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INTRODUCTION

Starting from my own experience of the death of my mother, as a Catholic priest I wonder if there is anything specific in my ministry to help patients, their families, and health care professionals, particularly in my home country Vietnam, when they have to face this critical moment of death. Having a mother who suffered much pain for nearly five years, both physically and spiritually, from uterine cancer, I deeply perceive the struggles for existence, for knowing the meaning of suffering and for accepting the reality of death in family life. Sometimes the difficulties are so great that we don’t think we are able to cope with them or even to live a life full of suffering like my mother did.

However, in my opinion, the people who work in the health care profession may have additional challenges, especially those who take care of critically ill patients. In this specific area of their profession, they have to deal with the extreme pain and suffering of the patients everyday, give appropriate care to them and attend to advance directives for their patients in order to make the right medical decisions. Moreover, though over the last several decades modern medical science has dramatically progressed, it also brings about many unsolvable problems and ethical dilemmas in caring for the dying patients. As a result, the people who are connected with health care ministry today have to face a lot of challenges, specifically those who deal with end-of-life issues.

It is even harder if the health carers are living as Christians, because sometimes they find out that the official teachings of the Church contradict the attitudes, values, and perspectives of their society. In other words, today “secular bioethics is becoming less and less receptive to dialogue with the Roman Catholic moral tradition.”¹ Never have Catholic health professionals been more urgently in need of a reliable moral compass to navigate the trends of secularization, postmodernism, and anti-rationalism in ethics. In the ever-changing circumstances of health care and its delivery, it is really challenging for Catholic health care professionals to do their work properly, and at the same time faithfully take part in the healing mission of Jesus Christ.

For these reasons I would like to study and discuss the topic: End-of-Life Issues: Challenges for Catholic Health Carers. This writing is going to principally determine the challenges which health care workers face when dealing with people at the end of their lives, and the basic foundations from which they learn how to overcome the difficulties in their profession.

without losing their Christian identity. It would, therefore, be necessary to clarify these questions: What are the challenges for health care professionals nowadays? Why do they find it more difficult when dealing with end-of-life issues? What are the solid grounds upon which Catholics can fulfill their duties as responsible health carers, as well as faithful followers of Jesus Christ? And finally are the end-of-life issues an opportunity for health workers to fully practise their Christian identity in a communist country such as Vietnam?

This thesis will endeavor to appropriately answer the above questions with four main chapters. Firstly, Chapter I will examine the significant opportunities and crucial challenges which health carers have to face in our present society. There are conflicts between the advantages of science and technology in the medical sphere and the challenges they bring about, between the personal benefit and the good of the community, between human dignity and social values. The Second Chapter will present a practical theological basis as well as the implications of principles for health care ethics. With these solid grounds, Catholic health care workers may handle wisely the dilemmas in their profession and properly resolve them. Chapter III is to focus on the aim of this work. It confronts us with some important issues in contemporary health care ethics, especially emphasizing the end-of-life issues: death and its determination, the ethics of pain management, forgoing treatment, withholding and withdrawing medically administered nutrition and hydration, ethical considerations concerning the persistent vegetative state, advance directives for health care decisions, physician-assisted suicide and euthanasia. It seems that these issues of the health care sector have the most bioethical controversies. The Final Chapter is related to the situation of health care in Vietnam. Along with medical progress and the difficulties still remaining, Vietnamese Catholic health carers can find an opportunity to make their contribution to their profession and enhancement in living their faith.
I. THE ACHIEVEMENTS AND THE NEW CHALLENGES OF RECENT MEDICAL PROGRESS

The 20th century and the first decade of the present century has been a time of great development in science and technology. This has been the time of deciphering many mysteries of the world that earlier were beyond human reach. This has been the time of seeking truth about human beings, the world and the universe. What has been strongly emphasised in this period of time has been human dignity, and the duty to respect human rights, including the right to life. This has also been the time of numerous deeds conducive to the welfare of humankind and the possible attainment of world peace.

It is true that scientific and technological progress has brought about many good things to the world – medicine is one of them. Medicine obviously is of major importance in this progress which has exceeded all expectations. When it focuses on serving humankind, when it results in good things, it is a wonderful gift for us, an assistance and support for all human health tragedies and suffering.² It is written in Donum Vitae that thanks to the development in medical sciences, humans can use even more effective means of healing. In practice, “biology and medicine work together for the integral good of human life when they come to the aid of a person stricken by illness and infirmity and when they respect his or her dignity as a creature of God.”³

I.1. Some Major Achievements in Medical Progress

Technology and science in medicine have been significantly developed in recent decades. As a result the health care system has been considerably improved, and new options for the quality of human life have been explicitly produced by the medical use of technology and new medications. Thanks to these dramatic developments, many people who previously might have been left to die because nothing could be done to help them, are today able to enjoy lives relatively free of debilitating pain and illness.

I.1.1. Epidemiology and Public Health

The emergence of clinical epidemiology marked one of the most important successes of medical science in the 20th century. The first significant success in clinical epidemiology was by Austin Bradford Hill and Richard Doll in the United Kingdom. This was the demonstration

³ Congregation for the Doctrine of the Faith, Donum Vitae (1987), Introduction n. 3.
of the relationship between cigarette smoking and lung cancer. This work was later replicated in many studies; currently tobacco is estimated to cause about 8.8% of deaths (4.9 million) and 4.1% of disability-adjusted life years – DALYs (59.1 million) worldwide.\(^4\)

Moreover, the application of epidemiological approaches to the study of large populations over a long period, has provided further invaluable information about environmental factors and disease. In fact, a substantial amount of work has gone into identifying risk factors for different kinds of diseases, such as hypertension, obesity and its accompaniments, and various forms of cancer. Risk factors defined in this way, and similar analyses of the pathological role of environmental agents such as unsafe water, poor sanitation and hygiene, pollution, and others, form the basis of *The World Health Report 2002*. It sets out a program for controlling disease globally by reducing ten (10) factors: underweight status, unsafe sex, high blood pressure, tobacco consumption, alcohol consumption, unsafe water – sanitation – and hygiene, iron deficiency, indoor smoke from solid fuels, high cholesterol and obesity. These factors are mainly calculated to account for more than one-third of all deaths worldwide.\(^5\)

### I.1.2. Partial Control of Infectious Diseases

The control of communicable diseases has been the major advance of the 20\(^{th}\) century in scientific medicine. It reflects the combination of improved environmental conditions and public health together with the development of immunization, antimicrobial chemotherapy, and the increasing ability to identify new pathogenic organisms. “Currently, live or killed viral or bacterial vaccines – or those based on bacterial polysaccharides or bacterial toxoids – are licensed for the control of twenty nine (29) common communicable diseases worldwide.”\(^6\)

The development of sulfonamides and penicillin in the period preceding World War II was followed by a period of progress in the discovery of antimicrobial agents effective against bacteria, fungi, viruses, protozoa, and helminths (parasitic worms). Overall, knowledge of the pharmacological mode of action of these agents is best established for antibacterial and antiviral drugs. However, particularly with the challenge posed by HIV/AIDS, a wide range


of antiviral agents has been developed; knowledge of the modes of action of antifungal and antiparasitic agents is increasing as well.\(^7\)

Although the war against infectious diseases is far from over, the development of new antibiotics and effective antiviral agents has made remarkable advances possible in the control of communicable diseases.

**I.1.3. Pathogenesis, Control, and Management of Non-communicable Diseases**

The second half of the 20\(^{th}\) century also yielded major advances in understanding pathophysiology and in managing many common non-communicable diseases. This phase of development of the medical sciences has been characterized by a remarkable increase in the acquisition of knowledge about the biochemical and physiological basis of disease. This information, combined with some exceptional developments in the pharmaceutical industry, has led to a situation in which few non-communicable diseases exist for which there is no treatment and many, although not curable, can be controlled for long periods of time.\(^8\)

Modern cardiology is a good example of the evolution of scientific medicine. The major technical advances leading to a better appreciation of the physiology and pathology of the heart and circulation included studies of its electrical activity by electrocardiography; the ability to catheterize both sides of the heart; the development of echocardiography; and, more recently, the development of sophisticated ways of visualizing the heart by computerized axial tomography, nuclear magnetic resonance, and isotope scanning… These advances have been supplemented by the development of effective drugs for the management of heart disease, including diuretics, beta-blockers, a wide variety of antihypertensive agents, calcium-channel blockers, and anticoagulants. In more recent times, the development of microelectronic circuits has made it possible to construct implantable pacemakers. Following the success of renal transplantation, cardiac transplantation and, later heart and lung transplantation, also became feasible.\(^9\)

Similarly, this period has also witnessed major progress in the diagnosis and management of cancer. This progress has followed from more sophisticated diagnostic technology combined with improvements in radiotherapy and the development of powerful anticancer drugs. This approach has led to remarkable improvements in the outlook for particular cancers, including

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childhood leukemia, some forms of lymphoma, testicular tumors, and – more recently – breast tumors.\textsuperscript{10}

The fields of molecular and cell biology were the major developments in the biological sciences in the second half of the 20\textsuperscript{th} century and the early part of this century. The announcement of the partial completion of the human genome project in 2001 was accompanied by claims that knowledge gained from this field would revolutionize medical practice over the next 20 years.\textsuperscript{11}

In addition, due to advances in medical sciences, the capability of prolonging life has been dramatically enhanced. With developments in biomedical technology over the past 50 years, the means are available for life support for any individual whose vital systems are functioning at a minimal level or not at all. Indeed, technology marvels have spectacularly altered the dying process and kept patients alive for years or even decades.\textsuperscript{12}

In summary, the progress of science and technology in medicine has made a spectacular contribution to the health of people throughout the world. In fact, a remarkable development in scientific medicine has allowed most countries to develop an increasingly effective high-technology in medical practice. It has helped control many epidemics, prevent many misfortunes and diseases and improve many areas of life.

\textbf{I.2. The New Challenges of Recent Medical Progress}

New science and new technology are part of the progress transforming the world in which we live. In medical science and medical technology, the pace of progress has been phenomenal; and medical practice has generally been able to keep up with this astonishing progress and apply it effectively in patient care. The result has been an enormous success – the best medical care the world has ever seen, and what the future holds simply astounds the imagination. But the progress of medicine and biology brings about not only good. It has become the source of concern and threats in the world. The expansiveness of human cognitive strivings and unlimited technical capacities have begun to jeopardise basic human values. Man may become a master of new possibilities with unpredictable effects. And mankind wants to become a master of interfering with human life at its very beginning through to its

\textsuperscript{10} Cf. Weatherall et al., “Science and Technology for Disease Control: Past, Present, and Future,” 123.
end stage. In fact, medical science is very quick to adopt new developments in science and technology. It has, however, raised some new serious issues related to medical practice, especially in the health care sphere. I would like to indicate some of these challenges in the following two sections.

I.2.1. Economic Consequences of High-Technology Medicine

The current high-technology medical practice based on modern scientific medicine inevitably causes a steady increase in expenditure. Regardless of the mechanism for the provision of health care, its spiralling costs caused by ever more sophisticated technology and the ability to control most chronic illnesses, combined with greater public awareness and demand for medical care, results in a situation in which the most industrially developed countries are finding it impossible to control the costs of providing all needed health care services.

In the United States, nearly one out of every seven dollars is spent on some form of health care; in 1998, this amounted to approximately 13.6 percent of the gross domestic product (GDP), or $4,178 per capita. Of this expenditure, critical care medicine accounts for approximately 15 to 20 percent of all hospital expenses, which in turn amounts to 38 percent of all U.S. health care expenditures. This increasingly significant investment of personal and social resources in high-technology medicine is driven by very real concerns to ameliorate the physiological collapse brought on by age, accident, injury, and disease.

The U.K. National Health Service (NHS) has offered an interesting example of the steady shift to high-technology hospital practice since its inception more than 60 years ago. Over that period, the NHS’s overall expenditure on health has increased fivefold. Although the number of hospital beds halved over the first 50 years of the NHS, the throughput of the hospital service increased from 3 million to 10 million inpatients per year, over a time when the general population growth was only 19 percent. Similarly, outpatient activity doubled, and the total of outpatient visits grew from 26 million to 40 million. In Malaysia, hospitalization rates have steadily increased since the 1970s. The number of private hospitals and institutions rose phenomenally – more than 300 percent – in the same period. In 1996, the second National Health and Morbidity Survey in Malaysia showed that the median charge per day in private

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15 By way of comparison, health care in Canada, Germany, Belgium, and Austria in 1998 respectively represented 9.5, 10.6, 8.8, and 8.2 percent of each country’s GDP, or approximately $2,312, $2,424, $2,081, and $1,968 per capita (OECD 2000). Cf. H. Tristram Engelhardt, Jr., and Mark J. Cherry, eds., Allocating Scarc Medical Resources: Roman Catholic Perspectives (Washington D.C.: Georgetown University Press, 2002), 19.
hospitals was 100 times higher than that in the Ministry of Health hospitals. These figures reflect, at least in part, the acquisition of expensive medical technology that in some cases has led to inefficient use of community resources. As in many countries, the Malaysian government has now established a Health Technology Assessment Unit to provide a mechanism for evaluating the cost-effectiveness of new technology.\textsuperscript{16}

These brief examples of the effect of new sciences and the practices of high-technology reflect the emerging pattern of medical practice in the 20\textsuperscript{th} and the beginning of the 21\textsuperscript{st} centuries. In particular, they emphasize how the rapid developments in high-tech medical practice and the huge costs that have accrued may have dwarfed expenditure on preventive medicine, certainly in some industrial countries and others that have gone through the epidemiological transition.

\subsection*{1.2.2. Ethical Issues}

Technology touches virtually every part of our lives; but the moral record of technology is certainly a mixed one. In reality, some advances of scientific medicine have raised new ethical issues for society. The genetic era has encountered many problems in this respect, and although many of the initial fears and concerns have been put to rest by sensible debate and the development of effective control bodies, new problems continue to appear.\textsuperscript{17} In laboratories, scientists keep working on the pathogenesis of human diseases, on changes in the composition of genes and inherited traits and on new techniques of conceiving a child. The ill-named field of therapeutic cloning is still full of unresolved issues regarding human embryo research, the creation of embryos for research purposes, and other uncertainties.\textsuperscript{18} Whatever one’s judgement about science and technology, their progress in biology and medicine leading to manipulating life processes may cause effects that are not good.


\textsuperscript{18} Every day brings information about new techniques of manipulating living creatures. Hibernation, pregnancy through other woman’s ovum and fertilisation with sperm of the unknown origin ceased to be a matter for the future and has become an everyday practice. There have been announcements about possibility to introduce into man a genetic piece of information to eliminate such diseases as cancer, to control biological mechanisms causing ageing and death. The whole world was stunned when the press announced that there had been a series of experiments with a chimpanzee ovum being fertilised with human sperm and that an initial cell division took place. Cloned Dolly is an example of the possibilities of cloning human beings. Certain cases of interference in chromosomal and genetic heritage are not of a healing character since they strive to produce human beings selected according to sex or other earlier fixed values. Cf. Grzeskowiak, “The Law Facing The Challenges of Biomedicine at the Turn of the 20\textsuperscript{th} Century,” 284.
Besides, there are some moral issues involved in limiting access to medical treatment. Throughout the industrial and the developing countries, new and costly diagnostic and therapeutic interventions have spurred a rise in health care costs, both in absolute terms and as a percentage of gross domestic product. Critical care dramatically illustrates the drama of these cost pressures.\(^{19}\) This care places particular burdens on health care budgets and the resources of health care units. Critical care is an especially attractive area for study, because it is one of the few areas where there are good clinical predictive measures regarding the likelihood of survival or death. As a result, one can with increasing accuracy predict the likelihood of saving lives and at what cost. One can rarely be sure that success is certain, only that the likelihood is very remote and at great cost.

Consequently, as a matter of morality and public policy it is essential to evaluate when unequal access to critical care is morally permissible and available standards of health care are unfortunately unfair. Must everybody have equal access to the very best standards of critical care? Is it morally permissible for different countries to have varying standards of critical care? Do standards differ within a particular country? From region to region? Or city to city? Or hospital to hospital? “Adequately to assess such questions requires the specification of a particular moral context within which one may know truly when to limit access to health care and when to draw back from certain types of treatments.”\(^{20}\)

In very general terms, secular axiology cannot adequately appreciate the depth of such difficulties, and provide a unique meaningful account of pain, disease, disability, suffering, and death, beyond the firing of synapses, the collapse of human abilities, and the mere end of life. Therefore, most contemporary bioethical accounts are remarkably meagre. Populated with the terms of duty and obligation, equality, autonomy, virtue, and beneficence – without careful analysis of the deep theological or moral significance of health care – these accounts are able to encourage us to expand choice, eliminate suffering, and reduce death, but unable authoritatively to determine which choices to make, which kinds of suffering to eliminate, or which deaths to postpone. Modern medical technology seems to confront us with many questions not faced even a decade ago. Human beings have always had to face decisions about preserving or prolonging their lives. For example, is it morally right to withhold or withdraw medically administered nutrition and hydration? Is euthanasia or assisting in the suicide of a patient with terminal cancer an act of mercy or murder? Should very-low-weight,

\(^{19}\) Cf. Engelhardt and Cherry, eds., *Allocating Scarce Medical Resources*, 19.
\(^{20}\) Engelhardt and Cherry, eds., *Allocating Scarce Medical Resources*, 20.
premature neonates be sustained regardless of expense, likelihood of survival, or quality of life? What about patients in a permanently vegetative state? Is reducing the total number of critical care beds a morally permissible means of allocating scarce health care resources?21

Facing the challenges in their profession, the health carers may ask: In attempting to be faithful to Christian values how do we professionals practise and develop effectively in a society where the secularization of contemporary bioethics has been rapid and deep?

21 Although it is nearly always possible to order additional tests, surgical interventions, or pharmaceuticals – which will convey at least marginal benefits in terms of additional disease prevention, greater alleviation of suffering, or marginal postponement of death – such expenditures impose ever-expanding financial, moral, social, psychological, and spiritual costs on patients, families, caregivers, and society. Cf. Engelhardt and Cherry, eds., Allocating Scarcе Medical Resources, 20.
II. THEOLOGICAL BASIS FOR CATHOLIC HEALTH CARE

Religion has been of major significance in shaping health care ethics as we know it today. It develops an understanding of the human person upon which an ethic of health care can be based. Religion is concerned with the meaning of human life in its ultimate dimensions: Why do we exist? When and how do we live at our human best? What kind of respect do we owe our human lives and those of others? In fact, religion has included in its searching and its theologizing these essential aspects of human living. That is the reason why human health and the processes of health care have been of central importance to much of Christian theology and Christian practice.¹ The next section of this document is to explore the idea of a theological basis for health care from the Catholic perspective.

II.1. The Dignity of Human Life and Human Health

The dignity of human beings is important in health care ethics. At the heart of the Ethical and Religious Directives for Catholic Health Care Services, the United States Conference of Catholic Bishops recognizes the inviolable dignity of each and every person. “It is love for the suffering individual that has drawn Catholics into health care and restrains them from ever doing anything that would harm or violate that individual in any way.”² At the very beginning of the document, the Directives states:

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.³

It is, therefore, very necessary to clarify the question from whence the dignity of the individual human person is derived.

