ISSUES AT THE END OF LIFE

The Revised Ethical and Religious Directives *Discuss Suicide, Euthanasia, and End-of-Life Procedures*

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CHA and the Center for Health Care Ethics at the Saint Louis University Health Sciences Center are collaborating to publish a series of articles on the Ethical and Religious Directives for Catholic Health Care Services. *This article is the fifth in the series, written by Sr. deBlois, CHA's senior associate for ethics, and Fr. O'Rourke, director of the Center for Health Care Ethics.*

Part 5 of the revised *Ethical and Religious Directives for Catholic Health Care Services (ERD)* reminds us that the Catholic healthcare ministry "faces the reality of death with the confidence of faith." As a witness to faith, "a Catholic health care institution will be a community of respect, love and support to patients and residents and their families as they face the reality of death."

Christians believe that life is a precious gift from God. Thus each person has a duty to preserve it. But this duty is not absolute. It ceases if prolonging life will not help a person achieve the purpose of life: to know God, to love God, and to serve God by serving and loving our neighbor as ourselves.[1] A person may reject life-prolonging procedures if sustaining life does not help him or her strive for the purpose of life (or the "goods" of life).

LIFE-PROLONGING THERAPY

In the Catholic theological tradition, life-prolonging therapy need not be utilized if it provides insufficient benefit or imposes an excessive burden. To put it another way, life-prolonging therapy, like anything else, must be judged in light of eternal life. If such therapy helps one strive for eternal life, then it should be used. If it does not, then it need not be used. As the directives state: "The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering and death. Only in this way are two extremes avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death."[2]

Christians believe that God has created each person for eternal life, that persons under grace strive for eternal life through their own free actions, and that death is necessary for the transition to eternal life. But Christians realize that a person's life may become so impaired that it does not benefit him or her to use aggressive means to prolong life. In other words, Christians acknowledge that aggressive medical care may not restore or improve a person's capacity to strive for eternal life. If this happens, medical care may be withdrawn.[3] In such situations, death occurs because a fatal pathological

Summary Part 5 of the *Ethical and Religious Directives for Catholic Health Care Services* reminds us that death is necessary for the transition to eternal life. Thus, although Christians have a duty to preserve worldly life, a gift from God, that duty is not absolute.

Suicide and euthanasia are never morally acceptable. On the other hand, life-prolonging therapy need not be used if it provides insufficient benefit or imposes an excessive burden.

Directive 55 describes the comfort and care that should be given to dying patients. Directives 56 through 59 discuss the ethical norms for either using or forgoing procedures designed to prolong life.

Directive 60 repeats the Church's teaching in regard to euthanasia and physician-assisted suicide (PAS)—that is, whatever the intentions of those who employ them, euthanasia and PAS remain forms of murder.

Directive 62 considers the methods used to determine that death has occurred. Directive 66 encourages patients to donate their organs and bodily tissue after death. However, the directive says, Catholic healthcare facilities should not make use of tissue obtained by direct abortions.

condition is allowed to take its natural course, not because those who have removed life support intended to kill the patient. Rather, their intention is to stop doing something useless or to stop imposing a burden on the patient. If death occurs after life support is removed, it is not the direct result of removing the life support. From a moral point of view, it is an indirect and unintended result of removing life support, even though it may have been a foreseen result.

> The determination of benefit or burden is often subjective.

Catholic tradition is, however, vehemently opposed to killing an innocent person directly and willingly, no matter how medically debilitated the patent might be. For this reason, "suicide and euthanasia are never morally acceptable options," according to the introduction to Part 5 of the *ERD*.

Today a debate rages over physician-assisted suicide (PAS). Physicians, ethicists, and theologians can be found on both sides of the issue. But the most telling argument against PAS is based on the nature of our relationship to God. Human beings simply do not have dominion over the lives of innocent people. Human beings are not morally competent to decide that killing a person is the best way to alleviate his or her suffering, that he or she would "be better off dead."

This does not mean that healthcare professionals may not take steps to alleviate pain in suffering people. In fact, "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 hasten death" (Directive 61). This is an application of the principle of double effect.[4]

Commentary on the Directives

There are 15 directives in Part 5 of the *ERD*. Directive 55 describes the comfort and care that should be offered to help dying patients prepare for death. This process is a sacred trust of all healthcare professionals and should be a notable characteristic of Catholic healthcare facilities. We know what death means; we know how to help people die.

