

Medical Decisions Regarding Life-Sustaining Treatments in the Catholic Tradition

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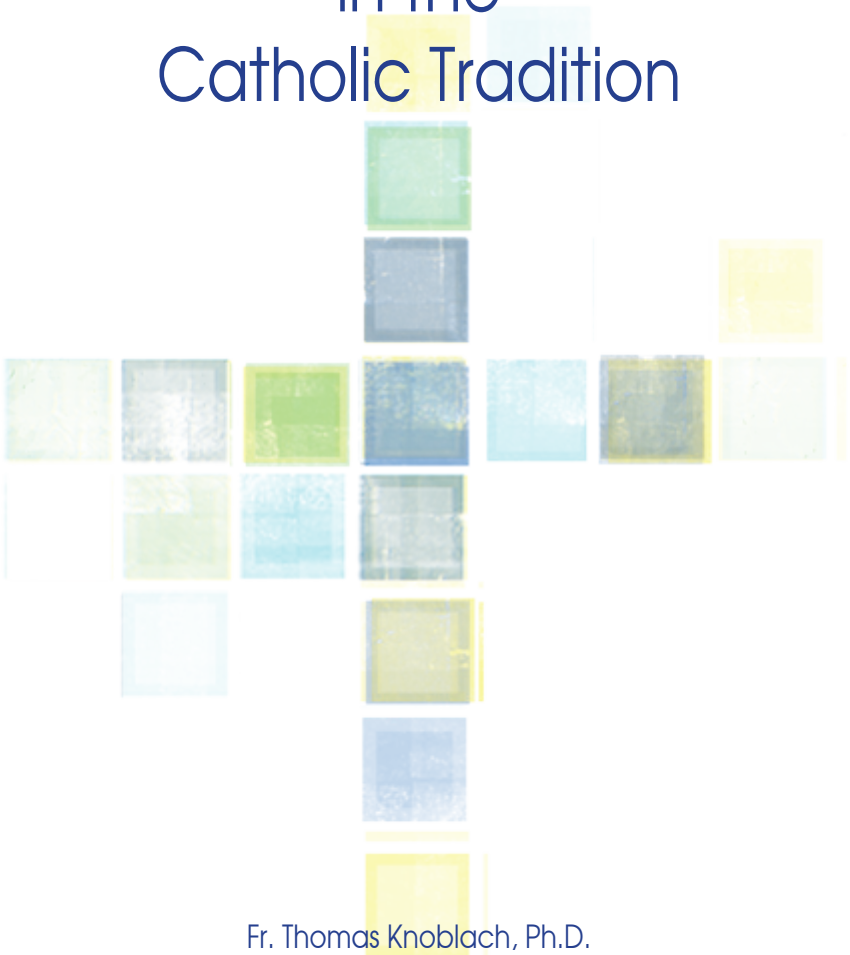
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Life Is a Gift from God

The Catholic tradition acknowledges that life is a gift from God, our Creator. Indeed, human life is the foundation for the enjoyment of all other goods in this life. Further, the human person is made in the image of God and is called to eternal life. Thus the inviolable dignity of each individual human life, made in the image of God, is the basis of all other Catholic moral teaching.

Christ Reveals the Meaning of Our Lives

Because of the Incarnation, every moment of human life, from conception to death, has been transformed by the presence of Christ, who has shared in our life fully. Suffering and death have not been eliminated from the human condition by the saving work of Jesus, but to the eyes of faith, their very meaning has been transformed. Our own sufferings can be joined to those of Christ and share in a profound way in His saving sacrifice. When the course of our earthly pilgrimage is completed in God's sight, death can be embraced according to God's will as a passage to new life.

Medicine and Stewardship of the Gift of Life

The contributions of medicine and technology are valued as part of our stewardship of the gift of life and our care for God's creation. Yet healthcare is not an end in itself. In particular, the value of life-sustaining treatments is assessed in light of their impact on the individual human person, in his or her specific circumstances. It is true that we are given responsibility to take reasonable care to preserve life and health in this world. At the same time, we also acknowledge the limitations of medicine and the fact that we are also called to eternal life and wholeness with God.