II.1.1. The Human Person Created in the Image of God

According to the Christian faith, the human person considers men and women to be the pinnacle of God’s creation. It is true that the climax of the Genesis story of creation is the creation of human beings: “Let us make humankind in our own image, in the likeness of ourselves… So God created humankind in the image of himself, in the image of God he created it; male and female he created them” (Gen 1:26-7). The narrator indicates stylistically that the creation of human beings forms the highest point of this story of creation. Six times in five days, after narrating the creation of the heavens, light, land, water, the plants, the sun, moon, and stars, and all things, living and non-living alike, in the world, the narrator emphasizes the goodness of creation: “God saw that it was good” (cf. Gen 1:1-25). The seventh time, however, on day six after the creation of human beings, the narrator highlights the superlative goodness of creation: “God saw all he had made, and indeed it was very good” (Gen 1:31).

So what is it about the human person that makes her and him like God? Though the answer is complex, it is at least partly because, like God, humans have dominion over the rest of creation. In other words, we are given authority and responsible stewardship over the earth and all the living creatures. Adam names the animals, a sign of authority over them (cf. Gen 1:28; 2:19-20). “They are not to fear the sun or moon which other nations worshipped as idols since these impersonal false gods are creatures of, and subject to, the one God, the Creator of humanity.”

In fact, the creation story is pervaded with a sense of man and woman being entrusted with gifts, the gifts of creation and of one another. These gifts are to be cherished and shared, not hoarded and abused. Human life and health is such a gift, a precious one at that. “God is the giver of life to men and women, who are called to reflect God’s creative and provident goodness. They belong to God in a special way and have no dominion over human life.” The religious viewpoint is perceived to affirm that the sanctity of life, or human dignity and value, is inalienable and so is ultimately conferred by God.

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4 Cf. Kelly, Contemporary Catholic Health Care Ethics, 12.
7 Ford, The Prenatal Person, 30.
Moreover, just as the story of creation affirms the dignity of humanity, so the incarnation, the Word becoming flesh, reaffirms and even intensifies this dignity.\(^9\) Jesus recognized the dignity of all people, especially the outcasts of his society, lepers (Mk 1:39-45; 14:3), tax collectors (Mk 2:15-17), and Samaritans (Jn 4:4-42). The Gospel according to Matthew narrated:

Jesus went on from there and reached the shores of the Lake of Galilee, and he went up onto the mountain. He took his seat, and large crowds came to him bringing the lame, the crippled, the blind, the dumb and many others; these they put down at his feet, and he cured them. The crowds were astonished to see the dumb speaking, the cripples whole again, the lame walking and the blind with their sight, and they praised the God of Israel.

“One may be poor, infirm or lowly but the value of human life depends on its Creator. Life is presented as a treasured divine blessing, a supreme earthly good.”\(^{10}\) Through the incarnation, the Word enabled us to be partakers of the divine sonship. The incarnation, therefore, exalts the dignity of humanity. One more time, the Directives make this clear: “The dignity of human life flows from creation in the image of God (Gen 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57).”\(^{11}\)

\section*{II.1.2. Human Dignity and Selected Moral Principles}

When we speak of human persons being created in the image of God, “the human individual possesses the dignity of a person, who is not just something, but someone. He is capable of self-knowledge, of self-possession and of freely giving himself and entering into communion with other persons.”\(^{12}\) Moreover, the Second Vatican Council affirms that “all women and men are endowed with a rational soul and are created in God’s image; they have the same nature and origin and, being redeemed by Christ, they enjoy the same divine calling and destiny; there is here a basic equality between all and it must be accord ever greater recognition.”\(^{13}\)

\(^{10}\) Ford, \textit{The Prenatal Person}, 31.
\(^{12}\) \textit{Catechism of the Catholic Church}, English translation. 2\textsuperscript{nd} ed. (1997), n. 357.
\(^{13}\) Vatican Council II, \textit{Gaudium et Spes}, Pastoral Constitution on the Church in the Modern World (7 December 1965), n. 29, in \textit{Vatican Council II-The Basic Sixteen Documents: Constitutions, Decrees, Declarations.}
Hence, from this foundation – the inherent dignity and sacredness of human life – derive the principles of medical ethics and morals. In other words, “human reason transcends the limitations of the here and now, of the particular and the concrete, and thus is able to formulate universal principles for moral conduct.”\textsuperscript{14} This is also stated in the Catechism of the Catholic Church:

Man participates in the wisdom and goodness of the Creator who gives him mastery over his acts and the ability to govern himself with a view to the true and the good. The natural law expresses the original moral sense which enables man to discern by reason the good and the evil, the truth and the lie... The natural law, the Creator’s very good work, provides the solid foundation on which man can build the structure of moral rules to guide his choices. It also provides the indispensible moral foundation for building the human community. Finally, it provides the necessary basis for the civil law with which it is connected, whether by a reflection that draws conclusions from its principles, or by additions of a positive and juridical nature.\textsuperscript{15}

This following section examines some selected moral principles which clearly signify the Church’s desire to avoid violating inherent human dignity, and to respect and protect this regardless of the nature of the person’s health problem or social status.

\textbf{II.1.2.a. The Principles of Integrity and Totality}

The Principle of Integrity and the Principle of Totality, as two interpenetrating and interdependent aspects of total personhood, are complementary. The latter contributes to the realization of the former as a means to an ultimate end.\textsuperscript{16} Human dignity in the Christian tradition is derived from men and women having been created by God, and the way in which God created them is as body and soul.\textsuperscript{17} Pope John Paul II, in his encyclical on moral theology – \textit{Veritatis Splendor}, also said: “The person, including the body, is completely entrusted to himself, and it is in the unity of body and soul that the person is the subject of his own moral acts.”\textsuperscript{18} The Pope emphasizes: “Only in reference to the human person in his

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‘unified totality,’ that is, as ‘a soul which expresses itself in a body and a body informed by an immortal spirit,’ can the specifically human meaning of the body be grasped.”

In fact, the Catholic teaching pertaining to integrity and totality owes much to the thinking of St. Thomas Aquinas. In his words, he holds that every member of the human body “exists for the sake of the whole as the imperfect for the sake of the perfect. Hence a member of the human body is to be disposed of according as it may profit the whole... If... a member is healthy and continuing in its natural state, it cannot be cut off to the detriment of the whole.” (*Summa Theologiae*, II-II, q. 65, art. 1) In other words, we can explain that surgery to save the life of someone who is sick is an honourable and noble use of the human reason and medical skill; but mutilation of a healthy human being is not, since it harms the integral human being God has created in his own image.

Usually the principle of totality is understood as the duty to preserve the physical whole of the human body, while the principle of integrity refers to each individual’s duty to “safeguard the notion of the human person as a totality in which intellect, will, conscience, sisterhood and brotherhood predominate.” Because all these values are entirely good, in a human person’s less important bodily functions as well as in his or her more worthy spiritual activities, they may never be directly violated at any level of their being.

However, it stands to reason that when a part or a function of the body becomes harmful to the whole body, one may sacrifice that part or function in order to preserve the life of the person. For example, if a person is suffering from breast cancer, the breast may be removed to save her life.

The Catholic moral tradition has developed the principles of integrity and totality as a guide to evaluate the morality of medical treatments and certain life threatening situations in which a part or a function of the body may be harmed. A part or a function of the body may be sacrificed if this is the only way that the health of the whole body and the integral function of the body can be preserved. In the *Ethical and Religious Directives for Catholic Health Care Services*, it is explicitly taught that:

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19 John Paul II, *Veritatis Splendor*, n. 50.
24 Kopaczynski, “Totality and Integrity,” 3A/3.
all persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity. The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.25

If a man’s testicles have cancer, they may be surgically removed to prevent cancer spreading to the whole body. The same would apply to any other parts of the body infected by cancer – it may be surgically removed.

II.1.2.b. The Principle of the Double Effect

There are many situations in everyday life when an action results in more than one effect with moral implications – that is, effects which the agent perceives as either good or evil.26 It is true that in human affairs harm may result as an unwanted side effect of the good we do.27 This happens very often in our lives, especially in the health care sector. Surgery to remove a cancerous organ is performed to save the life of a pregnant woman, but in the process the baby may be lost. A gangrenous leg of a diabetic person is amputated: the patient’s life is saved, but the ability to walk is greatly impaired… To deal with such situations in which one action is followed by two effects, one good (which is intended), the other bad (which is foreseen but not directly intended), there has developed the so-called “Principle of the Double Effect.” In fact, this principle is derived from the fundamental structures of human nature and action. Every truly good human act possesses a “moral integrity” of object, intention, and circumstances of the action. In other words, “the object, intention, and the circumstances make up the ‘sources,’ or constitutive elements, of the morality of human acts.”28

The principle of double effect says that a person may perform an act that he foresees will produce good and bad effects provided that the following conditions are verified at one and the same time:29

With respect to the object of the act:

1) The act to be performed must be good in itself or at least morally indifferent.

With respect to the intention of the act:

25 United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, n. 29.
26 Cf. Griese, Catholic Identity in Health Care, 248-49.
28 Catechism of the Catholic Church, n. 1751.
2) The good effect is directly intended and the bad effect is foreseen but not intended.

With respect to the circumstances, touching upon the effects and the act itself:

3) The good effect is not achieved by means of the bad effect;

4) There must be a proportionately grave reason for permitting the bad effect.  

The first requirement is evident, for if the act is evil of itself, evil would be chosen directly, either as an end or as a means to an end, and there could be no question of merely permitting or tolerating it. It cannot be the subject of the principle of double effect.  

The second condition to be met is that the intention of the person who acts is morally good. The good effect must be the only effect which is the direct object of the human will. The bad effect may be of its own nature merely an indirect consequence of the good act performed.  

The third condition is that the good effect must result immediately from the action and must not be brought about by means of the bad effect. In other words, the good effect cannot result as the consequence of the evil effect. “The evil must be only an incidental by-product and not an actual factor in the accomplishment of the good… We may never do evil in order that good may come of it. A good end does not justify the use of bad means.”  

The fourth condition requires that there must be a proportionate reason for permitting the foreseen evil to occur, a due proportion between the good and evil effects. However, to estimate the proportion may be difficult in practice, especially the vital exact proportion that is due between the intended good and the permitted evil. “It depends not only on a proper spirit of justice and charity, but also on a strong sense of human prudence.”  

The Principle of the Double Effect can be extremely reliable and helpful towards ensuring a sound moral judgement, especially in medical operation and procedures. If individuals had to abstain from performing good actions because of foreseen evil side effects, not only would much good remain unattempted and undone in the world, but many people would be tempted to use that prospect of evil side effects as an excuse to pass up opportunities of doing good

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30 Some authors add one more condition: “The good effect can only be achieved concomitant with, but not by means of, the bad effect.” Cf. Furton, *Ethical Principle in Catholic Health Care*, 83; cf. also Griese, *Catholic Identity in Health Care*, 249-53.


and even shirk their duties in their personal, social and professional lives. “Proper knowledge about the structure of moral act and the principle of the double effect, together with the exercise of prudence, are critically important factors in the moral decision-making process of the health care professional.”

II.1.2.c. The Common Good

In the Pastoral Constitution on the Church in the Modern World, Gaudium et Spes, the Second Vatican Council states:

Individuals, families, and the various groups which make up the civil community, are aware of their inability to achieve a truly human life by their own unaided efforts; they see the need for a wider community where each one will make a specific contribution to an even broader implementation of the common good... The common good embraces the sum total of all those conditions of social life which enable individuals, families, and organizations to achieve complete and effective fulfillment.

In general, the common good means that which is in the interest or well-being of the whole community. A common good is any good which is shared or participated in by many persons. Everyone enjoys some good – maybe a good to be produced or achieved, maybe an already existing good, maybe a true good or merely a temporary good – that is common to all of the citizens or the members of a community. The common good will provide a better quality of life for everyone rather than just a few. In other words, the term ‘common good’ more specifically is used “to designate the overall good at which society, acting together, aims.”

“By common good is to be understood the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily. The common good concerns the life of all.”

Among the elements that compose the common good in modern times are the material infrastructure (systems of transportation, information networks, food supply, waste disposal procedures, health care systems, etc.): a healthy economy – including a stable currency – in which all can productively participate; an educational system that educates the citizens for truth and moral virtue; a morally healthy environment; the administration of justice in all its

35 Griese, Catholic Identity in Health Care, 253-54.
37 Vatican Council II, Gaudium et Spes, n. 74.
forms. This last element is not limited to the adjudication of disputes between individuals and the punishment of criminals as occurs in individualistic political philosophies, but includes also, a fair distribution of the burdens faced to bring about the common good as well as a fair distribution to all the citizens of society’s common goods such as wealth, property, education, health care, etc. Such a distribution does not imply absolute equality, but rather, in accord with the principles of distributive justice, will be proportionate to both the needs of individuals as well as their own contribution to the common good. The requirement of justice implies that respect for the dignity and worth of each person is a necessary component of the common good of society.⁴⁰

Within the state, the government is the authority entrusted to care for the common good. Its function is to oversee and coordinate all the various elements of the common good; it carries out this task primarily by making and enforcing laws. This does not mean, however, that the state itself should take over the procurement and distribution of all the common goods. Rather, the state should encourage as much as possible that the components of the common good be achieved by smaller communities, especially the family. The government must act to procure those goods which it alone can provide such as national defense, the currency, the judicial system, and other goods which, due to historical circumstances, would be unavailable if the government were not to provide them, as for example, education or health care in some underdeveloped countries.

Consideration of the common good is relevant for questions involving health care. Health care itself is clearly a common good of society, an essential element of the general common good. It neither is, nor could it be, produced by a single person. In fact, it is the result of the coordinated efforts of a large number of persons, even of many not directly involved in health care. Also, as a common good, it must be distributed to those who use it, which is, in fact, all the members of the society. This implies, in the first place, that the provision of health care is not just a matter of commutative justice, a simple exchange of goods and services between the provider and the patient. Rather, it must be governed by the principles proper to distributive justice, and implied here is that all members of society have access to it. Second, it falls to the authority within society, ultimately the political authority, to ensure that the distribution of health care takes place and is just, and is consistent with the overall use of society’s resources.

Thus, the government’s concern in this area is legitimate and necessary. For example, the State should build and support public hospitals wherever they are needed.

II.1.2.d. The Ethical Issues of Material Cooperation

As human beings, we usually work together with each other to achieve or preserve important goods that all members of the community will share in. Furthermore, people also cooperate in some ways in order to diminish or avoid worse evil or harm. It is for these basic reasons, according to Catholic moral teaching, that we may legitimately cooperate in a limited way with others who do what we would consider to be wrong, depending on the type of cooperation. The problem is how to distinguish which type of cooperation is morally acceptable.

Among the types of cooperation, the primary distinction is between formal and material cooperation. Cooperation in another’s evil deed may occur by joining that person in the actual performance of the act or by supplying him or her with the means for performing it. In some situations, one person not only helps another to do evil but also knowingly and willingly joins in his or her evil intention. This is known as formal cooperation and explicitly immoral.

A lesser variety of cooperation occurs by assisting in another’s wrongdoing without approving it. The help given assists a person to perform the sinful action, although of itself the help is not wrong. This is known as material cooperation. Unlike formal cooperation, which pertains to the very nature or constitution of an evil action – that is, a sharing in the intent of the agent who performs the actions, material cooperation is merely something external to the evil action. Material cooperation is to be distinguished from formal cooperation principally in the matter of intention. Mentioning about this kind of cooperation, Milton A. Gonsalves says:

There is nothing wrong in what I do or in what I intend, but there is the bad circumstance that my otherwise innocent act aids others in their wrong doing. Consequently, if there is a proportionately grave reason for permitting this evil circumstance, material cooperation can be justified by the principle of double effect.

Material cooperation with another person’s evil actions is allowed provided certain conditions are fulfilled. Such collaboration is licit because the co-operator does not internally approve of the sin of another, nor does he or she approve of the sinful use to which the assistance is put.

42 Cf. Gonsalves, Fagohey’s Right and Reason, 43.
43 Gonsalves, Fagohey’s Right and Reason, 43.
by the other. Material cooperation has several inherent distinctions, but the most basic is that between immediate and mediate material cooperation.

- In immediate material cooperation, one person actually does something morally wrong with another person. Thus if a physician and an assistant are both engaged in a voluntary active euthanasia, the cooperation of the assistant is immediate. Immediate material cooperation in the sinful act of another is always wrong. That is why the Directive n. 70 of the *Ethical and Religious Directives for Catholic Health Care Services* specifically forbids Catholic health care organizations from engaging in immediate material cooperation in acts judged by the Catholic teaching to be intrinsically immoral, “such as abortion, euthanasia, assisted suicide, and direct sterilization.”

“Theologians maintain that in the objective order, immediate material cooperation is equivalent to implicit formal cooperation because the object of the moral act of the cooperator is indistinguishable from that of the principal agent.” It is pointless to say that a person who is not under duress performs a criminal action without intending to do so.

- To distinguish between immediate and mediate material cooperation, Orville N. Griese states: “Cooperation in evil can be allowed in certain circumstances if it is material (no sharing of evil intent) and mediate (sufficiently removed from actually joining the principal agent in performing the procedure)”.

Mediate material cooperation occurs in the wrong action of another, but not in such a way that one actually performs the act with the other or agrees with the evil intention of the other. While doing something that is in itself good or indifferent, a person rather gives an occasion to another’s sin, or contributes something by way of assistance. In addition, the assisting or facilitating action or deed must not only be something which, in itself, is either good or at least indifferent, but there must be a proportionately serious reason for cooperating as well as serious consideration of the scandal element. An example of this would be a health care worker employed in a secular hospital that also provides immoral procedures, but does not require those with the conscientious objections to participate in such procedures. It is a form of cooperating with the circumstances surrounding the wrongdoer’s act. Depending on how closely these circumstances impinge upon the act, there is a distinction between proximate and remote material cooperation. (Proximate material cooperation would be, for example, the work of the recovery room nurse

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who cares for all post-surgical patients, including those who may have undergone morally illicit procedures. This form of routine care is not intrinsically evil.)

The morality of mediate material cooperation is to be judged on the principle of the double effect. In fact, this kind of cooperation can be justified for a sufficient reason to permit the evil effect and if scandal can be avoided.

The extended discussion about the ethical issues of material cooperation may help the health carers, especially those who are employed in non-Catholic hospitals or clinics to make right decisions when facing dilemmas in their work.

II.1.2.e. Ordinary versus Extraordinary Means

Another issue which constitutes an important approach to the analysis of ethical dilemmas arising from the general obligation to preserve human life and the limits of that obligation is “ordinary” and “extraordinary” means of treatment.

