A Catholic Guide to End-of-Life Decisions

AN EXPLANATION OF CHURCH TEACHING ON ADVANCE DIRECTIVES, EUTHANASIA, AND PHYSICIAN-ASSISTED SUICIDE

At Central Medical Hospital, a woman with a serious illness rests in bed. Her name is Anne. Anne is a Roman Catholic who wants to make decisions about her medical treatment in the light of her Catholic faith. As would anyone in her condition, Anne has questions about the teachings of the Church. What are the Church's views on end-of-life decisions, and how difficult will it be to follow them? Must she endure a great deal of pain? What if she is no longer able to make medical decisions for herself? Anne wants to make certain decisions ahead of time in order to relieve her family of the burdens of determining what care might be most appropriate for her.

A time of serious sickness is naturally distressing for the one who is ill and for the family and friends of the one who is suffering. Making sound moral decisions in the face of such circumstances may be especially difficult when we consider the emotional strains that are part of watching a loved one suffer. This pamphlet describes how someone might approach end-of-life decisions in light of the teachings of the Catholic Church. We consider the redemptive nature of suffering, the difference between morally obligatory and optional means of conserving life, the role of advance medical directives and health care proxies (durable power of attorney), and the advocacy of euthanasia in America today.

The Redemptive Nature of Suffering

As a woman of religious conviction, Anne receives great consolation from her faith in God. She receives pastoral care from the hospital chaplains and Communion from the Eucharistic ministers. A priest has given her the Sacrament of Anointing, and should it become necessary, he is ready to administer Viaticum. In the past several weeks, however, Anne has begun to experience more pain. As her doctor performs new tests and prescribes additional medications, Anne experiences a greater degree of suffering.

Pain and suffering at times may be a profoundly distressing experience that raises deep questions about the meaning of life and even the nature of God. How can a merciful God allow us to experience the suffering of illness? It should be comforting to reflect on the fact that God Himself entered into human suffering through His Son who suffered and died so that we could overcome death.

Suffering and death entered the world with the sin of our first parents, but Christ's obedience to the Will of His Father can now infuse these afflictions with great redemptive power. By virtue of our being made one with Christ in Baptism, we can join our suffering to that of Our Savior on the Cross at Calvary and so assist in his work of salvation for the whole human race. Christ is with us during our illness and shares in our suffering as we share in His.

For those who have lost their faith in God, the suffering and helplessness of serious illness make little sense. Some may even come to contemplate suicide or euthanasia. Others who accept the existence of God wrongly believe that He does not care whether we shorten our lives. The testimony of Sacred Scripture and the constant teaching of the Catholic Tradition speak against ever directly intending one's own death. The Catholic, with a deep faith in Jesus Christ, may not be able to understand suffering, but he knows he can offer it up as a powerful source of grace for himself and others.

Obligatory and Optional Moral Means

Anne's doctor has informed her of a serious turn in her case. Anne has discussed the situation with her physician and considered the risks and benefits of the proposed treatment. She is aware that the suggested surgery may enable her to live longer, but in her case the risk of developing serious complications is much higher than normal and there is little likelihood of recovery. After talking it over with her family, Anne has decided to forgo the surgery. Had Anne been younger, or someone on whom others depended, she might have decided to undergo the treatment—despite its difficulties and poor prognosis. But we are free to forgo burdensome means of preserving life, even if we are not imminently dying.

One of the most important moral distinctions in end-of-life situations is that between what is morally obligatory and what is morally optional. What is morally obligatory we are bound to perform; what is morally optional we may include or omit at our own discretion. Moral theologians use the terms "ordinary" and "extraordinary" to make this distinction, in keeping with the words of Pope Pius XII: "Normally one is held to use only ordinary means—according to the circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A stricter obligation would be too burdensome for most people and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends" ("The Prolongation of Life," address to the International Congress of Anesthesiologists, November 24, 1957).

