Do No Harm:

A Guide to Human Dignity and Morally Sound End-of-Life Care

by

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Introduction

There are many terms, such as "dignity," "artificial," and "extraordinary," which can perplex people who are faced with making decisions on behalf of loved ones who suffer long term debilitative and/or potentially fatal illnesses or injuries. Coping with these situations is never easy. However, it is imperative that the decisions made on behalf of loved ones truly protect and promote their human nature and intrinsic dignity, while also respecting their freedom. This is a daunting task; however, it is also quite achievable.

This booklet provides foundational categories of Catholic moral thought, key directives, helpful principles, and relevant distinctions upon which one can rely when making the decisions that sometimes become necessary when caring for loved ones who may be immersed in such illness or disability. An absolutely clear answer to every possible end-of-life or long-term care scenario is impossible. However, there are clear distinctions which enable one to make headway when navigating the tempestuous seas of end-of-life care.

Human Nature & God's Law: Do No Harm

In order to distinguish correctly between good and bad medical interventions within end-of-life contexts, one must first understand the inclinations or parameters of human nature. After all, medical interventions are designed to help human patients. Bearing in mind both the Hippocratic Oath and Catholic moral thought, if a primary concern is "first do no harm," then of even greater concern is to ensure that human nature is not violated in any attempt to do good.[1]

Human nature can be sketched via five basic natural inclinations or parameters: (1) the inclination to the good; (2) the inclination to the knowledge of truth; (3) the inclination to self-preservation; (4) the

[1] Harvard Classics, vol. 38 (Boston: P. F. Collier & Son, 1910). <http://www.cirp.org/library/ethics/hippocrates/>. This Oath has been modified many times. For an exemplary Christian version see W.H.S. Jones. The Doctor's Oath (Cambridge: Cambridge University Press, 1924) 23, 25. <http://www1.umn.edu/phrm/oaths/oath3.html>.

inclination to live in society; and (5) the inclination to marriage and the rearing of offspring.[2]

God builds these five inclinations into every human being. That is to say, these inclinations cannot be separated from the term "human being." Therefore, moral reasoning must not violate any of these inclinations if one is truly to "do no harm." When any of these inclinations is directly violated, the person's nature is directly violated down to the depths of his or her being. For this reason, an act that directly violates one or more of these natural inclinations is always wrong and can never be justified, regardless of terrible circumstances, and no matter how good the intention which precipitate the action. For practical purposes, these inclinations serve as parameters not to be violated.

Again, God builds these parameters into every human being. They are the inclinations out of which natural law, permanently etched into the human heart, is rightly understood to amount to human participation in God's law. When a person acts, or chooses not to act, in direct violation of one or more of these parameters, both the law of God and the true best interest of the patient are violated.

These parameters help one ensure that no moral absolutes, such as "thou shall not kill," are violated in the name of healthcare. Even when immersed in terrible circumstances involving disfigurement, pain, or loss of control over basic bodily functions, to name but a few, these parameters serve as a reminder that directly hastening the death of a patient is never justifiable, regardless of any apparently good intention. They must not be breached in the name of concepts such as "death with dignity."

And yet, what about the struggling patient who may have achieved great professional or personal success, but who now may be reduced to being fed by spoon or, worse yet, a tube? Where is the human dignity in such cases?

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[2] Fr. Servais Pinckaers, O.P., The Sources of Christian Ethics, trans. Sr. Mary Thomas Noble, O.P. (Washington, D.C.: Catholic University of America Press, 1995) 407.

Natural Inclinations (Parameters) Applied[3]

Natural Inclinations	Application Within End-of-life Contexts
Inclination toward the good	There is a hierarchy of goods; thus, spiritual goods such as prayer, blessing, and sacraments ordered toward ultimate union with God are very important along with other goods such as comfort care and proper nutrition and hydration. Both knowledge and virtue are needed in order to make good choices; pain in its varied forms can and ordinarily should be relieved, but not via suicide or euthanasia, which disregard the inclination to self preservation (life), which is the foundation of the other goods.
Inclination to know the truth	Correct prognoses and diagnoses are required for well-reasoned decision-making. Any so-called "reasonable" decisions that directly disregard the sanctity of human life necessarily break from right reason (*recta ratio*) based in objective truth.
Inclination to self-preservation	The most basic of all inclinations, it drives desire for wellness at all levels, including the desire for continuation of life; it is presupposed in a logic to life (nothing exists primarily to be destroyed); it is the prerequisite for all other inclinations and freedoms. This inclination renders suicide and euthanasia contrary-to-human-nature and to right reason.
Inclination to live in society	Suffering, in one form or another, is central to the human experience; relationships between patient and friends/family can reduce desire for suicide; physician-assisted suicide and euthanasia affects associates of not only the patient, but also of the physician.
Inclination to marriage and rearing of offspring	Extends the individual inclination to self-preservation to a specific level in order to avoid functional extinction; the extension of life via the rearing of children subliminally precludes choices, such as suicide and euthanasia, that would contradict this vitally necessary inclination.

[3] Ibid. 405-456.

Attributed and Intrinsic Dignity: Can Human Dignity be destroyed by Illness or Disability?

