



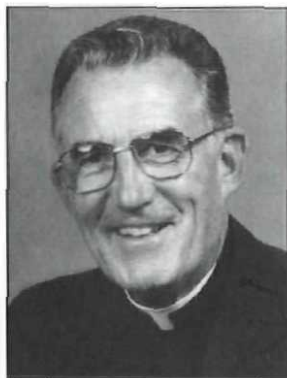
# END-OF-LIFE CARE AND CATHOLIC ETHICS

**I**n the maelstrom of publicity surrounding the conviction of Jack Kevorkian, MD, the Catholic Church's traditional teaching regarding pain relief, especially at the end of life, has sometimes been misrepresented. Health Progress recently sat down with Rev. James A. O'Donohoe, JCD, an ethicist at Covenant Health Systems, Lexington, MA, to clarify where the church—and Covenant Health Systems—stand on this important issue.

**What is the church's position when it comes to pain alleviation and end-of-life care? Do dying patients have the right to adequate pain relief?**

The church's position is quite clear, and I quote from the *Ethical and Religious Directives for Catholic Health Care Services*:

Patients should be kept as free of pain as possible so that they may die comfortably and with dignity and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of



Fr. O'Donohoe

consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to

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Conversation  
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hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.<sup>1</sup>

You also asked if dying patients have a "right" to adequate pain relief. That word is much abused in our American culture, and I prefer to use the term "a moral imperative," which emphasizes the dignity we possess as human beings who are made in the image and likeness of God. That fact would indicate that we are "owed" good pain management and thus put the issue into the realm of justice and rights.

**The directive you quoted says that patients experiencing pain that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering. Does this mean that the church believes suffering is good?**

In the Catholic tradition, the acceptance of suffering—of which physical pain is an example—can be a means of personal spiritual growth, since it is related to the redemptive sufferings of Christ. He himself experienced the depths of human suffering and thus became the paradigm of unconditional love and unreserved self-giving.

According to the Vatican's *Declaration on Euthanasia*, however, "It would be imprudent to impose a heroic way of acting as a general rule. On the contrary, human and Christian prudence suggest, for the majority of sick people, the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semiconsciousness and reduced lucidity." This declaration goes on, "It must be noted that the Catholic tradition does not present suffering or death as a human good but rather as an



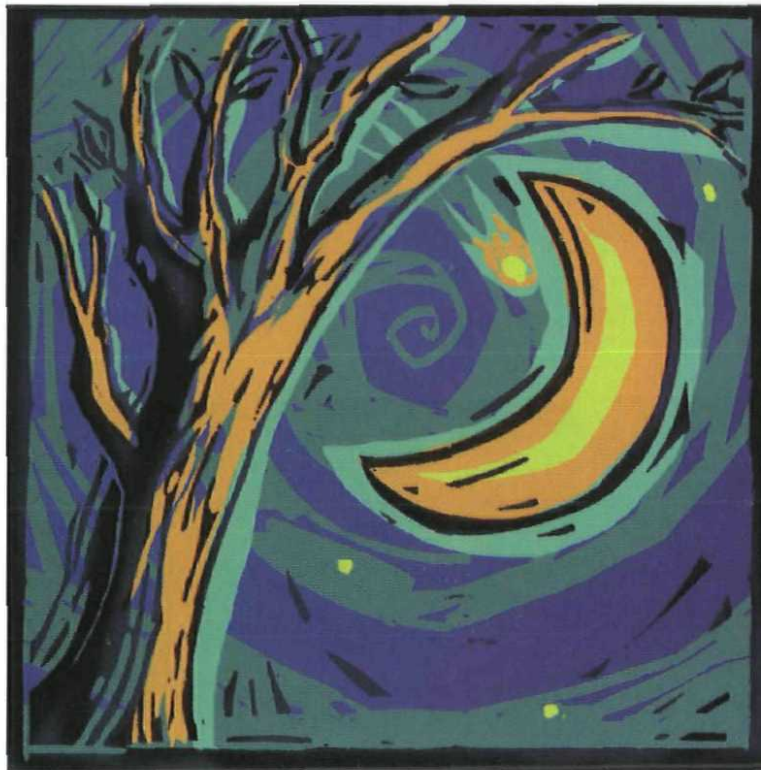
inevitable event which may be transformed into a spiritual benefit if accepted as a way of identifying more closely with Christ.”<sup>22</sup>

The fact that suffering can be redemptive is one of the primary reasons why the church insists on the importance of pastoral care teams in our healthcare facilities. As the directives point out, pastoral care is an integral part of Catholic healthcare, and it encompasses the full range of spiritual service, including help in dealing with pain.

**Does the church believe it's important to consciously prepare for death as a way of showing respect for and acceptance of life's final adventure? In other words, does the church hold that sedation at the end of life is not a treatment option?**

A group of anesthesiologists put a similar question to Pope Pius XII in 1957. They asked, “Is the suppression of pain and consciousness by the use of narcotics . . . permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?”

The pope said, “If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: yes.” Painkillers that cause unconsciousness require special consideration, however. We believe that a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. So Pius XII warned, “It is not right to deprive the dying person of consciousness without a serious reason.”<sup>23</sup> But there may be a serious reason for doing so in a terribly painful situation. The bottom line is that the decision is driven by the patient's spiritual and physical condition.



