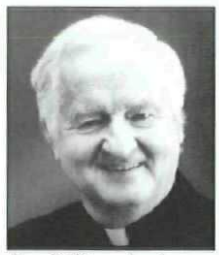
The Illinois Bishops on Death and Dying

A Pastoral Letter Presents Church Teaching in a Succinct and Understandable Manner

BY REV. KEVIN D. O'ROURKE, OP, JCD



Fr. O'Rourke is professor of bioethics, Stritch School of Medicine, Loyola University, Chicago.

In the past 15 years, American bishops—acting at times alone, at other times in state conferences, or as members of a committee of the U.S. Conference of Catholic Bishops—have issued more than 15 pastoral statements concerning the care of people approaching death.

Some of these statements were written in regard to specific people. For example, local bishops made statements regarding the care of Paul Brophy, Elizabeth Bouvia, Nancy Beth Cruzan, Christine Busalacchi, and Hugh Finn. In most cases, these statements acknowledged the anguish and suffering of those family members who had to make decisions about removing life support, and the bishops usually agreed that the family involved was not trying to kill its loved one but merely seeking to discontinue useless treatment or to remove an excessive burden.

Other statements have been issued by state Catholic conferences—for example, the conferences of Louisiana, Pennsylvania, New Jersey, and Washington—and by several bishops from the state conference of Texas and the Pro-Life Committee of the National Conference of Catholic Bishops.

All statements of this latter kind have been general in nature, considering issues from a more didactic point of view than did those issued for specific clinical cases. Often these statements seemed more concerned with combating the growing evil of euthanasia in the United States than with offering practical advice about death and dying. However, they did not always agree on the use of specific therapies. For example, some statements discouraged the removal of artificial hydration and nutrition from patients in persistent vegetative state (PVS). Others, basing themselves on the traditional teaching of the church as contained in Directives 56, 57, and 58 of the *Ethical and Religious Directives for Catholic Health Care Services* (ERD), have been inclined to allow removal of these devices if they were of no benefit to the patient or imposed an excessive burden upon the patient, the family, or society.[1]

The bishops of Illinois have recently issued a statement, entitled *Facing the End of Life: A Pastoral Letter from the Bishops of Illinois*, in regard to the ethical decisions that patients or their proxies must make.[2] Is this statement any better or worse than the aforementioned statements of individual bishops or groups of bishops? Does it contain new insights in regard to difficult medical and ethical decisions? Will it be helpful to people who must decide whether to use or forgo life-support devices designed to prolong life? For example, will it be helpful to the patient who realizes that, although an artificial heart might prolong his or her life another six months, it will not improve the quality of life significantly? The following considerations are intended to answer these questions.

Doctrinal Teaching

All of the U.S. bishops' general statements referred to above begin with doctrinal considerations. Basing themselves on principles of faith, the bishops make it clear that death is a natural and integral part of human life, not something that we experience apart from life. More than anything else, preparing for and experiencing death, whether it be one's own or that of a loved one, helps us to realize what it means to be human. Moreover, the various statements of the bishops integrate the many decisions that must be made as death approaches—whether medical, familial, or economic—with the spiritual good of the patient. Thus spirituality is not a separate aspect of dying; it is an integrating element for

everyone involved in the dying process of one of God's children.

Given these general ideas, each of the bishops' statements has its own identity. The Illinois bishops' statement is characterized by brevity. It is brief enough and clear enough to be understood by people facing death, by their families, and by the health care professionals providing the care. Most of the statements written by state Catholic conferences are simply too long and too opaque, so far as the general public is concerned. Often such statements were written by theologians for theologians, employing theological terms in a manner that neither laity nor health care professionals can grasp easily. The Illinois bishops' document is only six and one-half pages long. After presenting some foundational teaching that enables the reader to "consider death in the context of our faith," it highlights what it calls "three crucial issues":

- The role of medical care at the end of life
- The proper understanding of suffering and the value of suffering
- The difficulty Americans have with the loss of independence and control

In "considering death in the context of our faith," the pastoral letter focuses on the purpose of human life. "The value of human life is truly found in our supernatural destiny and a recognition that death is not the end," the bishops write. "Preparation for death is an essential part of life for a Christian. . . . The key to dying well is living well. Living well means a life characterized by love of God and love of neighbor. . . . Recognizing that the goal of our lives is eternal life with God, we prepare for that by prayer, reception of the sacraments and care for those around us, especially the poor and the forgotten" (p. 107). In carrying on the tradition of treating death as a part of life, the Illinois bishops call on the Catholic community to help build "a civilization of love amid our current American culture of death" (p. 109).