The Middle Ground between Overreliance on Technology and Euthanasia

Since we are stewards, not owners, of our lives, our faith allows us to avoid two extremes: first, to insist on ineffective or excessively burdensome medical

treatments that merely prolong the dying person's suffering; and second, to act or to deliberately withdraw life-sustaining treatments precisely in order to bring about the person's death. The Catholic tradition generally agrees with secular healthcare ethics in seeking this middle ground between absolutely mandating the use of medical technology on the one hand and euthanasia or assisted suicide on the other. However, the Catholic position is based not on patient wishes alone (though autonomy has an important place) or on giving up on certain lives (though we do acknowledge the limits of medical interventions). Instead, it is rooted in two related convictions: that each person is of infinite value and dignity, and that life in this world is a preparation for a greater life to come.

Why Dying Can Be More Difficult Today

In some ways, dying is more difficult today than in the past for several reasons:

1) While the advances in medical technology have allowed improved quality of life and longevity for many, they have also created new ethical challenges. We are now able to sustain life by means of technology not available to previous generations. But simply because we can prolong life does not necessarily mean that we must or that we ought to do so. These advances can also make it more difficult to determine when death has occurred, blur the lines of ordinary care and extraordinary technological interventions, and raise questions about the allocation of limited medical resources.

2) While death was once a familiar part of the life cycle to most people, many people now tend to expect that the remarkable progress in medicine implies that they can be kept from having to experience suffering and even death. Further, people tend to move more often, the population is aging, a patient often sees a wide variety of healthcare providers rather than "my family doctor," and the culture we live in exalts youth, vitality, productivity, and individual choice. All



of this tends to marginalize persons who are chronically ill, elderly, disabled, or dying. Thus death can become a threat to be avoided whenever possible, and controlled when it is no longer possible to avoid. Suffering, disability, and loss seem to be meaningless experiences for many and, increasingly, euthanasia is proposed as a reasonable solution to avoid such meaninglessness.

3) Despite many advances in high-technology medicine, inadequate management of pain and other discomfort that may accompany dying remains a concern. In fact, this fear of intractable suffering is part of the drive to legalize assisted suicide and euthanasia.

Euthanasia: A False Mercy

Euthanasia literally means “good death.” Among the ancient Greeks, the term was descriptive, referring to the happy circumstance of dying after a long and full life, surrounded by family and friends, and free from pain and suffering – an ideal scenario for life’s end. In recent years, however, this term has been used to refer to the active ending of life in order to alleviate physical and/or psychological suffering. The Church defines the term: “By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated” (Congregation for the Doctrine of the Faith, “Declaration on Euthanasia”(“Jura et Bona”) [May 5, 1980], n. 2).

Euthanasia has sometimes been called “mercy killing.” It seems to some people that it is preferable – an act of “mercy” – to avoid suffering when possible, even by causing death, rather than to endure pain, despair, and a sense of being a burden on others. Assisted suicide is simply one form of euthanasia in which the person receives the means to end his or her own life from another, but uses those means directly, rather than another person doing something that ends the person’s life.

However, the Catholic tradition rejects euthanasia, whether inflicted by self or by others, as a false mercy. We agree fully that suffering is an evil to be avoided when possible, and support pain and symptom management to alleviate physical discomfort and psychological distress. In fact, the Catholic tradition supports the palliation of pain by medications, even when this may

hasten the person's death, as long as this effect is merely foreseen but not directly intended. However, there are limits to our ability to prevent suffering in a world marred by the effects of original sin. We do not believe it is ever moral that the elimination of suffering can be morally achieved by directly acting to end the person's life.



Sickness and Death Affect the Whole Person

While "death" is an event (a particular moment in which the soul leaves the body and earthly life is ended), "dying" is often a process that extends over a period of time. This process of dying (especially in a prolonged illness)

usually involves suffering at all levels of the person:

- Physical
- Emotional/Psychological
- Relational/Social
- Spiritual

Physical – Properly used, medicines for pain management are extremely effective. The Church teaches that the use of such analgesics is completely acceptable, even if their use may cause unconsciousness or even hasten death, as long as the intention in using the medications is solely to alleviate pain and not directly to cause death. Palliative care provides a wide range of medicines and techniques to control suffering, pain, and other symptoms accompanying serious illness. No one need suffer unbearably.

