



A Guide through the Ethical and Religious Directives for Chaplains: Part Five - Care for the Seriously Ill and Dying

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*A Guide through the Ethical and Religious Directives for Chaplains:
Part Five - Care for the Seriously Ill and Dying*



A case . . .

Maria is an 81-year-old Hispanic widow who was admitted to the hospital for surgery to remove a kidney cancer. Prior to surgery, she had been able to walk with a walker. She lived with a sister who cared for her. She was able to get out of the house, and enjoyed spending time with her sister's grandson. She was mentally alert but forgetful. Maria had another sister and two brothers who were also attentive to her needs.

The surgery went well, but the postoperative course was complicated by problems from high blood pressure and diabetes. Her remaining kidney started failing and she had to begin dialysis. She wasn't able to swallow so a feeding tube had to be inserted. She aspirated from the feeding tube and developed pneumonia. Ten days after surgery, she suffered a stroke that left her paralyzed on the right side.

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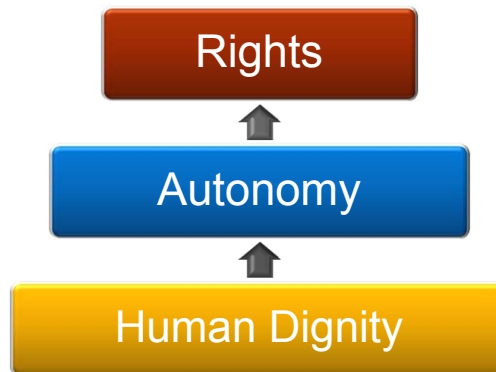
A case . . .

Despite the medical interventions, Maria continued to fail. She was lethargic and barely responsive. Her kidney function continued to deteriorate. Ulcers on her feet became worse and were difficult to manage. Maria's sisters, one of whom was durable power of attorney, met with the attending physician and requested that Maria only be made comfortable. The attending refused to remove the feeding tube saying that he "doesn't starve his patients to death." Maria's two brothers agreed with the physician. In the meantime, Maria suffered a cardiac arrest, but was successfully resuscitated and remained on a ventilator. Again, Maria's two sisters requested that treatment be stopped and that Maria only be made comfortable. The brothers objected saying "where there's life, there's hope." Five days after her first cardiac arrest, Maria suffered another. This time resuscitation efforts were not successful.

The Ethical and Religious Directives Part V: Care for the Seriously Ill and Dying

- What are the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs)?
 - A limited attempt to answer two questions:
 - What is Catholic health care? Who should it be?
(Catholic Identity)
 - In light of this identity, what should Catholic health care do?
(Moral Integrity)

End-of-Life Decisions: U.S. Point of View



Context for End-of-Life Decisions in the United States Today: Autonomy

- Many understandings . . .
 - Freedom to choose, causing one's own behavior, being one's own person.
- Legal understanding



– “No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”

➢ Justice Horace Gray,
Union Pacific R. Co. v. Botsford
121 U.S. 250 (1891)

– “The right to be left alone.”

➢ Thomas M. Cooley, *The Elements of Torts* (1888)



Context for End-of-Life Decisions in the United States Today: Technology

- Use of technology is the ordinary way that action is carried out.
- “Technological Monism”
 - All meaningful actions are technological.
 - Technological acts or omissions.
 - What nature does, its underlying causes and pathologies, is irrelevant.
 - No death is natural.
 - No natural cause is determinative unless failure to deploy technology makes it so.

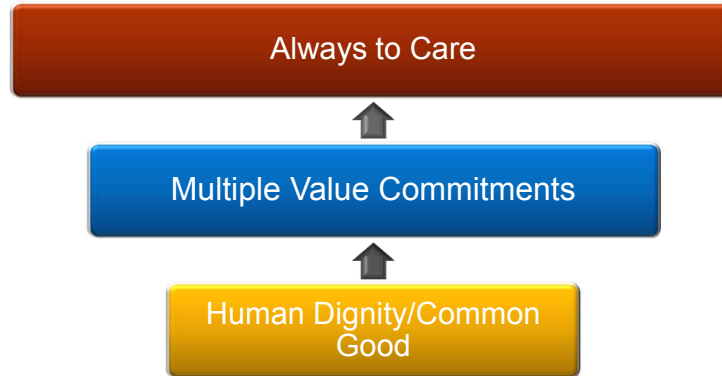
➤ Daniel Callahan, *The Troubled Dream of Life*

Context for End-of-Life Decisions in the United States Today: Technology

- “Technological Brinkmanship”
 - Pushing aggressive treatment as far as it can go in the hope that it can be stopped at just the right moment when it proves futile.
 - Saves lives
 - Disfigures dying

End of Life Decisions: Catholic Point of View

Always to care!