After outlining the "context of faith" within which decisions at the end of life should be made, the pastoral letter discusses the role of medical care in the dying process. Two extremes should be avoided. "The first is an attitude that one can end life, either by an action, like a lethal injection . . . or by deliberately withholding therapy with the goal of bringing about a person's death" (p. 107). Clearly, withholding therapy with the goal of bringing about a patient's death is a much different moral action than withholding therapy with the goal of ending futile or excessively burdensome therapy. The second extreme to be avoided is *vitalism:* "the erroneous belief that our life on earth has absolute value and all means must be taken for its preservation" (p. 107).

> The statement is clear enough to be understood by people facing death.

Advice to Health Care Professionals

To avoid these two extremes, the bishops, although not extending "a definitive pronouncement on every clinical decision (p. 107)," *do* offer some specific norms for physicians to apply when making clinical decisions.

Life-Sustaining Therapies "Physicians should not impose aggressive life-sustaining therapies on persons for whom such treatments will simply prolong the dying process" (p. 108).

Patients' and Families' Wishes "Doctors do wrong who insist on maintaining invasive life support when the patient or his or her family make clear that the burdens of treatment far exceed the benefits" (p. 108).

Frankness about Death "A good Catholic doctor speaks openly about death and dying with his or her patients, is frank about the limits of medical care, works hard to prolong life and never deliberately takes life, but recognizes that there are times when treatments should be withheld or withdrawn" (p. 108).

Pain control is also a prominent responsibility of physicians, and the pastoral letter distinguishes between physical pain, on one hand, and suffering, on the other. Suffering, the bishops write, "is part of the existential burden of knowing that our time on earth is ending, facing the loss of relationships and the good things of life, and dealing with the loss of independence and freedom that terminal illness often brings" (p. 109). Suffering is salvific if joined to the suffering of Christ, but this realization should not be transformed into a

"glorification of pain" (p. 109).

The bishops call attention to the compassion of nurses, which enables them to help ease the patient's and the family's fears and make sure that control of physical pain is a top priority in the medical and nursing plan (p. 108). To my knowledge, this is the first document of its kind to emphasize the role of nurses as patient advocates and to recognize explicitly that they are essential members of the healing team at the time of death.

Artificial hydration and nutrition are often not beneficial.

Advice to Patients and Families

The pastoral letter also offers sound ethical and medical advice to patients and to those who will implement the wishes of patients unable to make decisions for themselves. It declares, for example, that "there is no obligation to resort to every type of therapy in an effort to preserve life regardless of the likelihood of outcome. At the end of chronic illnesses like cancer or dementing illness, the benefit of life-prolonging therapy is greatly limited." For those, moreover, "who are suffering from metastatic cancer, end-stage congestive heart failure, or advanced Alzheimer's disease or other forms of dementia, it is difficult to see any justification for resuscitation in the event of cardiac arrest or the prolonged use of intubation and mechanical ventilation" (p. 108).

In discussing the refusal or removal of artificial nutrition and hydration for patients in conditions described above, the bishops refer to the more conservative viewpoint of the Pro-Life Committee of the National Conference of Catholic Bishops, but they also point out that using such therapy "in some cases at the end stage of terminal disease like cancer might directly increase the suffering of the patient and perhaps inadvertently hasten death" (pp. 108-109).

Overall, it seems that it would have been more effective to simply consider artificial hydration and nutrition as "just another" form of life-prolonging therapy and make decisions in its regard in accord with Directives 56 and 57. Once again, to my knowledge, this is the first document conveying church teaching regarding dying patients to list advanced Alzheimer's disease as a condition which might justify the withholding or removal of life support, even artificial nutrition and hydration. This conclusion fits the context of the purpose of life described at the beginning of the pastoral letter (p. 107). Unless able to perform human acts, a person cannot pursue the purpose of life; the symptoms associated with advanced Alzheimer's disease, for example, demonstrate that the person suffering from it cannot perform human acts, that is, acts of the intellect and will.[3] Recent articles in leading medical journals have, moreover, affirmed the fact that artificial hydration and nutrition are often not beneficial for dying patients.[4]

Omitted Distinctions

Finally, it is worth remarking that two distinctions included by some bishops in their statements on death and dying are omitted from the Illinois bishops' pastoral letter.

"Normal Care" Versus "Medical Therapy" The first is the distinction between "normal care" and "medical therapy." Normal care might be termed "comfort care," and some bishops and their theologians have used the distinction between it and medical therapy to justify continuing the administration of food and water to patients in PVS.

But research indicates that artificial administration of food and water offers neither comfort to the person in PVS nor hope that it can restore his or her impaired human function, even though it may prolong mere physiological function. Insofar as "comfort care" includes keeping the patient clean and comfortable, the distinction may be justified. But the fact that physicians, nurses, and many medical ethicists with clinical experience consider administering food and water to the body of a PVS to be a medical therapy—not comfort care—has not been acknowledged in the pastoral statements issued by the bishops and theologians who propound the distinction. Thus the distinction does not seem to be valid in so far as ethical decisions at the time of death are concerned.

