

## End-of-life: a Catholic view

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This is the sixth Viewpoint in a series about end-of-life issues for different religions

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Catholic bioethics is not a fully monolithic structure. Different theological and philosophical methodologies have resulted in differences of opinion on issues such as birth control, sterilisation, reproduction, and abortion. However, more common ground is found on end-of-life issues. The Catholic understanding of sickness, suffering, and death is grounded in a belief in Jesus Christ who, as the incarnation of God, suffered, died, and was resurrected. In light of this faith and hope for an afterlife, Catholics accept that although an effort must be made to eliminate sickness, suffering, and death, these things can also have a positive meaning. The belief that God participates in the human condition grounds Catholic values and positions on end-of-life issues. Catholic bioethics therefore has its source both in faith and in the ability of human reason to interpret scripture and, as Vatican II directed, to read the “signs of the times” in applying the teaching of the Church to contemporary situations.<sup>1</sup> In other words, Catholics should remain attuned to the message of Christ through history in attempting to “do the right thing”.

In Catholic bioethics, two basic human values<sup>2</sup> ground all others: human dignity, and the interconnectedness of every individual. The value of dignity of the individual arises from the belief that life has intrinsic worth because people are created in the image and likeness of God. Respect for human life results from this principle. Catholics believe that people are stewards, rather than owners, of their own bodies, and are accountable to God for the life that has been given to them, and for this reason life is said to be sacred.<sup>3</sup> However, life is not an absolute good to be preserved at all costs, but is subordinated to the good of the whole person. *Gaudium et Spes*,<sup>4</sup> one of the documents of Vatican II, makes the point that the dignity of the human person lies above all in the fact that he or she is called into a relationship with God. As social beings who are connected to each other in society, we also share a responsibility for one another.

All other values are derived from these two. The value of stewardship and creativity holds that we are accountable to God for the life that has been given to us. Belief in the value of the common good calls us to promote a just social order. This just order demands that we remain true to the value of charity or solidarity, in which we have a responsibility to respond to others in need, in particular the poor. This responsibility requires a commitment not only to the poor in our midst but also to those throughout the world. However, the huge gap between the rich and the poor of the world is widening, in large part due to the debt owed by developing countries. In 1960, the wealthiest fifth of the world's population enjoyed an income that was 30 times greater

than that of the poorest fifth, but a few years ago it was more than 80 times greater.<sup>5</sup>

This situation has implications for all aspects of health care, including end-of-life care, research ethics, priority setting, women's health, child health, mental health, and rehabilitation ethics.<sup>6</sup> Sadly, unlike most of these issues, quality of end-of-life care has not been addressed at the global level. Solidarity with the poor and a commitment to social justice require that health systems engage in interventions that can lead to improvements in the global problem of end-of-life care. Some of these interventions could include “culturally specific educational programs for public health workers and the public; population based strategies to destigmatise death . . . and changes in social policies in relation to care for orphans”.<sup>7</sup> Caution is needed here to avoid the pitfall of applying the perspectives of developed countries to developing nations. Rather, any approach that attempts to address end-of-life care in developing countries must include indigenous people and a sensitivity to their own ethnic and medical systems.

The impetus and foundation for this commitment to the poor lies in a notion of justice that is grounded in love and an adherence to the message in the Gospel of Matthew (25:40): “. . . in so far as you did this to one of the least of these brothers of mine, you did it to me”.

Belief in the values of human dignity and interconnectedness has implications for decisions at the end of life. The value of interconnectedness implies a relationship between physician and patient that is covenantal rather than contractual. It suggests a process of decision making that is multifaceted and goes beyond a strict adherence to an individualistic autonomy, while ensuring the patient's ongoing participation in making choices that affect his or her life. The value of human dignity and therefore respect for human life has implications relevant to the alleviation of pain and to the issues of withholding or withdrawing of treatment. The two values of the common good and charity require an awareness of the needs of people other than the patient when addressing the issues of patients' demands. The focus of this article will be on how the values of human dignity and interconnectedness affect end-of-life care. I will begin with a discussion of how interconnectedness affects the physician-patient relationship, and argue that the notion of covenant best describes the ideal relationship between physician and patient. Second, I will discuss how the values of human dignity and respect for human life affect the questions of pain and suffering and the withholding or withdrawing of treatment. I will conclude with some brief suggestions for resolution of conflicts in areas where patients' demands cannot be met.