According to Franciscan friar and physician Daniel P. Sulmasy, humans have two types of dignity:[4] Attributed dignity and intrinsic dignity. Attributed dignity can be gained and lost. For example, the chief of surgery at a given hospital has attributed dignity in accord with her position. This is both a dignity that she lacked prior to becoming chief of surgery, and a dignity that she will eventually lose. If attributed dignity is understood to be the sole aspect of human dignity, then one might logically hold that if the chief of surgery suffers a significant and permanent loss of rational capacity, her dignity will have been greatly reduced, if not completely lost. In recognizing this possibility, one may posit that she should be allowed to plan ahead for such a "loss of dignity" by signing an Advance Medical Directive enabling someone to help her end her "undignified" life. This line of thought proceeds from a far-too-narrow account of human dignity, in which the absence or existence of a patient's dignity is determined by another.

Although a permanent loss of rational capacity would occasion a tremendous loss of attributed dignity, intrinsic dignity always remains. All human beings are created by God in His image, loved by God as His children, and called by God to eternal union with Him. God endows all humans with equal dignity as His children. Of course, as tragic as is a tremendous loss of attributed dignity in a loved one because of illness or disability, the proper response is to strive intelligently and lovingly to help that person encounter God's love in accord with her God-given, intrinsic dignity. This Love of God is made present and tangible through each person who actively provides care for a suffering loved one. While attributed dignity can and will be lost, it is easy to see that what remains is an equally real, and far more permanent intrinsic dignity, which is bestowed by God upon every person.

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[4] Br. Daniel P Sulmasy, O.F.M., MD, PhD, "Dignity and Vulnerability," The Catholic Health Association of the United States 2003 Physician Leader Forum, Catholic Health Association, 2004. To obtain a copy of this 39 minute oral presentation and other educational resources log on to CHA's website www.chausa.org or contact CHA's order processing office at (314) 253-3458. See also Fr Christopher M Saliga, O.P., RN. "Nutritional Support and Human Dignity within the End-of-Life Context. Catholic Exchange: Catholic Bioethics: Life and Death. Right and Wrong. 24 Oct 2008. <http://bioethics.catholicexchange.com/2008/10/24/90/>.

Intrinsic Dignity & Attributed Dignity[5]

Intrinsic Dignity	Attributed Dignity
Equally proper to each human being as full member of the human species from the point of conception through natural death	Extrinsically accorded to persons based upon physical qualities, including intelligence, independence, and functionality; rooted in society ("worth") and the individual ("self-esteem")
Absolute; cannot be lost; basis for "sanctity of life" reasoning	Relative; transient; can be lost; can be unattainable in the context of illness or disability; a basis for "quality of life" reasoning
Baseline point of equality between humans regardless of disability or illness	Various points of inequality; can give rise to admiration, compassion, beneficence
Foundation of all universally inalienable, unconditional rights	Foundation for privileges and local, conditional rights
Grounded in God's unconditional love for each human being; God is the gift-giver of human life.	Edifies, but is not necessary to, the good life; basis of the idea of "quality of life," which can be lost; can impel patients to seek termination of life when things are "bad"
The human being is an end in him/herself; intrinsic value	Human beings seen as means to other ends; extrinsic value; "usefulness" in society
Sees all human beings as persons; Subjects worthy of rights from conception forward	May be used to distinguish between non-personal human beings and personal human beings based upon presence or absence of key attributes/indicators

[5] Ibid.

Action, Intention, & Circumstance: Do No Harm & Do Good.[6]

Having seen that no human being exists completely devoid of dignity, and understanding the parameters of human nature which may not be violated, how, then, can one make proper, moral choices for loved ones in the midst of difficult circumstances which can render moral intuition unreliable, especially when clouded by stress and heightened emotions?

There are three sources of human action by which one is equipped to do good for loved ones who need care. They are: (1) the action, (2) the intention, and (3) the circumstance. Most people today have no problem understanding what "intention" and "circumstance" mean. The "action," on the other hand, leaves most, including numerous doctors and nurses, in the dark.

Everyone is familiar with the phrase "the end does not justify the means." This is crucial: If the action is bad in and of itself, then neither good intentions nor terrible circumstances can make the action good. On the other hand, an action that is defined as acceptable in and of itself can become a morally bad action by either bad intention/s or wrong circumstance/s. The natural inclinations sketched out above enable one rightly to identify whether an action can never be taken or might sometimes be taken. Depending upon the set of circumstances, the action must be deemed either prudent or imprudent with regard to facts such as diagnosis, prognosis, psychological tolerance, other care options, etc.

Let us begin by briefly considering how circumstances–those things that surround or frame the action–can render an objectively good action imprudent. Consider the circumstance of post-operative care involving a concrete need for excellent pain management/relief. Within post-operative pain management, prescribing Percocet, which consists of both

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[6] Catholic Health Care Ethics: A Manual for Practitioners, *2nd Edition*. Ed. Edward J. Furton with Peter J. Cataldo and Fr. Albert S. Moraczewski, O.P. Philadelphia, PA: National Catholic Bioethics Center, 2009. 9-12.

a powerful narcotic and Tylenol, might make giving additional Tylenol imprudent, even though the patient complains of breakthrough pain.