The distinction between the “ordinary” and “extraordinary”, or “proportionate” and “disproportionate” means of treatment to preserve human life has a long history, especially in the Catholic Church. As conceived in the Catholic moral tradition, the approach to the treatment holds that one is obliged to preserve his or her own life by ordinary means, but is under no obligation to use extraordinary means. Over 50 years ago Pope Pius XII stated that the use of ordinary means for the preservation of life and health was morally necessary. His clarification of the morally relevant meaning of ‘ordinary’ and ‘extraordinary’ means in relation to patients and others is balanced and still relevant today: “… normally one is held to use only ordinary means – according to circumstances of persons, places, times, and culture – that is to say, means that do not involve any grave burden for oneself or another.”

It is also clearly stated in the Ethical and Religious Directives for Catholic Health Care Services:

While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of

47 Furton, Ethical Principle in Catholic Health Care, 134
48 Other terms have been suggested and are in general usage, such as “proportionate” and “disproportionate”, “reasonable” and “unreasonable”, or “heroic” and “nonheroic”, but there is no pair of words that exactly replaces the nuances of “ordinary” and “extraordinary”. In this writing, I prefer to use two pairs: “ordinary”-“extraordinary” and “proportionate” and “disproportionate” because they are more traditional and precise descriptive terms.
benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.\textsuperscript{50}

What, then, are ordinary and extraordinary means of treatment? According to Gerald Kelly, arguably the most important Catholic medical ethicist prior to the Second Vatican Council, they are: “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.” On the other hand, extraordinary treatment comprises: “all medicines, treatments and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.”\textsuperscript{51} His definition is seen to be approved by the Vatican when in the \textit{Declaration on Euthanasia}, the Church states that:

In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.\textsuperscript{52}

And in adopting the same approach, the Catholic Bishops of the United States also quote this definition as a source to clarify the terms:

A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgement of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose expensive expense on the family or the community. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgement do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.\textsuperscript{53}

From these definitions, we may have an initial concept of the distinction between ordinary and extraordinary means of treatment. It is important, however, to note that there has been a

\textsuperscript{50} United States Conference of Catholic Bishops, \textit{Ethical and Religious Directives for Catholic Health Care Services}, n. 32.

\textsuperscript{51} Gerald Kelly, \textit{Medico-Moral Problems} (St. Louis, Missouri: The Catholic Hospital Association of the United States and Canada, 1958), 129.

\textsuperscript{52} Congregation for the Doctrine of the Faith, \textit{Declaration on Euthanasia} (1980), section IV.

\textsuperscript{53} United States Conference of Catholic Bishops, \textit{Ethical and Religious Directives for Catholic Health Care Services}, nn. 56-57.
difference in the way the line is drawn, between ordinary and extraordinary means by medical science on the one hand and moral theology on the other hand.

In medicine, a means is ordinary when it is conventional or scientifically established, statistically successful and reasonably available. If any of these conditions is lacking, the means is considered to be extraordinary.

The alternate way of distinction, most often used today, is based on moral theology. It includes both burdens and benefits of the treatment to the patient. Morally speaking, a means is ordinary if it is beneficial, useful and not unreasonably burdensome to the patient. There is a consideration of reasonable cost as well. “Here, even if the treatment itself may be inexpensive and not cause any great discomfort, it is extraordinary and therefore optional if the benefits it promises are light or nonexistent when seen in the context of the patient’s overall condition.”\(^5^4\) In ethical analysis, the distinction between ordinary and extraordinary, or proportionate and disproportionate separates what is regarded as morally obligatory treatment for a particular patient with a serious but curable disease or illness (ordinary treatment) from what is merely optional (extraordinary treatment). However, the criteria for distinguishing between “morally ordinary” and “morally extraordinary” means to prolonging life are not very precise. In reality, some treatments that are freely available, inexpensive and that would, if applied, predictably prolong the patient’s life – are under certain circumstances considered “extraordinary” or “disproportionate”, and thus not obligatory.\(^5^5\) Many objective and subjective factors, therefore, must be weighed to make decisions in medical treatment, or to determine whether it is morally obligatory or morally optional.

In the light of the theological tradition and the Magisterium, there is no moral obligation to preserve life at all costs. “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.”\(^5^6\) The significant human benefits and the disproportionate burdens of a patient, or of his or her family and community, are perceived to be essential elements to determine ordinary (morally obligatory) or extraordinary (optional) means of treatment.

\(^{5^4}\) Kelly, *Contemporary Catholic Health Care Ethics*, 130.


\(^{5^6}\) *Catechism of the Catholic Church*, n. 2278.
II.2. The Implications of Theological Principles for Health Care

The discussion in the preceding sections has shown a basis for some selected moral principles, which respect and protect the inherent dignity and the sanctity of human life. This has been and still is considered the foundation of Catholic moral teachings for centuries. The Second Vatican Council states clearly that it is the duty of the Church “to declare and confirm by her authority the principles of the moral order which spring from human nature itself.”

This section continues to explore the implications of theological anthropology which somehow would be more specific for ethics and ought to be applied to the health care sector.

II.2.1. Quality of Life

The Roman Catholic tradition always admits that human life is sacred because it is God’s free gift and participates in God’s own holiness (cf. Gen 1:26-7; Mt 5:48). Human life is characterized by the sanctity of its origin and divine support. The Christian tradition, however, has historically sought to avoid any form of medical vitalism, which is a view that requires patients to continue to be treated in all circumstances and under any condition because life is considered an absolute value. It is never obligatory to make use of medical measures that are morally extraordinary in order to prolong or preserve life. In the words of the Catechism of the Catholic Church, “If morality requires respect for the life of the body, it does not make it an absolute value.” Human life is not to be judged and evaluated only by its intrinsic sanctity.

There is another factor which also plays an important role in making ethical decisions about health care – the quality of life. This phrase, “the quality of life”, has become popular in contemporary debates in different areas of the society, especially in medical ethics (for instance, euthanasia, abortion). An analysis of the concept “quality of life”, therefore, would be helpful in attaining a clear understanding of the various ways it can be used in practical ethics.

First of all, quality of life in some contexts focuses on improving the quality of life for members of a society or region – purer air, better food, water, privacy, education, leisure, working conditions, health and so on. The quality of life judgements, moreover, may be also

58 Cf. Section II.1.2.e. Ordinary versus Extraordinary Means
59 Catechism of the Catholic Church, n. 2289.
based on the criteria of human well-being. Some moralists accept that human life has special value because humans are self-aware, rational, autonomous, purposeful, moral beings, with the capacity for relationship, curiosity, hopes, ambitions, ideals... According to Joseph Fletcher, if any of these criteria are lacking “there is no person at all, or that such a being is a person but needs to be cared for, or that a person should strive for the optimal development of these human dimensions.”60 Here the argument is that human life loses all value when certain qualities are lacking. Consequently, certain human lives are considered unworthy of living. This point of view is actually a poor understanding of “quality of life” judgements. It is considered as pernicious by some who rely on these judgements to deny the equal value of all human beings.

The problem is the term “quality of life” has no finite definition; it is not clear to which empirical states the term refers, nor is it manifest how any particular person will evaluate those states. Quality of life may reflect the subjective satisfaction by an individual with his or her own life (physical, mental and social situation), or even the objective conditions of his or her family or society (wealthy or poor, developed or non-developed). That is why in some situations, a treatment has been judged excessively burdensome and thus not worth pursuing, even though it offers some benefits to the patient. These situations may be: it is too painful, too damaging to the patient’s bodily self and functioning, too psychologically repugnant to the patient, too restrictive to the patient’s liberty and preferred activities, too suppressive of the patient’s mental life, or too burdensome to his or her family (or community).61 The question is: Must or may the patients forgo the treatment available today to prolong life because of their quality of life? May they appeal simply to ‘quality of life’ considerations in assessing their duty to preserve their lives?

In Catholic moral teaching one may rightly choose to withhold or withdraw treatment or a means of preserving life, if that treatment/means employed is either useless or excessively burdensome. Treatment may morally be withheld or withdrawn from patients who are permanently unconscious or seriously debilitated (e.g. with strokes, cancers, Alzheimer’s disease or AIDS dementia), if it fails to heal or is an excessive burden. This would not improve the patients’ quality of life. However, it is very important to be sure that the judgement made here is not that the patient’s life is useless or excessively burdensome and so

60 Joseph F. Fletcher, “Four Indicators of Humankind: The Enquiry Matures,” Hastings Center Report 4, no.6 (December 1975): 4-7; Kelly, Contemporary Catholic Health Care Ethics, 35
not worth living; rather, that the judgement made is that the treatment or the means used to preserve life is useless or excessively burdensome. In other words, it is most necessary to scrutinize the reasons when making judgements based on the quality of life, “to ensure that such judgements are not guided by a discriminatory attitude regarding the value of the lives of persons with disabilities or by an intention of deliberately hastening the death of such persons.”

It is accepted that the term “quality of life” is useful as a contribution to shaping moral rules, and in determining just reasons for both maintaining or ceasing treatments to prolong human life.

II.2.2. Human Life as Individual and Social

While discussing the “Quality of Life” judgements, there appears to be another angle of human life which must be recognized and adequately considered by health care ethics: the human significance of both the individual and society. One of the most striking features of our world today is the emphasis on the individual. Individualist philosophy is trying to create structures where the individual could not only survive, but also could thrive. Individualism believes that a person has his or her own freedom and right to decide their own lives and develop their own interests without taking the interests of society into consideration. In health care ethics, this emphasis is of frequent occurrence. Some patients simply think that they have a right of access to every treatment no matter how costly the treatment is; or some others, because of their own reasons, just want to forgo the treatment to hasten their death without counting the impact on their family or community.

However, nothing of what we have discovered from the Christian understanding of the human person agrees with this emphasis. Sacred scripture teaches that men and women were created “in the image of God”, but God did not create men and women as solitary beings. From the beginning “male and female God created them.” (Gen 1:27) “This partnership of man and woman constitutes the first form of communion between people. For by their innermost nature men and women are social beings; and if they do not enter into relationships with others they can neither live nor develop their gifts.”

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63 Vatican Council II, Gaudium et Spes, n. 12.
social relationships, nurtured by them, fulfilled in them, and frustrated by them. \(^64\) Supporting this view-point, the Second Vatican Council states:

> The fact that human beings are social by nature indicates that the betterment of the person and the improvement of society depend on each other. Insofar as humanity by its very nature stands completely in need of life in society, it is and it ought to be the beginning, the subject and the object of every social organization. Life in society is not something accessory to humanity; through their dealings with others, through mutual service, and through fraternal and sororal dialogue, men and women develop all their talents and become able to rise to their destiny. \(^65\)

But there are dangers if the importance of the individual is neglected. Individualism is almost rejected in human society, but this rejection is sometimes done so easily that this theory could rightly be replaced by its opposite theory – collectivism or corporatism, which is also unacceptable. David F. Kelly suggests that: “While it is true that the individual cannot live in isolation and may not rightly neglect the common good, it is also true that the corporate whole of society, the collective, the state, may not rightly trample on individuals.” \(^66\)

In reality, society will flourish only if the individual flourishes as well. Individualism and corporatism, therefore, should together contribute their import in improving the society and fulfilling the life of human beings. Too much emphasis on the individual can lead to a decision that neglects the common good; a misplaced emphasis on the corporate whole can lead to unethical decisions. This is proved very clearly in medical ethics, especially in critical care. Human life of the individual is always sacred and inviolable but it does not mean that society is obliged to provide unlimited funds for the health care of a single human life. Is it morally right to perform a heart transplant operation, which may cost a fortune, while many people are starving? Scarce medical resources must be allocated in a just and effective way. On the other hand, society has to meet its obligations to provide medical care to those who need it because health in all its manifestations is “such an essential part of the dignity and indeed the destiny of human life.” \(^67\)

II.2.3. Autonomy

Autonomy is a word often used by philosophers in the recent centuries. The prevailing interpretation of autonomy is that of ethical liberalism, which attributes a supreme value to


\(^{65}\) Vatican Council II, *Gaudium et Spes*, n. 25.

\(^{66}\) Kelly, *Contemporary Catholic Health Care Ethics*, 38.

\(^{67}\) Kelly, *Contemporary Catholic Health Care Ethics*, 40.
the individual’s freedom and rights. According to this philosophy, autonomy is limited only by the obligation to respect others’ freedom to choose and to follow their own plans, or to fulfill commitments still outstanding, or not to cause harm to others.  

68 Thomas Shannon gives a standard definition: “Autonomy is a form of personal liberty of action in which the individual determines his or her course of action in accordance with a plan of his or her own choosing.”

69 Gerald Dworkin began a book on autonomy by listing about a dozen distinct understandings of the notion. He suggested that it has been variously equated with: liberty (positive and negative), dignity, integrity, individuality, independence, responsibility and self-knowledge, self-assertion, critical reflection, freedom from obligation, absence of external causation and knowledge of one’s own interests.  

70 In many ways, autonomy, or the right to self-determination, mandates a strong sense of personal responsibility for our own lives, especially the freedom to make of ourselves what we want to be, by making decisions according to our own values and plans. In common usages, autonomy implies being one’s own person or being able to act according to one’s beliefs or desires without interference.

With the perspective of Christian anthropology, the Second Vatican Council makes it clear that autonomy should be properly understood in full accordance with the Christian message:

Many of our contemporaries seem to fear that a close association between human activity and religion will endanger the autonomy of humanity, of organizations and of science. If by the autonomy of earthly affairs is meant the gradual discovery, utilization and ordering of the laws and values of matter and society, then the demand for autonomy is perfectly in order: it is at once the claim of humankind today and the desire of the creator.

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Here we can see that Catholic and secular perspectives concur in their affirmation of the importance of autonomy. To Y. Michael Barilan, “respect for personal autonomy is respect for persons disposed to the development and pursuance of coherent, non-predatory, and rich life plans and their corresponding systems of values.”

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In health care, autonomy plays a prominent role for treating patients as persons with values, goals, and limits. When the autonomy of a competent adult comes into conflict with virtually


71 Vatican Council II, Gaudium et Spes, n. 36.

any other principle in bioethics, particularly beneficence, autonomy always takes priority.\textsuperscript{73} Physicians are expected to respond to the needs of patients in treating and making decisions related to their health, because autonomy is a right of every person to control his or her body and life decisions. It means that a person has the right, in accordance with his or her own value commitments and beliefs, to determine whether and to what extent he or she shall submit himself or herself to any recommended course of treatment. This is also the case in relation to terminally and hopelessly ill patients and, accordingly, a patient has the right to refuse even life-sustaining treatment.\textsuperscript{74} Those who hold this view argue that our liberty should include the freedom to choose and control not only life but also how and when we die. Competent individuals may have the right to end treatment upon request or even ask the physician to assist them in dying because of their free choice which harms no other person. Many people believe that the more autonomy is practised, the higher the human dignity is respected.

Such an opinion is unwise and would take us too far afield when exercising our autonomy. In fact, misinterpreted and improperly practised, autonomy proves destructive of authentic human good. Autonomy is not without its limits. It is not the only value and respect for autonomy is not the only moral imperative. In the real circumstance, there are physical conditions or disease, or some elements of the social and cultural context which may impair the freedom and knowledge of a person and thus, inhibit his or her autonomy. A person, for example, with diminished capacity or lack of maturity may not be able to understand the facts about a particular medical procedure or may not be able to process them effectively enough to make an adequate decision.\textsuperscript{75} In this case, the principle of beneficence or of distributive justice should be applied. Moreover, “if by the term ‘the autonomy of earthly affairs’ is meant that material being does not depend on God and that humanity can use it as if it had no relation to its creator, then the falsity of such a claim will be obvious to anyone who believes in God. Without a creator there can be no creature.”\textsuperscript{76}

While no one doubts that autonomy is a crucial value of human beings, too heavy a reliance on autonomy can isolate one from the community, from one’s family, and worse according to the Christian perspective, from God the Author of autonomy and life. To precisely determine

\textsuperscript{73} Peter Hung Manh Tran, \textit{Advancing the Culture of Death: Euthanasia and Physician-Assisted Suicide} (Melbourne, Victoria: Freedom Publishing, 2006), 104.
\textsuperscript{76} Vatican Council II, \textit{Gaudium et Spes}, n. 36.
the authenticity of this notion, it is essential to examine the theological principles of divine dominion and human stewardship.

II.2.4. Divine Dominion and Human Stewardship

Christian theology always believes that human beings live in a world of grace. Everything comes to us as a gift from the gratuitousness of a gracious God, even a sharing in the creative action of God in the world. This notion is found in the first chapter of Genesis:

God created man in the image of himself, in the image of God he created him, male and female he created them. God blessed them, saying to them, ‘Be fruitful, multiply, fill the earth and conquer it. Be masters of the fish of the sea, the birds of heaven and all living animals on the earth. (Gen 1:27-27)

The story obviously demonstrated that it was God’s original purpose to create the human person with a gift of the rational nature (intelligence and freedom) and with a special status in the realm of creation and subjugated all other creatures to him – a reasonable sharing in God’s dominion or authority over the rest of creation. This sharing involves a stewardship, which should never be abused or misused, on all of creation. (Gen 1:26) “Created in God’s image, we were designed to function as God’s representatives.”77 However, one of the major concerns of Christian moral reflection is to answer such a question as this: How far does this sharing dominion of human beings extend?

Indeed, the good steward is the person who exercises his God-given autonomy and dominion for the good not only of self, but also of the others entrusted to the care of the steward. The leading U.S. evangelical Richard Cizik supposes that: “When I die, God isn’t going to ask me: ‘Did I create the Earth in six days or five days?’ but ‘What did you do with what I gave you?’”78 Moreover, the steward has free range of action, yet this in the sense of autonomy and dominion is not unlimited. Two Dominican scholars, Benedict M. Ashley and Kevin D. O’Rourke, in their writings related to human stewardship, also elaborate on what they call the “Principle of Stewardship and Creativity”:

The gifts of multidimensional human nature and its natural environment should be used with profound respect for their intrinsic teleology. The gift of human creativity especially should be used to cultivate that nature and environment, with a care set by the limits of human beings’ actual knowledge and the risks of destroying these gifts.79

78 Quoted by Juliet Eilperin, Washington Post, 8 August 2007, A01.
The principle of divine sovereignty asserts that God alone has absolute sovereignty over creation, we share in God’s dominion only as creatures. God never ceases being God and we never cease being creatures. This Lordship of God especially holds true in the matters of life and death. “Human life and death are thus in the hands of God, in his power: “In his hand is the life of every living thing and the breath of all mankind,” exclaims Job (12:10). “The Lord brings to death and brings to life; he brings down to Sheol and raises up” (1Sam 2:6). He alone can say: “It is I who bring both death and life.” (Deut 32:39) In fact, to confess that God is the Lord of life and death affirms the fundamental distinction between Creator and created, and it affirms that as creatures, humans owe their existence, value and personal dignity to God. We are not absolute masters of our own life and body. We have no dominion over life but responsibility for it as one of stewardship, not ownership. The renowned Bernard Haring argues from his fundamental conviction that human life is a sacred gift of God and similarly supports that: “Life is entrusted to man’s freedom and co-responsibility. He is not an independent lord of his life but a steward under the sovereignty of God.”

