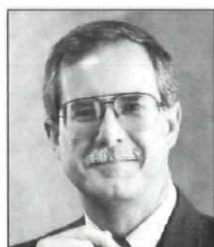


A BETTER APPROACH TO CARE OF THE DYING

Catholic Healthcare and the Catholic Community Can Present an Alternative to Physician-Assisted Suicide

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Despite last year's U.S. Supreme Court decisions rejecting physician-assisted suicide as a constitutional right, both acceptance of the practice and efforts to legalize it continue. The issue has not gone away, and is not likely to do so any time soon.¹ What does this mean for the Catholic community and especially for Catholic healthcare? It must mean more than mounting campaigns against the legalization of physician-assisted death and using moral arguments to try to persuade the citizenry and members of the community of faith. It must also mean more than formulating institutional policies prohibiting physician-assisted suicide and stating publicly that this practice is not an option for terminal care.

These efforts are undoubtedly important. Nevertheless, Catholic healthcare facilities remain complicit in the growing acceptance of physician-assisted suicide to the extent that they provide poor or mediocre end-of-life care. And communities of faith comply to the extent that they fail to

provide care and support for the terminally ill and their families as well as resources for their members to come to terms with the reality of death in the context of faith. If Catholic healthcare and the Catholic community are to make a significant and lasting difference in the acceptance of physician-assisted suicide, it is increasingly urgent that they walk the talk, that they demonstrate an alternative way of approaching death and the care of the dying.

Just a few weeks prior to his death, Card. Joseph Bernardin wrote a letter to the U.S. Supreme Court expressing his opposition to any decision that would legalize physician-assisted suicide. It was a powerful statement—partly because of what it said, partly because of who authored it, but particularly because, at the time he wrote it, he was actually demonstrating a different way of approaching death. The statement, without the example of the alternative, would have been less effective. What will be remembered is not so much what he said, but how he embraced his imminent

Summary To combat physician-assisted suicide, Catholic healthcare and the Catholic community cannot solely focus on mounting campaigns and formulating policies. They must also demonstrate an alternative way to approach death and care of the dying, taking a leadership role in improving end-of-life care.

To accomplish this, Catholic healthcare must foster a culture that recognizes death as the inevitable outcome of human life and makes care for the dying as important as care for those who may get well. The ministry must acknowledge the limits of human life, human abilities, human ingenuity, and medical technology; and respect decisions to forgo life-sustaining therapies. In addition, physicians must address advance directives with

patients before hospitalization and must be willing to offer hospice care as an option to dying patients and their families.

More effective pain management must be devised. Catholic facilities must develop palliative care policies and commit to ongoing education to provide such care. It is essential that they pay attention to the environment in which patients die; identify the physical, psychosocial, and spiritual needs of family members; and use prayer and rituals in meaningful ways.

With a clear focus on improving end-of-life care, Catholic healthcare—in partnership with other denominations—can eliminate some of the factors that can make physician-assisted suicide seem appealing to suffering people.

death and how he did his dying.

Rev. Richard Gula has it right when he says in his book *Euthanasia: Moral and Pastoral Perspectives*:

Now it is time to "walk the talk," as it were, if our principles and arguments are ever going to be convincing. . . . In moral matters, witness is more compelling than arguments. Principles may teach, but shining examples make principles come alive and influence public opinion more strongly. Why? Because we learn morality primarily through real-life people and their stories, which have a fascinating appeal to the moral imagination. . . . The true significance of our Catholic opposition to euthanasia ultimately rests on the kind of witness that runs ahead of and behind the convictions which we say make euthanasia untenable. In order to be a credible player in the debate, then, we have to bear convincing witness, personally and corporately, to the way we care for the sick, the elderly, the dying, the unsuccessful. What kind of persons and community should we be in order to encourage people to view death as an inevitable outcome that no one needs to hasten through lethal injection?²

This is the principal and urgent challenge facing Catholic healthcare facilities and communities of faith—individually and collaboratively en fleshing the principles in practice by focusing considerable energies in a concerted and public way on improving our approach to death and the care of the dying and their families.³

What would have to happen in Catholic healthcare facilities and communities of faith for this to occur? The following areas, although not exhaustive, if adequately addressed, could begin to make a difference.⁴

ACCEPTING DEATH

Catholic healthcare facilities, while continuing to cherish and nourish life, must also foster a culture that recognizes death as the inevitable outcome of human life and cure as an oftentimes unreachable goal. Some patients in these facilities have reached the inevitable conclusion of their lives.