"Imminent and Inevitable Death" The Catholic Church

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The Illinois bishops' pastoral letter is a step forward because it presents church teaching in an understandable manner.

has traditionally maintained that life support may be withdrawn if it is not beneficial for the patient or it imposes an excessive burden on the patient or his or her family or community. Thus this teaching has not implied that the patient must be in the throes of death before he or she (or a proxy) decides that life support is not beneficial. In the past few years, however, some statements coming from authoritative sources—the encyclical *Evangelium Vitae* (n. 65), for example—have suggested that life support may not be removed unless "death is imminent and inevitable." Of course, life support may be removed if death is imminent and inevitable, but must a pathology be so far advanced before life support is withheld or removed? Is it not ethically acceptable to remove or reject life support if it is determined to be ineffective or an excessive burden *before* death is "imminent and inevitable"? Over the centuries, moral theologians have offered examples of people who need not accept exotic or burdensome forms of life support even though death was not "imminent and inevitable." Thus following an expensive or exotic diet, even if it would prolong life, was not deemed morally necessary. Moreover, moral theologians maintained that a person would not have to move to a better climate, or change his or her manner of making a living, in order to prolong his or her life. The norms set forth in Directives 56 and 57 do not say that death must be imminent and inevitable before life support can be rejected or removed. If taken literally, saying that death must be "imminent and inevitable" before life support is withheld or removed would not seem to be an accurate statement of Catholic tradition. As Francis de Vittoria, the pioneer in death and dying theology stated in the 16th century, "It is one thing to shorten life and another thing not to prolong it."[5]

A Step Forward

In sum, the Illinois bishops' pastoral letter is a step forward because it presents church teaching in a succinct and understandable manner. Its enlightened tone may be owing to the fact that a practicing physician contributed to it, along with theologians and bishops. This collaboration has produced a patient- and family-centered document for physicians, other health care professionals, and patients and their families. "In consulting with legitimate church teaching, our consciences can be formed so that decisions made even in emotionally laden situations are moral, compassionate and appropriate" (p. 109). □

Copies of Facing the End of Life: A Pastoral Letter from the Bishops of Illinois *may be had by calling the Illinois Catholic Health Association at 312-368-0011 or by accessing the organization's web site, www.il-cha.org.*

NOTES

1. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Services*, 4th ed., Washington, DC, 2001, p. 31.
2. Illinois Bishops, "Facing the End of Life," *Origins*, June 21, 2001, pp. 105, 107-109.
3. Thomas Aquinas, *Summa Theologica*, II-II, q. 1. a. 1., Benziger Brothers, New York City, 1947.
4. A. Finucane, "Tube Feeding in Patients with Advanced Dementia," *JAMA*, October 13, 1999, pp. 282-294; B. Gillick, "Rethinking the Role of Tube Feeding in Patients with Advanced Dementia," *New England Journal of Medicine*, January 20, 2000, pp. 342-346.
5. Francis de Vittoria, *On Homicide*, J. P. Doyle, ed., Marquette University Press, Milwaukee, 1997, p. 103.

A "JUST WAGE"

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Survival of the organization is paramount.

not to substitute these programs for the organization's responsibility as a Catholic employer.

In developing their plan, leaders must understand that survival of their organizations—and the jobs they represent—is paramount. An organization forced to scale back its jobs cannot provide a just wage.

Once leaders have all the necessary facts, they should establish a wage rate that is sensitive to local cost-of-living standards and is complementary to the overall fabric of the plan. They must be prepared to discuss such difficult topics as "wage compression"—eliminating low-paying jobs to raise the pay of other workers—without apologies. They must document their plan and its goals and communicate them to the entire workforce. And, finally, they should not be afraid to *have faith* that they are doing the right thing. If their plan is realistic, sensitive, and well thought-out, they probably are. □

NOTES

1. Pope John Paul II, Laborem Exercens, 1981, paras. 19 and 93.
2. Pope Pius XI, Quadragesimo Anno, 1931, para. 74.
3. Pope Leo XIII, Rerun Novarum, 1891, mentions the worker's need for time in which to rest and worship.
4. Human Resource Executives of Large Catholic Health Systems, "Position Statement on Just Wages and Affordable Access," p. 1.
5. Pope Pius XI, para. 72.
6. Bureau of National Affairs, "Survey: Economists Predict Living Wage Laws Will Reduce Jobs, Promote Hiring of Skilled Workers," *BNA Daily Labor Report*, August 17, 2001.
7. Pope Pius XI, para. 65.
8. www.solucient.com.