Bearing in mind the concrete bad effects that Tylenol has on the liver when given in doses too high, if the upward limit of a safe Tylenol dosage has been reached, this otherwise objectively good act of comfort becomes very bad in this circumstance, because too much Tylenol can result in a lethal blow to the patient's liver, a vital organ without which the patient cannot live. Thus, it is clear that an individual objectively good act, such as one of comforting a patient with Percocet, can, based upon circumstance/s, become very bad, even deadly. The objectively good action becomes imprudent: too much Tylenol is very bad for the patient.

To use another concrete example, the act of giving a much-higher-than-normal dose of a powerful narcotic, such as morphine, with the intention of permanently ending the patient's suffering by hastening his death, amounts to an act of euthanasia.[7] Bearing in mind the previously summarized parameters of human nature built into every human person by God, euthanasia is never morally acceptable because it directly violates the natural inclination (parameter) to self-preservation, or life. For this reason, euthanasia is rightly called *contrary to human nature* (also called "intrinsically evil" or "objectively evil"). Although the intention to end the patient's suffering is good, and the circumstances may be quite terrible, directly killing a patient to end suffering is *always wrong*. This is a moral absolute that binds all mankind.

Of course, many medical actions have mixed effects. In end of life contexts, these mixed effects can make morally sound decision-making quite difficult and distressing. Fortunately, there is a principle by which one can systematically work through such decisions in order to uphold the God-given natural inclinations and honor the intrinsic dignity of a loved one, while prudentially providing them with the best possible care.

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[7] Congregation for the Doctrine of the Faith. Declaration on Euthanasia. 5 May 1980. Vatican Web Site 06 Mar 2010 <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html>.

The Principle of Double Effect

The principle of double effect (PDE) is a tool by which one analyzes whether or not a proposed medical action, despite its bad side-effects, can be taken in hope of obtaining a well-intended, good outcome.[8] For example, the PDE equips us to analyze more fully whether or not a morphine dose can be increased without committing the objectively evil act of euthanasia even when death is a real risk.

As regards the act in and of itself, the first of the five criteria of the PDE must be met. Simply put, **the act must, in itself, be good or morally neutral.**[9] As always, keeping in mind the parameters of human nature, it makes perfect sense that this first criterion must be met before considering the other criteria of the PDE. After all, if the action directly violates human nature, as is the case with euthanasia, then there is no reason to consider the other four criteria. *Not even the most heartfelt good intentions or terrible circumstances can justify the use of means which are objectively contrary to human nature*.

Not all pain management actions are euthanistic. In fact, pain management and many other forms of palliative care are good. So long as the patient's inclination to self-preservation is not directly violated, any number of palliative actions can, and often should, be taken. Writhing in pain is not good. Being comforted certainly is good.

As regards the second criterion for considering PDE, the **intention** of the person acting on behalf of a patient must be that **the good effect or outcome must be directly intended, while the bad effect or outcome is foreseen but is not intended**. Again, pain management, as a true palliative action, is morally good. While there are problematic side effects involving the use of narcotics such as morphine, there are also excellent results. Increasing the level of morphine in order to decrease pain is frequently the right thing to do. As long as doing so is not designed to

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[8] For concise and accurate explanation of the PDE see: National Catholic Bioethics Center, Ethical Principle in Catholic Health Care: Selections from 25 years of Ethics & Medics. Edward J. Furton and Veronica McLoud Dort, eds. (Brighton, MA: National Catholic Bioethics Center, 1999) 81-84.

[9] Ibid.

kill the patient, in order to alleviate suffering permanently (euthanasia), and even though the increase in dose may hasten the patient's demise, the dose can sometimes be increased to achieve the good of a patient's comfort.[10]

Having considered (1) the act in and of itself in order to determine whether or not it is, in fact, contrary to human nature and thus never good regardless of good intentions or terrible circumstances, and (2) the intentions in order to ensure that an objectively good or neutral act is not rendered immoral by bad intentions, one must carefully consider the final three PDE criteria, and the circumstances surrounding the action. The following three criteria must be met: **the good outcome is not brought about by means of a bad effect**, or "good ends don't justify bad means;" **the good outcome is well proportioned to the problematic side effects**–in other words, the action is medically and morally prudent as the next course of action; **the good effect can only be achieved alongside, but not by means of, the bad effect**–here a true distinction must be made between "effects" and "side effects."

Increased dosage of the powerful narcotic morphine causes depressed breathing. This is a side effect which can hasten the death of the patient, but which in no way helps to achieve a state of acceptable comfort (pain management).[11] Because depressed breathing is not a means of achieving comfort—the desired good outcome—it is truly a side effect of the use of morphine as a form of comfort care. Thus, even though increasing morphine will probably depress breathing, doing so may prove to be morally acceptable for a particular patient, if the PDE criterion that **the good outcome is not brought about by means of the bad effect**

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[10] United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Healthcare Services, 4th ed., (Washington, DC: United States Conference of Catholic Bishops, 2001). <http://www.usccb.org/bishops/directives.shtml#partfive>. Directive 61 states: "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." This is consistent with CDF, *Declaration on Euthanasia*. Part IV. 1980. <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html>.

[11] Morphine has other problematic side effects as well. Here, just one of these is considered in order to demonstrate concisely how to analyze the morality of an action which has both good and bad effects.

has been met. The next step would be to ensure that using morphine is truly prudent.