Based on this conviction, the Roman Catholic moral tradition has regarded taking innocent human life as “intrinsically evil” by defect of right because human persons have only a right to the use of human life, not to dominion over human life. St. Thomas Aquinas when arguing against suicide asserted that we have the reasonable “use” of our lives, not their “possession” and thus, the end of human life is not subject to a person’s free judgement:

That a person has dominion over himself is because he is endowed with free choice. Thanks to that free choice a man is at liberty to dispose of himself with respect to those things in this life which are subject to his freedom. But the passage from this life to a happier one is not one of those things, for one’s passage from this life is subject to the will and power of God. (II-II, q. 65, a. 5, ad 3)

Once again, the moralist Bernard Haring makes an explicitly theological argument against any direct intervention in the dying process to end life on the basis of sovereignty and the limits of human stewardship. For Haring, we exercise our freedom in death by accepting ourselves as creatures of God and by admitting to our powerlessness in the face of death. Our freedom does not extend to bringing about death at the time and under the conditions we

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82 Cf. Gula, *What Are They Saying about Euthanasia?*, 32.
stipulate. Pope John Paul II also argued against euthanasia by asserting our limited stewardship over life and death:

The man is certainly free, inasmuch as he can understand and accept God's commands. And he possesses an extremely far-reaching freedom, since he can eat "of every tree of the garden". But his freedom is not unlimited: it must halt before the "tree of the knowledge of good and evil", for it is called to accept the moral law given by God.

However, not all moralists definitely agree with this argument. They vary in the way of dignifying the freedom of human beings, especially in issues related to human life. For example, Richard Westley, on the basis of faith in the incarnation, claims that the divine and human are so wedded to one another as to eliminate any talk of divine and human prerogatives. According to Westley, the mystery of the Incarnation tells us that God has chosen to make divine work our own. Since God lives in us, whatever belongs to divine dominion also belongs to us. Westley also challenges absolute sovereignty and limited stewardship by exploring the meaning of life as a “gift” from God. If life is given as a gift, then it is obviously subject to our freedom. Like Westley, Daniel C. Maguire makes an equation of Creator and creature but on different grounds. He draws upon an interpretation of the human person as being an “image of God,” a co-creator with God. On this basis, he finds an opening for a more expansive moral authority over life and death.

It is true that much more could be said regarding the principles of divine dominion and human stewardship, but each interpretation must be an expression of Christian anthropology: the human being should always be in the proper relation to God the Creator. Perhaps one line from the Second Vatican Council comes as close as possible to saying it best of all: “remembering that in all temporal matters they are to be guided by a Christian conscience, since not even in temporal business may any human activity be withdrawn from God’s dominion.”

85 John Paul II, Veritatis Splendor, n. 35.
87 Richard Westley, Morality and Its Beyond (Mystic, CT: Twenty-Third Publications, 1984), 238.
II.3. The Moral Status of Compassion

Suffering is an indispensable reality of human life. The Buddha spoke of what he called dukkha, or suffering, that none of the members of the human family can avoid. In one way or another, we have to be faced with the painful conditions that life brings us. They may be spiritual sufferings (despair, guilt, bad conscience, anguish and loneliness), or physical pains (disease, accident); or financial worries, poverty, hunger, starvation for some, family concerns and personal stress, environmental and social problems, being victims of war, violence and terrorism for others. There is much more detailed analysis about suffering in the works of Eric Cassell, one of the leading experts in suffering. He says:

These two facts, that suffering always includes ideas about the future and suffering always rests on the meaning of events, give us the most important fact about suffering; bodies have no sense of the future and bodies do not assign meaning. Only persons have a sense of the future and assign meaning. Bodies do not suffer, only persons suffer. Suffering is the specific distress that happens when persons feel that their intactness or integrity is threatened or is disintegrating and it continues until the threat is gone or intactness or integrity is restored.

Though all the world’s faiths admit the presence of suffering and cannot inoculate us against the painful conditions of life, many religious traditions can provide spiritualities that address the suffering. One of them is compassion. This notion refers especially to the concept of karuna in Buddhism, ‘humaneness’ in the Confucian tradition, and rahmah in Islam.

Father James McNamara shares his experiences when dealing with others’ suffering. He insists that dramatic moments of others may lead us to compassion. Hardships and misfortune of others may teach us a lot about the power of the virtue of compassion. In fact, compassion is not simply about feeling sorry for the vulnerable, nor is it even just about empathy. Rather, compassion is both a response to the vulnerable and a determination to help them. In other words, compassion presents a complex but more easily identifiable structure, which in Martha Nussbaum’s analysis entails a combination of cognitive, affective and

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volitional elements. In compassion we see another’s distress (cognition), we feel moved by it (affectively) and we actively seek to remedy it (volition).\textsuperscript{94}

II.3.1. Compassion: The Sentiment and the Virtue

Compassion is a word used frequently in the moral lexicons of most religions, especially Catholic Christians, and secular humanism. Both Christians and secular humanists begin at the same point that the feeling of compassion is an emotion experienced by everyone in the presence of another person’s suffering. Compassion, therefore, is an affective state founded on the dignity of human beings: feeling something of another’s suffering, suffering along with another, and making another’s suffering at least partially our own.\textsuperscript{95} Professors of the University of Murcia, Ortega Ruiz and Minguez Vallejoz, in their article The Role of Compassion in Moral Education say:

It is only because man has dignity that he is capable of compassion. Without compassion, nobody would feel pity for him and he would not feel pity for others. Only if the dignity of others is recognised and respected can misery, suffering and oppression be considered as an offence toward man and engender our compassion.\textsuperscript{96}

However, there is a significant difference when Christians and secular humanists come to access the moral status of compassion and the way each responds to its urgings. On the one hand, Catholic teachings always present the image of Christ full of compassion for the sick, the dying, the afflicted, the aged, and affirm the Church’s commitment to health care ministry “to see healing and compassion as a continuation of Christ’s mission.”\textsuperscript{97} Christians are invited to be compassionate as Christ was compassionate: to relieve suffering, but always with respect for the inviolable sanctity and dignity of all human life, however fragile, young or old, sick or well.\textsuperscript{98} For the Christian, compassion alone is not yet a virtue but a sentiment which cannot function as a reason for moral choice. Sentiment is not a virtue unless ordered by reason. On the other hand, there is the claim of secular humanists that the sentiment of compassion has moral weight of its own. For them, compassion is, itself, a virtue and not only an emotion or spontaneous feeling beyond the control of reason. “It is not a negation of life or the resigned acceptance which darkens this life and finally destroys it. Compassion inevitably

\textsuperscript{95} Cf. Furton, Ethical Principle in Catholic Health Care, 13-14.
\textsuperscript{97} United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, General Introduction; cf. also Pope John Paul II’s encyclical Evangelium Vitae.
\textsuperscript{98} Cf. Furton, Ethical Principle in Catholic Health Care, 13.
expresses itself in the fight for justice.” The secularists believe that compassion justifies taking the lives of those who are in pain, helping them to take their own life, or taking the lives of others to relieve suffering, for example, by aborting the genetically imperfect foetus or by ending the lives of terminally ill individuals.

Between the Christian and secular interpretations of compassion, there is a grave moral and conceptual dissonance. As Evangelium Vitae so richly attests, the resulting dichotomy leads in opposite directions – to a “new culture of life” on the one hand, or to the culture of death on the other. “In our present social context, marked by a dramatic struggle between the “culture of life” and the “culture of death”, there is need to develop a deep critical sense, capable of discerning true values and authentic needs.”

II.3.2. Compassion in the Secular World

As mentioned above, secular humanists claim that the sentiment of compassion itself is a warrant for action, and in itself is a virtue to which reason can add little. In fact, the modern secular meaning of compassion arose with the sentimentalist philosophers of the eighteenth century who assumed a moral sense that made humans compassionate. Jean-Jacques Rousseau (1712-1778), for example, argues that compassion for the suffering of others is a natural sentiment which is a better guide to virtue than Christian teaching. “The possibility of compassion is lodged deep inside us, and it is one of the most basic aspects of who we are. We can choose to ignore the feeling and live unnaturally, or we can cultivate the experience of compassion to bring us closer to the rest of humankind.”

David Hume (1711-1776), when defending the sentiments against the excessive claims of reason, also insists that “reason is and ought to be the slave of compassion,” and that morals are beyond the grasp of reason. They, and others, presume that the feeling of compassion is a virtue without the need for guidance by reason. For them, suffering is the greatest evil, and the relief of suffering, the greatest good.

Today, this theory is considered as the religion of conscientious secular humanists. It exalts the sentiment of compassion to a self-justifying principle. As long as a thing is done out of genuine compassion, as long as it ‘feels good,’ it is morally good and, even if taken to an

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100 John Paul II, Evangelium Vitae, n. 95; cf. also Furton, Ethical Principle in Catholic Health Care, 13.
extreme, morally requisite. This has come to mean killing or assisting in the suicide of the chronically and terminally ill (inoperable cancer or the last stage of AIDS) or comatose adult who is reluctant to die. It also entails killing or failing to provide sustenance for the badly handicapped infant whose prospects for a “quality” life are dim, aborting the inconvenient pregnancy, hastening the death of severely depressed persons whose life has lost its satisfaction. Many share the impression that those who die quickly of trauma or quietly in their sleep have “good deaths.” According to the secularists, thus, when we have it in our power to facilitate such “humane deaths,” we fail in our obligations to our fellow beings when we do not do so.

To Michael Manning this argument is straightforward, but problematic. The major impetus is focused on the right to self-determination. It does not follow, indeed it seems contradictory, to place the power of life and death in the hands of others, even if they act out of mercy and compassion. William F. May is also a severe critic of the argument of secular humanism about compassion. He feels that the true test of a compassionate society lies not only in investing even more money in intensive care facilities, but in shifting our medical priorities to preventative, rehabilitative, long-term, and terminal health care services, which would provide all patients with a realistic alternative to a quick death.

It is undeniable that suffering is certainly an unavoidable element of the human condition, and the suffering of others often elicits our compassion. But to rank compassion as a virtue in itself which results in reducing or eliminating suffering at all costs and by whatever means is hardly acceptable. Compassion needs not to be opposed to reason if it is to be a virtue and not degenerate into a vice. Edward J. Furton believes that the logical outcome of tenderness separated from its source in Christ is terror. Compassion is an emotion that itself demands to be served, to have its source removed – the suffering of the observer – as much as the suffering of the patient.

II.3.3. Compassion as a Christian Virtue

For the Christian, compassion in itself, simply as an emotion, is neither a virtue nor a vice. It is not a self-justifying principle. It is the way we choose to act with reference to the emotion that makes it a virtue or a vice. In this view, Aristotle said:

104 Cf. Furton, Ethical Principle in Catholic Health Care, 14.
105 Manning, Euthanasia and Physician-Assisted Suicide, 42.
107 Furton, Ethical Principle in Catholic Health Care, 15.
Neither the virtues nor the vices are feelings, because we are called good or bad on the basis not of our feelings, but of our virtues and vices; and also because we are neither praised nor blamed on the basis of our feelings (the person who is afraid or angry is not praised, and the person who is angry without qualification is not blamed but rather the person who is angry in a certain way), but we are praised and blamed on the basis of our virtues and vices.\textsuperscript{108}

It is true that when compassion becomes a habitual disposition, a consistent willingness to share in, and to relieve, another’s suffering, it becomes a character trait. This character trait becomes a virtue when it inclines a person to make good moral choices with the means used to relieve suffering. To make choices, the sentiment of compassion must be ordered by reason to the good for humans.\textsuperscript{109} That is the reason why, as a virtue, Christian compassion disposes us to do all we can to relieve suffering, but only in a way that also helps the sufferer to attain the ultimate good, the best interests. It cannot respond by elimination of the sufferer on the basis of compassion. To do so would violate the sanctity of life and the sovereignty of God as I discussed in the previous sections. Rather, Christian compassion relieves suffering as zealously as does the secular humanist but more effectively within the ethical constraints of natural and divine law.

Christian compassion recognizes charity as the source without which the emotion of compassion can so easily justify the remedy of death and oblivion for any disposition we take to be suffering. Charitable compassion gives us insight; it enables us to see Christ in our suffering neighbour. Without this insight, we experience the emotion but may not be able to direct it to healing rather than extinguishing the sufferer along with the suffering. Without charity, compassion ceases to be a virtue and becomes a vice that blinds us to the true needs of the suffering person. “Compassion as a virtue is, however, more than a general agreement that it is desirable to reduce or eliminate illness and disability. It is both a response to the ill and disabled and a determination to help them.”\textsuperscript{110} Edmund D. Pellegrino and David C. Thomasma also affirm that: “Compassion is the concrete evidence that the virtue of charity is at work in the healer. It is the leitmotif of Christ’s own healing. We need to understand that his compassion is more than pity or sympathy. It transcends social work, philanthropy, and


\textsuperscript{109} Furton, \textit{Ethical Principle in Catholic Health Care}, 15.

\textsuperscript{110} Gill, \textit{Health Care and Christian Ethics}, 101.
government programs.” Furthermore, those who believe in Christ conceive that to kill the sufferer is to interrupt his or her way of the cross, his or her journey to salvation. In the Declaration on Euthanasia, the Congregation for the Doctrine of the Faith states:

What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses... According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will. Therefore, one must not be surprised if some Christians prefer to moderate their use of painkillers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified (cf. Mt. 27:34).

A focus on compassion as a Christian virtue also helps us to recognize that suffering comprises more than physical pain. It calls upon us to discern the many spiritual causes of human suffering – alienation from healthy people, anger with God, feelings of guilt for being a burden to others, shame at one’s physical appearance, weakness, and the anguish resulting from avoidance and rejection by the world of the healthy. Fully in agreement with this argument, American Catholic bishops apply it to the health care sector:

Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human persons. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and to relieve human suffering.

In short, compassion for suffering is an emotion felt by all decent human beings. Both Christians and secular humanists agree that compassion motivates the desire in all conscientious persons to alleviate suffering. But moral choice determines the way this desire is expressed in beneficent action. In each choice, the feeling of compassion functions in agreement with reason and revelation. Without these, compassion can become an instrument of death. The only answer to suffering lies in the Gospel of Life. As Pope John Paul II tells us,

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112 Furton, Ethical Principle in Catholic Health Care, 16.
113 Declaration on Euthanasia (1980), section III.
this is the only antidote to the nihilism, self-delusion, and despair of a society in which oblivion and death are the panaceas for human ills.\footnote{Cf. John Paul II, \textit{Evangelium Vitae}, nn. 29-31; cf. also Furton, \textit{Ethical Principle in Catholic Health Care}, 16.}
III. APPLICATIONS TO THE END-OF-LIFE ETHICAL ISSUES

With the solid foundation derived from the theological basis for Catholic health care, medical professionals may find out the answers for their concerns: For example how to overcome challenges in their profession without failing to meet the requirements for authenticity as a Catholic and Christian. This chapter is to analyze some important issues in modern-day health care ethics, especially emphasizing the end-of-life issues. It seems that these issues are some of the areas where ethics come into play most visibly. In other words, this is the place where Catholic health care workers can at the same time have both opportunities and challenges in their profession and living out their faith.

III.1. Determination of Death

One of the most critical moments in our life is the end of that life. We all have general agreement that death is an important moment of our lives. Discussion however, about that moment, about death’s significance and its occurrence is not as simple and indisputable as it may seem. In contrast, determining death and even defining death have become the focus of intense debate in recent times among theologians, ethicists, jurists and the public at large.¹ This debate will definitely continue and bring about a number of sharply conflicting ethical frameworks for the resolution of treatment dilemmas at life’s end. Consequently, human death has been raising some challenging issues for those who are involved in caring for the lives of terminally or otherwise hopelessly ill patients.

III.1.1. The Need for an Examination of Criteria for Determining Death

It is important to distinguish the notion of the definition of death from the notion of the determination of death. A definition of death is an ontological concept: it pertains to what death is. In contrast, criteria for the determination of death are epistemological concepts: they relate ways in which we know whether death has occurred or not.² If criteria for the determination of death are confused with the definition of death, then, depending upon what the criteria are, some people might not be truly dead but nevertheless meet the criteria. For example, if an individual is declared dead because it is determined that a substrate or base for

consciousness is lacking, then even though the individual spontaneously continues to function as an integrated organism, he or she would be considered dead.\(^3\)

The consequence of this confusion causes some significant problems for the health care professionals when they deal with patients at their end-of-life stage. There are two possibilities, which have raised a number of ethical issues if death is not properly determined. The first one is that a dying patient may be treated as if he or she is dead: forgoing the treatments, life-support systems being switched off, and more seriously, with the increasing use of organ transplants, a person may have vital organs removed before he or she is actually dead. Robert Veatch has rightly suggested a reason which has moral primacy: a person who is alive ought not to be treated as though he or she were dead. Until death can be clearly determined, a patient retains all human rights and must be treated with the respect due the living, even though he or she may be dying.\(^4\) The second possibility is that a patient will be treated as alive though he or she is actually dead, e.g. a person’s brain is completely destroyed but his or her circulation and respiration are being artificially maintained by mechanical devices. This is not so much about the self, but rather a concern for the patient’s relatives. They will be emotionally distressed by the continued concern and misplaced hope for the person’s recovery and by the financial burden which the family or community may have to carry in order to keep up the mere appearance of life in a family member’s corpse.\(^5\) The truth is we ought to provide appropriate care to the living, but once death occurs we would offend human dignity if we did not replace artificial life-support means with behaviour more befitting a deceased patient.\(^6\)

The framework developed by Veatch has been still highly influential in this discussion. He identifies four approaches of death as competing in the determination of death discussion: Cardiopulmonary Death (a person is dead when his or her heart and lungs stop), Metaphysical Death (a person is dead when his or her soul separates from his or her body), Whole Brain Death, and Cerebral or Neocortical Death.\(^7\) Each of these approaches implies that human life involves some interconnectedness of various aspects of the human person and that death results when this interconnectedness breaks down. However, the problem is that these

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\(^6\) Cf. Gula, What Are They Saying about Euthanasia?, 10.

\(^7\) Cf. Shannon and Kockler, An Introduction to Bioethics, 131-33.
approaches cannot be treated as though they exist on the same level. The philosophical and theological concept of the separation of soul and body does not share the empirical or physiological plane of the others.\(^8\) Therefore, a common definition and accepted standards for determining death are necessary, especially for the medical profession.

For this reason, the following sections are going to discuss an examination of the definition of death and its diagnostic criteria. The need to determine death clearly and precisely is essential not only for the professions of medicine to fulfill properly and confidently their duty, but also for the patients and their relatives to believe that death is not so much the end but to humbly accept death as a ‘rite of passage,’ for human beings.

### III.1.2. Philosophical and Theological Dimensions of Determining Death

While medical and scientific professions are trying to affirm the criteria to determine death, philosophers and theologians talk more about the concept of death. Although the philosophical and theological definitions of death are not on the same level with the empirical criteria for determining death, these dimensions are very important in solving significant debates about the determination of death.