In addition, all care that would normally be given to patients is to be given to persons who are terminally ill, dying, advanced in age, suffering from forms of dementia, or in the "persistent vegetative state." We distinguish between therapeutic interventions, which intend to cure or heal an existing disease, and palliative means or interventions, which aim at providing comfort and alleviating suffering. Even when cure is not possible, we are still obliged to offer comfort and normal care.

Psychological – It is natural and normal for a person in severe illness, advanced age, or other situations of approaching death, to experience a range of emotions, including disbelief, fear, regret, anxiety, sadness, anger, depression, and – ideally - eventual acceptance and peace. Sincere and empathetic listening, personal presence of family and friends, and gentle and understanding interactions by healthcare professionals will all help to alleviate the person’s emotional distress and reassure him or her of being valued as a unique person of infinite worth and dignity.

Social – The dying person may encounter isolation, loneliness, and inevitable changes in relationships with the need to bring closure and say goodbye to loved ones. The presence of family and friends are very important in times of illness, and especially as death nears. Being surrounded by loved ones brings great comfort, even if the person facing death cannot consciously respond to their presence. This presence is also important for the family members and friends themselves, so that they may say their goodbyes and come to acceptance and closure. Sometimes, there may be a need for reconciliation and forgiveness so that the person can die with peace of mind and spirit.

Spiritual – The mystery of death naturally opens us to the transcendent dimensions of human life. Yet it can also be a crisis of faith, as one’s trust in God and hope for eternal life are tested. The dying person should be given the opportunity to visit representatives of his or her own faith community. Catholic patients in particular are to be strengthened in this final stage of life with pastoral care and in particular the sacraments of Reconciliation, Anointing of the Sick, and with the Eucharist if they are able to receive Communion.

Medical Science and Accepting Death

There is inevitably a time in each life when all reasonable possibilities of forestalling death are exhausted. The Catholic tradition does not require that earthly life must be prolonged in every possible way and at all costs. Such a position would be contrary to human dignity, moral intuition, and the will of God. ***When further efforts at sustaining earthly life are ineffective or will only secure a burdensome prolongation of life, such efforts or interventions may be foregone, or withdrawn if already in use.***

Accepting the limits of medical science and human efforts to forestall death is not a failure of faith or charity towards the dying person; in fact, it is an expression of faith and a commitment to accompany the person through the final stages of the pilgrimage of earthly life.



When the time of death nears, our commitment to healing and care is not ended, but it takes a different form: we turn our attention from efforts at restoring health and function towards maintaining comfort and preparing for death. This time is unique to each person in his or her specific case, and a variety of factors and voices must come into play to discern it.

Determining when this time has come can be difficult. The complexity of some cases, from medical and moral standpoints, can blur the line between a morally justified “allowing to die” and a morally repugnant “causing death” in the minds of those involved. The simplest criterion for drawing this line correctly is to answer as honestly as possible this question: “What will cause this death?” Is it the underlying pathology or injury which resists all reasonable efforts to cure or manage? Or would death intentionally be caused by the action or omission taken, without which action or omission life would continue for the present? If the former, we are allowing the person to die by forgoing futile or excessively burdensome interventions. If the latter, it is euthanasia.

Ordinary and Extraordinary Means

The traditions of the Church and the consensus of the medical community have long distinguished between ordinary means and extraordinary means to sustain life. Other terms are sometimes used for this distinction. One may see a discussion of “proportionate” and “disproportionate” means, emphasizing the proportion between the expected benefit and the burdens incurred. Again, sometimes the terms “ethically obligatory” and “ethically optional” are used, to emphasize that evaluating the means to be used is not merely a medical assessment, but has an ethical component.

Whatever the terms used to make the distinction, the Catholic tradition holds that one is morally obliged to use ordinary means to preserve life; while one is not obliged, but may be permitted, to use extraordinary means. While this teaching is quite straightforward at the theoretical level, it can become quite difficult in actual cases to determine what, specifically, is ordinary and to be done, and what is extraordinary and therefore not required. As noted previously, advances in medical technology, changes in healthcare delivery, and other factors have made it increasingly complicated to draw a clear line between the ordinary and the extraordinary.