Directives 56 through 59 discuss the ethical norms for either using or forgoing medical and surgical procedures designed to prolong life. Those procedures which offer a reasonable hope of benefit and do not entail an excessive burden are called "ordinary" or "proportionate" means to prolong life. If the means are ordinary or proportionate, we have a moral obligation to use them. The term "ordinary means to preserve life" has been used in Catholic theology since at least the seventeenth century. The term "proportionate" was suggested in the "Declaration on Euthanasia" (1980)[5] because by then the terms "ordinary" and "extraordinary" had become somewhat misleading. If one uses "ordinary" and "extraordinary" as ethical and not medical terms, they convey the proper meaning.

Directive 57 describes the medical and surgical means to preserve life that the patient may forgo because they do not impose a moral obligation. These means are called "extraordinary" or "disproportionate." "Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden or impose excessive expense on the family or the community."

Applying Directives 56 and 57

Five points should be made concerning the application of Directives 56 and 57:

- The factors used in determining whether the means to prolong life are ordinary or extraordinary are separate criteria. That is, both reasonable hope of benefit and excessive burden are used to determine whether life support is ordinary or extraordinary. Ordinary means are those which offer a reasonable hope of benefit *and* do not entail an excessive burden. Extraordinary means are those which do not offer a reasonable hope of benefit *or* entail an excessive burden.
- The burden in question may be one imposed on the patient or "on the family or the community." Thus the social nature of healthcare is recognized. In the Catholic tradition, the patient is not autonomous in an absolute sense of the word.

• The determination of "reasonable benefit" or "excessive burden" may at times be objective. For example, some medical conditions would allow the removal of life support in all cases. Removing a respirator from a comatose person with metastatic cancer would be accepted by all. This condition may be ascertained and acted on. On the other hand, the determination of benefit or burden is often subjective, and opinions may well differ from one person to another. Some persons in a quadriplegic condition have decided that a respirator which sustains their breathing imposes an excessive burden and have asked to have it removed. More frequently, patients in this condition believe that the respirator allows them to pursue the goods of life and therefore determine that it is not an excessive burden.

Catholic health-care institutions should encourage patients to donate their organs.

• Death need not be imminent in order to forgo or remove life support. According to the legal usage of the term, "imminent death" means that death will occur, whether or not life support is used. Hence it would be contrary to the meaning of Catholic teaching (Directives 56 and 57) to insist that life support could be removed only if death cannot be avoided.[6]

• A therapy to prolong life may not be judged to be ordinary or extraordinary until the actual medical condition of the patient is considered. Hence a respirator or even an organ transplant is not in itself an extraordinary means to prolong life. The decision concerning the ethical obligation to either use or forgo a form of life support depends on the benefit or burden it will offer a particular patient.

Potential Disagreements

Because the decision concerning the use of life support is sometimes subjective, patients (or their surrogates) may disagree with the attending physician. For example, it is not unusual for physicians to think that therapy which has a slight chance of prolonging life for a few days offers "reasonable hope of benefit." Patients and their surrogates, on the other hand, often determine that prolonging the patient's life for a few days, especially if he or she is severely debilitated, does not offer a reasonable hope of benefit. Directive 59 states that the free and informed judgment of a competent adult should "always be respected and normally be complied with, *unless* it is contrary to Catholic moral teaching" (emphasis added).

Recall that Directives 24 and 25 discuss the rights of a surrogate to make decisions for an incapacitated patient, even if the patient has made an advance directive. The directives concerning the determination of ordinary and extraordinary means to prolong life and the right of the surrogate to make decisions for incapacitated patients should be explained to medical and nursing personnel to prevent disagreements between care givers, patients, and their proxies. Clinical experience indicates that decisions in regard to continuing or removing life support cause more conflict than any other ethical issue. Healthcare professionals need constant instruction in this regard.

Directive 58 and the later part of the introduction consider the use of artificial hydration and nutrition, especially for patients in a persistent vegetative state (PVS). Unfortunately, the authors of the *ERD* faced a conflict of opinion among members of the Church hierarchy in regard to this question.[7] Had the bishops allowed artificial hydration and nutrition to be treated as another form of life support, the use or removal of these means could have been handled by applying Directives 56 and 57. (In fact, this is still possible in spite of the extra attention devoted to the issue in the *ERD*.) Because of conflicting statements of the U.S. hierarchy, the *ERD* treat artificial nutrition and hydration as a special form of life support; the *ERD* say that a presumption should be made in favor of their use "as long as this is of sufficient benefit to outweigh the burdens involved to the patient." Directives 56 and

57 make it clear that the expense to the family and the community must be considered before artificial hydration and nutrition are utilized. This is simply a repetition of Directive 32.