Philosophers have argued convincingly that the definition of death, while grounded in human biology, is, ultimately, a philosophical question. To define death, one must answer the question ‘What function is so essential that its irreversible loss signifies the death of a human being?’ Once a correct definition of death is chosen, a criterion can be selected for determining that the definition has been fulfilled. In other words, specific criteria are valid only because they fulfill a philosophically defensible definition.\(^9\)

Like the theological point of view, most philosophers believe that death is defined by the separation of the soul from the body. The soul is the ultimate integrating factor of the human being. Since the soul is the integrating principle of an individual’s existence, the brain, which is considered an instrument for this purpose must be the organ by which the organization of the human is effected. Therefore, current philosophers accept medical standards to determine brain death as a valid means for determining human death, “as long as they are applied correctly, to suitable subjects, and the various precautions identified by neurologists and others competent in the field are carefully observed.”\(^10\) Bernard Haring also accepts whole

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\(^8\) Gula, *What Are They Saying about Euthanasia?*, 11.


brain death: “Personally, I feel that the arguments for the equation of the total death of the person with brain death are fully valid.”\textsuperscript{11} The problem is that philosophy fails to answer some questions related to the soul: When does the soul exactly separate from the body? What happens to the soul? What relationship does the soul retain to the body and the material world?

Theologically speaking, death means that a person has lost the capacity to continue God’s gift of life. When a person’s receptive capacity for this gift ceases, then human life ends, the person is dead. For a Christian, death is not seen as a total destruction or annihilation of the human person. Death is a transition to eternal life.\textsuperscript{12} Death, then, can be viewed from two different perspectives, death as disintegration and death as transformation. Consequently, the classical theological formula for death has been “the separation of body and soul”, but when we look at death, “we are not witnessing the termination of a person but rather the transformation of a person from one life to another life.”\textsuperscript{13} From this notion of death, it seems that Christian theology lacks the competence to determine the moment of death. Even the Catholic Church in the United States also acknowledges this reality when she said: “The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.”\textsuperscript{14}

Even though both philosophical and theological understandings of death are not incompatible with neurological or cardiopulmonary criteria to establish the time of death, they, with the value of speaking of death as the separation of body and soul, do indicate the question we need to ask when determining death, namely, ‘When does the inner unity of the person cease?’\textsuperscript{15} To answer this question, we need empirical criteria which are discussed in the next section.

\textbf{III.1.3. Medical and Scientific Dimensions of Determining Death}

Traditionally theologians, philosophers, moralists and lawyers have agreed with physicians about the standards of defining death and clarifying the criteria for determining when death has occurred. According to them, the death of human persons has been determined by certain

\textsuperscript{11} Haring, \textit{Medical Ethics}, 136.
\textsuperscript{12} Cf. Donald G. McCarthy and Edward J. Bayer, eds., \textit{Handbook on Critical Life Issues} (St. Louis, Missouri: The Pope John XXIII Medical-Moral Research and Education Center, 1982), 212; cf. also Gula, \textit{What Are They Saying about Euthanasia?}, 12.
\textsuperscript{13} McCarthy and Bayer, eds., \textit{Handbook on Critical Life Issues}, 212.
\textsuperscript{14} United States Conference of Catholic Bishops, \textit{Ethical and Religious Directives for Catholic Health Care Services}, n. 62.
\textsuperscript{15} Cf. Gula, \textit{What Are They Saying about Euthanasia?}, 13.
clinical signs: the cessation of spontaneous respiration and the absence of a heartbeat. In other words, when the heart stopped beating and the lungs stopped breathing, the person was considered dead. In most cases, the circulatory and respiratory criteria are sufficient to determine death. However, modern medical technology has thoroughly changed this way of determination. For example, the biomedical revolution may render the means of keeping persons alive when otherwise there would be no spontaneous respiration or heartbeat. Such means include the use of mechanical respirators, mechanical heart assistance, and pharmacological agents that stimulate and strengthen cardiovascular activity.\textsuperscript{16} In the case that a person’s life is being sustained by these technological devices, it is very difficult to determine, using the traditional criteria for death, whether the individual is dead or alive.

Since the possibility of a false determination of death using the traditional methods – cessation of spontaneous respiration and circulation – medical science has developed an alternative means: brain-death criteria. With the specific function of regulating the capacity for bodily integration, whole brain death has been adopted by the great majority of physicians and bioethicists as a clear sign of a person’s death. Richard Gula holds that neurological integration of the body’s physiological system is very necessary. It is important to take into consideration the vitality of the person as an integrated whole, not just of one or two organs taken independently of the whole. Without the whole brain functioning, the individual is able to integrate neither his or her internal bodily environment nor social environment through consciousness. Whole brain death is considered an improvement over the cardiorespiratory determination of death because it shows that breathing and circulation are necessary though not sufficient to establish that a person is alive.\textsuperscript{17}

While the method of whole brain death seems to be generally accepted in the medical profession to determine human death, brain-death criteria would detect the difference. In 1968, Doctor Henry Beecher of the Ad Hoc Committee of the Harvard Medical School first proposed a set of criteria which are popularly know as the “Harvard Criteria” to determine the surety that the brain is dead. The following criteria describe the characteristics of an irreversible coma and are the ones most widely recognized to determine brain death:

1. Total unawareness of externally applied stimuli and complete unresponsiveness to even the most painful stimuli.

\textsuperscript{17} Gula, What Are They Saying about Euthanasia?, 14-15.
2. No spontaneous muscular movements and no spontaneous breathing. After the patient is on the mechanical respirator, the total absence of spontaneous breathing is tested by turning off the respirator for three minutes to observe whether any effort is made to breathe spontaneously.

3. No reflexes except those mediated by the spinal cord (pupils fixed and dilated and do not respond to bright light; no ocular movements; no evidence of postural activity; no oral activity; no motor reflexes).

4. An isoelectric or flat electroencephalogram (EEG) for at least a full ten minutes is to be used to confirm the three tests above. This is not diagnostic but only confirmatory.\textsuperscript{18}

If all the above tests, upon being repeated twenty-four (24) hours later reveal no change, the person is to be considered dead on the basis of irreversible brain damage. The validity of the data as indications of whole brain death depends on excluding two conditions: hypothermia (body temperature below 90° F) or the use of central nervous system depressants, such as barbiturates.\textsuperscript{19}

Over the last forty years, many clinical experiences prove that if the Harvard criteria are properly applied, then one can be secure that the determination of death is correct, that the person is dead. Though there are still arguments against these criteria, it can be said that no person known to have met the Harvard criteria has survived.

It must be noted that brain-death criteria and the traditional criteria as I mentioned above do not represent tests for two different deaths. One death is determined by two different means. Since the loss of respiratory and cardiac function will inevitably destroy the brain, the heart-lung criteria are reliable determinations of death and can serve as short-cuts for determining death in most cases. Only when the heart-lung criteria cannot be used are the brain-oriented criteria very necessary.\textsuperscript{20} In his research, George Khushf believes that: “Two criteria are advanced for determining death: (1) irreversible cessation of circulating and respiratory


\textsuperscript{19} Cf. Gonsalves, \textit{Fagothey’s Right and Reason}, 283-84; cf. also Gula, \textit{What Are They Saying about Euthanasia?}, 16.

functions and (2) irreversible cessation of all functions of the entire brain, including the brain stem.”

It is obviously true that the significant uncertainty and debate about the definition and determination of death will still continue. This also brings about a lot of challenges for health carers, especially those who are caring for the dying persons. These challenges could be: How to assure that positive care for the dying is always available at the proper time and in the appropriate manner? How to help the dying patients come to terms with their death and make their relatives ready to cope with the bereavement at the loss of a loved one? How to control the anxiety aroused by the need of organ and/or tissue transplants for physicians to exercise their moral responsibilities in determining death?

In my opinion, the right attitudes of health care professionals in dealing with the death of patients should be caring with respect for the ill and dying until their very end-of-life stage, and thus humbly accept death as an indispensable fact for human beings. Medical staff cannot help people to live forever. Pope Benedict XVI says in his Spe Salvi that “it is true that to eliminate death or to postpone it more or less indefinitely would place the earth and humanity in an impossible situation, and even for the individual would bring no benefit.” Rather, it should be part of the purpose of the health care profession to let the patients afflicted by a terminal illness or condition, die naturally with peace and dignity when it has exhausted its resources and measures to help them live.

### III.2. The Ethics of Pain Management

When approaching the end of their lives, most people wish to die comfortably. Related to this issue, well-known health scientist Karen E. Steinhauser, whose primary interest is end-of-life care, proposed six major components of a ‘good death’: identifying pain and symptom management, clear decision making, preparing for death, completion (of activities in one’s life), contributing to others and affirming the whole person. Among these six important aspects for making the end of peoples’ lives ‘good’, pain management plays a significant role. Poorly managed pain can not only create unbearable pain and suffering for patients and for family members who witness it, it can also prevent the patient from engaging in necessary

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psychological, existential, or spiritual work. For this reason, an adequate pain management plan must be carefully considered in medical practice for the dying.

III.2.1. Categories of Pain

Pain is a common experience throughout life and also a common fear surrounding dying. Pain operatively is a subjective, complex and multidimensional experience which has physical, psychological, emotional and spiritual elements. Due to its complexity, a simple agreed definition for pain is elusive. According to Harold Merskey and Nicolai Bogduk, the International Association for the Study of Pain (IASP) defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” The description of pain as “a sensory and emotional experience” indicates that it can negatively affect patients’ emotional states. In turn, emotional states can influence pain perception. Even beyond this, pain has a global effect on the functioning aspects, including fear that any activity will make the pain worse.

There are many ways to distinguish different types of pain, but one of the broadest categories is acute and chronic pain. Acute pain is usually of brief duration (less than six weeks) associated with tissue injury such as surgery, dental work, burns or other somatic damage, which normally subsides as healing takes place. Acute pain serves a precise biological purpose, alerting the system that damage has occurred. Mild acute pain may be managed successfully with patient intervention at home. However, the pain may also indicate problems and motivate the person to seek medical advice.

Chronic pain, on the other hand, is generally described as pain that has been persistent for some time; the accepted standard of duration for diagnosis is six months. However, in the case of patients with advanced diseases, this time frame does not necessarily apply and may actually result in underestimation of the patient’s suffering and, thus, in poor pain management. Chronic pain may be further divided into non-malignant pain and malignant pain.

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29 Strada, The Helping Professional’s Guide to End-of-Life Care, 94.
pain. Non-malignant pain, e.g. back pain or arthritis, is not life threatening and palliative medicine is the therapeutic response. Such pain is defined as “the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.” While the disease and condition may be untreatable, most of chronic non-malignant pain and symptoms often can be treated effectively. The other kind of chronic pain is malignant. Chronic malignant pain is associated with terminal conditions, often linked to cancer, where the progression and spread of the disease lead to pain. Malignant pain is one of the severest categories. Millions of cancer patients suffer pain that could be relieved and managed by proper treatment. Analgesic drugs in particular, are an effective approach to managing cancer pain; these include aspirin, codeine, morphine, and their substitutes. In general, chronic pain is usually viewed as appropriately treatable on a long-term basis by opioid analgesics.

Dying comfortably and with dignity is the overall goal for the patients with terminal illness, especially for the patients who are approaching death. However, this goal cannot be achieved if patients’ pain is not well controlled. Therefore, it is essential to note that pain must be actively treated with all modalities available in patient care, particularly in caring for those who are suffering with persistent, agonizing pain in their final moments of life.

III.2.2. Obstacles to Pain Management

Pain management is defined in the most recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines as “a comprehensive approach to the needs of patients, residents, clients, or other individuals served who experience problems associated with acute or chronic pain.” Hence, an understanding of pain and its management are important aspects in patient care. Therefore greater focus needs to be given to pain management. “Failure to properly manage pain – to assess, treat, and manage it – is professional negligence.”

31 That is why some documents use the term “cancer pain” to indicate this kind of pain; cf. Chamley and James, “Pain Management,” 656.
However, pain management is so complex – not only because of different types of pain, but also differences in the way individuals react to their pain and to pain medication – that it may bring about some problems for health carers.

Firstly, it is really difficult for a physician who has the responsibility of managing a patient’s pain while trying to minimize adverse effects of the analgesic. These undesired effects may include, for example, drowsiness, respiratory depression, constipation, urinary retention, as well as the potential for physiological drug dependency. More than that, using analgesics, particularly the narcotic analgesics, may cause sedation, drug addiction or with an overdose of morphine or other drug, even hasten death of the patient. This means of relieving pain arouses some unresolved moral and legislative debates related to making treatment decisions and physician-assisted suicide issues which will be discussed in the following sections.

Secondly, many patients believe that God relates to their pain, namely, they see pain as a punishment or a test from God. For them, if a disease or pain is God’s punishment for sin, “what right do we have to try to change God’s punishment? What right do we have to undo what God wants done?” Or if pain is a test from God the same as in the biblical story of Job, the patients may feel guilty about analgesics, since it might seem that they are avoiding the test of God. These arguments, together with the difficulties noted above, may be major obstacles to recovery or to pain management. To find out the exact solution for these problems, let us focus on the ethics of pain management.

III.2.3. The Morality of Pain Management

Father Albert S. Moraczewski, O.P., said: “To die with dignity and gracefully, means at the very least, to be free from the fear of death and dying; to be free from pain; to be able to communicate with family and other loved persons; and to be at peace with God, having received the sacraments of consolation.” Clearly, the patient has a right to pain relief, particularly when they are dying, and it is the physician’s responsibility to manage pain when the patient experiences it. More recently, the National Conference of the United States Catholic Bishops reaffirms: “Patients should be kept as free of pain as possible so that they

36 Kelly, Contemporary Catholic Health Care Ethics, 224.
may die comfortably and with dignity, and in the place where they wish to die.”\textsuperscript{38} However, to control pain satisfactorily sometimes raises important ethical considerations.

For the majority of patients, pain can often be well managed with medications, including opioids, while preserving consciousness.\textsuperscript{39} But in some extreme cases, pain medications may bring forth some side effects, such as sedation which can cause the loss of consciousness or even hasten the moment of death for the patient. Pope Pius XII has officially addressed this issue:

Is the removal of pain and consciousness by means of narcotics (when medical reasons demand it) permitted by religion and morality to both doctor and patient even at the approach of death and if one foresees that the use of narcotics will shorten life? The answer must be: “Yes” – provided that no other means exist, and if, in the given circumstances, that action does not prevent the carrying out of other moral and religious duties.\textsuperscript{40}

Pope John Paul II taught the following on the use of pain-killing drugs:

…it is licit to relieve pain by narcotics, even when the result is decreased consciousness and a shortening of life, "if no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties". In such a case, death is not willed or sought, even though for reasonable motives one runs the risk of it: there is simply a desire to ease pain effectively by using the analgesics which medicine provides.\textsuperscript{41}

The Catholic Church in America also 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.”\textsuperscript{42} To justify this statement, it is helpful for health care professionals to apply the Principle of Double Effect that has already been discussed. Sedation or even death is the possible bad effect, which is not necessary to achieve the goal of pain relief, the good effect. There is no intention on the part of doctors to cause death when caring for patients with appropriate medications to relieve pain. What is sought

\textsuperscript{38} United States Conference of Catholic Bishops, \textit{Ethical and Religious Directives for Catholic Health Care Services}, n. 61.
\textsuperscript{40} Pius XII, \textit{Anaesthesia: Three Moral Questions}, Address to a Symposium of the Italian Society of Anaesthesiology, February 24, 1957, English translation in \textit{The Pope Speaks} 4, no. 1 (1957): 48.
\textsuperscript{41} John Paul II, \textit{Evangelium Vitae}, n. 65.
\textsuperscript{42} United States Conference of Catholic Bishops, \textit{Ethical and Religious Directives for Catholic Health Care Services}, n. 61.
directly is relief from severe pain, not death.\textsuperscript{43} Engaging in this argument, the \textit{Charter for Health Care Workers} affirms:

Sometimes the use of analgesic and anaesthetic techniques and medicines involves the suppression or diminution of consciousness and the use of the higher faculties. Insofar as the procedures do not aim directly at the loss of consciousness and freedom but at dulling sensitivity to pain, and are limited to the clinical need alone, they are to be considered ethically legitimate.\textsuperscript{44}

The moral issue arising here is what about the patient who does not wish to be sedated? This decision may be for good reasons (to be alert to talk with visiting relatives, to be given the opportunity to take care of spiritual matters…) or even for other reasons (to suffer more for past sins and thus escape God’s wrath).\textsuperscript{45} “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.”\textsuperscript{46} Therefore, the ethical answer to this question is that if patients are capable of making treatment decisions, their decision is to be followed. It would be ethically wrong to sedate patients without their knowledge.\textsuperscript{47} If the level of pain is so severe that management may cause the patients to be unconscious, it is morally important for them to be aware of this possibility before being administered sufficient quantities of pain medications.

Another problem that health care providers should also be attentive to is drug addiction. Some people believe that using morphine and similar compounds may result in drug addiction for the patient, and so this kind of pain control is immoral. Once again, the specific Catholic moral rule – the Principle of Double Effect – can be effectively applied. When no other means exist, high doses of morphine may be administered in pain treatment for the dying because even though physical addiction may be foreseen, the intention of achieving the good effect is to be free from severe pain (e.g., as a patient with terminal cancer), not drug addiction. In other words, strong pain medications, usually morphine or other opioids, are ethically acceptable to be used for the proportionately grave reason of treating severe pain in a very ill patient for whom there is no other means of relieving the suffering.\textsuperscript{48} In a case where the

\textsuperscript{43} Moraczewski, “The Ethics of Pain Management,” 14/3.
\textsuperscript{45} Pope John Paul II affirmed that “while praise may be due to the person who voluntarily accepts suffering by forgoing treatment with painkillers… such ‘heroic’ behaviour cannot be considered the duty of everyone,” in \textit{Evangelium Vitae}, n. 65; cf. also Kelly, \textit{Contemporary Catholic Health Care Ethics}, 225.
\textsuperscript{46} United States Conference of Catholic Bishops, \textit{Ethical and Religious Directives for Catholic Health Care Services}, n. 61.
\textsuperscript{47} Kelly, \textit{Contemporary Catholic Health Care Ethics}, 225.
\textsuperscript{48} Putnam, “Pain Management and Palliative Care,” 150.
patient is not dying and addiction to drugs is likely to prove harmful to the patient, the physician has to seek to adjust the dose or even eliminate it if possible.\textsuperscript{49}

To sum up, pain management is one of the most efficient means of providing comfort and of helping prepare dying patients and their families for the process leading up to death. Nevertheless, this process is not taken as lightly as it sounds. Indeed, when caring for the patients at this traumatic time as death approaches, medical professionals have to deal with the complexities of treating pain, and the anxieties of the patients and their relatives. It is, therefore, very important for health carers to be fully aware of the best knowledge with a thorough assessment of pain management and also other elements (psychological, emotional, spiritual...), that cause suffering for the patient and family at the end of life. “Clarifying issues for patients and families around pain relief and level of consciousness is central to reassurance and to providing appropriate care.”\textsuperscript{50} Furthermore, in my view, Catholic health workers can be of significant support and consolation by explaining the Catholic tradition and teachings for pain management to the patients and their loved ones. Thanks to this guidance, the patients can not only be very comforted by the pain treatment administered, but also deeply appreciative of the meaning of the pain they are enduring. “Suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will.”\textsuperscript{51}

\textbf{III.3. Forgoing Treatment}

Natural reason and Christian morals say that man (and whoever is entrusted with the task of taking care of his fellowman) has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health. This duty that one has toward himself, toward God, toward the human community, and in most cases toward certain determined persons, derives from well ordered charity, from submission to the Creator, from social justice and even from strict justice, as well as from devotion toward one’s family.\textsuperscript{52}

It is clear that the goal of the medical profession is curing patients and helping them live as comfortably as possible. Nowadays, in spite of the best intentions and the rapid medical technological advances, health care providers sometimes fail to give this “necessary treatment for the preservation of life and health.” It occurs daily in most hospitals that in some


\textsuperscript{50} Putnam, “Pain Management and Palliative Care,” 150-51.

