



# *Priests Who Minister To Patients Regarding Physician-Assisted Suicide*

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By FR. GERALD D. COLEMAN, PSS, PhD

**A**s more states consider legalizing physician-assisted suicide, patients or their families might ask Catholic priests to minister to persons contemplating ending life in that way. This essay attempts to suggest how this ministry might be done well.

Currently, physician-assisted suicide is legal in Washington, Oregon, California, Vermont and, disputably, in Montana.<sup>1</sup> In 2015, 23 states and the District of Columbia sought to codify the practice, as well. This unprecedented legislation wave represents more than double the number of such bills introduced in any year since 1995, and a sixfold increase relative to 2014.<sup>2</sup> Results from the May 4-8, 2016, Gallup "Values and Beliefs" survey make it clear that nearly 7 of 10 people polled in the U.S. say doctors should be allowed to end a terminally ill patient's life by painless means if the patient requests it, the highest level in a decade.<sup>3</sup>

## **PHYSICIAN-ASSISTED SUICIDE**

Physician-assisted suicide is sometimes called "medicalized suicide," "assistance in dying" or "physician-assisted dying." It refers to a request by a mentally competent person to seek aid in

dying from a physician, who prescribes barbiturates whose purpose is to end life. Under present protocols, a person must be able to self-administer the medication. The drugs most commonly used are secobarbital or pentobarbital in high dosages. The medication is usually prescribed with drugs that help suppress nausea or vomiting. The average time for dying is 25 minutes, but, in some cases, dying has taken up to four days.

Together, the medicines typically cost about \$5,000. Insurance companies are not required to cover this treatment. However, as one example, Medi-Cal (California's health plan for low-income Californians) will cover the treatment.

The major concerns raised about physician-assisted suicide include inaccuracies and difficulty in predicting a terminal illness; patients are not required to receive a screening for depression; there is no requirement to notify the indi-

vidual's family about his or her intent to ingest physician-assisted suicide medication; there are no sufficient safeguards to ensure that a patient is not coerced into taking the medication; no doctor or nurse is present in case complications ensue when the patient takes the medication. And importantly, physician-assisted suicide is fundamentally incompatible with a physician's role as healer.

Statistics from Washington State and Oregon help pinpoint the major reasons why a patient would seek aid in dying:

- Losing autonomy (91.5 percent)
- Less able to engage in activities making life enjoyable (88.7 percent)
- Losing control of bodily functions (50.1 percent)
- Being a burden on family, friends, and caretakers (40 percent)
- Concern about adequate pain control (24.7 percent)

A priest would perform an important ministry if he were able to assist a patient to articulate the reasons why he or she is contemplating physician-assisted suicide — and then helped the patient surface viable answers and remedies for those reasons.

## THE LAWS

Laws governing physician-assisted suicide vary to some degree in terms of jurisdiction, for example, the relationship of witnesses to the patient, or the grounds for proving residence in the state where physician-assisted suicide is legal. As a general rule, however, the laws encompass certain common parameters although they are called by such differing names as the Death with Dignity Act in Oregon and Washington, and the End of Life Option in California. The California law, which took effect on June 9, 2016, does not allow the practice of physician-assisted suicide to be called euthanasia, mercy killing, assisted suicide or homicide.

The laws require a person requesting physician-assisted suicide to be at least 18 years of age and a resident of the state where physician-assisted suicide medication is requested and dispensed. A well-known case in this regard concerns Brittany Maynard, who moved from Oakland, California, (before physician-assisted suicide was

legal in that state) to Portland, Oregon, in order to gain access to the Death with Dignity Act.<sup>4</sup>

Normally, two physicians are involved: the attending physician (the one who has primary responsibility for the patient) and the consulting physician (an independent physician who can make a professional diagnosis regarding an individual's terminal illness). The patient must be competent, that is, in the opinion of the attending and consulting physicians and perhaps a psychiatrist or psychologist, sometimes referred to as a "mental health specialist," the patient has the capacity to make medical decisions, understands and acknowledges all relevant facts and has made a fully informed decision. The "mental health specialist" determines if the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. In California, the attending physician "shall refer" to a mental health specialist if the physician determines there are indications of a mental disorder. In other words, consultation with a mental health specialist is not always a mandatory part of the law.