### The notion of covenant

Medicine today has become focused on the rational and intellectual, with emphasis on outcomes and evidence. Bioethics over the past 25 years has focused on the ordering of principles and the development of rules, but such development is inadequate, in that it has “not offered much insight into those ordeals confronting patients (and sometimes practitioners) that do not wholly admit of solution”.<sup>8</sup> Writers such as William F May believe that these problems need to be faced, rather than solved, since “Moral reflection about such events does not simply trace back to a brace of sometimes conflicting principles; it forces meditation on the human condition; it probes one’s deepest convictions; it may even unsettle one’s habits; it asks of the agent the mobilization of resources, some of them already in place but untested; others, as yet, unbidden”.<sup>8</sup>

Whereas the notion of covenant takes its roots in the biblical context, it also figures prominently in the Hippocratic tradition in which the physician has, first, a duty to his or her patients; second, a “covenantal obligation to one’s teacher and . . . family; and third, sets both within the context of an oath to the gods”.<sup>9</sup>

Respect for the value of interconnectedness and a focus on covenant demands that the physician and patient enter into a relationship of trust with each other. The patient’s trust of the physician is in fact an act of faith in the good intentions of the physician. An ethic of trust calls the physician to enter into a relationship with the patient in order that he or she might begin to understand what the patient’s wishes might be. This interaction clearly transcends the limits of a contractual model of physician/patient relationship; rather, it demands a covenantal relationship between both participants, who see each other as a “gift”, with the ensuing obligations that this implies.

One of the necessary conditions that must be met for a covenantal relationship, which holds true to the value of interconnectedness, is trust. However, trust between physician and patient is complex. Patients since the time of Hippocrates have been asked to trust their doctors, but only recently, perhaps due to the arrival of the legal doctrine of informed consent, have physicians been asked to trust their patients by having conversations with them about their treatment options. For conversation to be meaningful, authors like Jay Katz in his book *The Silent World of Doctor and Patient*<sup>10</sup> propose that we must differentiate between trust that is blind and trust that is earned following an acknowledgment that one person does not hold all of the answers. This understanding is crucially important in discussions around end-of-life issues, in which prognosis is often uncertain. Katz suggests that the proponents of patient self-determination have not appreciated or fully understood the difficulties in expression of uncertainty. In fact, as he notes, the only specific advice on conversation in the Hippocratic Oath “speaks against disclosure”.<sup>10</sup> Similarly, Katz holds the

opinion that physicians of ancient Greece would have found the notion of shared decision making unnecessary “because they viewed doctor and patient as united through *philia*, friendship, which made their objectives one and the same”.<sup>10</sup> In covenantal relationships, on the other hand, the objectives of each party are not viewed as identical. Catholic bioethics places a strong focus on the informed and voluntary wishes of the capable patient in determining which treatments should be given or withheld. In view of the belief that human beings are created in the image of God, each person has an intrinsic tendency towards the good. However, every individual is also endowed with freedom and therefore can make choices not only for the good but also for things that are not good. The dignity of the human person, as one who is oriented toward God, requires him or her to make choices for the good within a free and informed conscience.<sup>4</sup> In view of the proposed covenantal approach to the physician-patient relationship, the physician, capable patient, and anyone who the patient wishes to participate, together should make the decision as to which treatment plan is best aligned with the values of the patient. If the patient is not capable of making these decisions in partnership with their physician, then family members or substitute decision makers are called upon to make treatment decisions in the best interests of the patient.