Catholic healthcare must foster a culture that recognizes death as life's natural end.

Recognition of this reality is a prerequisite to transforming how the dying are cared for. Were such a culture to take hold in our healthcare institutions, there might be fewer efforts to unreasonably prolong the dying process.

FOCUS ON CARE

Also critical to transforming the culture is fostering the belief that caring for the dying is as important as caring for those who may get well.

So much attention is given to curing that death is seen as a failure, and the dying viewed as second-class patients, undeserving of as much attention as patients "for whom something can be done." When the marvels of medical technology and the skills of health professionals fall short of cure and are overtaken by advancing death, one often hears, "There is nothing more we can do," and the patient is left to die. There is great wisdom in the old French adage about the goals of medicine: "To cure sometimes, to ameliorate often, to care always." Patients who may be beyond cure are never beyond care. Medicine, when it is holistically understood, still has much to offer those whose primary need is control of physical, psychosocial, and spiritual symptoms.

RECOGNIZING LIMITS

Transforming the culture also means fostering a healthy recognition of limits—the limits of human life, of human abilities, of human ingenuity, of medical technology. So much of the abuse that occurs at the end of life is due to the inability to recognize or to accept that limits are inherent to human nature and to the human condition. This acceptance of limits needs to occur among health professionals as well as among the lay public. For some of the latter, communities of faith can be places where such an attitude is nourished.

RESPECT FOR PATIENTS' DECISIONS

To avoid unnecessary prolongation of the dying process, Catholic healthcare facilities must foster and embody a respect for decisions to forgo life-sustaining therapies, whether communicated verbally by a patient with decisional capacity or through advance directives. Neither patients nor their families should have to fight to be allowed to make this decision.

PROMOTING ADVANCE DIRECTIVES

In a similar vein, Catholic healthcare facilities should expect their physicians to routinely address advance directives with their patients prior to hospitalization, and the institution itself should have effective mechanisms in place to address advance directives with hospitalized patients who do not have them. Advance directives have their own limitations, some of them serious, but at least they provide some guidance with regard to patient preferences and permit individuals to have some say, some control, in how their lives will end. Currently, about 15 percent of the population has an advance directive. Typically physicians do not promote them in their offices and hospitals do not generally do well dealing with them despite the Patient Self-Determination Act of 1991. Long-term care facilities also need to address advance directives with their residents and their families. Too often, resident or family wishes are unclear, resulting in inappropriate resuscitations and hospitalizations that end up subjecting patients to aggressive treatment that provides little or no benefit.

PALLIATIVE CARE POLICIES

An important component of improving end-of-life care in Catholic facilities is the development of guidelines for the formation of a palliative care policy and a palliative care plan (see **Box** below). Virtually all hospitals today have policies regarding CPR, limitation of treatment, and so on. These policies focus on what is not going to be done. A palliative care policy and guidelines begin to address what will be done and, to some degree, how to do it. Many physicians tend to lack experience in caring for the dying. Palliative care protocols can assist them and other health professionals in that process. And they can provide something of an antidote to the belief that forgoing aggressive treatment means "doing nothing" for the patient. The alternatives are not between doing everything and doing nothing. An aggressive plan of symptom management—of physical, psychosocial, and spiritual symptoms—can go a long way in improving the way people die.

MORE EFFECTIVE PAIN MANAGEMENT

The SUPPORT Study, which collected data on thousands of seriously ill patients from 1989-1994,

PALLIATIVE CARE PLAN AND POLICY

In April 1996, a subcommittee of the Lutheran General Hospital Bioethics Committee met for the first time to explore ways to improve end-of-life care at the hospital, with a particular focus on patients who are expected to die in the hospital within 72 hours. The subcommittee comprised seven physicians, two chaplains, and one person from each of the following departments: nursing administration, administration, social work, legal, pharmacy, and ethics.