Part Five of ERDs: Care for the Seriously Ill and Dying

VALUE	THEOLOGICAL REFLECTION
Stewardship over Human Life	We are not the owners of our lives and hence do not have absolute power over them. We have a duty to preserve life.
Priority of Care	The task of medicine is to care even when it cannot cure. Such caring involves relief from pain and the suffering caused by it.
Community of Care	A Catholic health care institution will be a community of respect, love and support to patients and their families as they face the reality of death.
Respect for the Dying	The use of life-sustaining technology is judged in the light of the Christian meaning of life, suffering and death. One should avoid two extremes: (1) insistence on useless and burdensome technology even when a patient legitimately wishes to forego it and (2) withdrawal of technology with the intention of causing death.

Part Five of ERDs: Care for the Seriously Ill and Dying

- Decisions about use of technology made in light of ...

- Human dignity
- Christian meaning of life, suffering and death



- Avoid **two** extremes

- Employing “useless” or burdensome means
- Withdrawing technology expressly to cause death

Stewardship Over Human Life

“We are not the owners of our lives and hence do not have absolute power over them. We have a duty to preserve life.”

➤ *Ethical and Religious Directives, Introduction to Part Five*

- This, however, is a **limited** duty.
 - Human life is sacred and of great value, but not absolute.
 - Because it is a limited good, duty to preserve it is limited to what is beneficial and reasonable in view of purposes of human life.
 - Since the 16th century, among Catholic moralists it was agreed that one need only employ “ordinary” means of preserving life, but not means deemed “extraordinary.”
 - “Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good.”

➤ Catechism of the Catholic Church, par 2288

Limited Duty to Preserve Life

This view is reflected in two papal documents:



Pope Pius XII
"The Prolongation of Life"
November 24, 1957

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



Pope John Paul II
The Gospel of Life, 1995
Introduction, Section 2

"It is precisely this supernatural calling which highlights the relative character of each individual's earthly life. After all, life on earth is not an 'ultimate' but a 'penultimate' reality"

Catholic Tradition

- Ordinary and Extraordinary Means
 - Middle or mediating position
 - When death is immanent one may withhold or withdraw those treatments that "would only secure a precarious and burdensome prolongation of life."
 - *Vatican Declaration on Euthanasia*
 - » Not the equivalent of suicide
 - » Rather, acceptance of the human condition
 - No person is obliged to submit to a health procedure that the person has judged, with free and informed consent, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.
 - *Vatican Declaration on Euthanasia*

Benefit and Burden ... in the Tradition

- Benefit and burden are the key criteria for assessing whether any means is ordinary or extraordinary.
- What constitutes “benefits” and “burdens”?
- They have been understood broadly in the tradition to include not only the physical effects of a means but also overall effect on the person holistically considered.
 - “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.”

➤ ERDs, Directive 33

Benefit and Burden ... in the Tradition

- From a moral perspective the question in assessing the duty to use any means, no matter how basic, comes down to this:
 - Can the means in question improve the person’s overall condition so that he/she can pursue her or his life’s goals, at least at a minimum level, without major burdens?
 - Are the burdens of the means proportionate to the benefits?

Benefit and Burden ... in the Tradition

Francisco De Vitoria (1486-1546) makes this clear:

- "I say that one is not held to lengthen his life because he is not held to use always the most delicate foods, that is, hens and chickens, even though he has the ability and the doctors say that if he eats in such a manner, he will live *twenty years more*, and even if he knew this for certain, he would not be obliged . . ." (emphasis added).
- Lengthening life in and of itself is not the fundamental consideration.



Benefit and Burden ... in the Tradition



- Extraordinary Means according to St. Alphonsus Liguori (1696-1787).
 - Great effort
 - Enormous pain
 - Exquisite means and extraordinary expense
 - Not obliged to spend an exorbitant amount of money to conserve one's life.
 - Severe dread (*Vehemens horror*)
 - A procedure or means can be so feared that it becomes a moral impossibility.