### Withholding or withdrawing treatment

Since at least the 16th century,<sup>11</sup> Catholic theologians have made a distinction between ordinary and extraordinary measures. This position holds that while patients are obliged to choose ordinary methods for preserving life, they have the choice as to whether or not to accept extraordinary methods. A common definition of these terms is one proposed by Gerald Kelly: “Ordinary means of preserving life are all medicines, treatments, and operations which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain or other inconvenience . . . Extraordinary means of preserving life . . . mean all medicines, treatments, and operations, which cannot be obtained without excessive expense, pain or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.”<sup>12</sup>

It seems that the term “ordinary” was originally used to mean “what is medically customary”. However, in today’s medical practice, in which many measures such as cardiopulmonary resuscitation are routinely used in dying patients, many extraordinary measures are in danger of becoming customary. Again, the free and informed choice of the patient and family in collaboration with the treating team and the medical indications should inform and guide the process.

It has also become clear that the expressions cannot be defined in terms of categories of treatment; there is not one list of ordinary procedures, and another list of extraordinary procedures.<sup>13</sup> Mechanical ventilation, for

example, could be ordinary at one stage in an illness, and extraordinary at a later stage as the illness advances. Although the physician has a right and an obligation to provide the patient and family with information about what is medically possible, what is medically indicated, and which treatment provides the best outcome in terms of a risk-benefit analysis, it is primarily the patient and family who have the right to determine what is or is not ordinary or extraordinary from an ethical point of view. For patients, issues of pain and suffering play a crucial role in determining whether or not a procedure should be used, not the fact that the procedure has become routine.

### Pain and suffering

The issue of pain and suffering is important to Catholic bioethics. However, it is prudent at the outset to make the distinction between the two. Pain is the physical discomfort that often accompanies illness, whereas suffering refers to the existential anguish experienced by patients when they come face to face with the loss of all that they have hoped for in the future. However, the two issues are connected. Authors like Ira Brock<sup>14,15</sup> have pointed out that untreated physical pain can lead to an increase in suffering. Patients whose pain is untreated often experience feelings of abandonment, which in turn increases their suffering. While Catholic bioethics believes that the experience of pain and suffering is not without meaning, this belief does not imply that pain relief should be withheld in order that a patient might come to understand the redemptive nature of suffering. Control of physical pain is a patient's right and not a privilege that is meted out to those who we feel deserve it. Although personal growth may occur through suffering, the Catholic tradition does not present pain and suffering as goods in themselves. As early as the 1950s, a group of anaesthesiologists asked Pope Pius XII whether or not pain relief should be offered to a patient, if in so doing the patient's life might be unintentionally shortened. The Pope replied that painkillers should be offered if no other means existed, even if this led to unconsciousness and the inability to fulfil one's moral duties and family obligations. This judgment reflects the principle of double effect, which has a critical role in the care of the dying and specifies that "An action with 2 possible effects, one good and one bad, is morally permitted if the action: (1) is not in itself immoral, (2) is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect even though it may be foreseen, (3) does not bring about the possible good effect by means of the possible bad effect, and (4) is undertaken for a proportionately grave reason".<sup>16</sup>

In Pellegrino and Thomasma's book, *Helping and Healing: Religious Commitment in Health Care*,<sup>17</sup> the authors point out that when patients suffer, they experience a sense of their own vulnerability and finitude, as well as a disruption and fracture of their own person and sense of community. As a result, while the experience

of suffering can be an opportunity to experience God, this experience occurs through an encounter with another person. Since human beings are interconnected, human flourishing comes to fruition in community and not in isolation, especially in the experience of illness. However, in illness, the patient has specific needs that can only be fulfilled by the healer. As a result, treating pain, holding a patient's hand, administering chemotherapy, and performing surgery have the potential to become moments of opportunity for the experience of God, according to Pellegrino and Thomasma. As such, the practice of medicine takes on the nature of sacrament, the visible sign of the invisible presence of God.

According to Pellegrino and Thomasma,<sup>17</sup> the sense of finitude, vulnerability, loss of self, and destruction of a person's normal life that is experienced in illness can be transformed when a sacramental approach to medicine is taken. They note that the art of medicine is a human endeavour that imitates the beauty and creativity of God. In experiencing this art, the patient experiences transcendence rather than despair. In this way finitude is transformed. When physicians treat patients regardless of how the patient might have contributed to their own illness, and when they respond to the cry of the patient for help, vulnerability is overcome. When an attempt is made to treat the whole person, rather than focusing on bodily functions, personhood is restored. Finally, when the focus of medicine is to place the patient, even though he or she may be dying, back into the community where he or she has the opportunity to experience the love of those around him or her, the sense of disruption of life is attended to. All these components of healing function as signs of God's grace. However, "the clinical event first and foremost becomes a saving event if the intention of the healer is to imitate what Christ did as a sign of sacrificial love, a love that joins the participants together with Christ."<sup>17</sup>