A patient is diagnosed as terminally ill if he or she has an incurable and irreversible disease that will result in death within six months. Only the patient can make a request for physician-assisted suicide. No one can make this request on behalf of the patient. The patient must normally make two oral requests for physician-assisted suicide at a

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minimum of 15 days apart, and a written request to his or her attending physician. The laws provide appropriate forms for these requests. The written request must be signed and dated in the presence of two adult witnesses who know the patient, and the patient may withdraw or rescind his or her request at any time, or decide not to ingest the drug. A person who might be present when a patient self-administers the drug is not subject to civil or criminal liability solely for being there,

but no person may assist the patient in taking the medication.

A health care provider or professional organization or association can refuse to participate in physician-assisted suicide. Coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug, or destroying a withdrawal or rescission of a request, is punishable as a felony. A health care provider (attending and consulting physicians) is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability or medical staff action, sanction or penalty or other liability for participating in physician-assisted suicide. The death certificate of a patient who has ingested physician-assisted suicide medication gives the person's terminal illness as the cause of death, and does not indicate that the person died by physician-assisted suicide.

#### CATHOLIC TEACHING

Euthanasia in all its forms is contrary to Catholic teaching. Euthanasia can be active (intervening with the direct intention to terminate the life of a seriously ill patient, e.g., administering a lethal dose of pain killers) or passive (withholding treatment with the intention of terminating the life of a seriously ill patient.) Physician-assisted suicide is a form of active euthanasia on the part of the person taking the medication. The physician who prescribes the medication with the intention of assisting in ending a life is guilty of formal cooperation in evil, which is prohibited in Catholic teaching.

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Great caution must be taken not to confuse legitimate termination of extraordinary or disproportionate means with passive euthanasia. The *Ethical and Religious Directives for Catholic Health Care Services* explains: "A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive bur-

den, or impose excessive expense on the family or the community."<sup>5</sup>

It is permitted to administer drugs that are intended to relieve pain and suffering even if they also may result in the shortening of life; and it is permitted to refuse certain treatments to preserve life if they are deemed by the patient to be disproportionate or useless.<sup>6</sup>

The *United States Catholic Catechism for Adults* presents clear explanations of euthanasia and physician-assisted suicide: "The Catholic Church proclaims that human life is sacred and that the dignity of the human person is the foundation of a moral vision for society. Our belief in the sanctity of human life and the inherent dignity of the human person is the foundation of all the principles of our social teaching. In our society, human life is under attack from ... assisted suicide."<sup>7</sup>

"Suicide contradicts the natural inclination of the human being to preserve and perpetuate his life. It is gravely contrary to the just love of self. It likewise offends the love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations. Suicide is contrary to love for the living God."<sup>8</sup>

Physician-assisted suicide is an "evil" that "corrupts us spiritually and psychologically."<sup>9</sup> "Intentional euthanasia, sometimes called mercy killing, is murder. Regardless of the motives or means, euthanasia consists of putting to death those who are sick, are disabled, or are dying. It is morally unacceptable. The emergence of physician-assisted suicide ... seeks to legalize what is an immoral act ... Suicide is gravely sinful whether committed alone or aided by a doctor. Serious psychological disturbances, anxiety, fear of suffering, or torture can diminish the responsibility of the one committing suicide... Although suicide is always objectively sinful, one 'should not despair of the eternal salvation of

persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives' (*Catechism of the Catholic Church*, no. 2283). The pastoral care of families and friends of those who have taken their own lives is an important focus for the Church's healing and compassionate ministry."<sup>10</sup>

## **The priest should suggest good alternatives, such as palliative care, hospice care, the ability of treatments to relieve pain and anxiety, Do Not Resuscitate orders.**

### **ROLE OF A CATHOLIC PRIEST**

A patient or his or her family members might consult a Catholic priest about physician-assisted suicide. These conversations can take place in one of three scenarios: (1) a person who is considering physician-assisted suicide, (2) a person who has requested and attained physician-assisted suicide medication, or (3) a person who has come to a decision to self-administer the medication. A priest must adjust his pastoral approach according to the particular scenario he encounters. In each case, Pope Francis' 2016 apostolic exhortation *Amoris Laetitia* provides helpful guidance:

