

## PAS: How Should Catholic Health Care Respond?

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Physician Assisted Suicide – Is this an issue that you or your institution may have to deal with in the near future, or are already facing? With the addition of California, Colorado, and soon the District of Columbia, to states that have already legalized it, approximately 20% of Americans now live in jurisdictions that permit this transformation in the practice of medicine and delivery of health care. Whether it is called physician assisted suicide, physician assisted death, or death with dignity, the legislative bills and their justifications are essentially the same. This is because they have been primarily sponsored by the same national organization, Compassion and Choices. Prototype bills passed in Oregon in 1997, in Washington, in 2008 and Vermont in 2013 have been introduced in at least 20 additional states in 2017. This alone makes it necessary and timely to consider an appropriate response, both personal and institutional. I believe the

unfortunate proliferation of these bills presents us with an opportunity to deepen our commitment to Catholic values.

For those involved in Catholic health care, it may come as no surprise to find that many of our professionals, patients, and employees have not formed opinions in opposition to this issue. It is not merely the euphemisms such as death with dignity that obscure and soften the matter - even the name of the sponsoring organization, Compassion and Choices, sounds like a good thing and something that should be supported.

Framed in this way, a change in the law is then proposed, allowing physicians to write a lethal prescription for terminally ill patients to take upon their request.

In addition to the requirement of a terminal illness, standard provisions in these bills include patients must be 18 years of age or

older, expected to die within six months, competent and acting voluntarily with informed consent, and able to take the medication themselves. The physicians involved can refer the patient for further evaluation if they think the patient is depressed, but are not required to do so. Moreover, physicians are forbidden from listing physician-assisted suicide as the cause of death on the death certificate, but must list the terminal illness that was expected to take the patient's life in the near future. Absent from these "safeguards" is a requirement that any medical professional be in attendance at the time of ingestion or the time of death in order to ensure the voluntary nature of the ingestion. It is important to note that suicide is already legal everywhere in the United States; it is only the act of assisting in a suicide that is being changed by these laws, which therefore protect physicians from criminal liability, civil lawsuit, and peer review.

Understandably, not even the proponents of these bills expect them to be embraced by those in Catholic health care. They frequently complain about "narrow religious objections" to assisted suicide. Certainly they are right to suppose that those with a

strong faith tradition would find much to oppose in these bills, particularly the violation of the commandment "Thou Shalt Not Kill". But if proponents were to dismiss all opposition as simply based on unshared religious scruples, their understanding would fall far short of the mark. Many physicians, no matter their religious background or lack of it, adhere strongly to the Hippocratic dictum to "do no harm" and to the words in the oath to "abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest such counsel." They correctly see that deliberately and intentionally causing the death of their patient consists of doing them the ultimate harm.

The reason that many in the health care professions oppose changing the laws regarding assisted suicide can be understood without reference to religious principles at all. This will be important in formulating a response to proposed changes in the law that may seem rational and worthy of support to those who work within our hospitals and clinics. Strong medical and social reasons for opposition revolve around the deleterious effects on our patients, our profession and our whole society. For our patients, we have

seen that these bills offer no significant new options or protections – they merely protect doctors who write the prescriptions for them. Proponents point to real and tragic stories of suffering in individuals at the end-of-life; these stories are heartbreaking and make all of us want to do something to alleviate such situations. However, when we look closely at the reasons patients give for seeking a lethal prescription we find some surprises. According to information compiled in Oregon and Washington,<sup>1</sup> the chief reason for such a request is not intractable pain associated with their terminal disease. In fact, intractable pain does not rank first, second or third on the list. Rather, patients are concerned about loss of control, loss of pleasurable activities, and fear of being a burden to others. Depression seems to play a significant role in many of these situations, and it should be recognized that even more of these patients appear to be experiencing an existential and spiritual crisis near the end of their lives. They are truly suffering, but the suffering is not primarily from physical pain.