In its initial meeting, the group identified eight potential areas for improvement and decided to begin by targeting three: guidelines for development of a palliative care plan, a hospital-wide palliative care policy, and palliative care standing orders. The guidelines and palliative care policy follow. The subcommittee continues to meet monthly to consider other aspects of end-of-life care, such as improved pain management and a palliative care team.

GUIDELINES FOR DEVELOPING A PALLIATIVE CARE PLAN

1. What are the patient's/family's needs and goals? What is important to them in the time that remains? How do they want to spend their time?
2. In light of these goals, what therapies should be withdrawn, retained, or continued to promote the patient's comfort? (See Palliative Care Order Form, p. 58.)
3. What physical symptoms need to be addressed to provide comfort? (See Palliative Care Order Form, p. 58.)
4. What psychosocial issues need to be addressed, including location in which comfort care will be provided (e.g., cur-

rent location, home, nursing home); whether hospice referral is appropriate; the environment in which palliative care will be provided (noise, monitors and other equipment removed, privacy, sufficient seating for family, etc.); family involvement (who, when, for how long, etc.); family issues?

5. What emotional/spiritual issues need to be addressed (including emotional/spiritual support; ritual/prayer; contacting a representative of the patient's faith community; facilitation of life review; facilitation of grieving; referral to support groups)?

6. Has the palliative care plan been reviewed with patient/family?

7. Has a clear order been written (Palliative Care Standing Order Form) and have the appropriate individuals been contacted for implementation of various parts of the plan?

LUTHERAN GENERAL HOSPITAL ADULT PALLIATIVE CARE POLICY**I. Policy**

Lutheran General Hospital-Advocate recognizes that in the care of patients with advanced disease it is medically appropriate and ethically acceptable to shift the primary goal of treatment to palliative care if this is judged to be medically appropriate by the patient's physician and consistent with the wishes of the patient or the patient's surrogate.

II. Objectives

The purposes of this policy are to:

- A. Clarify the meaning of palliative care, often referred to

indicates that more than 50 percent of conscious, hospitalized dying patients experienced moderate to severe pain. Other studies have also indicated serious inadequacies in effective pain management. And yet pain is one of the most feared aspects of the dying process and profoundly affects a patient's physical, psychosocial, and spiritual well-being. Catholic hospitals and long-term care facilities could make an enormous contribution to good patient care and to end-of-life care if they could assure all their patients, but especially their dying patients, that every effort will be made to relieve their pain. The technology and the knowledge are both available. What is needed is the will to change practice and to acquire needed information and skills.

HOLISTIC SYMPTOM MANAGEMENT

Pain management does not address all of a patient's symptoms. Even if pain management were effective, it would not be sufficient. What is also necessary is a holistic approach to symptom management—an approach that deals with the patient's other physical symptoms as well as the

patient's and family's psychosocial and spiritual needs. A palliative care order form—modeled after the one developed by Lutheran General Hospital, for example—assists physicians to take a more comprehensive approach to palliative care and to avoid general orders such as “comfort care only” (see **Box**, p. 58). In-service sessions will likely be required for this to be done effectively. As part of dealing with symptoms, more attention might be given to various modes of alternative healing, such as music therapy, healing touch, and relaxation response.

HOSPICE CARE

Improvement of end-of-life care in Catholic hospitals and long-term care facilities will entail a greater willingness on the part of physicians to offer dying patients and their families the option of hospice care. Despite improvement on this front over the years, many physicians are still reluctant to transfer their dying patients into a hospice program. And, surprisingly, many people are still either unfamiliar with hospice itself or with what hospice has to offer. Catholic healthcare institutions have an

as “comfort care.”

- B. Promote comprehensive and consistent palliative care.
- C. Establish a process for determining appropriate palliative care for individual patients.

III. Definition

Palliative care consists of all treatments and services aimed at alleviating physical symptoms and addressing the psychological, social, and spiritual needs of the patients and their families so as to enhance patients' and families' quality of life to the greatest degree possible.

Palliative care:

- affirms life and regards dying as a normal process;
- implies the cessation of all diagnostic measures and all life-sustaining and other therapeutic treatments that do not directly contribute to the patient's comfort or to patient and family goals;
- consists of active management of pain and other distressing symptoms. In the relief of pain, it is ethically permissible to administer analgesics, in sufficient amounts, to control the patient's pain even if this has the unintended effect of depressing the patient's respiratory function.
- is multidisciplinary in order to address the physical, psychosocial, and spiritual needs of patient and family.