Assessing Ordinary and Extraordinary: PREHAB

Useful criteria for determining whether proposed interventions are ordinary or extraordinary include consideration of the following factors: **Patient Preferences; Risk; Expense; Hope; Availability; and Benefits/Burdens**. The acronym PREHAB may help to remember these factors.



Patient Preferences: Patient autonomy is an important value in healthcare ethics, rooted in the same commitments

to responsibility and moral freedom as the need for informed consent for treatment. The competent patient himself or herself has the primary say in what will or will not be done. Healthcare providers are normally obliged to follow the person's wishes, as long as they are not contrary to law or the ethical obligations of the institution rendering care. Each patient is also obliged to choose following these same criteria, with the responsibility to take reasonable measures to preserve life and health.

When the person becomes incapable of so choosing due to unconsciousness or incompetence, family members or other proxy decision-makers enter the process. It is a great help in such instances to have an advance directive for healthcare decisions in place, which indicates the person's wishes so that other decision-makers will clearly know them. More information on advance directives is found below.

Risk: This is when an intervention is still experimental, or when there is a danger in using the intervention for this particular person. Any medical procedure entails some risk; the degree of risk to be endured must be measured against the likelihood of potential benefits to the person.

Expense: This factor can relate to absolute or relative financial terms. Given contemporary concerns about rising medical costs and limited resources, it is important to assess expense carefully. While expense can be a factor in determining whether an intervention is extraordinary or not, it is not the sole factor; the person's innate right to life takes precedence over costs. However, expense may be a confirming factor when risk or burden are high and hope of benefit is low.

Hope: This refers to the reasonable, founded expectation that a particular intervention will have its intended benefits. This does not always mean hope of recovery or a return to full health and function. In some cases, such recovery is no longer possible, but the person's quality of life can still be enhanced. Hope is to be assessed on the basis of whether a given means is likely to be effective or bringing about its own intended goal, as well as effective in the overall well-being of the patient.

Availability: This refers to access to this intervention, for this person, here and now. For instance, if a person could only have access to a particular surgery through a hospital which is distant, and if the required transport would present a grave risk, then such a surgery may be "unavailable" and thus extraordinary for that person, even if it is routinely done in the other hospital. Or, in situations of epidemic, when there is an overwhelming demand for the required equipment or personnel, those interventions may be "unavailable" in practical terms. In addition, as a general moral principle, the factor of availability reminds us that there are many places in our world where persons who are morally equal to us often simply do not have access even to routine and minimal resources that we take for granted.

Benefits/Burdens: This is the core factor in determining whether a proposed intervention is ordinary or extraordinary. It refers to a carefully considered calculation or "weighing" of the proposed intervention in terms of the expected

benefits to the patient in his or her concrete circumstances, measured against the burdens to be endured by the patient.

These benefits and burdens refer primarily and fundamentally to the effects of the intervention on the patient. Only secondarily and subordinately are benefits and burdens on the person's family, caregivers, healthcare professionals, and society as a whole to be considered. Always at the center of the consideration is the patient, whose good is not placed in competition with other factors.

Benefits and burdens are considered holistically: that is, they include not only physical factors, but also psychological, relational, and spiritual effects. When the burdens to be endured genuinely outweigh the expected benefits foreseen, the intervention is extraordinary and may be legitimately foregone. Whenever the person is competent (sometimes termed "legally capable"), he or she has the right and responsibility to make this informed judgment. Sometimes, however, the person is not capable of making this decision due to unconsciousness, dementia, or some other factor. In such cases, proxy-decision makers and healthcare professionals dialogue together to make this discernment based on any known previously-expressed wishes of the patient and/or the patient's best interests.



It is well to emphasize again that this discernment of ordinary and extraordinary means must be made on a case-by-case basis. It is unique to each individual in the concrete circumstances of the moment. It is to be reassessed regularly as time passes and the person's status changes.

Withholding vs. Withdrawing Life-Sustaining Interventions

From an ethical standpoint, as long as the above criteria are observed, there is no moral difference between withholding an intervention and withdrawing one already in use. In either case, the discernment is made that the means in question is extraordinary and therefore ethically optional.

However, it can be far more difficult emotionally to discontinue a means currently in use; since death may result when the means is withdrawn, it can seem like the decision to withdraw is the direct cause of death. Yet, if the discernment is correct, it is the underlying pathology that causes death; the withdrawal of means simply allows that pathology to take its natural course, no longer forestalling death by technological means.