Because this topic is controversial, it might have been better if the bishops had omitted explicit consideration of it, since the thoughts offered do not advance the discussion. Every medical group that has considered the ethical issue has agreed that artificial hydration and nutrition can be removed from PVS patients because the treatments offer no benefit.[8] In theological terms, prolonging the life of persons in PVS does not seem to enhance their ability to strive for the purpose and goods of life.

Euthanasia and Determining Death

Directive 60 repeats the Church's teaching in regard to euthanasia. It also points out the method for helping patients overcome the pain and depression that may lead them to request euthanasia: "loving care, psychological and spiritual support and appropriate remedies for pain and other symptoms."

Much of value has been written refuting the need for euthanasia and physician-assisted suicide.[9] Many in the field of healthcare and healthcare ethics agree with the Church that PAS is not beneficial, but they usually agree for pragmatic reasons. Many opponents argue that PAS would be very difficult to control if it were to become legal and that it would debase the profession of medicine. The Church, on the other hand, teaches that euthanasia and PAS are forms of murder because, even though they seek to alleviate suffering, they still involve direct killing of an innocent human being.

Directive 62 considers the methods used to determine that death has occurred. Usually, this determination is made by ascertaining that cardiopulmonary function has ceased irreversibly. But if this cannot be determined because the patient is on a respirator, then evidence that total brain death has occurred should be used. Usually, the criteria of total brain death are used if an organ is to be removed after death and transplanted to a living person.[10] Hence there are not two methods of defining death or two different forms of death. Rather, there are two ways of determining the fact of death.

Donating organs to other persons is considered a laudable action in the Catholic tradition.[11] For this reason, Catholic healthcare institutions should encourage patients to donate their organs and bodily tissues after death. The use of tissue and organs taken from infants after death is permitted if the parents or guardians give consent. However, "Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes" (Directive 66).

The Heart and Soul

The ethical norms for caring for people as death approaches have been pondered and formulated by theologians and the magisterium over the past 500 years. But the inspiration for the norms in Part 5 of the *ERD* is even more ancient. The heart and soul of these norms can be traced to the teachings of Christ: "Love one another as I have loved you." □

NOTES

1. *Catechism of the Catholic Church*, Liguori Publications, Liguori, MO, 1994, n. 1; n. 1879.
2. *ERD*, Introduction to Part 5.
3. *Catechism*, n. 2278.
4. Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," *Origins*, August 14, 1980, p. 156.
5. Congregation for the Doctine of the Faith.
6. John Connery, "Prolonging Life: The Duty and Its Limits," *Catholic Mind*, October 1980, p. 45ff.
7. Committee for Pro-Life Activities, "Nutrition and Hydration: Moral and Pastoral Reflections," *Origins*, April 9, 1992, p. 705; Texas Bishops, *Origins*, June 7, 1990, p. 53ff; John Leibrecht, *Origins*, January 11, 1995, p. 525ff; William Bulloch, *Origins*, January 30, 1992, p. 553; Pennsylvania Bishops, *Origins*, January 30, 1992, p. 543ff.
8. Statement of the American Academy of Neurology, *Neurology*, January 1989, p. 125; Committee on Ethics, American Nurses Association, "Guidelines on Withholding and Withdrawing Food and Fluid," Kansas City, MO, 1987; American Dietetic Association, "Issues in Feeding the Terminally Ill Adult," *Journal of American Dietetics*, January 1987; Council on Ethical and Judicial Affairs of the American Medical Association, "Current Opinions," Chicago, 1995; Consensus Panel, Intensive Care Physicians, *Chest*, April 1990, p. 949ff.
9. CHA Task Force, "Pain Management," *Health Progress*, January-February 1993, pp. 30-65; Richard Gula, "The Virtuous Response to Euthanasia," *Health Progress*, December 1989, pp. 24-25.
10. See "Brain Death," *Medical Ethics, Sources of Catholic Teaching*, Georgetown University Press, Washington, DC, 1993, pp. 64-70.
11. See "Organ Donation and Transplantation," *Medical Ethics, Sources of Catholic Teaching*, pp. 64-70.