When asking **whether or not the good outcome (comfort) is proportionate to the problematic side effect (depressed breathing)** further questions should be asked regarding how bad the discomfort is for a given patient, and whether or not there are other options which might increase comfort without risky side effects such as depressed breathing. In other words, one must consider whether the care being offered is the best option for achieving the excellent outcome of increased comfort in this case. Is the care offered the most prudent next step in a course of palliative care? If so, one must then consider the final criterion of the PDE.

Asking **whether or not the good outcome (comfort) can only be achieved alongside, but not by means of, the bad effect** ensures that the bad effect is truly a "side effect" that does not enter into the intentions of the person taking the action. Again, since depressed breathing is in no way related to increased comfort (i.e. decreased pain), it must be in no way intended, for example, as a means of hastening death, but merely foreseen as a problematic and regrettable side effect. If all five criteria have been met, the Morphine dosage can be increased.

Having considered two morally opposed actions–euthanistic increase of morphine on the one hand and a truly palliative increase of morphine on the other— it is clear that the same actions, though behaviorally the same, are not morally equivalent. Proper identification of morally acceptable versus morally unacceptable actions can be accomplished by properly grounding each action in full respect for: (1) parameters of human nature (natural inclinations); (2) *intrinsic* dignity which is permanent and more profound than attributed dignity; and (3) analysis of the act in question via the principle of double effect (PDE), the intentions of the one administering care, and the circumstances which surround or frame the act in question.

How to Proceed When Considering the Principle of Double Effect (PDE)[12]

Systematic Moral Analysis	PDE's Five Criteria with correlative Questions
Step A: *The Act in and of itself*	**The action is good or at least morally indifferent.** Does this action directly violate human nature (e.g. euthanasia, assisted suicide, direct abortion, rape, murder)? If so, the action absolutely cannot be taken. If not, proceed to Step B.
Step B: *Intention*	**The good outcome is directly intended and the bad effect is foreseen but not intended.** Is the bad effect actually what is desired? If so, the action cannot be taken. If not, proceed to step C.
Step C: *Means, Ends*	**The good outcome is not brought about by means of the bad effect.** Is the bad effect a true "side effect?" If so, proceed to step C. Remember, "Good ends do not justify bad means."
Step D: *Prudence*	**The good outcome is proportionate to the bad effect.** Is this the prudent next step, in light of the facts? If not, the action should not be taken. If so, proceed to step E.
Step E: *Certainty*	**The good outcome can only be achieved alongside, but not by means of, the bad effect.** Has the analysis of Step B, Step C, and/or Step D been accurate? If not, then the action cannot be taken. If so, then the action can be taken.

[12] National Catholic Bioethics Center, Ethical Principle in Catholic Health Care: Selections from 25 years of Ethics & Medics Edward J. Furton and Veronica McLoud Dort, eds. (Brighton, MA: National Catholic Bioethics Center, 1999) 81-84.

Key Directives & Relevant Distinctions: A Commentary[13]

The Ethical and Religious Directives for Catholic Health Care Services (ERDs) provides concise directives for Catholic health care institutions, their clinicians and, by extension, patients and their loved ones. Regardless of the type of hospital within which Catholic patients find themselves, these directives can help them, and their loved ones, make healthcare decisions that are authentically Catholic. The preamble of the ERDs reads:

> The *Ethical and Religious Directives*...express the Church's moral teaching.... [They] flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From this source the Church has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity.

New distinctions within this section, in combination with the basic Catholic moral thought presented above, will help to clarify important key directives articulated in the ERDs, which were designed to help people make truly Catholic decisions within end-of-life contexts. These directives give clear parameters that promote and protect morally excellent clinical action for the true benefit of patients.

Included in the directives are highlighted statements referring back to (1) the parameters of human nature (the natural inclination); (2) intrinsic dignity as permanent and therefore more profound than attributed dignity; (3) analysis of the act in question via the principle of double effect (PDE), the intention of the one administering care, and the circumstances which surround the act; and (4) new distinctions and cases, presented as examples, which illustrate situations similar to those a reader, whether patient or caregiver, might face. Again, it is important to distinguish between a trend towards actions which promote euthanasia, and which amount to abandonment, versus actions that are truly palliative and supportive.

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[13] United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Healthcare Services, 4th ed., (Washington, DC: United States Conference of Catholic Bishops, 2001) Directives 26-28, 55-61. <http://www.usccb.org/bishops/directives.shtml#partfive>.

Directive 60 states:

> Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

Killing in the name of palliative care violates the natural inclination to self preservation, or life--the most basic inclination--and therefore necessarily violates every other inclination as well. This absolute "NO" to euthanasia presupposes a profound "YES" to the full protection and promotion of human flourishing in accord with the natural inclinations and human dignity of even the most seriously ill and debilitated.[14]

One extreme view, the "vitalistic" mindset, holds that a person's life should be prolonged by all means, for as long as possible, no matter what.[15] For those who are pro-life, this extreme can occur when there is a failure to understand what the Church teaches on certain issues such as ventilation (breathing machine), cardiopulmonary resuscitation (CPR), and artificial nutrition and hydration (tube feeding).

The other extreme is the "euthanistic" mindset, which has no problem with hastening death in order to end suffering.[16] Those pressing for legal changes on "death with dignity" issues, and "aid in dying" (assisted suicide), are obviously of this mindset. This damaging notion is currently written into law in both Oregon and Washington, and is a travesty of legislation that is contrary to human nature. This further

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[14] Catholic Health Care Ethics, 9-12.