Withholding a means can seem less dramatic, but in fact takes greater moral certitude that the means would be extraordinary if used. When withdrawing a means in use, there is some evidence that the means is ineffective or excessively burdensome; while withholding a means relies on speculation that it would be ineffective or burdensome. Nonetheless, this discernment can be ethically made according to the above criteria, with due diligence in assessing the medical facts and likely outcomes.

Moral Certitude

It is crucially important to realize ethical decisions about matters as weighty as using or foregoing life-sustaining treatments are very complex and often uncertain. As the great Greek philosopher Aristotle noted over four centuries before Christ, "It is wisdom to expect no more certitude than the subject matter allows." Saint Thomas Aquinas noted the same reality: that we can have certitude at the level of principles, but the more we deal with specific cases, the greater the uncertainty we encounter. For this reason, the Catholic tradition does not require absolute certitude – the kind of logical necessity we find in mathematics, for instance – about such complex decisions in the face of the mystery of death. We may not be able to come up with a completely satisfying, logically compelling argument about the course of action we choose to take; people of equally good will may differ; we rely on dialogue, honesty, and intuition; and we may have to live with ambiguity and probabilities rather than clear guarantees.

The Church does require, however, that we have "moral certitude." We achieve this kind of certitude in dialogue with others. First, we listen to all the facts of the situation, including: the medical diagnosis and prognosis; the possible alternatives for treatment; the risks and benefits of each; the economic, psychological, and social costs foreseen with each; and the expressed wishes

and preferences of the person. We assess these facts without prejudice or bias and weigh them carefully in light of the accumulated wisdom found in the teachings of our faith. We take time to listen carefully to the voice of our conscience and seek God's will in sincere prayer. We consult with others who have special expertise in the various aspects of the question, and who can help us with honest discernment. Then, we reach a decision that we believe sincerely to be right in this specific case. These decisions are an exercise of the virtue of prudence; thus they are sometimes known as "prudential judgments."

Advance Directives

Although people may express their preferences about care and treatment verbally, an advance directive is generally defined in law as a written document prepared by an individual to instruct healthcare professionals and family members about that person's healthcare preferences in case he or she is unable to communicate them at the time when decisions need to be made. Advance directives are an extension of the legitimate right to direct one's own health care and to exercise one's responsibility and stewardship for the gifts of life and health. They are supported by the Church as long as they would direct care in accord with Catholic principles.

Since 1990, each patient entering a healthcare facility that receives federal funds is obliged to ask if the person has an advance directive; and, if not, if he or she would like to compose one. No one may be denied services or given a different level of care if an advance directive is absent, nor is one required to have one.

Advance directives took two general forms over the years, commonly called the "living will" and the "durable power of attorney for healthcare" (DPAHC). The living will was an earlier form of advance directive that attempted to be specific about interventions, spelling out particular conditions and technologies that would or would not be desired by the person in those conditions. Living wills proved ineffective in practice because they were made out well in advance of actual need, and it was impossible to predict one's precise medical situation, and how one's preferences might be affected by future circumstances and developments in medical technology. Many of them were vague and not helpful in the specific situations that arose. Finally, living wills only applied

when death was imminent and could not guide care earlier in the person's illness.

The durable power of attorney for healthcare was developed to address these concerns. In the DPAHC, the person appoints a surrogate or proxy decision-maker (and usually an alternate if the first person is not available when need arises) to make healthcare decisions in his or her stead. This power of attorney for healthcare operates only if the person is incompetent; the proxy can never override a competent person's wishes. Further, the surrogate advocates for the person's ongoing care needs, rather than only in situations of imminent death. The surrogate must make a sincere effort to give truly informed consent and to speak on behalf of the patient's best interests as the patient would view them. It is presumed that the patient has clearly expressed his or her values and preferences before decisions must be made.



This durable power of attorney gives authority only for healthcare decisions (it does not grant the surrogate any power over the person's other legal or financial matters). The DPAHC formalizes what usually happens in the absence of any advance directive: those closest to the patient are asked to make decisions.