Generally, a medical procedure that carries with it little hope of benefit and is unduly burdensome is deemed "extraordinary" and is not obligatory. For example, in some

circumstances, a person may judge in good conscience that the pain and difficulty of an aggressive treatment for cancer is too much to bear and thus decide to forgo that treatment. Whether a particular treatment is excessively burdensome to an individual patient is a moral question that may require the input and advice of others. Individual patients and their families should seek the guidance of the Church whenever there is any doubt about the morality of a particular course of action.

Most medical treatment received during the course of one's lifetime is routine and does not raise serious moral questions. Sometimes, however, medical circumstances require considerable reflection about what procedures are appropriate for a given medical condition and time of life. When aggressive and experimental methods are recommended by a physician, the Church teaches that we are free to pursue such treatment whenever there is a reasonable hope of benefit to the patient. We are also free, however, to refuse treatment when it is of dubious benefit or when its burdens are significant. The use of extraordinary means always remains optional, and the moral obligation to conserve life obliges us simply to act in the most reasonable manner. For example, I might want extraordinary medical means used to extend my life in order to receive the sacraments of the Church, or to see friends or relatives one last time, or to be reconciled with someone from whom I have been estranged.

"Life, health, all temporal activities are in fact subordinated to spiritual ends."

POPE PIUS XII

Specific Moral Teachings of the Church

By refusing aggressive treatment for her condition, Anne realizes that she faces the possibility of death in the near term. She will continue to receive basic care for her illness even though recovery for her is unlikely. Such basic care would include food and water as long as they continue to provide her a benefit.

To make sound moral decisions, a patient must receive all relevant information about his or her condition, including the proposed treatment and its benefits, possible risks, side-effects, and costs (*Ethical and Religious Directives for Catholic Health Care Services* [*ERD*], U.S. Conference of Catholic Bishops, 2009, n. 27). The patient may also consider the expense that the treatment may impose on the family and the community at large (*ERD*, n. 57). It is important to know of all the morally legitimate options that are available. Normally, the patient's judgment concerning treatment should guide others in their decisions, unless the treatment is medically unwarranted or contrary to moral norms. Ideally, the patient, in consultation with others, decides the course of medical treatment.

There should be a presumption in favor of providing food and water to all patients, even to those in a comatose state, but there are exceptions (*ERD*, n. 58). Obviously, when the body can no longer assimilate food and water, they provide no benefit and may be withdrawn. Sometimes placement of a feeding tube may cause repeated infections. Some patients with advanced dementia may display agitation at the sight of a tube and may pull it out repeatedly. Certain patients may experience other burdensome complications, such as repeated aspiration and the constant need for suctioning of the throat. All of these are factors that may cause one to reevaluate the placement of a feeding tube.

When there are no exceptional circumstances, tube feeding should be considered a part of ordinary care. Normal care always remains morally obligatory, but refusal of additional interventions deemed extraordinary is not equivalent to suicide. Such a decision should be seen instead as an expression of profound Christian hope in the life that is to come. An instruction to "avoid heroics," when communicated ahead of time to family and friends, may give great comfort to loved ones during emotionally stressful times.

Giving Instructions for Future Care

Anne is blessed to have family and friends who love and care for her and who visit often. Not all the patients at Central Medical are so fortunate. Should it happen that Anne is no longer able to make decisions on her own, there are family members and friends who are capable of making decisions on her behalf. Anne must decide whether to designate a particular member of her family to serve as her "proxy" or "agent." There is also the question of whether she should specify which medical procedures she feels will be most appropriate for her in the future should she become unable to make her wishes known.

An advance medical directive (sometimes called a "living will") and a health care proxy (sometimes called a "durable power of attorney for health care") are legal documents that take effect if the patient becomes incapacitated or otherwise unable to make health care decisions. These documents can be prepared without the assistance of an attorney. An advance medical directive specifies what medical procedures the patient wishes to receive or to avoid. A health care proxy specifies a particular individual (variously called a "proxy," "agent," or "surrogate") to make medical decisions on behalf of the patient (or the "principal") when the patient is no longer able to do so. When neither of these instruments is drawn up, the task of making important medical decisions usually falls to the family.