\textsuperscript{51} \textit{Declaration on Euthanasia} (1980), section III.

\textsuperscript{52} Pius XII, “The Prolongation of Life,” 94.
situations life-prolonging treatments seem to prolong a life of suffering and the dying process rather than give a chance for healing or recovery. The questions therefore, are: Must medical professionals initiate treatment or continue it once initiated? Might it be morally acceptable to forgo or withdraw life-sustaining treatments? These problems in fact, have been promoted by the case of Karen Ann Quinlan in 1976 and continued to raise unceasing legal and ethical controversies about a ‘right to die’, euthanasia, guardianship, civil rights and especially ‘forgoing treatment’.

III.3.1. Duty of Reasonable Care and Treatment of Patients

“The term and concept of health care embraces all that pertains to prevention, diagnosis, treatment, and rehabilitation for greater equilibrium and the physical, psychic, and spiritual well-being of the person.” It is thus, necessary to acknowledge that health is an important human good, and in health care ethics, the basic moral principle is that we are morally bound to undergo the reasonable medical treatment for the preservation of health and life. Doctors normally have a moral duty to provide, and patients to accept, ordinary or proportionate means of healthcare “according to circumstances of persons, places, times, and culture – that is to say, means that do not involve any grave burden for oneself or another.” From the foundation rooted in a commitment to promote and defend human dignity and a concern to respect the sacredness of human life, the Catholic Church clearly states: “Everyone has the duty to care for his or her own health or to seek such care from others. Those whose task it is to care for the sick must do so conscientiously and administer the remedies that seem necessary or useful.”

However, the duty of care for health and life is not unlimited. Though human life and health are inherent goods of the person they are not absolute values. Francis J. Moloney through biblical reference, gives an explanation of the relative importance of life on earth:

53 Karen Ann Quinlan, a young American girl, had lain in persistent vegetative state in hospital since April 15, 1975 without any prospect of recovering consciousness. Her breathing was assisted by means of a respirator and she was fed through a tube inserted in her stomach. Her adoptive parents, devout Catholics, applied to the courts for permission for the respirator to be switched off. The judge at first refused permission but the New Jersey Supreme Court eventually ruled in her parents’ favor. Her case affected the practice of medicine and law around the world. Cf. I. M. Kennedy, “The Karen Quinlan Case: Problems and Proposals,” Journal of Medical Ethics 2, no. 1 (March 1976): 3-7.
54 Pontifical Council for Pastoral Assistance to Health Care Workers, Charter for Health Care Workers, n. 9.
57 Declaration on Euthanasia (1980), section III.
Could it not sometimes be said of a certain fanaticism to protect and prolong life at all costs that the Old Testament understanding of God’s blessings being available only to “this life” still predominates? According to the whole of the Bible (both Old and New Testaments) life as we live it in the world is certainly central, but it still has a certain relative status vis-à-vis the greater biblical idea of the universal lordship of God which transcends life and death.\(^{58}\)

This explanation is actually addressed by Pope Pius XII when he states the moral implications of prolonging life: “A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities, are in fact subordinated to spiritual ends.”\(^{59}\) Pope John Paul II agrees with this opinion and he teaches:

when death is clearly imminent and inevitable, one can in conscience "refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted". Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.\(^{60}\)

And it is also necessary to reiterate the words of Pope Benedict XVI in his encyclical letter \textit{Spe Salvi} in 2007: “it is true that to eliminate death or to postpone it more or less indefinitely would place the earth and humanity in an impossible situation, and even for the individual would bring no benefit.”\(^{61}\)

In reality, there are some situations such as, a confident prognosis indicates the patient’s condition is incurable or that a cure might be possible but the cost to the patient in terms of suffering and pain might be too much for the patient to bear, or the treatment is too burdensome or disproportionate to the availability of medical resources, personnel, family and state finances… in which health care professionals “are not morally obliged to go beyond the bounds of reason to provide every possible medical treatment.”\(^{62}\)

\(^{59}\) Pius XII, “The Prolongation of Life,” 94.
\(^{60}\) John Paul II, \textit{Evangelium Vitae}, n. 65.
\(^{61}\) Benedict XVI, \textit{Spe Salvi}, n. 11.
It is true that the moral permissibility of patients forgoing life-sustaining medical treatment has gradually been accepted. While intentional killing is always wrong, in some situations the terminally ill or dying can refuse or withdraw treatment. For health care workers, their duty is not only to restore health or to save life, but also to help the dying patients to prepare emotionally and spiritually to die naturally, in peace and with dignity. Consequently, forgoing life-prolonging treatment is not a failure of the medical profession. On the contrary, it is in specific circumstances a good medicine, a responsibility to fulfill and a proper way to express “acceptance of the human condition in the face of death.”

**III.3.2. Ethical Issues in Forgoing Treatment**

Although forgoing treatment has come to be widely accepted and applied in medical practice all over the world, there is still some confusion and anxiety among the patients, their families and even the health carers. One can base decisions to forgo or withdraw medical treatment on a variety of principles and values, but it is proved that most of ethical issues in forgoing and withdrawing treatment concentrate on three thematic distinctions: between ordinary and extraordinary means, killing and allowing to die, and the tension between a sanctity of life perspective and a quality of life perspective. Since these distinctions were initially mentioned in Chapter II, there is no need for further repetition. However in this section, they should be briefly reiterated in terms of their great effects in forgoing treatments.

* **Ordinary and Extraordinary Means of Treatment**

This is a crucial distinction in making decisions whether to undergo or to forgo a treatment. It is simply held that while extraordinary treatment can be permissibly forgone, ordinary treatment cannot. This distinction probably originated within Roman Catholic moral theology where extraordinary treatment was understood as treatment which was excessively burdensome for the patient. From that standpoint, many court decisions and health care institutions have made reference to extraordinary treatment when endorsing the permissibility of forgoing life-preserving treatment.

The problem here is that there is much confusion to obtain a clear distinction between ordinary and extraordinary treatment. It is not easy to determine ‘ordinary’ or ‘extraordinary’ merely basing it on medical or empirical factors (readily available, relatively inexpensive, likely to employ, and no longer experimental…). It must be also considered under the criteria

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of moral analysis (the foreseen burdens and the benefits reasonably expected of the treatment). Moreover, because of the difference among humans, it must be recognized that the burdens and the benefits involved may be evaluated differently by different persons. It is therefore, very necessary to identify and assess the benefits and burdens to the patient, the family or the community at a particular place and time. A treatment that is ordinary for one patient in particular circumstances can be extraordinary for another or even for that same patient in different circumstances (for example, a Jehovah’s Witness likely sees a blood transfusion as extraordinary because his or her religion prohibits it under penalty of eternal damnation).

In short, to ascertain whether it is ethically right to forgo or withdraw a life sustaining treatment, one has to consider the interpretations of ‘ordinary’ and ‘extraordinary’ being made by both medical or empirical routine and moral judgements. Furthermore, it is always vital to notice the patient’s particular perspective when making decisions about the forgoing or termination of treatment.

- Killing and Allowing to Die

The second distinction on which one can make decisions regarding forgoing treatment is between killing and allowing to die. According to this distinction, the intentionally direct killing of an innocent human being is always morally wrong, but allowing a person to die naturally is sometimes morally right. It is clear that in this difference, which is embodied in the Catholic traditional Principle of Double Effect, the intention plays a very important role. Intention is not the only element to consider here, but it is an essential element. “The moral worth of a person is not jeopardised in the case of the indirect permitting of harm for proportionately justifying reason, but it is always eroded by directly intending moral evil.”

Thus, direct and indirect ‘intention’ makes a moral difference between killing and letting die. For example, in caring for the terminally ill, physicians sometimes find themselves facing the conflict in medical contexts. They want to relieve the patient’s unbearable pain, but in some instances relieving pain (e.g., stopping life sustaining treatment is one of the ways) may cause the patient to die. In this case, physicians can be generally justified because death becomes the indirect effect of an action intended to relieve pain, the direct effect. In other words, forgoing or withdrawing treatment when the intent is never the death of the patient, but rather

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65 Shannon and Kockler, An Introduction to Bioethics, 146; cf. also Brock, Life and Death, 169.
66 Cf. Kelly, Contemporary Catholic Health Care Ethics, 134; cf. also Brock, Life and Death, 172-75.
68 Cf. Gula, What Are They Saying about Euthanasia?, 39.
the cessation of non-beneficial treatments or technology that just prolongs the natural dying process this is morally acceptable.\textsuperscript{69}

Nevertheless, the treating team must be aware of not only what they are doing and intend to do, but also the knowledge of the patients. They need to be informed about the various treatment options and/or about stopping treatment as well. Adequate communication between all concerned – doctors, nurses, patients and family members – is particularly important in making decisions to forgo treatment and even in resolving any eventual ethical difficulties.

In fact, the Catholic tradition of maintaining a moral difference between killing and allowing to die on the basis of intentional discriminations is a complex one, and there are even some arguments against the significant role of ‘intention’ about this issue (such as Robert Veatch, Daniel C. Maguire, Paul T. Menzel, Dan W. Brock, …). In the practice of medicine, however, all physicians rightly believe that the directly intended termination of any patient’s life is always morally wrong; and at the same time, most of them also agree that the withdrawal of futile and unwarranted treatment in terminal cases is a good medicine. Doctor Norman M. Ford, SDB in his writing affirmed:

> Neither the community nor doctors should regard the existence of incurable disease or the inevitability of death as indicators of failure. A time does come when health care professionals may, and/or should, after discussing matters with their patients and obtaining their consent, cease life prolonging medical treatment in favour of initiating palliative care in the best interests of their patients.\textsuperscript{70}

\textit{The Sanctity of Life and the Quality of Life}

Another distinction pertaining to forgoing treatment is a tension between the sanctity of life and the quality of life. Those who argue for a sanctity of life ethic believe that human life is valuable and sacred and thus, absolutely inviolable. According to the secular version of the sanctity-of-life doctrine, one must protect human life at almost any cost and it is never allowed to terminate human life under any circumstances.\textsuperscript{71} This view supports the idea that a patient’s life must be prolonged even if continued life is not of benefit to the patient. It is one of the reasons why forgoing or withdrawing treatments which may cause death to the patient is normally condemned by supporters of the sanctity-of-life doctrine. On the other hand, according to a quality of life ethos, one may encounter circumstances in which the obligation

\textsuperscript{69} Shannon and Kockler, \textit{An Introduction to Bioethics}, 147.
\textsuperscript{70} Ford, “Ethical Dilemmas in Treatment Decisions at the End of Life,” 69.
to protect and preserve human physical life no longer exists. For example, it is not obligatory to continue chemotherapy in a patient with advanced cancer if the therapy causes more suffering than benefit for the patient. It seems that the notions of sanctity of life and quality of life may sometimes lead the arguments over forgoing medical treatments in opposing ways.\textsuperscript{72}

Here we should notice that in Catholic theological perspective, though “human life is the basis of all goods, and is the necessary source and condition of every human activity and of all society”\textsuperscript{73}, staying alive is not of ultimate value. Pope John Paul II recognized that the good of human life is limited. In \textit{Evangelium Vitae} he stated that “certainly the life of the body in its earthly state is not an absolute good.”\textsuperscript{74} This perspective reminds us that while preserving human life is good, the biological life particularly in the health care context, is not the highest value. “Life is not an absolute good that must be preserved at all costs, and death is not an absolute evil to be avoided at all costs.”\textsuperscript{75} It is thus, not always wrong to be killed (e.g., individual self-sacrifice, the defense in war of the values of democracy and liberty), but to intentionally kill an innocent human being is morally prohibited. It is true that the secular humanist position which seems to be saying that the sanctity of life ethos is absolute, has gone too far beyond the theological viewpoint. Furthermore, we also need to obtain a proper understanding of quality of life to avoid misusing the term. The phrase is not used so as to deny the human dignity of debilitated patients by categorizing their lives as unworthy to be lived.\textsuperscript{76} James J. Walter, who seeks to reconcile the tension between sanctity and quality of life, offers a definition that we should put into consideration:

the word “quality” in the phrase quality of life does not and should not primarily refer to a property or attribute of life. Rather, the quality that is at issue is the quality of the relationship which exists between the medical condition of the patient, on the one hand, and the patient’s ability to pursue life’s goals and purposes (purposefulness) understood as the values that transcend physical life, on the other.\textsuperscript{77}

Both terms – sanctity of life and quality of life – have their own important role in health care ethics in general and particularly in forgoing medical treatments. It is essential to profoundly

\textsuperscript{72} This issue has been discussed in Section \textbf{II.2.1. Quality of Life}; cf. also Shannon and Kockler, \textit{An Introduction to Bioethics}, 148.

\textsuperscript{73} \textit{Declaration on Euthanasia} (1980), section I.

\textsuperscript{74} John Paul II, \textit{Evangelium Vitae}, n. 47.

\textsuperscript{75} Gula, \textit{What Are They Saying about Euthanasia?}, 137.

\textsuperscript{76} Cf. David Albert Jones, \textit{Approaching the End: A Theological Exploration of Death and Dying} (New York: Oxford University Press, 2007), 214.

understand their functions and to reflect on how to balance the perspectives of these positions in decision making to forgo treatments. “We must recognize that there comes a time when the treatment alternatives are exhausted, the burdens difficult or unbearable, and the benefits few… The ethical task then is to stop the efforts to cure, and to intensify our care as we accompany the patient on his or her last journey.”

**III.4. Withdrawing and Withholding Medically Administered Nutrition and Hydration**

Whereas forgoing medical treatment has come to be more morally and legally approved, the ethical problem of withdrawing and withholding artificial delivery of nutrition and hydration is often more difficult and raises more controversies. It has recently gained much attention in public and health care discussions, especially due to technological advances in keeping people alive.

Most ethicists agree that artificial nutrition and hydration should be given to patients who cannot eat and drink naturally because food and water are basic and necessary elements for preserving life. It is therefore, unjustifiable for physicians to withhold or forgo medically administered nutrition and hydration (MANH). This might seem to make them the direct cause of their patients’ deaths by starving and dehydrating them, and would be wrong. Many worry that artificial feeding is ordinary care, not extraordinary and so must be obligatory.

The questions arising here are: Is MANH always sufficient to properly achieve its purpose which is providing nourishment without causing any suffering for the patients, especially those who are in post-coma unresponsiveness (PCU) or in a persistent vegetative state (PVS)? Is MANH really an ordinary care which brings about no expensive costs or heavy burdens for the patients, their families and communities at all times?

To obtain a satisfactory solution on this issue, it is important to more carefully consider the term medically administered nutrition and hydration, because it would be overly restrictive to hold that anyone is morally obliged to do something that is of not really significant benefit.

**III.4.1. Artificial Delivery of Nutrition and Hydration: Comfort Care or Medical Treatment?**

The first thing which should be stressed is that there are persons who believe that providing artificial nutrition and hydration (ANH) is not normal care but medical treatment. According to them, this technology is sometimes considered ‘extraordinary’ treatment and thus, can be

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79 Cf. also Brock, *Life and Death*, 184.
80 The issue concerning persistent vegetative state (PVS) will be developed in more detail in the next section.
withheld or forgone. Related to this issue, the American Academy of Neurology asserts that: “The artificial provision of nutrition and hydration is a form of medical treatment and may be discontinued in accordance with the principles and practices governing the withholding and withdrawing of other forms of medical treatment.”

Though they admit that feeding (providing food and drink) is part of basic care and sick people must always be fed, ANH is a world apart from naturally eating and drinking. It is a medical technology to provide food and fluids for those who cannot consume them orally. The Australian Catholic Bishops’ Committee for Doctrine and Morals agrees that MANH involves a medical decision:

While the act of feeding a person is not itself a medical act, the insertion of a tube, monitoring of the tube and patient, and prescription of the substances to be provided, do involve a degree of medical and/or nursing expertise. To insert a feeding tube is a medical decision subject to normal criteria for medical intervention.

ANH may be delivered through a nasogastric tube, gastronomy or intravenous which requires skilled medical professionals to administer. For example, a nasogastric (NG) tube is inserted into a nostril, down the throat and into the stomach, or percutaneous endoscopic gastronomy (PEG) tube is inserted through the abdominal wall and placed in the stomach, or intravenous (IV) feeding is a technique of direct infusion into a peripheral vein such as the arm or leg.

To make their arguments convincing, the proponents of withholding and withdrawing ANH mention some risks or burdens of this means of feeding the patients and their relatives. There may be costing, discomfort, irritation of the nasal passage, sore throat, infection, perforation of the bowel, diarrhoea, temporary nausea and vomiting, the blockage of or leaking from the tube, collapse of the vein or even death. Then this provision of nutrition and hydration may be judged to be extraordinary or disproportionate and may be forgone.