[15] William Winslade. "Never Say Die: Vitalism, False Hopes, and Value Conflicts. 30 March 2005. <http://www.ethics.emory.edu/news/archives/000376.html>.

[16] Congregation for the Doctrine of the Faith. Declaration on Euthanasia. 05 May 1980. <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html>. See also Directive 60 of ERDs <http://www.usccb.org/bishops/directives.shtml#partfive>.

distinction between the vitalistic and euthanistic mindsets clarifies the beauty and truth of the absolute "NO" of the Catholic Church, and is most clearly stated in the introduction to Part V of the ERDs:

> {There are} two extremes to be avoided…an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.

What the Church desires for all people is a death coherent with human nature, which allows for all kinds of interventions, many of which may involve real danger, yet are, nevertheless, truly palliative. This guidance equips people to intervene on behalf of loved ones, while also safeguarding their deepest inclinations, their human nature and their dignity.

Directive 56 states:

> A person has a moral obligation to use ordinary or proportionate **{prudent}** means of preserving his or her life. Proportionate means are those that in the judgment of the patient **{or that of his/her health care proxy decision maker (proxy)}** offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.

If the judgment of the patient or proxy is in grave error given the medical facts of the case, then an attempt to educate on that which is in accord with the natural inclination to know truth and to obtain the good should be made, so that the patient or proxy can come to a prudent decision.

Directive 57 states:

> A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment **{or that of the healthcare proxy decision maker}** do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

When mindful of the three sources of human actions above–the action in and of itself, the intentions and the circumstances—and after considering the five criteria of the principle of double effect (PDE), there can be no doubt that truly prudent actions will not be disproportionate.

Directive 58 states:

> 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.[17]

A real-life case involving the discontinuation of artificial nutrition and hydration expresses this directive quite clearly. This case involved a patient who was in a permanent vegetative state complicated by end-stage, multi-systems organ failure.[18] The patient's body was rejecting a bone marrow transplant so profoundly that he was rejecting his own organs. In spite of their very best efforts, the clinicians were not able to stop his bodily shut-down. Within this dying process, the patient's system could no longer absorb food and fluids. The medical team knew that the feeding should be stopped, and they met with the patient's health care proxy decision maker to seek his informed consent to do so.[19]

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[17] Ibid. See also Edward J Furton, The Revision of Directive 58 of the Ethical and Religious Directives for Catholic Health Care Services, (Philadelphia PA: National Catholic Bioethics Center, 16 December 2009). <http://ncbcenter.org/NetCommunity/Page.aspx?pid=1026>. 20 & 33.

[18] For the full essay see Fr. Christopher M. Saliga, O.P., RN, "Nutritional Support and Human Dignity within the End-of-Life Context," Catholic Exchange: Catholic Bioethics: Life and Death. Right and Wrong 24 October 2008. <http://bioethics.catholicexchange.com/2008/10/24/90/>.

[19] For a clear understanding of loss of responsiveness and/or consciousness in a variety of states, see Joseph J Fins, MD. "Brain Injury: The Vegetative and Minimally Conscious States," From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns. Ed. Mary Crowley. Garrison, NY: Hastings Center, 2008, 15-20. <http://www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2166>. It should be noted that the Catholic position on artificial nutrition and hydration (tube feeding) is that it is ordinary care in cases of non-complicated Permanent Vegetative State, as well as any other similar non-complicated states. Thus, the discontinuation of tube feeding in the well-publicized case of Terry Schiavo, recognized by Fins as in a non-complicated permanently vegetative state, was an act of euthanasia by which lethal dehydration and starvation took place in order to eradicate her "suffering." For the full Catholic position on tube feeding for patients in non-

The proxy was in a very tough spot. The patient had made it known both verbally and in his written advance directives that he wanted "everything possible" to be done for him. The proxy had heard that the Catholic Church had said that "food and fluids must be given in all circumstances" because not doing so amounted to "killing the patient." He wanted to ensure that his loved one's life and dignity were fully respected, and would not consent to discontinuing the tube feeding.

The proxy's baseline instinct was excellent regarding human life and dignity. Also, he was doing his best to honor doing "everything possible," according to the patient's written request. However, in the heat of this gut-wrenching situation, he did not understand that the Church's position on tube feeding also takes into account proportionality. (See directive 57, above.) He also failed to see that it was no longer possible for the patient to benefit in any way from the artificial nutrition and hydration.

As he was helped to fully grasp the patient's irreversible, impending death, and to understand that his friend's body could no longer benefit from tube feeding, the proxy was then able to allow the medical team to discontinue the feedings, while remaining highly attentive and responsive to the complex needs of the patient. This type of educational intervention in order to help either patient or proxy make informed decisions is in full accord with both directives 56 and 57, above.

The patient received the last rites, and was commended to the intercession of the Blessed Mother, while all other supportive measures continued. In the end, the patient's inclination to life and his intrinsic dignity were respected, as he was imminently dying, not from lack of food or fluids, but from irreversible organ failure.