All hospitals and health care facilities are required by law to provide written information to the patient about the right to accept or refuse medical treatment and the right to formulate an advance directive and designate a health care proxy. The health care facility must also provide written policies stating how the

patient's advance directive or durable power of attorney will be implemented. Through your advance directive, you may wish to forbid any action that the Catholic faith considers to be immoral, such as euthanasia or physician-assisted suicide. Some advance directives in common use today permit food and water to be ended simply because one is in a comatose state. A Catholic hospital will not follow a directive that conflicts with Church teaching (*ERD*, n. 24). Once a directive is made, copies should be distributed to the agent and anyone else the patient deems appropriate. One should periodically review the provisions of an advance directive and, if it has been revised, destroy all previous copies.

The usefulness of an advance directive, which gives specific instructions for care, is limited because of its inflexibility. If circumstances change significantly between the writing of the advance directive and its implementation, the instructions may be of little value to those acting on a patient's behalf, and could even hinder their freedom to make good decisions. There may also be a problem of interpreting the document when it is not clearly written. An advance directive often does not allow for adequate informed consent, because one must make a decision about a future medical condition which cannot be known in advance. When drawing up an advance directive, therefore, one should focus on general goals and concerns rather than on specific medical procedures.

Assigning a health care proxy is preferable to drawing up an advance directive because it leaves decisions in the hands of someone whom the patient has personally chosen. A proxy agent also can be more sensitive and responsive to the particulars of a given case. When assigning a health care proxy, one should choose an agent of good moral character—someone who is known to be capable of making sound decisions under stressful circumstances. The agent should know the teachings of the Church and possess the practical wisdom to apply them to changing circumstances. An agent, of course, must also survive the patient. One may designate alternative agents in case one's first choice, for some reason, is unable to act.

A good agent makes decisions for the patient in light of what the patient would choose if able to do so. The proxy, therefore, should be very familiar with the moral convictions and wishes of the principal. When there is an advance directive from the patient, this can provide guidance. When there is not, the agent must act on the oral instruction that has been given. Sometimes, however, acting in the best interests of the patient means ignoring instructions that are obviously unwarranted or clearly immoral. No agent is bound to carry out actions that conflict with sound morality or good judgment.

The Specter of Euthanasia

Anne shares her hospital room with a woman whose condition is similar to her own. Recently, a stranger visited her roommate and the two of them had a long discussion together. After he left, Anne was surprised to learn that the man was an advocate of euthanasia. Apparently he knows of a doctor who has already helped some sick people to end their lives. He is trying to convince Anne's roommate to do the same.

Human life is a precious and inviolable gift from God. Our love of God and His creation should cause us to shun any thought of violating this great gift through suicide or euthanasia. We read in Wisdom, "God did not make death, nor does He rejoice in the destruction of the living. For He fashioned all things that they may have being" (1:13). St. Paul reminds us, "If we live, we live to the Lord, and if we die, we die to the Lord" (Rom. 14:8).

When formulating an advance directive or discussing end-of-life issues, we should avoid using the expression "quality of life." Life itself is always a good, and this is a quality that can never be lost. Our focus should be not on whether someone's life has enough "quality" to it (quality will always be diminished during sickness or disease), but rather on whether a proposed medical treatment would be unduly burdensome and insufficiently beneficial for his or her particular circumstances. "Physician Orders for Life-Sustaining Treatment" forms can also raise ethical concerns. POLST forms may be written to permit the withholding of antibiotics, nutrition and hydration, and other easily provided medical care. Signed by a medical professional, they mandate compliance by health-care workers, including emergency responders. Catholics should exercise great caution before agreeing to be bound by such documents.

Euthanasia was defined by Pope John Paul II, in *The Gospel of Life*, as "an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering" (n. 64). Supporters of euthanasia often justify it, along with physician-assisted suicide, on the grounds that the pain of terminal illness is too great for the average person to bear. They hold that it is more merciful to kill the suffering patient.