IV. Procedure

- A. A discussion should be initiated between the attending physician and the patient and/or the patient's family

about the appropriateness of shifting goals of treatment to palliative care.

- B. The attending physician and other members of the healthcare team should develop a palliative care plan with the patient and/or the patient's family (usually in the context of a family conference), taking into account their particular goals and needs. Special attention should be given to:
 - (1) what therapies and procedures should be continued, discontinued or initiated;
 - (2) symptom control, especially the management of pain and anxiety;
 - (3) the most appropriate setting for the patient's death to occur, including the appropriateness of hospice care.
- C. The physician should document the patient's and/or family's agreement with the plan in the medical record.
- D. The physician should complete the “Palliative Care Order Form.” A general order like “comfort care only” is not acceptable.
- E. A regular review of the palliative care plan should occur and adjustments made as the patient's condition changes.

V. Endorsements

Medical Staff Executive Committee
Nursing Executive Team

LUTHERAN GENERAL HOSPITAL ADULT PALLIATIVE CARE ORDER FORM

DATE: _____

TIME: _____

1. RESUSCITATION STATUS

This patient is no-CPR. In the event of cardiac or respiratory arrest, cardiopulmonary resuscitation will not be attempted. No "code blue" should be called.

2. INITIATE THE FOLLOWING ORDERS TO PROVIDE COMFORT:

Pain/air hunger: _____

Anxiety/delirium: _____

Sleep: _____

Constipation: _____

Diarrhea: _____

Nausea/vomiting: _____

Thirst: _____

Fever: _____

Other: _____

3. The following therapies may not contribute to providing comfort. If this patient is currently receiving any of these, please indicate below if they are to be continued or discontinued.

IV hydration	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Diagnostic procedures	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
ECG and O ₂ sat monitoring	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Supplemental O ₂	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Parenteral and/or enteral nutrition	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Arterial lines	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Central venous lines	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Peripheral venous lines	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
PT/OT	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Blood products	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Radiation therapy	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Dialysis (Please notify nephrologist Dr. _____)	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue
Blood draws for standing laboratory orders	<input type="checkbox"/> Continue	<input type="checkbox"/> Discontinue

4. Please discontinue the following medications: _____

5. Consult Pastoral Care and Social Work departments

6. Social Work Department to evaluate patient for appropriateness of hospice care

7. Transfer orders: _____

important opportunity to promote an understanding of hospice care, the increased use of hospice, and even the creation of hospice units within their walls if they don't already exist.

STAFF TRAINING

Palliative care is different from acute care or cure-oriented care. If Catholic healthcare institutions are truly committed to improving end-of-life care, some training will be required for staff who care for the dying. Commitment to ongoing education will be essential to providing good palliative care. In addition, Catholic hospitals might consider forming a palliative care team that could advise physicians on how best to address patients' symptoms and families' needs. More and more palliative care teams are springing up in hospitals across the country.

IMPROVING THE ENVIRONMENT

Improving end-of-life care also means paying attention to the environment in which patients die. This could involve something as simple as removing unnecessary equipment from a dying patient's room to the creation of homelike palliative care rooms or units. They would be analogous to birthing rooms, which have been successfully created and employed in many hospitals.

CARE OF FAMILIES

Transforming the way dying occurs in healthcare facilities also implies identifying the needs of family members—physical, psychosocial, spiritual—as they journey with their loved one, and changing practices and structures to meet those needs. Some kind of follow-up with immediate family after their family member has died is also an important component of good end-of-life care.

USE OF PRAYER AND RITUAL

Foster the use of prayer and rituals in ways that are meaningful and suitable to the patient and the patient's family. Of critical importance, chaplains must be able to help patients and their families address the basic "meaning questions" that arise in these situations, such as suffering, dependency, and hopelessness. Hastening death becomes a more attractive option as the experience of dying becomes more meaningless.