Respect for the dignity of the human person reminds us that physical health is only one good among many and, in itself, is not the highest good. The Catholic tradition believes that God has created the human person within the context of a destiny that lies beyond the earthly condition.<sup>4</sup> As a result, for Catholics, the process of dying is more than a medical crisis. While dying may provoke feelings of fear and abandonment it is also a time for remembering both the joyful and the painful moments of one's life. It is therefore an opportunity for celebration as well as forgiveness and reconciliation. As a result, spiritual support is crucial. The presence of the chaplain and priest should be offered to patients as part of their ongoing care during the process of dying. The sacraments become of particular importance at this time because of the need of patients to be nourished and strengthened in their faith. In particular the "sacrament of the sick", or "extreme unction", is not only a sacrament for patients who are about to die, but also for those who are perhaps proceeding to the end of their lives due to illness.<sup>18</sup>

**Panel: Summary of major points**

- 1 Life is a sacred gift from God and has intrinsic worth and dignity
- 2 Bodily life is not an absolute good to be preserved at all costs
- 3 God participates in the human condition
- 4 Understanding of sickness and death is grounded in a belief in Jesus Christ who as the incarnation of God, suffered, died, and was resurrected
- 5 While attempts must be made to alleviate sickness and suffering, these experiences can have a positive meaning
- 6 Two basic human values—human dignity and the interconnectedness of every individual—ground all other values
- 7 The value of stewardship and creativity holds us accountable to God for the life that has been given to us
- 8 The value of the common good calls us to promote a just social order
- 9 The value of charity or solidarity demands us to respond to others in need, in particular the poor
- 10 The notion of covenant best describes the ideal relationship between physician and patient
- 11 The importance of the sacraments and the nature of medicine as a sacrament

Sadly, for some people the journey through illness is more an experience of terror than one of entering into the mystery of life and death. When this happens, many families and patients respond by demanding treatments that not only are medically futile but in fact are not in keeping with their own personal values or religious beliefs. Although respect for human dignity requires an understanding of the patient's values and the fostering of free and informed choice, it does not necessitate blind obedience to demands that are not beneficial or may even be harmful. However, a response that focuses on legal rights and obligations is a pitfall to be avoided. Medical practice must operate within the law, but it should not be reduced to the law. Christian justice does not operate within a set of abstract principles or apart from the human condition. Neither does it focus on what one is owed. Rather, it offers a way of love shown to us by Christ. This provides direction in situations of conflict.

A covenantal approach to care of the dying requires an ongoing commitment of each party to come to an understanding of the other's position. With dying patients who are Catholic, a priest or chaplain can be of invaluable assistance. Unreasonable demands on the part of patients or families often arise more out of a deep sense of anxiety, grief, and unfinished business rather than a philosophical position on autonomy and justice. As Henri Nouwen writes, the deepest fear experienced by the dying person and family is rejection: "Indeed we can be healed from our fear of death, not by a miraculous

event that prevents us from dying, but by the healing experience of being a brother or sister of all humans—past, present, and future—who share with us the fragility of our existence".<sup>19</sup>

In conclusion, this discussion has pointed out some of the main components of Catholic bioethics that affect end-of-life care (panel). The value of interconnectedness results in a relationship between physician and patient that is like kinship and demands ongoing conversation and trust. The value of human dignity results in an approach to pain and suffering that requires appropriate medical intervention, participation in the patient's journey, and an awareness that the process of dying is more than a medical event concentrated at the end of life. Here the importance of the priest or chaplain in addressing the spiritual and religious needs of the Catholic patient has been raised. Of crucial importance is an acceptance that physicians are called both to cure and to care. For Catholic bioethics, care involves a recognition of the fragility and vulnerability of every human being as one who has first been loved by God and therefore deserves our total commitment.

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