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complicated Permanent Vegetative State and other similar non-complicated states see Congregation for the Doctrine of the Faith, Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration (Rome: United States Conference of Catholic Bishops, 01 August 2007). <http://www.priestsforlife.org/euthanasia/concerning-artificial-nutrition-and-hydration.htm>. See also Archbishop Justin F. Rigali and Bishop William E. Lori, "Human Dignity and the End of Life: Caring for Patients in a Persistent Vegetative State," America 04 Aug 2008: 18 & 33. <http://www.americamagazine.org/content/article.cfm?article_id=10952&comments=1>.

The spiritual intervention of sacramental Anointing is vitally important. Again, human, intrinsic dignity is ultimately grounded in God's unconditional love. God is the gift-giver of human life and salvation, and spiritual interventions are of the utmost importance in care for the entire human being, comprised of body and soul.

Directive 55 states:

> Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

A distinction between "healing" and "cure" will help to clarify precisely what "spiritual support" involves. For example, many well-intentioned people, such as health care professionals, patients, their family members and health care proxy decision-makers often confuse "healing" with "cure." Following upon this confusion, they also misunderstand the place of the healing sacraments, such as the Eucharist, Penance and Anointing, in a patient's overall quest for healing. When this misunderstanding occurs, some individuals "tend to consult priests for sacramental interventions when it is thought that there is nothing left to do but pray—a last-ditch, placebo-type, 'holistic' palliative intervention."[20]

"Cure" refers to a patient's scientifically measurable positive response to a treatment or series of treatments. For example, someone who

[20] Fr Christopher M. Saliga, O.P., RN and Fr Carlos Quijano, O.P., "Spiritual Care in Hospital Policies: Incorporating Sacramental Interventions," Ethics & Medics 32.2 (February 2007): 3.

has been afflicted with fairly advanced breast cancer that requires mastectomy, removal of lymph nodes and chemotherapy, yet achieves remission for a sufficient amount of time, is happily said to be "cured."[21] And yet, health regained by curative interventions is said to amount to far more than the mere absence of disease. "The World Health Organization [WHO] defines health as a state of complete physical, mental, or social well being and not merely the absence of disease or infirmity."[22] Each human dimension explicitly recognized in this WHO definition can be scientifically measured because none transcends this life on earth. As such, the goals attained, which are truly excellent and desirable, are also bound to life on earth.

Healing as "sanctifying" is ultimately understood within Catholic thought to involve the soul, and to transcend earthly life. That is to say, healing may or may not involve a cure from illness. This is because healing is understood in relation to mankind's ultimate reason for being, which is the face-to-face, beatific union with God for all eternity.

Because ultimate healing, as understood within Catholic thought, transcends this life, the Church recognizes sacraments which, when embraced by a well-disposed recipient, actually bring about sanctification. Anointing of the Sick is one such sacrament, which perfects "the virtue of repentance."[23]

When a person is anointed, even when unable to confess personal sins in order to receive absolution, God's grace effectively: (1) removes personal sin and its aftereffects; (2) strengthens the sick person's soul; and, (3) causes great trust in God's mercy, so that the sick person is able to bear the burdens of the cross.[24] St. Thomas Aquinas teaches the efficacy of the sacrament: "For [St. Thomas]…the Anointing [of the Sick] is directed

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[21] Donald Venes, M.D., M.S.J., ed., 20th ed. Taber's Cyclopedic Medical Dictionary. (Philadelphia: F.A. Davis, 2005). Within this dictionary, "cure" is concisely defined as: "(1) Course of treatment to restore health; (2) Restoration to health." Also, because "healing" is considered from a merely temporal perspective, it is synonymous with "cure:" to heal is "to cure; to make whole or healthy."

[22] Ibid.

[23] Coleman O'Neill, O.P., Meeting Christ in the Sacraments (New York: Alba House, 1991) 287.

[24] Ibid. O'Neill cites the Council of Trent in recognizing these effects of sacramental Anointing of the Sick.

primarily against the after-effects of sin."[25] Punishment, the "aftereffect" proper to sin, destroys the possibility of beatific union with God.

This removal of the punishment due to sin is clearly seen in specific prayers said by the priest when Anointing of the Sick is as given as part of the last rites. The priest, in one of two forms, gives the patient the apostolic pardon:

> (A) Through the holy mysteries of our redemption, may almighty God release you from all punishments in this life and in the life to come. May he open to you the gates of paradise and welcome you home to everlasting joy.[26]

> (B) By the authority which the Apostolic See has given me, I grant you a full pardon and the remission of all your sins in the name of the Father, and of the Son, and of the Holy Spirit.[27]

Even in cases in which patients are no longer capable of confessing sins or expressing any outward signs that they are well-disposed to receiving sacramental Anointing of the Sick, one may assume that these patients intend to receive the sacrament, which is sufficient for validity.[28] Through the sacrament, there is reason to hope for the eternal beatific union with God, as prayed at Mass during the memorial acclamation, options B and D: B) Dying You destroyed our death, rising You restored our life. Lord Jesus come in Glory. (D) Lord, by your cross and resurrection You have set us free. You are the savior of the World.

The Anointing of the Sick, as do all seven of the sacraments, draws the person into greater union with Jesus, who laid down His life for all.

> Yes, God so loved the world that He gave His only Son, that whoever believes in Him may not die but may have eternal life. God did not send the Son into the world to condemn the world, but that the world might be saved through Him.[29]

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[25] Ibid.

