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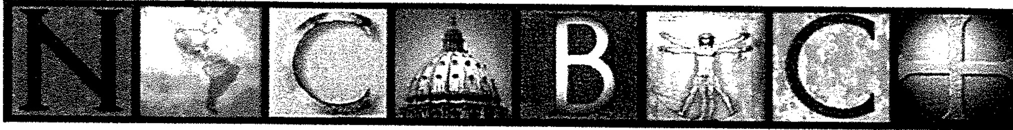

ETHICAL ISSUES AT THE END OF LIFE

PREPARED BY THE ETHICISTS OF THE NCBC
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"Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death."
—USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (2009), n. 60.

"Life is a gift of God, and on the other hand death is unavoidable; it is necessary, therefore, that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity. It is true that death marks the end of our earthly existence, but at the same time it opens the door to immortal life. Therefore, all must prepare themselves for this event in the light of human values, and Christians even more so in the light of faith. As for those who work in the medical profession, they ought to neglect no means of making all their skill available to the sick and dying; but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness and heartfelt charity. Such service to people is also service to Christ the Lord, who said, 'As you did it to one of the least of these my brethren, you did it to me.'"
—Congregation for the Doctrine of the Faith, *Iura et bona*, Declaration on Euthanasia (1980), conclusion.

❖ SUMMARY ❖

Ordinary/Proportionate versus Extraordinary/Disproportionate Means of Preserving Life

- *Ordinary or proportionate means* are those that (in the judgment of the patient assisted by health care professionals) offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community. A person has a moral obligation to use ordinary means.
- *Extraordinary or disproportionate means* are those that (in the judgment of the patient assisted by health care professionals) do not offer a reasonable hope of benefit, do entail an excessive burden, or do impose excessive expense on the family or the community. A person may forgo extraordinary means.
- These terms may refer to either objective factors, such as the seriousness of a pathology or the technical capacity of a certain hospital or area, or subjective (individual) factors, such as the economic situation of the patient or the psychological condition of the patient or the patient's relatives.

Euthanasia and Assisted Suicide

- *Euthanasia* is an act or omission that of itself or by intention causes death to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way.
- Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

Nutrition and Hydration

- In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally.
- Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be excessively burdensome for the patient or would cause significant physical discomfort.

For further information, visit the NCBC website at www.ncbcenter.org.
To request a consultation, go to www.ncbcenter.org/page.aspx?pid=1170 or call 215-877-2660.

❖ FAQs ❖

Question 1. What is the difference between foreseeing death and intending death?

Reply: The difference ultimately lies in the intentionality of the patient or health care professional. A person should never intend in any way the death of a patient or the hastening of a patient's death. Sometimes it is difficult to determine whether a medical decision made during end-of-life care includes such an intention. Certain means can be used to alleviate a patient's pain, for example, by a physician who foresees that the patient's life may be shortened as a result (as an indirect, non-intended but tolerated effect of the therapy), but similar means could be used to intentionally shorten a patient's life.

Question 2. Are proportionate or ordinary means the same for all persons?

Reply: Basic care (such as nutrition and hydration, pain relief, antibiotic treatment, and postural change) is generally the same for all patients and should always be provided. The evaluation of proportionate or disproportionate means, however, is based on objective and subjective factors for an individual patient. For example, total parenteral nutrition may be a proportionate means in an industrialized country but a disproportionate means in a developing country, where it is not affordable or is technically too difficult to administer. A treatment may also be disproportionate because it is futile or because it causes complications that are too hard for the patient or the patient's family to bear.

Question 3. What ethical issues are there with advance directives?

Reply:

- The right of patients to self-determination can lead them to include morally illicit requests in advance directives, such as requests to have ordinary care withdrawn.
- An effective therapeutic alliance between a physician, a patient, and the patient's proxy is the best way to address end-of-life issues. Requests made by a patient in an advance directive may preclude therapeutic dialogue, preventing such an alliance.
- A patient may react to an illness or a specific therapy differently than expected, or medical advances occurring after a directive was written may change the patient's treatment options in unexpected ways. In such situations, an advance directive may prevent objective moral analysis.
- Advance directives are often difficult to interpret and apply in the actual circumstances encountered by health care professionals, relatives, and proxies.
- Advance directives that do not differentiate between proportionate and disproportionate treatments may be promoted by pro-euthanasia associations as a first step toward acceptance of euthanasia.