When patients present themselves in such a condition, what will it mean, for both them

and the medical profession, to have a physician include in the standard therapeutic offerings the hope of a cure, needed palliative care, or an offer to accelerate their death with a lethal prescription? The latter is a massive shift in the orientation of the doctor-patient relationship. Doctors who traditionally could be relied upon to do everything that might possibly benefit their patients would now be offering to be their instruments of an early death. How then would patients know which track the physician was selecting as the appropriate one for them? Reports from Belgium and the Netherlands, where such practices have been in place longer than in the United States, prove this is not really a theoretical concern. Elderly patients have expressed fear of entering hospitals that might look upon them as “lives not worth living” and encourage their suicide or euthanasia as a therapeutic option.

We must make no mistake about this; such a change for society would be tantamount to a tectonic shift. In order to exercise “compassion” we would have selected out a category of lives, for which causing death is a legitimate and supposedly therapeutic medical option. This option will inevitably

be seen as attractive not simply for the patient's sake, but for potential cost savings as well. Such an analysis has already taken place in Canada, with potentially millions in savings projected from their newly legalized practice of euthanasia and assisted suicide.<sup>2</sup> Society will be relieved of the burden of their care, and patients who already fear being a burden will be subtly pointed in this direction.

Coupled to this new definition of “compassion” is the concept of “choice” included in the law. The legitimate concern here is that the choices are meant to honor the patient's autonomy, but the law as presently written restricts those choices in an apparently arbitrary way. What is the justification in the law for offering this new “compassion” only to those who are terminally ill, and expected to die within six months – why not nine months, 12 months, two years? Why can't we just relieve all intolerable suffering, whether they are dying or not? Why must we require them to be able to take the drugs themselves – can't we just infuse them if the patient is too weak, too obtunded, comatose, or with dementia? And why should infants and children not be

offered “compassionate” intervention? Using the frame of autonomy, it is a short trip from choice to compassion to euthanasia.

If this is not the future we want for our patients, our institutions, or ourselves, what should be our response? Obviously, the first and best outcome would be to oppose such laws and prevent their passage. This has been the response of most of the states in which these laws have been proposed, year after year. In those places where it fails, or has already failed, an “opt out” provision is routinely offered to both individuals and institutions. This is clearly the best route to take in such situations for the reasons previously mentioned, given the evidence that it is not in the best interest of our patients, and is not compatible with our institutional or personal values. Several hospital systems in California and Colorado have chosen to “opt out,” including those that are secular hospital systems. They have explained that, without even taking a position about the arguments that should discourage assisted suicide, they find no place for this activity in their inpatient facilities, and therefore no reason to participate. When it is practiced, assisted suicide typically takes place in the privacy of

an individual's home, not in a hospital or a clinic. Many have also chosen to discourage the involvement of their affiliated practitioners. This would be especially true when these health care professionals were seen as representing an institutional affiliation with a Catholic hospital or clinic. There is ample precedent for this approach in Catholic health care for the avoidance of direct involvement in abortion and contraception. It will come as no surprise to those who are affiliated with Catholic health care institutions that their hospital or clinic will not plan to participate in the legalized suicide of their patients.

If opting out was the sum total of the response of the Catholic health care institutions, it would prove inadequate to meet the needs of the patients, and to meet the high standards of the core values of Catholic health care.

Too often in the public arena, the distinguishing features of Catholic health care are perceived negatively in terms of what we don't do. The issue of physician-assisted suicide, however, is a situation in which the best characteristics of Catholic health care can and should be raised loud

and clear. The first Catholic hospitals were founded to provide for all the needs of the patient—physical, psychological, and spiritual. For patients near the end-of-life who are undergoing an existential crisis, fear of abandonment, or fear of being burdensome, they should know that they can find the solace and support they need, as well as the safety they may seek, in Catholic health care institutions. We can allay the fears of those patients: the fear of death, the fear of abandonment, the fear of devaluation. Catholic health care's emphasis on *cura personalis*, the care of the whole patient, offers a unique opportunity to serve all patients in ways that may be diminished or absent in secular health care systems. Our response provides a safe haven coupled with the continued commitment to clinical excellence that marks the best in the tradition of Catholic health care.

## References

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