[26] Pastoral Care of the Sick: Rites of Anointing and Viaticum (New York: Catholic Book Publishing Co., 1983) 242.

[27] Ibid.

[28] O'Neill, O.P., Sacraments 288.

[29] Jn. 3:16-17 The New American Bible.

The need to provide an opportunity to prepare for death via the sacraments, as stated in Directive 55 above, should be taken very seriously given the demands of intrinsic dignity. All treatment should be provided with care for the patient in accord with his intrinsic dignity and natural inclination to live in society. Thus, the distinction between "cure" and "healing" helps safeguard patients from abandonment when they are most vulnerable, simply because nothing more can be done to cure them of illness. Prayer is always the first and last thing that should be done for any patient.[30]

Directive 59 states:

> The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

Directive 26 States:

> The free and informed consent of the person or the person's surrogate [proxy] is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

Catholic moral teaching is always grounded within God-given human nature. Therefore, if a patient seeks help in taking action that directly violates his nature (one or more of the parameters of human nature), a Catholic simply cannot do as the patient requests. The patient must be educated (remember the patient's inclination to know the truth and to obtain that which is truly good) in the truth regarding his intrinsic dignity, even though he might not share the Catholic perspective. Patience and veracity are crucial in end-of-life situations.

Medically assisted nutrition and hydration are basic to the human inclination to self-preservation. By way of an everyday example, no one would consider drinking soda through a straw to be unusual, contrary to

[30] The commentary that follows is heavily dependent upon the contributions of Edmund D. Pellegrino, MD, PhD, regarding the physician-patient relationship. For a concise entre into Pellegrino's contributions see Edmund D. Pellegrino, The Philosophy of Medicine Reborn: A Pellegrino Reader, ed. H. Tristram Engelhardt, Jr. and Fabrice Jotterand. (Notre Dame, IN: University of Notre Dame Press, 2008) 204-220.

human nature or imprudent, although neither straws nor soda are found in nature. Rather, they are made by human artifice. This is also the case with school buses by which students ordinarily travel to school. Within this context, riding to school on horseback in South Chicago, though far more "natural," would certainly be considered extraordinary.

Riding school buses and drinking through straws do not contravene human nature. In fact, they make sense within a contemporary context. Because an attempt to educate must be made, in light of the natural inclination to know truth, gaining the free and informed consent of the patient or the proxy when possible, is imperative.

Furthermore, coercion, or forcibly restraining a patient in order to force feed him, would violate the natural inclination to live in society. In such a case, the patient ought not to be abandoned, but should be encouraged to make the next best decision. This might be accomplished by simply helping him to eat and drink what little he can, given the circumstances. Forcing either the patient or the proxy to embrace a treatment or a caring intervention is not acceptable. In legal terms, patients have rights that cannot be violated.

Directive 27 States:

> Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

Directive 28 States:

> Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

Having considered a case in which a proxy made the prudent decision to discontinue tube feeding in the face of impending death via multi-systems organ failure, it is well also to consider a case in which a proxy chose to allow respiratory support by ventilator and the placement

of an artificial feeding tube. While these two interventions are certainly "artificial," (or not found in nature), neither of the treatments are unnatural. That is, they are not contrary to human nature, nor were they disproportionate (imprudent) in the case cited below.

An elderly woman who had suffered a serious stroke, complicated by a history of heart damage from an earlier heart attack, had Advance Medical Directives stating that she did not want tube feeding if she became unconscious, and did not want to be resuscitated if her heart or breathing stopped. She wanted to "let nature take its course." Most importantly, she named one of her daughters as her proxy. Her daughter and she were very close, and they were both practicing Catholics.

The daughter was faced with a morally distressing decision when the medical team suggested that the placement of feeding and breathing tubes were very important, given the facts of her mother's case. As a matter of fact, they were necessary for the best possibility of recovery from her stroke and improved long-term survival.

After a stroke, even a serious stroke complicated by a cardiac history, it takes time to assess the probability of recovery. The medical team considered it most prudent to give their patient the best chance for such recovery by protecting and promoting her breathing, providing proper nutrition and palliative support. Now that the daughter, as proxy, had responsibility and authority to make decisions on behalf of her mother, she was faced with the toughest decision of her life, a decision requiring prudence, courage and love.

She had to decide whether to give informed consent for these two caring, artificial interventions.[31] Notwithstanding what the Advanced Medical Directive stated, what would her mother want, here and now, if

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[31] According to the Congregation for the Doctrine of the Faith, "the administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented." Congregation For the Doctrine of the Faith, Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration (Rome: Congregation for the Doctrine of the Faith, 01 August 2007) 18 & 20. <http://www.priestsforlife.org/euthanasia/concerning-artificial-nutrition-and-hydration.htm>.

she knew the facts? She had written of a disinclination for these types of interventions, and yet, promotion and protection of breathing and vitally important nutritional support by "artificial" devices were being proposed as necessary parts of actions that were natural, in that they were coherent with human nature–specifically the inclination to self-preservation. Supported breathing and supported eating were proportionate to her mother's hope of recovery, based on scientifically verified probabilities and time lines. In other words, it seemed most reasonable and loving to support her mother by helping her to breathe and eat at least long enough to give her the best chance of survival.