More recently, other forms of advance directives have combined features of these two approaches. They allow both the appointment of a health care agent to speak on one's behalf, and the indication of treatment preferences. Because there is such a variety of forms, those making an advance directive are urged to read them carefully and seek expert advice, if necessary, to ensure that the form used accurately expresses the person's wishes and ethical commitments. Catholics are encouraged to use the Minnesota Catholic Health Care Directive, which can be found online at www.mncc.org. This form follows the general outline of the Minnesota Department of Health format, but includes guidance in Catholic teaching.

Among the issues the person should discuss with the surrogate decision-maker are his or her preferences regarding cardiopulmonary resuscitation

(CPR); having a “do not resuscitate” order (DNR); the use of antibiotics to treat infections; surgery; hospitalization; medically-assisted nutrition and hydration; pain management strategies; continuing dialysis or other interventions or medications the person may be using; hospice and palliative care wishes; and desires for spiritual care.

Anyone can make an advance directive, and the services of an attorney are not required. An advance directive can be revoked at any time. Copies of one’s advance directive should be filed with one’s primary physician, with one’s surrogate decision-makers, and perhaps with other family members: the goal is to make them readily available for consultation should the need arise.

Since advance directives always require interpretation and application to the concrete specifics of each situation, the most important factor in honoring a person’s wishes is for those close to that person to have discussed his or her preferences and values clearly, so they can speak with confidence and have access to current medical information about the person’s condition, prognosis, and treatment options. This is why the appointment of an agent is always preferable to a mere list of treatments.

In Minnesota, advance directives are known as “health care directives.” The Minnesota form adopted in 1999 allows one either to indicate preferences for specific interventions, or to appoint a proxy decision-maker, or to do both. To be legal in Minnesota, a health care directive must:

- 1) be in writing;
- 2) indicate the person’s name;
- 3) be signed;
- 4) be dated;
- 5) be witnessed by a notary public OR by two witnesses, neither of whom is the person’s proxy;
- 6) offer some meaningful directive about future healthcare preferences when the person cannot speak for himself or herself.

Earlier forms of advance directives are also upheld in Minnesota law as long as they met the standards in place at the time they were made. Again, as noted previously, an advance directive can be revoked or changed at any time, and it

is a good idea to update them regularly as medical science advances and one's own condition, outlook, and preferences may evolve.

More recently, a document called POLST has been proposed as a way to ensure that patient wishes are honored at the end of life. POLST stands for "Provider Orders for Life Sustaining Treatment." While the goal of honoring patient wishes and improving end of life care is laudable, there are some ethical concerns with informed consent and sufficient attention to detail and the current situation of a patient with a POLST form that need clarification. The bishops of Minnesota discourage the use of POLST for Catholic facilities and patients, and encourage instead the careful dialogue with providers and appointment of a health care agent as outlined above.

What If I Still Have Questions?

Of course, a guide like this can only outline general principles. It is not meant to answer every question and give direction in specific situations. Patients and families should feel free to pose questions to healthcare providers, social workers, chaplains, and other appropriate staff in hospitals or long-term care facilities. Most facilities have an ethics committee or a similar resource that can help to address concerns and foster communication so the best decisions are made for the good of the person. Questions about Catholic doctrine can be addressed to your pastor or another trusted person familiar with Catholic moral teaching.

Conclusion

In dialogue with physicians, nurses, other healthcare professionals, ethics committees, family members, and other concerned persons, proposals for life-sustaining treatments can be considered in the light of these criteria to determine whether they are, in the specific circumstances of this patient, ordinary and thus required, or extraordinary and thus allowed but not necessary. The goal of this discernment is always to do what is judged best for the person who is facing the mystery of death, and who is called to eternal life with God.

For Further Reading:

United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Healthcare Services*, fifth edition (Washington, D.C.: USCCB, 2009). See especially the Introduction to Part Five, "Issues in Care for the Dying," and directives 24, 25, 28, 32, 33, and 56-61.

Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (Jura et Bona) (May 5, 1980). Can be found at www.vatican.va.

John Paul II, encyclical on the *Gospel of Life* (Evangelium vitae) (March 25, 1995), especially nn. 64-67. Can be found at www.vatican.va.

The Catechism of the Catholic Church (1994), nn. 2276-2283.

Minnesota Catholic Health Care Directive and Guide. Can be found at www.mncc.org.



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