Contemporary Retrieval of the Catholic Tradition

- Ordinary (Proportional) v. Extraordinary (Disproportional) Means
 - Benefits
 - Restoration to relative health
 - Pain relief
 - Notable increase in physical mobility
 - Return to consciousness
 - Enhanced ability to communicate
 - Burdens
 - Excessive pain
 - Great cost
 - Grave inconvenience
 - Severe Dread (*Vehemens horror*)
 - Patient-specific

Catholic Tradition: Always to Care

- In Catholic tradition, not care v. cure – but always to care
 - Often, care involves the use of aggressive interventions to cure.
 - There does come a time when such aggressive interventions are no longer care.
- The task of medicine remains to care even when it cannot cure.
 - Such caring may involve relief from pain and the suffering caused by it.
 - Importance of palliative care.
 - Importance of simply being present.

Directive 61

Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in a 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. 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. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

Implications of the ERDs: Remaining present and caring

- Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment.
- A Catholic health care institution will be a community of respect, love and support to patients and their families as they face the reality of death.
 - ERDs, Introduction, Part Five
- Catholic moral tradition not simply a “no” to initiatives such as assisted suicide but rather is a “no, but . . .”
 - A respectful alternative

Implications of the ERDs: Palliative care and pain control

- Appropriateness of good pain management, even where death may be *indirectly* hastened through use of analgesics.
 - Principle of Double Effect
 - Action, independent of its effects, must not be morally wrong;
 - The evil effect must not be intended but merely tolerated;
 - Evil effect must not be a means to the good effect for then it would be intended;
 - There must be a proportionate reason for performing the action in spite of its evil consequences.

Implications of the ERDs: Palliative care

- The respectful alternative to euthanasia and assisted suicide
 - Palliative care in the Catholic ministry context is rooted in the belief that every person is sacred gift and every human being a unity of body, mind, and spirit.
 - A 2010 *New England Journal of Medicine* article studied the care for patients with metastatic non-small cell lung cancer concluding that early palliative care not only “led to significant improvements in both quality of life and mood” and “had less aggressive care at the end of life but longer survival.”
 - Palliative care is a hallmark of Catholic health care, intrinsic to our healing mission.
 - Palliative care is also cost effective.

Directive 58

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. This obligation extends to patients in chronic conditions (e.g., the “persistent vegetative state”) who can reasonably be expected to live indefinitely if given such care.⁴⁰ 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 example resulting from complications in the use of the means employed.’⁴¹ For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

➤ ERDs, 5th edition, 2009

Medically Assisted Nutrition and Hydration

- Presumption in favor of nutrition and hydration as long as it is of sufficient benefit to outweigh burdens.



- (Medically assisted) nutrition and hydration in principle an ordinary means for one who can reasonably be expected to indefinitely if given such care.
- Morally optional when (1) cannot reasonably be expected to prolong life or (2) when excessively burdensome.

Directive 58

Advance Directives

- Patients have a right to make advance directives for their medical treatment. Directive 24

- Patients may identify in advance a representative to make health care decisions as a surrogate in the event that the person loses the capacity to make health care decisions. Directive 25
 - Should be told that they are “agent”
 - “Substituted judgment”
 - “Decisions by surrogate should be faithful to Catholic moral principles and to the patient’s intentions and values”

- Free and informed decision is to be followed so long as it does not contradict Catholic principles. Directive 28

Implications of the ERDs: POLST

- POLST
 - Physician Order for Life-Sustaining Treatment
 - Tool for translating a patient’s goals for treatment into an actionable medical order.
 - Not an advance directive
 - Intended for patients with serious advanced, progressive illness and/or frailty, whose physician would not be surprised if they were to die within the year.

- Controversies regarding POLST
 - Some bishops and Catholic Conferences are opposed while others are cautiously supportive.
 - POLST is a tool that can be used well or poorly.
 - Probably the greatest danger is to regard POLST as just another routine form to be completed and separate it from advance care planning.
 - Understand your state’s POLST legislation/policies

What are people's responsibility?

- On the part of physicians, other health care workers, patients, and their families:
 - Develop sense of limits/stewardship or resources
 - Accept mortality
 - Advance directives
- How can chaplains help facilitate the discussion?

“Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good.”

➤ Catechism of the Catholic Church, #2288

Continuing Tension in Catholic Medical Ethics