Question 4. What is therapeutic obstinacy?

Reply: Therapeutic obstinacy is the use of all possible means, even disproportionate ones, to delay death, even in the absence of hope for improving health status or preventing pain and discomfort. Therapeutic obstinancy may be a result of medical paternalism or an overextension of patient autonomy. Advance directives were seen as a way to avoid therapeutic obstinacy.

❖ Resources ❖

John M. Haas, "Therapeutic Proportionality and Therapeutic Obstinacy in the Documents of the Magisterium," in *Alongside the Incurably Sick and Dying Person: Ethical and Practical Aspects—Proceedings of Fourteenth Assembly of the Pontifical Academy for Life* (*Vatican City, 25–27 February 2008*), ed. Elio Sgreccia and Jean Laffitte (Vatican City: Libreria Editrice Vaticana, 2009), 143–157.

Rita L. Marker, "End-of-Life Decisions and Double Effect: How Can This Be Wrong When It Feels So Right?" *National Catholic Bioethics Quarterly* 11.1 (Spring 2011): 99–119. Reproduced by permission.

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Caring for Each Other, Even Unto Death

Marie T. Hilliard, RN, JCL, PhD

Recently the daughter of a man dying of cancer called the National Catholic Bioethics Center's consultation line.[1] Her father, while still able to swallow, was ingesting less and less as death approached. He had received the Anointing of the Sick and *Viaticum* (i.e., the Eucharist given to the dying). The daughter asked if there was a moral obligation to provide assisted nutrition and hydration as death drew near. After determining that her father's vital organs no longer could assimilate food and water, causing the decreased appetite, the moral decision was made not to initiate assisted nutrition and hydration.

The next day the daughter called, stating that her father had died, and expressing gratitude for the advice. It was obvious that the underlying pathology, not euthanasia through starvation and dehydration, had caused his death.

Families also get advice from other sources. Tragically, some have been wrongly advised by the medical community that preserving their loved one's "dignity" and ending their suffering require ending their life—by active intervention, or more frequently, by omitting basic care. Many families are unsure about moral options for the care of their loved ones. Fortunately, the popes and bishops of the Catholic Church have provided invaluable guidance concerning end-of-life decisions, including issues of pain control and consciousness, the provision of food and water to dying or unconscious patients, the right to refuse certain treatments, and the duty to care, even when a cure is no longer possible. In a pamphlet, one can only highlight these teachings, so readers are encouraged to read the entire statements and directives mentioned below, which are available online.

What does the Church teach about pain control and consciousness?

The *Ethical and Religious Directives for Catholic Health Care Services*[2] (ERDs) state, "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 consciousness without a compelling reason…." In some cases, pain control may require brief or prolonged periods of unconsciousness. Pain control can be provided even if, in rare cases, the needed doses may have an anticipated, but unintended effect of hastening death.[3] The intention is to control extreme pain, not to hasten death. With euthanasia, however, there is an explicit intent to terminate the patient's life, representing a grave evil with eternal consequences.

Currently, three states allow physician-assisted suicide. Some states practice a more covert form of euthanasia, providing patients who suffer from physical or even psychological pain with high doses of sedation, when other effective relief is available. Then assisted nutrition and hydration are withheld, causing death by dehydration or starvation, not the underlying pathology. This is sometimes called "terminal sedation," distinguishable from the legitimate use of sedation as a last resort to treat patient suffering in their last days. The difference is in the physician's intent, whether it is to end life or control pain.

What does the Church teach about providing food and water to unconscious or dying patients?

Pope John Paul II taught: "I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a

medical act. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering."[4] This principle has been affirmed by the Congregation for the Doctrine of the Faith[5] and incorporated into the *Ethical and Religious Directives* in 2009 (n. 58).

What does the Church teach about the patient's right to refuse or forego certain medical treatments?

The papal encyclical *The Gospel of Life* condemns euthanasia, drawing a key distinction between euthanasia and the decision to forego "medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience 'refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted'" (n. 65).

It is clear that there is no moral requirement to utilize burdensome treatments that merely prolong the dying process. Unless the patient is very near death, however, the provision of nutrition and hydration, even by artificial means, should be administered as long as they can sustain life and alleviate suffering without imposing serious risks or side effects to the patient.