**Many leaders in the right-to-die movement agree that improvements in pain control would reduce the number of people who request assistance in hastening their own death. Can you speak to that?**

I also agree. One of the reasons such attention is given to physician-assisted suicide is that we really haven't made known the critical importance and necessity of treating pain. A recent national study showed that half of all patients who died in the hospital were in moderate to severe pain much of the time.

In regard to mismanagement of pain, it is interesting to look at an article by Rev. James Keenan, STD, in which he pointed out the following: “Pain relief is in fact a minor factor in the motivation of people who seek PAS. . . . Holland's Rummelink Report states that pain relief played a role in only 32 percent of the requests for PAS in the Netherlands, where PAS has been legal since 1984.”<sup>24</sup> He also quotes the medical ethicist Ezekiel Emanuel, MD, who states: “No study

has ever shown that pain plays a major role in motivating patient requests for physician-assisted suicide or euthanasia.” The main concern of patients seems to be “being a burden.”<sup>25</sup>

**What is the caregiver's responsibility when it comes to getting dying patients to communicate about their level of pain and their wishes about end-of-life care?**

As with any aspect of patient care, it's a team effort. An open dialogue with the patient, his or her proxy and family, and other health professionals is imperative and encourages the expression of diverse perspectives on these complex issues. All members of the healthcare team must be knowledgeable about the fundamental princi-



ples of ethics that may guide analysis of complex decisions such as these. Above all, we must always see the patient as a complete person, not just the "gallbladder in bed five."

As in so many other issues involving a patient's condition, the family can play an important role here as well. They should discuss the degree of pain and its location with the competent patient and gather some precise data, which they should then report to the proper caregivers. If the patient is not competent, members of the family should discuss the possible pain issue with appropriate members of the healthcare team.

**What should we do when family members disagree on end-of-life decisions such as DNR orders or the withdrawal of life-sustaining treatments, and the patient isn't conscious?**

Situations such as these make it clear why every patient should have advance directives, such as

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durable power of attorney for healthcare. That way, he or she makes his or her wishes known while still conscious and able to do so. A great deal of emotional anguish—not to mention legal wrangling—can be avoided.

When an unconscious patient has not left any advance directives and has not designated anyone to be his or her proxy, end-of-life decisions can become very complex. In situations such as these, the pastoral care person can be of considerable assistance. If the latter senses disagreement about treatment among family members, he or she should attempt to have a meeting with them to bring about some compromise or alternate form of treatment. Should they not wish to meet with such a person, some effort should be made to get the whole team together to resolve the problem. The pastoral care minister might be able to initiate such a meeting with the caregiver in charge and should attend if possible. In most cases a solution can be reached, but it demands patience, imagination, and the ability to facilitate team discussion with the family. Some training in conflict resolution is often helpful.

**What is the most important guidance you can offer caregivers who are caring for dying patients in pain?**

Ethical decision making in the care of dying patients is a dynamic process that requires reflection, discussion, and evaluation. This is especially true in cases involving pain management. In the end, it can be difficult to find a single right answer. But as ethical beings, we must struggle with the issues and, after careful consideration, arrive at the best decision possible within a moral context. □

## COVENANT HEALTH SYSTEMS' PAIN-MANAGEMENT INITIATIVES

Covenant Health Systems (CHS) has taken several steps to improve pain management and end-of-life care, including the following:

- Two day-long pain management programs were held for the members of CHS and other interested people on February 12, 1998, and on April 8, 1999; another is being planned for April 6, 2000.

- A systemwide pain management/palliative care work group was established. This is an interdisciplinary body that supports the implementation of the CHS pain management/palliative care policy. Members consist of staff from CHS-related facilities and include nurses, physicians, social workers, administrators, chaplains, and therapists. The work group's functions include the development of assessment tools, measurement tools, and satisfaction surveys addressing the spiritual and ethical dimensions of pain management and palliative care. The purpose of the work group will be evaluated every two years.

- The CHS board approved a pain management/palliative care policy on February 26, 1999. Implementation of the policy includes three steps:

1. Each sponsored and member organization will develop a board-approved statement of commitment to effectively manage pain and other symptoms for all residents and patients.

2. Each sponsored and member organization will develop and implement a facility- and service-appropriate plan to provide effective pain management and palliative care in order to reduce pain and suffering of each patient and resident in CHS-related facilities.

3. CHS will support these efforts through sponsorship of educational programs, a systemwide work group, and other resources.

### NOTES

1. *Ethical and Religious Directives for Catholic Health Care Services*, National Conference of Catholic Bishops, Washington, DC, 1995, n. 61.
2. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, St. Paul Books & Media, Boston, 1980, p. 10.
3. *Declaration on Euthanasia*, p. 10. For the full text of Pope Pius XII's talk to the anesthesiologists, see *The Catholic Mind*, vol. 55, 1957, p. 260.
4. James Keenan, "No Case for Physician-Assisted Suicide," *America*, November 14, 1998, p. 16.
5. Ezekiel Emanuel, "Euthanasia: Historical, Ethical, and Empiric Perspectives," *Archives of Internal Medicine*, September 10, 1994, p. 1900. See also "Pain Management: Theological and Ethical Principles Governing the Use of Pain Relief for Dying Patients," *Health Progress*, January-February 1993, pp. 30-39.