

Ethical Issues at the End of Life
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I. Introduction

- A. Why are we here?
- B. Terri Schiavo and the Catholic moral tradition on care of the dying

II. The Context

- A. The success of medical technology to prolong life.
- B. The frustration over the poor handling of issues at the end of life.
- C. The Schiavo case
- D. The critical question: **What aspect of your life do you not want to lose, so that if you lost it, you would not want your life prolonged?**

III. Criteria for determining treatment

- A. The Karen Quinlan case and a basic Catholic conviction:
“We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome.” (ERD, V)
- B. Life is a basic value, but we are not to absolutize biological life to the neglect of the holistic appreciation of the person.
“The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.” (ERD #33)
- C. The long-standing Catholic principle dating to the 1500s:
 - 1. Francisco De Vitoria, Spanish Dominican theologian (1486-1546):
 - a. On whether it violates the moral law if one fails to eat certain foods:
If a sick man can take food or nourishment with some hope of life, he is held to take the food, as he would be held to give it to one who is sick. [However], if the depression of spirit is so low and there is present such consternation in the appetitive power that only with the greatest of effort and as though by means of a certain torture, can the sick man take food, right away that is reckoned a certain impossibility, and therefore he is excused, at least from mortal sin, especially where there is little hope of life or none at all. (see Panicola, Hastings Report, Nov-Dec 2001, p. 15-16)

b. On whether one is obliged to use every possible means to prolong life: One is not held, as I said, to employ all the means to conserve his life, but it is sufficient to employ the means which are of themselves intended for this purpose and congruent. . . .When one is sick without hope of life, granted that a certain precious drug could produce life for some hours or even days, he would not be held to buy it but it is sufficient to use common remedies, and he is considered as though dead. (Ibid, p. 16)

2. Domingo Banez, Dominican theologian (1528-1604)

a. On the issue of amputation:

Although a man is held to conserve his own life, he is not bound to extraordinary means but to common food and clothing, to common medicines, to a certain common and ordinary pain; not, however, to a certain extraordinary and horrible pain, not to expenses which are extraordinary in proportion to the status of this man. (Ibid., p. 16)

3. John De Lugo, Spanish Jesuit cardinal and theologian (1583-1660):

a. On the exception to the requirement of ordinary means:

If a man [facing certain death by burning at the stake], while he is surrounded by the flames, were to have at hand water with which he could extinguish the fire and prolong his life, while at the same time other wood is being carried forward and burned, he would not be held to use this means to conserve his life for such a brief time because the obligation of conserving life by ordinary means is not an obligation of using means for such a brief conservation—which is morally considered nothing at all. (Ibid, p. 16)

b. On the interpretation of extraordinary means, De Lugo drew a distinction between actively killing oneself and allowing death to take place by refusing to submit to burdensome means.

c. De Lugo also refined the understanding of how to interpret what is ordinary or extraordinary by making their determination contingent upon the person's condition or state of life.

He contends that a religious person living an ascetical life who gets ill is not morally required to return to the world, give up the asceticism, and eat the same diet as common persons. He explained that what is ordinary for common persons living in the world may be extraordinary for the religious ascetic.

4. Our contemporary rendition of the ordinary/extraordinary distinction:

“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 burden, or impose excessive expense on the family or the community.” (ERD #57)

- D. Two guide questions for using this criterion:
1. In the patient's judgment, does the proposed treatment offer a reasonable hope of benefit?
 2. Will the means to prolong life impose an excessive burden to the patient, family, or society?
- E. Other famous cases:
1. Cardinal Bernardin
 2. James Michener
 3. Jacqueline Kennedy Onassis
 4. Pope John Paul II
- F. From "ordinary/extraordinary" to "burden and benefit"
1. Confusing "ordinary" with "standard of practice" and "extraordinary" with "risky" or "experimental."
 2. Judge appropriateness of treatment on the basis of what is beneficial or burdensome to the patient as a whole and not to its effects on an isolated bodily system, organ, or function.

"It will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."
(1980 Vatican Declaration on Euthanasia)
 3. Judging the "result that can be expected" includes benefits (restoration of bodily function and health) and burdens (physical, psychological, socio-economic).
 4. The judgment is always patient-specific, and must include the patient's values, and emotional, spiritual, relational, economic capacities.
 5. The inevitable subjective component of this judgment forces us to ask: What aspect of your life do you not want to lose, so that if you lost it, you would not want your life prolonged?
 6. Withdrawing ineffective treatment is neither murder nor suicide.

"One cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community."
(1980 Vatican Declaration on Euthanasia)

IV. Medical Assisted Nutrition and Hydration

A. The cases of Nancy Cruzan and Terri Schiavo

B. The debate and final compromise of the U.S. Bishops:

“There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.” (ERD #58)

C. The clinical reality of withdrawing nutrition and hydration is not to be put on par with starving a person to death—a lesson from the experience of hospice.

D. Interpreting the Directive of “presuming in favor.”

“Presume in favor” but can withdraw when burden outweighs the benefit. Florida Bishops on Schiavo case: “While [withdrawing nutrition and hydration] will certainly lead to her death, if this is being done because its provision would be too burdensome for her, it could be acceptable.”

E. The controversial address of Pope John Paul II in March 2004.

The Pope’s statement said that medically assisted fluids and nutrition “should be considered, in principle, ordinary and proportionate, and as such morally obligatory,” as long as it is “providing nourishment to the patient and alleviation of his suffering.”

F. The 2007 CDF response to the US Bishops’ inquiry about artificial nutrition and hydration for patients in PVS:

1. The Questions of the USCCB

a. Is there a moral obligation to administer nutrition and hydration to a patient in PVS? CDF Ans. Yes.

b. May nutrition and hydration be discontinued when there is moral certainty that the patient will not recover consciousness? CDF Ans. No.

2. The exceptions: poverty and geography; inability to assimilate; burden; discomfort.

3. Judge the moral requirement on the basis of proportion of benefit to burden from the patient’s perspective.

V. Caring for the Dying

A. Pain and suffering

1. Pain is a physiological response to stimuli and relative to the stimuli and the patient’s capacity to tolerate it.

2. Suffering is a subjective response of distress and relative to one's meaning for life.

a. Coping with suffering caused by pain.

b. Responding to suffering is tied to the meaning of life.

B. Responding to Suffering

1. Claim our mortality.

2. Being present to those who suffer.

3. Becoming a community of care

a. Ease pain

“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. . . Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person’s life so long as the intent is not to hasten death.” (ERD #61)

b. Personal presence

c. Spiritual resources