 92, no. 1 (January-February 2011): 10-57.

Baker, Nadine, "Enhancing the Quality of Life for Advanced Dementia Patients," *Health Progress* 89, no. 4 (July-August 2008): 62-64.

Congregation for the Doctrine of the Faith, "Response to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," (August 1, 2007).

Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, 1987.

deBlois, Sr. Jean and Rev. Kevin O'Rourke, "Issues at the End of Life," *Health Progress* 76, no. 8 (November-December 1995): 24-27.

DuBois, James, "Non-Heart-Beating Organ Donation," *Health Progress* 82, no. 1 (January-February 2001): 18-21.

Guinan, MD, Patrick, "Is Assisted Nutrition and Hydration always Mandated?" *National Catholic Bioethics Quarterly* 10, no. 3 (Autumn 2010): 481-488.

Haas, John, "Catholic Teaching regarding the Legitimacy of Neurological Criteria for the Determination of Death," *National Catholic Bioethics Quarterly* 11, no. 2 (Summer 2011): 279-299.

Hamel, Ron and Rev. Thomas Nairn, "The New Directive 58: What Does It Mean?" *Health Progress* 91, no. 1 (January-February 2010): 70-72.

O'Rourke, Rev. Kevin, "The Catholic Tradition on Forgoing Life Support," *National Catholic Bioethics Quarterly* 5, no. 3 (Autumn 2005): 537-553.

Sanders, Alan, "The Clinical Reality of Artificial Nutrition and Hydration for Patients at the End of Life," *National Catholic Bioethics Quarterly* 9, no. 2 (Summer 2009): 293-304.

Sheehan, Rev. Myles, "Feeding Tubes: Sorting out the Issues," *Health Progress* 82, no. 6 (November-December 2001):22-27.