PARTNERSHIPS WITH PARISHES AND CONGREGATIONS

Improving care of the dying is likely to be much more effective if it results from a partnership between Catholic healthcare institutions and parishes (as well as congregations from other religious traditions). Some aspects of end-of-life care are better addressed in the context of religious communities, which have as a primary function the

formation and education of their members. Matters of religious and ethical beliefs and of spirituality are better dealt with before terminal illness and in a context and by people more suited to those dimensions of the person. Again quoting Richard Gula:

Daniel Callahan has it exactly right when he asserts that we cannot guarantee how we will react to the prospects of suffering and dying, but we can begin to shape the self we will bring to that experience. He says, "How we die will be an expression of how we have wanted to live, and the meaning we have found in our dying will be one with the meaning we have found in our living." Therefore, even now when death seems like "a distant thunder on a summer's day," as W. H. Auden once put it, I can still prepare to face death by working to become the kind of person I want to bring to it. I need not be a mere victim of what dying has in store for me. Rather, I can actively engage my dying by developing those habits of heart which will make a difference in the way I adapt to unwanted circumstances and endure what I cannot change. If we do not develop these habits for living throughout our life, then we will not have them to strengthen us in the face of death. So what kind of person do we want to bring to our sickness, suffering, and decline in order to make euthanasia unthinkable?⁵

Individual members of the faith community must be educated about ethical issues at the end of life. That education must extend to how we view and cope with death, how we understand and respond to illness, suffering, and dependency on others, and how as people of faith we understand and exercise autonomy in a way that is congruent with our basic faith commitments. Our parishes also need to form communities of care that develop a variety of ministries to the dying and their families, whatever the context (i.e., hospital, nursing home, or home). End-of-life care is not solely the responsibility of health professionals, nor can it be expected to be. It is also the responsibility of the community of faith, which is called to carry on the ministry of Jesus.

Just a little more than a year before he died, Cardinal Bernardin issued a pastoral letter on healthcare in which he identifies hope as the distinguishing feature of Catholic healthcare:

As Christians, we are called, indeed empowered, to comfort others in the midst of their suffering by giving them a reason to

hope. We are called to help them experience God's enduring love for them. This is what makes Christian healthcare truly distinctive. We are to do for one another what Jesus did: comfort others by inspiring in them hope and confidence in life. As God's ongoing, creative acting in the world and the love of Christ make it possible for us to continue to live despite the chaos of illness, so too our work in the world must also give hope to those for whom we care. Our distinctive vocation in Christian healthcare is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life. The ultimate goal of our care is to give to those who are ill, through our care, a reason to hope.⁶

Many aspects of physician-assisted suicide seem to be the antithesis of hope. Catholic healthcare institutions, in cooperation with communities of faith, have a singular opportunity to "walk the talk" of their moral convictions by making a concerted effort to lead the way in improving care of the dying. In doing so, they can be signs of hope amid the tragic dimensions of death and dying. □

NOTES

1. Physician-assisted suicide's challenge to the Catholic community comes not only from without. Increasing numbers of Catholics, physicians, and other healthcare professionals are coming to view physician-assisted suicide as a morally legitimate option. Many of these are either seeking or providing end-of-life care in Catholic facilities.
2. Richard Gula, *Euthanasia: Moral and Pastoral Perspectives*, Paulist Press, Mahwah, NJ, 1996, pp. 44, 45.
3. A significant initiative in this direction is Supportive Care for the Dying: A Coalition for Compassionate Care, composed of CHA and 12 Catholic healthcare systems. See Sylvia McSkimming et al., *Living and Healing During Life-Threatening Illness*, A Coalition for Compassionate Care, Portland, OR, 1997. Both an executive summary and video are available under this title. See also, Alicia Super and Lawrence Plutko, "Danger Signs," *Health Progress*, March-April 1996, pp. 50-54; Ann Neale, "The Cultural Basis of Inadequate Care," *Health Progress*, May-June 1996, pp. 50-51, 70; Stephen Franey, "Three Factors Critical for End-of-Life Care," *Health Progress*, September-October 1996, pp. 30-32, 44.
4. The focus here is on those facilities where currently the majority of people die—hospitals (approximately 63 percent) and long-term care facilities (approximately 17 percent)—especially the former. Where people die is itself a problem that needs to be addressed.
5. Gula, *Euthanasia*, pp. 49-50.
6. Joseph Bernardin, *A Sign of Hope*, Catholic Health Association, St. Louis, 1996, p. 5.