However, according to a radical pro-life viewpoint, ANH is not extraordinary and disproportionate, even if the patient is incurable and only alive vegetatively because feeding is identified with basic care. Because the purpose of ANH is to deliver food and fluids, many

82 Australian Bishops’ Committee for Doctrine and Morals, Briefing Note on the Obligation on Provide Nutrition and Hydration (Bishops’ Committee for Health Care and Catholic Health Australia, 2004)
ethicists, lawyers, and medical personnel conclude that it is simply an aspect of the normal care owed to any patient.\textsuperscript{84}

But there have been and still are some significant debates among Catholic ethicists and theologians regarding this topic. Some state conferences of Catholic bishops in the U.S. (Rhode Island, Oregon, Washington, Texas, Wisconsin) have supported the possibility of forgoing artificially assisted nutrition and hydration, whereas other bishops (New Jersey, Pennsylvania) argue that artificial nutrition must be maintained. In 1992 the U.S. Bishops’ Pro-Life Committee issued a statement that makes a strong presumption in favour of continuing feeding by medically assisted nutrition and hydration even of permanently comatose persons.\textsuperscript{85}

The opponents of withholding and withdrawing MANH hold that starving a person or refusing to provide food and drink is universally seen as wrong and inhumane.\textsuperscript{86} They ask people to think through carefully the intention of withdrawing ANH: Does it aim to relieve the patient, families and caregivers of a particular burden (financial and emotional) imposed by medically assisted nutrition and hydration? Or does it aim to avoid the total burden of caring for the patient?... If so, does it achieve this aim by deliberately bringing about his or her death by malnutrition and dehydration?\textsuperscript{87} They firmly believe that if feeding by providing artificial food and water is not excessively burdensome, then it would be morally wrong to stop it. The reasons are:

First, the cost of providing food and fluids by enteral tubes is not, in itself, excessive. Such feeding is generally no more costly than other forms of ordinary nursing care (such as cleaning or spoonfeeding a patient) or ordinary maintenance care (such as the maintenance of room temperature through heating or air conditioning). Second, one must also take into account the benefits that such care may provide both to the patient and to the caregivers.\textsuperscript{88}

\textsuperscript{88} May et al., “Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons,” 200.
This position is confirmed in Pope John Paul II’s allocution on assisted nutrition and hydration in March 2004: 89

I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering. 90

It is true that the arguments on whether assisted artificial nutrition and hydration is a comfort care or a medical treatment have not been resolved thoroughly, and continue to raise many controversies in health care ethics. Even so, people in general agree that: “Whether it is viewed as treatment or care, it would be morally wrong to discontinue nutrition and hydration when they are within the realm of ordinary means.” 91

III.4.2. Is It Ever Morally Right to Withhold or Withdraw Medically Administered Nutrition and Hydration?

Facing the arguments regarding the decision to provide or withhold and withdraw MANH, there has not been a complete resolution to the problem if we just focus on the distinction between ‘medical treatment’, which may be forgone, and ‘comfort care’, which must be continued. Moreover, even the official teaching of the Catholic Church “has not resolved the question whether medically assisted nutrition and hydration should always be seen as a form of normal care.” 92

However, the Ethical and Religious Directives for Catholic Health Care Services of the U.S. Bishops gives a directive concerning medical administered nutrition and hydration that is helpful in conciliating and resolving the controversy. Together with the introduction to Part Five, Directive 58 makes it clear that artificial nutrition and hydration is not always obligatory on the basis of official Catholic teaching. It clearly states:

89 It is said that when Pope John Paul II made a short declaration on this issue in March 2004, rather than settle the matter he provoked further controversy, both among Catholics and among non-Catholics. His allocution seems to be considered unconvincing to bioethicists and theologians, as well as to ordinary thinking persons. Cf. Jones, Approaching the End; cf. also James F. Drane, “Stop Nutrition and Hydration Technologies: A Conflict between Traditional Catholic Ethics and Church Authority,” Christian Bioethics: Non-Ecumenical Studies in Medical Morality 12, no. 1 (April 2006): 24-27.
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 and presumably irreversible conditions (e.g., the “persistent vegetative state”) who can reasonably be expected to live indefinitely if given such care. 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.”

The Vatican’s *Charter for Health Care Workers* also claims that: “The administration of food and liquids, even artificially, is part of the normal treatment always due patients when this is not burdensome for them.”

It is, therefore, very important to realistically assess the benefits and burdens associated with the provision of ANH, because this is the only way to determine whether this type of feeding is morally obligatory or not. The benefits of ANH may easily be identified when applying to medical conditions from which the frail elderly, including those who have a terminal illness or patients with advanced dementia, are far more likely to suffer, such as Alzheimer’s disease, Parkinson’s disease, cancer and stroke. The benefits may be: improved nutritional status, the prolongation of life, the symbolic value of giving food and drink, relief from symptoms of hunger when these are experienced, prevention of aspiration pneumonia, reducing the risk of pressure sores or infections due to poor nutritional status and immobility, improving function, providing comfort, and maintaining human community. Even for people in a state of post-coma unresponsiveness or persistent vegetative state, the Pennsylvania bishops concluded that the provision of ANH is clearly beneficial because it fulfills the purpose of sustaining life. At the same time, the bishops determine that ANH in these circumstances is not seriously burdensome, because it could be administered easily and with negligible levels of pain or suffering. Thus, to remove ANH from an unconscious patient is to withdraw an ordinary means of sustaining life and, as a consequence, to directly cause the death of the patient by malnutrition and dehydration. They definitely agree with the allocution of Pope John Paul II that: “Death by starvation and dehydration is, in fact, the only possible outcome as a result of

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94 Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers*, n. 120.
95 CCBF, “Reflections on Artificial Nutrition and Hydration,” 780.
their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission.”

Nonetheless, Richard McCormick, one of the most influential Catholic moral theologians, said in his article that:

Let me conclude with a fanciful scenario. Imagine a 300-bed Catholic hospital with all beds supporting P.V.S. patients maintained for months, even years by gastronomy tubes. Fanciful? Not if the guidelines of the Pennsylvania bishops are followed. Appalling? In my judgment, yes – not least of all because an observer of the scenario would eventually be led to ask: “Is it true that those who operate this facility actually believe in life after death?”

Administrating ANH in some situations actually brings about risks or burdens. It may be too physically distressing, damaging to the body and its functioning, too psychologically repugnant, too restrictive of the patient’s preferred activities, too suppressive of the patient’s mental state or too costly in some countries. In cases like these, where ANH delivery is believed to be excessively burdensome for the patient, or if the patient could no longer assimilate the nutrients provided to him or her, it would no longer be an obligatory treatment. The withdrawing of ANH that inevitably results in death does not necessarily imply one intends to kill or cause death. It represents the withdrawal of disproportionate and futile artificial means of nutrition and hydration from one in a fatal irreversible condition in the context of the acceptance of inevitable death. Some Catholic bishops support this opinion that while there is a presumption of a duty to give ANH, this duty does not seem to be absolute. Indeed the Texan Bishops firmly state:

The Declaration on Euthanasia, as well as the teaching of Pius XII, explicitly states that such forgoing or withdrawing are not suicide; rather they should be considered as the acceptance of the human condition and simply letting nature take its course…The morally appropriate forgoing or withdrawing of artificial nutrition and hydration from a permanent unconscious person is not abandoning that person. Rather, it is accepting the fact that the person has come to the end of his or her pilgrimage and should not be impeded from taking the final step.

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100 Ford, “Ethical Dilemmas in Treatment Decisions at the End of Life,” 79.
Thus, the omission of ANH can only be acceptable under conditions which render this means morally non-obligatory. In other words, judgements that this means of feeding has become morally optional must be scrutinized with the utmost prudence, to ensure that such procedures have no medically reasonable hope of sustaining life or pose excessive risks and burdens, when death may be foreseen but not intended.

Furthermore, it is also essential to acknowledge that the withholding or withdrawing of ANH should only occur after there has been sufficient deliberation based upon the personal information available. Though “it would be inhuman to refuse ANH to competent or conscious mentally impaired patients who want it,”102 according to even the most conservative moralists, forcing nutrition and hydration technology on a patient is wrong, especially on the dying.103 For example, if a competent patient through personal communication or advance directive gives valid reasons (e.g., there is nothing decided that is opposed to moral principles) and thus ANH is not to be employed in his or her case, the request should be honored. The U.S. Bishops explicitly said in the Ethical and Religious Directives for Catholic Health Care Services that: “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.”104

To conclude, there is a need for health care workers to fully acknowledge their important role in making a judgement for treatment options, including the artificial delivery of nutrition and hydration. “In all cases, the judgements about the care due to patients should be based on the relevant medical and ethical criteria, not on the quality of the patient’s life or state of consciousness.”105 They must be sure of the position taken by the Catholic Church that “the health care workers who cannot effect a cure must never cease to treat,” and that the withholding or withdrawing of nutrition and hydration with the intention of causing death is immoral. However, they should also admit that the decision to withhold or withdraw ANH from patients fosters the belief that death is an inevitable reality of human beings. This acceptance helps them, the patients, their families and community avoid misunderstandings, distress and the unnecessary prolongation of the dying process.

102 Ford, “Treatment at the End of Life and Ethics,” 4.
104 United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, n. 59.
105 Australian Bishops’ Committee for Doctrine and Morals, Briefing Note.
III.5. Ethical Considerations Concerning Persistent Vegetative State (PVS)

It is believed that the debates regarding withholding or withdrawing medically administered nutrition and hydration are most controversial in the rare, chronic condition called persistent vegetative state (PVS). To understand why the condition of PVS raises medical, ethical and legal problems, it is first necessary to be clear about the clinical aspects of this condition.

III.5.1. Clinical Aspects of PVS

According to neurological research, the human brain functions at two levels. The lower brain controls what are sometimes called the involuntary automatic aspects of the human person (breathing, swallowing…). On the other hand, there is the command system, the activity of the upper brain: the process of thinking, of remembering, of communicating knowingly both with self and with others. Sometimes the irreversible or permanent impairment to the upper brain does not cause any damage to the functions of the lower brain.106 This condition of the human brain is usually found in the state of coma and vegetative state.

Some scholars and researchers hold that there is a distinction between coma and vegetative state. Coma is a “state of presumed profound unconsciousness from which the person cannot be roused when examined. Coma is not brain death; some brain function remains, and some or all may be recoverable.”107 A comatose person is unaware of the environment and of external stimulation. Something happens which causes an assault leading to a dysfunction in the upper area of the brain, the place where blind sensation is translated into human awareness. Coma patients appear to be asleep and some of them may recover their previous level of function and some may deteriorate to a permanent vegetative state.108 Vegetative state (VS) seems to be different. It is defined clinically as arousal (or wakefulness) without awareness, i.e., being awake without being aware of self or environment.109 To clarify, the persistent vegetative state (PVS) is a form of eyes-open permanent unconsciousness in which the patient has periods of physiological sleep/wake cycles, absence of signs of awareness of

106 Cf. Christie, Last Rights, 103.
107 National Health and Medical Research Council (NHMRC), Ethical Guidelines for the Care of People in Post-Coma Unresponsiveness (Vegetative State) or a Minimally Responsiveness (Canberra ACT: Australian Government, 2008), 48.
self and of the surrounding environment. In neurology, being awake but unaware is the result of a functioning brain stem and the total loss of cerebral cortical functioning. In other words, “vegetative patients have suffered severe brain damage that puts the cerebral cortex – the thinking, feeling part of the brain – out of function.”

With respect to the diagnosis of PVS patients, it is true that there is “no set of specific medical criteria with as much clinical detail and certainty as the brain death criteria. Furthermore, even the generally accepted criteria, when properly applied, are not infallible.” Though it is not easy to diagnose the condition, at least there seems to be consensus among medical workers about these following points:

- An important fact about a PVS patient is that he or she is usually stable and not dying.
- Assuming the condition is correctly diagnosed, few emerge from the PVS state after six months; and
- Those in PVS do not suffer.

Another thing which should be noticed is that “it is not uncommon for patients to survive in this condition for five, ten and twenty years.”

Because of these features, there are many arguments concerning caring for the person who is in the condition of PVS, especially the morality of providing and discontinuing life support to those patients.

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110 Cf. NHMRC, Ethical Guidelines for the Care of People in Post-Coma Unresponsiveness (Vegetative State) or a Minimally Responsiveness, 50.
112 “Continued survival in the vegetative state requires only basic nursing care and tube feeding. In the early months a number of patients die, normally from chest infections, but those who survive the first year are relatively stable and can live for many years. Several survivals of 18 and 20 years are recorded, one of 37 and one of 40 years.” Bryan Jennett, “Managing Patients in a Persistent Vegetative State since Airedale NHS Trust v. Bland,” in Death, Dying and the Law, ed. Sheila A. M. McLean (Aldershot, England: Dartmouth Publishing Company Limited, 1996), 19-21.
III.5.2. Arguments in defense of forgoing life support to PVS patients

Admittedly, most of the arguments in support of forgoing or withdrawing life-sustaining care from persons in PVS are similar to those of proponents who would forgo treatment or withhold and withdraw MANH. These arguments could be based on some principles such as: the ordinary/extraordinary means distinction, the benefit and burden considerations, the sanctity of life and the quality of life, the medical situation, the respect for patient autonomy... However, because the patients in a vegetative state have some particular features, this section just mentions the affirmation of human dignity as one of the crucial principles of moral debate on providing food and fluids to the patients. It is of significant importance to answer the question: Does the life of a patient in PVS have the same inherent value and dignity as the lives of others?

Many deny that keeping people alive benefits them when there is no prospect that they will ever gain or regain the use of their specifically human capacities. They believe that it is useless to sustain life unless doing so helps a person to pursue the purpose of life. For example, Kevin O’Rourke, OP, focusing on the tube feeding of comatose persons, writes: “In order to pursue the purpose of life, one needs some degrees of cognitive-affective function.” Richard A. McCormick, SJ, makes a more general assertion along similar lines: “Life is a value to be preserved precisely as providing the condition for other values and therefore insofar as these other values remain attainable. To say anything else is, I submit, to make an idol of mere physical existence.” In considering the case of a patient in PVS, Peter Singer reasons that “…the most significant ethically relevant characteristic of human beings whose brains have ceased to function is not that they are members of our species, but they have no prospect of regaining consciousness. Without consciousness, continued life cannot benefit them.” Thomas A. Shannon and James J. Walter quote in their article a conclusion relating to this issue from a document of the U.S. Hierarchy:

117 These issues have been mentioned in the previous two sections. Cf. III.3. Forgoing Treatment and III.4. Withdrawing and Withholding Medically Administered Nutrition and Hydration.
Merely maintaining biological life is not evaluated as being in and of itself humanly beneficial. Life is something more than biological existence. Life is a conditional value which couples biological existence with social, spiritual and human activities such as loving, praying, remembering, forgiving and experiencing. Life is all these things.\footnote{122}

It seems that some of those who support the termination of the provision of food and water to patients in conditions such as PVS invoke the address of Pope Pius XII to the congress of anaesthesiologists in 1957. In his address, the Pope stated: “Life, health, all temporal activities are in fact subordinated to spiritual ends.”\footnote{123} On reading this view, some ethicists and philosophers who oppose caring for the comatose presume that since those correctly diagnosed with this condition will not be able to fulfill the higher, spiritual aims of life, it is acceptable to discontinue food and water. According to their arguments, there is generally no moral obligation to sustain the life of a patient in a vegetative state, even by food and fluids, because such a patient can no longer pursue the spiritual purposes which require a minimum of cognitive and affective function. To indefinitely feed and maintain the life of a PVS patient only preserves a ‘biological existence’ incapable of engaging in human acts.\footnote{124}

However, despite any arguments in defense of forgoing life support to PVS patients, there is a problem that the proponents of this position have not yet given a satisfactory answer. The issue is not whether to feed persons in PVS or not, but whether to care for them or to abandon them and even to kill them by starvation and dehydration. In actuality, many people agree that a decision not to feed a PVS patient could have only one or the other of two possible meanings, neither of which is morally permissible: a choice to resolve the situation by killing the patient or a choice to abandon him or her.\footnote{125}

\footnote{122} Shannon and Walter, “The PVS Patient and the Forgoing/Withdrawing of Medical Nutrition and Hydration,” 151.
\footnote{123} Pius XII, “The Prolongation of Life,” 94.
\footnote{125} Cf. Grisez, “Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?” 183-84.
III.5.3. Arguments of Those Who Would Continue to Provide Life Support to PVS Patients

Though some moralists and theologians recognize that it is not easy to solve completely the real dilemmas involved in the issue of feeding PVS patients, they always warn against the use of ‘human dignity’ to dismiss the values of disabled patients’ lives, especially of those who are in the state of persistent unconsciousness. In 1992, the U.S. Bishop’s Committee for Pro-Life Activities issued a document titled “Nutrition and Hydration: Moral and Pastoral Reflections” to confirm this warning:

We believe people should make decisions in light of a simple and fundamental insight: Out of respect for the dignity of the human person, we are obligated to preserve our own lives and help others preserve theirs by the use of means that have a reasonable hope of sustaining life without imposing unreasonable burdens on those we seek to help, that is, on the patient and his or her family and community…it is important to ensure that the inherent dignity of human persons, even those who are persistently unconscious, is respected and that no one is deprived of nutrition and hydration with the intent of bringing on his or her death.126

This affirmation was totally supported by Pope John Paul II when he spoke to a group of U.S. bishops:

The statement of the U.S. bishops’ pro-life committee, “Nutrition and Hydration: Moral and Pastoral Considerations,” rightly emphasizes that the omission of nutrition and hydration intended to cause a patient’s death must be rejected and that, while giving careful consideration to all the factors involved, the presumption should be in favour of providing medically assisted nutrition and hydration to all patients who need them.127

The Holy Father obviously continued claiming that the decisive fact is the patient’s inherent dignity as a human being and his or her status as a child of God, in need of care and support – not the kinds of acts that may make a life seem worthwhile to an outside observer.128 In 2004, the Pope one more time strongly reaffirmed the intrinsic value and personal dignity of every human being, no matter what the concrete circumstances of his or her life. He said: “A man, even if seriously ill or disabled in the exercise of his highest functions, is and always will be a man, and he will never become a “vegetable” or an “animal.” Even our brothers and sisters

128 Doerflinger, “John Paul II on the “Vegetative State”,” 211.
who find themselves in the clinical condition of a “vegetative state” retain their human dignity in all its fullness.”

The rationale of Pope John Paul II’s teaching is that the patients in PVS must always be treated as human beings, and their inherent dignity should be respected at all times and in whatever conditions they are. Consequently, he has established the provision of food and fluids as a general norm for all helpless patients, including those who seem completely unresponsive to the outside world.

Moreover, it is important to acknowledge that according to recent studies, with a novel functional magnetic resonance imaging (fMRI) technique, the evidence of some PVS patient’s preserved cognition is definitely proved. A. M. Owen and colleagues used fMRI to show that conscious awareness could be preserved in a patient deemed to be in PVS state. “When asked to imagine playing tennis or moving around her home, the patient activated predicted cortical areas in a manner indistinguishable from that of healthy volunteers.” fMRI is a technique for measuring brain activity and works by “detecting the changes in blood oxygenation and flow that occur in response to neural activity.” When this occurs a part of the brain becomes active, thereby requiring more oxygen supplied by an increased flow of blood. This activity can be mapped by fMRI thereby indicating the part of the brain that is activated. In this way, fMRI can produce activation maps showing the parts of the brain involved in any mental activity.

The attractions of fMRI have made it a popular tool for imaging normal brain functions including memories, learning, especially for psychologists. Over the last decade it has provided new insight to the investigation of how memories are formed, pain and emotions. In fMRI it is the magnetic signal from hydrogen nuclei in water (H2O) that is detected. The key to MRI is that the signal from hydrogen nuclei varies in strength depending on the surroundings. This provides a means of discriminating between gray matter, white matter and cerebral spinal fluid in structural images of the brain. The oxygen is delivered to neurons by

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132 fMRI has some special advantage: being non-invasive and without any radiation, it is safe for human subjects and it is not difficult to use imaging normal brain functions.
haemoglobin in blood red cells. “When neuronal activity increases there is greater demand for oxygen and the local response in an increase in blood flow to regions of increased neural activity.”

