

## **Catholic Social Teaching on End-of-Life Issues**

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### **Introduction**

The many advances in medicine during recent decades have greatly complicated the decision whether to undergo or forego medical treatment, since medicine and now save many people who would simply have been allowed to die in the past. Today many people continue to live for long periods in comatose or semi-conscious states, unable to live without technological assistance of one kind or another. This means that great care is required in applying the moral law to particular cases, and each person should consider how they will do so, and how they will ensure that they receive morally appropriate care when they are not able to decide for themselves.

The Catholic Church does not allow euthanasia for terminally ill patients. But when a patient has been diagnosed with a terminal illness, the Catholic Church believes that patients should be kept as free from pain as possible until they die a natural death with dignity in the place of their choice. Bodies of those who have died must be treated with respect, in the faith and hope of the Resurrection on the Last Day.

### **What is the church's position when it comes to pain alleviation and end-of-life care? Do dying patients have the right to adequate pain relief?**

The Ethical and Religious Directives for Catholic Health Care Services states: 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. 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.

In the Catholic tradition, the acceptance of suffering — of which physical pain is an example — can be a means of personal spiritual growth since it is related to the redemptive sufferings of Christ. He himself experienced the depths of human suffering and thus became the paradigm of unconditional love and unreserved self-giving. According to the Vatican's Declaration on Euthanasia, however says: "It would be imprudent to impose a heroic way of acting as a general rule". On the contrary, human and Christian prudence suggest, for the majority of sick people, the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semiconsciousness and reduced lucidity.

The fact that suffering can be redemptive is one of the primary reasons why the church insists on the importance of pastoral care teams in our healthcare facilities. As the directives point out, pastoral care is an integral part of Catholic healthcare, and it encompasses the full range of spiritual service, including help in dealing with pain.

### **Does the church hold that sedation at the end of life is not a treatment option?**

"If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: yes." Painkillers that cause unconsciousness require special consideration, however. We believe that a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. It is not right to deprive the dying person of consciousness without a serious reason.

### **What is the responsibility of the health care personal?**

An open dialogue with the patient, his or her proxy and family, and other health professionals is imperative and encourages the expression of diverse perspectives on these complex issues. All members of the healthcare team must be knowledgeable about the fundamental principles of ethics that may guide analysis of complex decisions such as these.

### **What is the role of the family?**

As in so many other issues involving a patient's condition, the family can play an important role here as well. They should discuss the degree of pain and its location with the competent patient and gather some precise data, which they should then report to the proper caregivers. If the patient is not competent, members of the family should discuss the possible pain issue with appropriate members of the healthcare team.

### **What the Health System can do when the family can't accept the withdrawal of life-sustaining treatments, and the patient isn't conscious?**

Situations such as these make it clear why every patient should have advance directives, such as durable power of attorney for healthcare. That way, he or she makes his or her wishes known while still conscious and able to do so. When an unconscious patient has not left any advance directives and has not designated anyone to be his or her proxy, end-of-life decisions can become very complex. In situations such as these, the pastoral care person can be of considerable assistance.

### **What is the role of the Pastoral Care Minister (Chaplain) when the family members disagree about the end-of-life decisions?**

He or she should attempt to have a meeting with them to bring about some compromise or alternate form of treatment. Should they not wish to meet with such a person, some effort should be made to get the whole team together to resolve the problem. The pastoral care minister might be able to initiate such a meeting with the caregiver in charge and should attend if possible. In most cases a solution can be reached, but it demands patience, imagination, and the ability to facilitate team discussion with the family. Some training in conflict resolution is often helpful.

### **What is minimum assistance that a dying person can receive?**

The natural law requires that all ordinary means be used to preserve life, such as food, water, exercise, and medical care. The Church has recognized that the human beings are not morally obligated to undergo every possible medical treatment to save their lives, even very ordinary ones. Such as 1. Unduly burdensome. 2. Sorrowful to a particular person such as imputation. 3. Beyond the economic means of the person and 4. Those that only prolong the suffering of a dying person. The patient can choose them or not, but they are not morally obligated to do this.

### **What the CEC States about discontinuing medical procedures?**

2278 Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.

2279 Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.

### **What are the human actions that the church doesn't allow?**

#### **1.- The Euthanasia**

2276 Those whose lives are diminished or weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible.

2277 Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons.

It is morally unacceptable. Thus, an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator.

The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.

## **2.- The Suicide**

2280 Everyone is responsible for his life before God who has given it to him.

It is God who remains the sovereign Master of life.

We are obliged to accept life gratefully and preserve it for his honor and the salvation of our souls.

We are stewards, not owners, of the life God has entrusted to us.

It is not ours to dispose of.

2281 Suicide contradicts the natural inclination of the human being to preserve and perpetuate his life.

It is gravely contrary to the just love of self.

It likewise offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations.

Suicide is contrary to love for the living God.

## **3.- Dysthanasia**

Dysthanasia is the term for futile or useless treatment, which does not benefit a terminal patient. It is a process through which one merely extends the dying process and not life *per se*. Consequently, patients have a prolonged and slow death, frequently accompanied by suffering, pain and anguish. When one invests in healing a patient who has no chance of cure, s/he is actually undermining the person's dignity. Advanced measures and their limits should be assessed to benefit the patient and not to hold science as an end in itself.

### **Biography**

1. Ethical and Religious Directives for Catholic Health Care Services, National Conference of Catholic Bishops, Washington, DC, 1995, n. 61.

2. Sacred Congregation for the Doctrine of the Faith, Declaration on Euthanasia, St. Paul Books & Media, Boston, 1980, p. 10.

3. Declaration on Euthanasia, p. 10. For the full text of Pope Pius XII's talk to the anesthesiologists, see *The Catholic Mind*, vol. 55, 1957, p. 260.

4. James Keenan, "No Case for Physician-Assisted Suicide," *America*, November 14, 1998, p. 16.

5. Ezekiel Emanuel, "Euthanasia: Historical, Ethical, and Empiric Perspectives," *Archives of Internal Medicine*, September 10, 1994, p. 1900.

6. Catechism of the Catholic Church 2278 and 2279

7. Pessini L. Questões éticas-chave no debate hodierno sobre a distanásia. In: Pessini L, Garrafa V, organizadores. *Bioética: poder e injustiça*. São Paulo: Loyola; 2003. p. 389-408.

8. Carvalho RT. Legislação em cuidados paliativos. In: Conselho Regional de Medicina do Estado de São Paulo. *Cuidado paliativo*. São Paulo; 2008. p. 613-29.