Today active interventions or omissions of basic care are proposed for ending the lives of not only the dying, but also patients suffering from a long-term cognitive disability, such as advanced dementia or a so-called persistent "vegetative" state. Some argue that patients who cannot consciously respond have lost their "human dignity." This view is dangerously wrong: Human beings never lose their dignity, that is, their inherent and inestimable worth as unique persons loved by God and created in His image. People can be denied respect affirming that dignity, but they never lose their God-given dignity.

What does the Church teach about our duty to care for dying or vulnerable family members?

When a family or health care providers refuse to provide basic care (nutrition, hydration, cleanliness, warmth, and prevention of complications from confinement to bed), finding it "inconvenient" to accompany the loved one on the final journey, the assault on human dignity is grave. When such abandoning of the disabled or unconscious patient is codified in state laws, the implications for society are frightening. Pope Benedict XVI states in his encyclical *In Hope We are Saved* (*Spe Salvi*), Nov. 20, 2007: "The true measure of humanity is essentially determined in relationship to suffering and to the sufferer.... A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through 'com-passion' is a cruel and inhuman society" (no. 38).

Christ calls us to love one another: "This is my commandment: love one another as I love you" (John 15:12). He loved us unto death, even death on the cross. Few are called to such a sacrifice; but we are called to be companions to each other, especially to those suffering on life's journey. "Companion" is taken from the word "*cum-panis*," meaning "with bread." Thus, we are called to share the bread of Eucharist with each other, responding with Christ's sacrificial love. We are asked not only to care for each other, but to nourish each other, even unto death.

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1 The National Catholic Bioethics Center provides a 24 hour ethics consultation service, free of charge: 215-877-2660.
2 United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th Ed. (2009) n. 61.
3 John Paul II, Encyclical *The Gospel of Life* (*Evangelium Vitae*), March 25, 1995, n. 65.
4 Pope John Paul II, Allocution *"On Life-Sustaining Treatment and the Vegetative State"*, March 20, 2004, n. 4.
5 Congregation for the Doctrine of the Faith, *Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration*, 2008.

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	Legally Recognized End-of-Life Decision Making Document in PA			Not Statutorily Authorized
	Health Care Power of Attorney	Living Will	Out-of-Hospital Do Not Resuscitate Orders (DNR)	Pennsylvania Orders for Life Sustaining Treatment (POLST)
Definition	A **health care power of attorney** is a written document which designates a trusted individual (health care agent) to make health care decisions for you should you be incapacitated.	A **living will** is a written document which sets forth a person's wishes and gives instructions about health care treatment when the person has an end-stage medical condition, or is permanently unconscious.	An **out-of-hospital do not resuscitate order (OOH-DNR)** requires emergency medical service providers to withhold cardiopulmonary resuscitation (CPR) from the patient in the event of respiratory or cardiac arrest. CPR is the only treatment addressed by the DNR.	**Pennsylvania orders for life sustaining treatment** are portable, actionable medical orders that are issued after an informed discussion between the patient or surrogate and their health care provider. The orders dictate whether to withhold or provide CPR, antibiotics, and nutrition/hydration.
	Often the health care power of attorney and living will are drafted together into one document called an **advance health care directive.**			
Appropriate Patient Population	All adults 18-years or older	All adults 18-years or older	Patients diagnosed with an end-stage medical condition or are permanently unconscious.	Patients diagnosed with terminal illness whose doctors would not be surprised if they died within a year.
Necessary Signatures	Patient, two witnesses, Notary (not mandated, but encouraged)	Patient, two witnesses, Notary (not mandated, but encouraged)	Attending physician, patient or surrogate	Physician, physician assistant or certified registered nurse practitioner, and patient or surrogate
Binding or Non-Binding Doctors' Orders	Legal documents, but not binding medical orders. The living will expresses the wishes of the patient. Based on those guidelines decisions about specific treatment are made at the discretion of the health care agent and physician.		A DNR is a binding medical order; resuscitation will be withheld as directed.	POLST is a binding and immediately actionable medical order. Treatment will be withheld or provided as directed. Health care professionals do not need to consult with a health care agent.
Triggering Condition	A health care agent acts according to the patient's wishes outlined in the living will when the patient is unable to consent to medical decisions for him/herself.		For those with a diagnosis from an attending physician of an end-stage medical condition for which DNR is appropriate.	SB 623/HB 1196 do not require a triggering condition. As written, the bills would have no legal restriction on which patients would be denied treatment with POLST.