The prospect of intractable pain may be frightening, but such extreme distress rarely occurs. The physician almost always can minimize or eliminate the pain that may accompany terminal illness. Most people, in fact, die peaceful deaths. *The Gospel of Life* holds that "*euthanasia is a grave violation of the law of God*, since it is the deliberate and morally unacceptable killing of a human person" (n. 65, original emphasis). Fundamentally, it is an unreasonable act. Although it is certainly preferable to die in a conscious state of prayer, no one should feel obliged to

forgo medications and pain relief even though they may bring about disorientation or produce unconsciousness. The Church encourages appropriate treatment for pain, even when such treatment may indirectly shorten life, so long as the intent is not to hasten death. What is chosen is pain relief. This is an application of the principle of double effect. The Church asks only that appropriate conditions exist before such medication be taken.

Hope of the Resurrection

At death, we do not cease to exist but continue to live by God's grace as we await the resurrection of the body. Though we will be united with our bodies once again, the Church encourages us to consider deceased organ donation. Care should be taken to ensure that a proper determination of death is made, that the donation is not used for commercial purposes, and that the body is not trivialized in any way. When we direct organ and tissue donation to the personal good of others, we share the gift of life.

We hope that these explanations of the moral teachings of the Catholic Church have been helpful to you. Christians should approach death with the joyful anticipation of a new life with our Blessed Lord. In order to prepare themselves to see God face to face, Catholics should try to confess their sins to a priest before death. Efforts should be made to assure that the dying can receive the Sacrament of the Sick, and the blessing of Viaticum, our Lord's body and blood as "food for the journey." When our loved ones have passed on from this life, we should remember our obligation in charity and justice to pray for the repose of the souls of the faithful departed—and in this way remain in communion with our beloved family members and friends.

Glossary of Terms

advance medical directive (sometimes known as a "Living Will"): a legal instrument that specifies which medical procedures a patient wishes to receive or avoid, should the patient become incapacitated.

Anointing of the Sick: a sacrament, which customarily includes confession of sins, that is administered to one in a seriously weakened state of health because of grave illness or the infirmity of old age (not confined to the "deathbed" visit, and repeatable if one's condition worsens). The sacrament can bring the consolation of interior healing and a sense of God's loving presence.

double-effect, principle of: a moral principle that provides guidance when an act or omission will have two consequences, one of which is moral and intended, the other evil but not intended, even though foreseen; in palliative care, treatment that seeks to alleviate pain but which also has the foreseen but unintended consequence of shortening life would be morally permissible.

euthanasia (also "mercy killing"): "an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering. . . . *Euthanasia is a grave violation of the law of God*, since it is the deliberate and morally unacceptable killing of a human person" (John Paul II, *The Gospel of Life*, nn. 64, 65, original emphasis).

health care proxy (also "durable power of attorney"): a legal instrument that specifies an "agent" (or "proxy" or "surrogate") who will make medical decisions on behalf of the patient (or "principal") if the patient becomes incapacitated.

informed consent: a decision freely made in the full possession of one's mental faculties and with adequate knowledge of all relevant moral and medical consequences.

morally obligatory and morally optional means of prolonging life (also "ethically ordinary and extraordinary means"): the moral difference between what one must do (or omit) to preserve life and what one may do (or omit) to preserve life; not to be confused with ordinary and extraordinary medical procedures (defined immediately below).

ordinary and extraordinary medical procedures: medical means that are scientifically established, statistically successful, and reasonably available; not to be confused with morally obligatory and optional means of prolonging life.

physician-assisted suicide: a form of euthanasia in which a physician provides the lethal substance or otherwise assists a patient in self-destruction.

Physician [or Medical] Orders for Life-Sustaining Treatment (POLST or MOLST): an actionable order signed by a health care professional that instructs others on what treatment to provide or withhold from a patient.

Viaticum: final reception of the Sacrament of the Eucharist (within Mass, if possible) in the face of death, as a pledge of our resurrection in Christ.

Useful Documents

Declaration on Euthanasia, Congregation for the Doctrine of the Faith, Rome, 1980.
Ethical and Religious Directives for Catholic Health Care Services, United States Conference of Catholic Bishops, 2009.
On Life-Sustaining Treatments and the Vegetative State, Pope John Paul II, March 20, 2004.
Address to the Eighteenth International Congress of the Transplantation Society, Pope John Paul II, August 29, 2000.

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