"Pastors must know that, for the sake of truth, they are obliged to exercise careful discernment of situations' (*Familiaris Consortio*, no. 84). The degree of responsibility is not equal in all cases and factors may exist which limit the ability to make a decision. Therefore, while clearly stating the Church's teaching, pastors are to avoid judgments that do not take into account the complexity of various situations, and they are to be attentive, by necessity, to how people experience and endure distress because of their condition."<sup>11</sup>

"Develop the habit of giving real importance to the other person ... Never downplay what they say or think, even if you need to express your own point of view. Everyone has something to contribute, because they have their life experiences, they look at things from a different standpoint and they have their own concerns, and what it is that they are trying to communicate, however aggressively. We have to put ourselves in their shoes and try to peer into their hearts, to perceive their deepest concerns and to take them as a point of departure for further dialogue."<sup>12</sup>

In 1999, the Pontifical Academy for Life issued

a statement that included comments about euthanasia and the alleviation of the pain of the dying: "We reject forcefully and with absolute conviction any type of euthanasia . ... At the same time, we wish to express our human and Christian closeness to all the sick, and especially to those who see approaching the end of their earthly existence and are preparing for their encounter with God. ... For these our brothers and sisters, we ask that 'therapeutic abandonment' be avoided, which consists in the withholding of treatments and therapies which alleviate their sufferings."

In light of the guidelines in *Amoris Laetitia*, and this teaching from the Pontifical Academy for Life, these ways-of-accompaniment are deemed useful and prudent:

- In any of the three scenarios already mentioned, if someone asks to speak with a priest, the answer should always be "yes."

- The priest should demonstrate empathy and compassion for the person by listening carefully to what the person has to say and praying with

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the person. In this regard, there are many helpful prayers in *Pastoral Care of the Sick: Rites of Anointing and Viaticum*.

- The priest should speak to the person about the church's teachings on physician-assisted suicide and on the meaning of death as surrendering oneself to God. The priest should suggest good alternatives, such as palliative care, hospice care, the ability of treatments to relieve pain and anxiety (i.e., pain control), Do Not Resuscitate orders.

In the *Code of Canon Law*, canon 1007 states that "the anointing of the sick is not to be conferred upon those who persevere obstinately in manifest grave sin." The Sacrament of Penance or Reconciliation requires a penitent to be properly disposed to receive this sacrament, a disposition that necessitates "rejecting sins committed and having a purpose of amendment," according to canon 987.

As painful as the decision might be, a priest should not celebrate the Sacrament of the Anointing of the Sick or give Holy Communion as Viaticum (“food for the journey”) unless the person rescinds his or her decision to self-administer physician-assisted suicide medication. Should this rescinding occur, the celebration of the Sacrament of Reconciliation would be most appropriate.

If a patient is determined to self-administer physician-assisted suicide medication, the priest can certainly pray with the person and his or her family. Should a person take physician-assisted suicide medication, the family should be assured that the church never despairs of a person’s eternal salvation. “By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives.”<sup>13</sup>

A priest should never be present when a person self-administers physician-assisted suicide medication, in order to avoid scandal and giving the false impression of approval.

According to canon 2282 in the *Code of Canon Law*, Catholic funerals are usually not denied to those who commit suicide, as the church recognizes that “grave psychological disturbances, anguish, or grave fear of hardship, suffering or torture can diminish the responsibility of one committing suicide.” After consultation with the diocesan bishop, a Catholic funeral and burial can be given to a person who dies by physician-assisted suicide, assuming there are no impediments present and no public scandal is given. A Catholic funeral and burial might be refused when a family openly rejects the church’s teaching on physician-assisted suicide and makes public and gives approval of their loved one’s assisted-suicide death.

Pastoral care of the family and friends of someone who commits suicide should remain an important focus for the church, as can be demon-

strated in a priest’s ongoing healing and compassionate ministry.

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## NOTES

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