When the patient etched out her Advance Medical Directives, she had no way of knowing what the actual facts of her medical condition would be. Those directives, as all Advance Medical Directives, were written outside of any given set of circumstances. The daughter had to decide whether or not to give informed proxy consent with the support of her other family members and loved ones close to the case, aided by a true understanding of her mother's situation relative to Church teaching and medical fact. The staff's efforts to educate the daughter were fully consistent with her right and responsibility to make a well-informed decision regarding her mother's care. The mother's Advance Medical Directives were taken into account quite seriously. With her best calculation of what her mother would likely have decided, given the circumstances, the daughter gave informed proxy consent for ventilator support and placement of a temporary feeding tube.

Ironically, the mother took a turn for the worse within a few days, during the time the clinicians needed in order to more fully assess whether or not she would recover. As her condition deteriorated, the goals and interventions were modified appropriately. The patient died of heart failure just a few days later. While support was maintained, cardiopulmonary resuscitation was not initiated, in full and prudent accord with her Advance Medical Directive, considering her active demise and her complex medical history.

Prior to the patient's death, she was anointed and given the Apostolic Pardon as part of the last rites. She and her daughter and loving

family members were blessed every day. As far as can be known, she died in peace, with hope for resurrection intact. Her loved ones and clinicians together shed tears and said hope-filled post mortem prayers over her mortal remains.

Several months later, the daughter sent a thank you card. She was grateful for the help she received in making "the right" decision during the "most difficult time" of her life. While she had found herself in moral distress several months earlier, that distress was now replaced with the confidence that she had truly done her best for her mother. Furthermore, she was convinced that her mother would have asked for the same care, had she been able to, notwithstanding her previously written Advance Medical Directive. Her daughter had acted neither vitalistically nor euthanisically on behalf of her beloved mother, and was able to make a morally sound decision based on accurate information and her mother's best interest.

Advance Medical Directives & Health Care Proxy Decision Makers

In light of the cases above, it is a good idea that, within an Advance Medical Directives, a primary (and perhaps secondary) health care proxy decision maker is named, who can be trusted to make morally excellent health care decisions. While crafting such directives, being overly precise can sometimes cause problems due to unforeseeable circumstances; however, knowledge of the foundations and ERDs covered herein can help when crafting morally excellent directives. The National Catholic Bioethics Center also provides a helpful, Internet-accessible resource on this topic.[32]

[32] National Catholic Bioethics Center, A Catholic Guide to End-of-Life Decisions: An Explanation of Church Teaching on Advance Directives, Euthanasia, and Physician Assisted Suicide. <http://ncbcenter.org/NetCommunity/Page.aspx?pid=347>.

Conclusion

While much more can be written on the topics of human nature, God's Law, and intrinsic and attributed dignity, the three sources of human action and the Principle of Double Effect equip us to make morally good end-of-life decisions for ourselves and/or those in or care. While no one can know for certain what he will face late in life, even in the midst of really tough situations, one can succeed in making morally excellent health care decisions in preparation for, and within, end-of-life contexts.

Some Helpful Catholic Internet Resources

Catholic Bioethics: Life and Death. Right and Wrong. <http://bioethics.catholicexchange.com>. This page has accessible, easy-to-read essays written by several Dominican authors and others on a wide range of bioethical issues.

National Catholic Bioethics Center. <http://ncbcenter.org/NetCommunity/Page.aspx?pid=183>. This excellent page deals with the full range of bioethics issues. It includes both scholarly and pastoral works, many of which address political concerns.

National Catholic Bioethics Center. National Catholic Certification Program in Health Care Ethics. <http://ncbcenter.org/NetCommunity/Page.aspx?pid=356>. This strong on-line course is designed to take the student deep into the heart of the Ethical and Religious Directives for Catholic Health Care.

Priests For Life. <http://www.priestsforlife.org/>. While this page deals primarily with beginning of life issues, it does have some information that can be helpful in considering end-of-life issues. It is pastoral and political in scope.

United States Conference of Catholic Bishops. Ethical and Religious Directives for Catholic Health Care Services, 4th edition. http://www.usccb.org/bishops/directives.shtml. In addition to the directives, there are helpful introductory sections and footnotes that delve into primary Church documents, authors, etc.

Westchester Institute for Ethics and the Human Person. <http://www.westchesterinstitute.net>. This page deals very well with the full range of human life concerns. It includes both scholarly and pastoral works, many of which address political concerns.

About the Author

Father Christopher M. Saliga, O.P., R.N. currently serves as the Chaplain of Walsh University in North Canton, OH where he also teaches bioethics. Additionally, He serves as an ethics consultant to The Dominican Friars' Health Care Ministry of New York, and as a columnist for the Catholic Exchange bioethics web page. Prior to arriving at Walsh University, he served as a health care chaplain and ethicist with the Dominican Friars' Health Care Ministry of New York, Saint Catherine of Siena Church and Priory from 2005-2008, while also serving part time in the Catholic ministries at Columbia and Quinnipiac Universities. He has lectured on select topics in health care ethics at various hospitals, medical schools and universities; he has written on select topics in health care ethics and spirituality; he has directed undergraduate students in writing on select topics in health care ethics for internet publication. Prior to his service as a Dominican friar and priest, he served in paramedical and nursing capacities within in both the military and private sector from 1984-1998. In July 1998, Fr. Chris entered the Dominican Order's Province of St. Joseph, and was ordained a priest in 2005.