Hemoglobin has paired electrons when oxygenated but unpaired electrons when deoxygenated. “This difference in magnetic properties leads to small differences in the MR signal of blood depending on the degree of oxygenation. Since blood oxygenation varies according to the levels of neural activity these differences can be used to detect brain activity. This form of MRI is known as blood oxygenation level dependent (BOLD) imaging.”

A point to note is the direction of oxygenation change with increase activity. There is a momentary decrease in blood oxygenation immediately after neural activity increases, known as the ‘initial dip’ in the hemodynamic response. This is followed by a period where the blood flow increases, and even overcompensates for the higher demand following neural activation. In fact, “the blood oxygenation actually increases following neural activation. The blood flow peaks after around 6 seconds and then falls back to baseline, often accompanied by a “post-stimulus undershoot.”

It is true that the fMRI technique which relies on selective auditory attention, though seen to be in some cases highly controversial at present, can be used to efficiently detect conscious awareness and communicating with behaviourally nonresponsive, brain-injured patients. More important, with this technique Lorina Naci and Adrian M. Owen proved for the first time that a patient who had been in a vegetative state for 12 years was able to selectively pay attention to some external events in his environment while ignoring others, according to

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133 A haem protein responsible for the red colour of blood which carries oxygen to the tissues.
134 Devlin, “What is Functional Magnetic Resonance Imaging (fMRI)?”
135 Devlin, “What is Functional Magnetic Resonance Imaging (fMRI)?”
136 Devlin, “What is Functional Magnetic Resonance Imaging (fMRI)?
command, and to repeatedly communicate correct answers to binary (Yes/No) questions.\[137\] “[T]his method may provide initial screening for more complex abilities, the presence of which may have important ethical and practical implications for the [PVS] patient’s standard of care and quality of life.”\[138\] Nonetheless, it would be a mistake to consider those who oppose forgoing food and water for PVS patients as ‘vitalists.’ They realize that although human life is a basic good of the person that should be preserved, it never means that we have to keep the patients in PVS state alive at all costs. Those who support continuing to provide life sustaining nutrition and hydration to unconscious patients admit that there may be objective conditions (e.g. the administered procedures may be excessively burdensome or the patient is unable to assimilate to nutrition provided by MANH) which would allow the ethical withdrawal of food and water without intending direct killing.\[139\] It is to be hoped that progress will be made in this direction in due time. The situation for now world-wide has not yet changed.

In the meantime and to be brief, there has not yet been an exhaustive answer to the question: If a patient is medically diagnosed to be in a PVS, does the continuation of life support efforts become ethically optional? Much more time, research and information are still need to specifically determine this issue. Health care workers, however, should be aware that it is in serving those who may never visibly respond to our care that we find the ultimate test of our Christian charity and our respect for the inherent dignity of each human being.\[140\] Faithfully caring for PVS patients benefits them, not only sustaining their lives but also maintaining a moral bond of human solidarity with them.\[141\]

In addition, there is scope for pastoral applications. As progress is made pastoral carers could ask patients in PVS (who are proved to be able to communicate correct answers to binary questions in the scanner\[142\]) if they would like to see a Catholic priest or their own religious minister. In this way priests and ministers could ask if MANH makes their lives

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burdensome. They could also ask if they want the Sacrament of Reconciliation and the Anointing for the dying. These are examples of the use of pastoral care for such PVS patients.

III.6. Advance Directives for Health Care Decisions

Bioethicists have widely agreed that patients have a right of self-determination over how they are treated. To guarantee this right, which is said to be based on the ‘principle of respect for autonomy,’ to be fully exercised is the duty of all health care professionals. The difficulty is some patients at their very end of life may have lost competence and ability to practise this right. Advance directives are considered as the solution to exercise that right. These directives enable people to decide in advance what medical treatment they will receive later, when they become incompetent. However, the use of advance directives has induced a lot of criticism in medical, legal and ethical debates concerning patient’s preferences and desires about a whole range of treatment matters, especially regarding refusal of medical treatments: Can people foresee their futures well enough to make informed decisions in advance? Treatment options might change between the time the directive was given and the time it must be followed. The individual in the debilitating state is not the same as the person who created the advance directive… This section seeks to point out what advance medical directives really are and to what extent they can help the dying patients to die in the way they wish.

III.6.1. Two Kinds of Advance Directives

Advance directives were first developed in the United States. They are much more common there with two kinds: living wills (often called ‘treatment directives’) and powers of attorney for health care (sometimes called ‘proxy directives’). In other jurisdictions, these terms are quite distinct as Dworkin says:

Every state in the United States now recognizes some form of advance directive: either living wills – documents stipulating that specified medical procedures should not be used to keep the signer alive in certain specified circumstances, or health-care

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143 Cf. Section II.2.3. Autonomy.
145 Typically, treatments specifically refused might include cardiopulmonary resuscitation, antibiotics, chemotherapy, dialysis, blood transfusion, enteral feeding or ventilator support. Generally, incompetent patients who have not signed living wills have neither consented nor refused, but the legal defense for giving them treatment is outlined in J. Mason and R. McCall-Smith, Law and Medical Ethics (London: Butterworths, 1987), 142-45.
proxies – documents appointing someone else to make life and death decisions for the signer when he no longer can.\textsuperscript{147}

- Living Wills

‘Living will’ is perhaps the most widely known form of advance directive. It is a legal document “drawn up or a form filled out by a competent person giving instructions concerning the kind of treatment he or she wishes if and when he or she is seriously ill or injured and not able to make treatment decisions.”\textsuperscript{148} Hereinafter is the operative paragraph in a standard form of the type of living will, which is adapted with permission of \textit{Choice in Dying}, formerly \textit{Concern for Dying}, an organization formed to help people prepare for death:

If my death is near and cannot be avoided, or if I become comatose and lose the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible due to my mental or physical condition, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.\textsuperscript{149}

It is true that though some directives may request aggressive treatment, most ‘living wills’ ask for the limit of treatment. This document gives physicians at least a general sense of patients’ wishes and is considered morally acceptable if patients’ general desires concerning treatment are in keeping with the medical morality.\textsuperscript{150}

- Proxy Directives

A ‘proxy directive’ is also called by many different names: durable power of attorney (DPA), durable power of attorney for health care decisions (DPAH), medical power of attorney (MPA), or health care proxy. All these names signify the same reality. This is a document by which a person designates a surrogate (maybe a family member or a friend, a medical professional) to make one’s treatment decisions when he or she is rendered incompetent.\textsuperscript{151}

\textsuperscript{150} Cf. Kelly, \textit{Medical Care at the End of Life}, 69.
Therefore, a ‘proxy directive’ does not go into effect until the patient loses the decision-making capacity, namely, incompetence.\textsuperscript{152}

This kind of advance directive establishes a \textit{personal} proxy (not an \textit{instrumental} proxy as in a living will) which brings about some advantages: its flexibility and its emphasis on human friendship and love. A health care proxy allows for decisions based on an actual situation, not a hypothetical one. In addition, it helps one person express trust in another to do what is best for him or her during later incompetence. Assuming that the actions taken by the surrogate do not include active euthanasia and physician-assisted suicide, the response of the Catholic leaders and theologians to health care proxy legislation has been favourable.\textsuperscript{153}

\section*{III.6.2. Difficulties and Dilemmas Arising from the Use of Advance Directives}

Truly, despite some significant advantages in making treatment decisions, advance directive has its difficulties which sometimes raise a lot of dilemmas in health care profession. Here we shall address some of these problems.

The first problem has been evoked by Rebecca Dresser and other bioethicists: Is it possible to make decisions for the future?\textsuperscript{154} This is the most glaring issue that does not allow for adequate informed consent, because one must make a decision in the present moment about a future medical condition which cannot be exactly known in advance.\textsuperscript{155} In reality, there are some people who do change their minds about what they specified in living wills when they can still speak for themselves. In the words of Dolores Christie: “Empirical studies have demonstrated that a ‘change of mind’ is more likely the result of changed circumstances or more accurate perceptions of the implications of particular treatments.”\textsuperscript{156}

The second problem arises when the instructions given in advance directives and the scenarios provided for discussion are generally either too vague to be clear or too medically specific to be helpful in common clinical situations.\textsuperscript{157} For example, in her living will a patient stated vehemently: “Do not keep me alive with machines.” This advance directive

\textsuperscript{152} The patient is considered incompetent when he or she is rendered unconscious or is determined to be otherwise mentally incompetent. Cf. Smith, “Advance Directives for Health Care Decisions,” 18/2.

\textsuperscript{153} Cf. Kelly, \textit{Medical Care at the End of Life}, 67-68; cf. also Smith, “Advance Directives for Health Care Decisions,” 18/2.


\textsuperscript{155} Smith, “Advance Directives for Health Care Decisions,” 18/2.

\textsuperscript{156} Christie, \textit{Last Rights}, 70.

does not explicitly determine whether she would never want to be on a life-sustaining machine, or that she would just not want to be on a machine if she could not be cured from a critical condition; she would not want to live her life hooked to a machine. Of course one of the best ways to overcome this ambiguity is to appoint a surrogate who knows the patient well enough to make decisions which reflect her values.\textsuperscript{158} Also for these reasons, the Australian Bishops encourage people to appoint a representative to speak on their behalf, rather than to write a ‘living will’. They says:

The most helpful part of future health care planning is the fact that someone is able to speak on behalf of the person when that person is unable to do so. A patient representative is responsible for being adequately informed about the circumstances and the treatment options, as well as about the person’s values and previous wishes.\textsuperscript{159}

However, the proxy directive approach is not perfect, and the next problem is posed by the use of this type of advance directive. Surrogate decision makers may not be well informed about what the patient would want, or may disregard instructions in the living will or power of attorney.\textsuperscript{160} Indeed, for further concern people may ask: What of possible conflict of interest between the patient and the surrogate? What of the burden this might impose on the surrogate? In some cases, the designated decision maker might be unavailable when needed or even might become incompetent to make good decisions for the patient.\textsuperscript{161} It is, thus, very important to have a knowledgeable and assertive surrogate.

Another difficulty which should also be mentioned is that for some reasons, i.e. fearing legal reprisals or accusations of negligence and malpractice, medical institutions may refuse to honor a person’s advance directives. Sometimes, a ‘living will’ is severely restricted by the state statutes, or surrogate decision makers who also make decisions with which physicians sharply disagree. It is said that such challenges may cause advance directives to be seriously compromised and then, the right of patients to make treatment decisions for themselves would be violated.

\section*{III.6.3. Are Advance Directives Appropriate for Catholics?}

Facing the difficulties advance directives pose, many ethicists and medical professionals try to seek the stance and guidance of Catholic Church concerning these issues.

\textsuperscript{158} Cf. Christie, \textit{Last Rights}, 73.
\textsuperscript{159} Australian Bishops’ Committee for Doctrine and Morals, \textit{A Guide for Health Care Professionals Implementing a Future Health Care Plan}, section 3.1.
\textsuperscript{160} Davis, “Precedent Autonomy, Advance Directives, and End-of-Life Care,” 353.
\textsuperscript{161} Cf. Tom L. Beauchamp and James F. Childress, \textit{Principles of Biomedical Ethics}, 6\textsuperscript{th} ed. (New York: Oxford University Press, 2009), 186.
It is clear that people write advance directives because they want that their wishes to have or to refuse treatment when they are terminally ill or permanently unconscious to be honored. In fact, most living wills or even proxy directives stipulate what is not wanted by the patients. That is the reason why much confusion and many dilemmas are caused by identification of advance directives with ‘physician-assisted suicide’ and ‘euthanasia.’\textsuperscript{162} From the point of view of Catholic tradition, if advance directives specify the patient’s wishes either not to be treated aggressively or to have treatment removed in case little hope exists for a good outcome, they totally rest on Catholic principles and presuppositions.\textsuperscript{163} With moral stances of autonomy and the dignity of the human person, the Church affirms that the right of persons to chart their own course of treatment is an inherent right, which must be respected and cannot be denied by any perspective, even legislation. As Kevin O’Rourke put it, “Court decisions and state laws may recognize and structure our decision-making rights, but they do not create these rights.”\textsuperscript{164} Nevertheless, it does not mean that advance directives can force the others to comply with whatever the patients want. It is true that a patient’s request to do anything that would be unethical or conflict with the common good and attention to social justice, or with the conscience of the medical personnel, should not be honored.

These requirements are entailed by Directive 24 of the \textit{Ethical and Religious Directives for Catholic Health Care Services}:

In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.\textsuperscript{165}

As final thoughts, I do believe that though there are still significant problems, perhaps insurmountable, advance directives “express a person’s preferences concerning her future care in the event she is no longer competent, and the use of such directives is often seen as a means of extending patient autonomy.”\textsuperscript{166} In other words, the advance directive is a

\textsuperscript{162} These two issues will be discussed in the following section.
\textsuperscript{163} Cf. Christie, \textit{Last Rights}, 77.
\textsuperscript{164} Kevin O’Rourke, \textit{A Primer for Health Care Ethics}, 2\textsuperscript{nd} ed. (Washington, D.C.: Georgetown University Press, 2000), 83.
\textsuperscript{165} United States Conference of Catholic Bishops, \textit{Ethical and Religious Directives for Catholic Health Care Services}, n. 24.
promising, valid and safe way for incorporating the values of the patient into health care
treatment decisions when these values are unable to be incorporated directly. Unfortunately, as I mentioned above, there appears to be a number of difficulties which interfere with the implementation of advance medical directives and then, accidentally defy
the person’s values.

It is, therefore, essential for health care workers to recognize the role and criteria of advance
directives in treating patients at their end-of-life stage. It helps them to wisely and responsibly
assess if the patient’s advance directives should be substantially respected or appropriately
disregarded. Furthermore, since the validity of advance directives is considered as “the proper
mechanism for determining treatment,” it is also necessary to notice that at the very least hospital staff might suggest or even aid the patients in making an advance directive or to modify it. In any case, they should not try to persuade patients: it would be a better outcome if there had been dialogue between patients, and their loved ones, with the physician, based on specific knowledge of the patients’ present diagnosis and prognosis. In proposing these things, both health care professionals and patients must be subject to the principles and values
of the Catholic Church, whose teachings are always the understanding of and witness to the
dignity of the human person.

III.7. Physician-Assisted Suicide and Euthanasia

The rights and values pertaining to the human person occupy an important place
among the questions discussed today. In this regard, the Second Vatican Ecumenical Council solemnly reaffirmed the lofty dignity of the human person, and in a special way his or her right to life. The council therefore condemned crimes against life “such as any type of murder, genocide, abortion, euthanasia, or willful suicide” (Gaudium et
Spes, n. 27).169

According to the Catholic moral tradition, that physician-assisted suicide (PAS) and
euthanasia are two forms of unjust killing, which must be condemned. The Catechism of the
Catholic Church describes suicide as a contradiction of the “natural inclination of the human
being to preserve and perpetuate his life,” and declares it an act “gravely contrary to the just
love of self.” Similarly, voluntary co-operation in the suicide of another is “contrary to the

(Baltimore: The Johns Hopkins University Press, 2002), 76.
168 May, Bioethics in a Liberal Society, 77.
169 Declaration on Euthanasia (1980), Introduction.
moral law.”\textsuperscript{170} This tradition certainly derives from the lines of Genesis (4:10-11) that “those who cooperate voluntarily in murder commit a sin that cries out to heaven for vengeance.”\textsuperscript{171} Suicide and murder are violations of the Fifth Commandment, “Thou shalt not kill.”

However, because of some factors such as: advances in medical technology, misdirected aggressive treatment, progress in palliative and hospice care, a shift in demographics towards an older population, the emergence of the civil rights movement,\textsuperscript{172} … PAS and euthanasia have become a public concern which is freely discussed and stridently debated among medical specialists, ethicists or legislatures in many countries, especially in the United States, Canada, Netherlands, England and Australia.\textsuperscript{173} Michael Manning has summed up PAS and euthanasia debate as follows: Is it morally acceptable, and so ought it be legally permissible, for a physician to assist the competent, terminally ill patient in taking his or her own life, or for a physician to take the life of a competent, terminally ill person who requests it?\textsuperscript{174}

The next section is going to examine the concepts of these issues, which sometimes cause confusion about the terminology describing the care at the end of life. Besides, both sides of fundamental arguments, pro and against PAS and euthanasia, will be generally presented, so that there can be appropriate evaluations and response, specifically in the health care profession.

\textbf{III.7.1. Definitions and Distinctions}

The definition of euthanasia, as well as physician-assisted suicide, is highly confusing. There is confusion in language, in ethical and legal analysis, in intent, in causation, in interpreting common-law…\textsuperscript{175} Hence, it is very important to have a clear conception, and where possible, dispel these confusions.

If suicide is an act or an instance of intentionally killing oneself, physician-assisted suicide is generally understood as a physician providing medications or other means to a patient with knowledge that the patient is going to use them to commit suicide. In other words, the

\begin{itemize}
\item \textsuperscript{170} \textit{Catechism of the Catholic Church}, nn. 2281.82.
\item \textsuperscript{171} Gen 4:10-11: “‘What have you done?’ Yahweh asked. ‘Listen! Your brother’s blood is crying out to me from the ground. Now be cursed and banned from the ground that has opened its mouth to receive your brother’s blood at your hands.’” Cf. also \textit{Catechism of the Catholic Church}, n. 2268.
\item \textsuperscript{172} Kenneth R. Mitchell, Ian H. Kerridge and Terrence J. Lovat, \textit{Bioethics and Clinical Ethics for Health Care Professionals}, 2\textsuperscript{nd} ed. (Australia.: Social Science Press, 1996), 262.
\item \textsuperscript{174} Manning, \textit{Euthanasia and Physician-Assisted Suicide}, 4.
\end{itemize}
physician gives assistance in that he or she provides access to the appropriate and adequate medical means, then these patients administer the means to themselves in committing suicide.\textsuperscript{176} So the final lethal act in the case of PAS is performed by the patient, even when the physician provides assistance in the form of information and means.\textsuperscript{177}

It is contrary to the case of euthanasia in which there have been more controversies and various arguments. Euthanasia requires the physician to perform a medical procedure that causes death directly. For the sake of clarity, euthanasia should be defined as “a deliberate act or omission that causes death, undertaken by one person with the primary intention of ending the life of another person, in order to relieve that person’s suffering.”\textsuperscript{178}

The original meaning of the word ‘euthanasia’ was simply ‘good death’ from the ancient Greek language (\textit{eu} for good or noble, and \textit{thanatos} for death), a reference to the common practice of voluntary suicide among old or sick people who sought to induce a painless death by drinking the poison hemlock.\textsuperscript{179} However, in modern society euthanasia has come to mean ‘mercy killing’ – deliberately and intentionally causing death by killing the suffering patient. In this sense, euthanasia includes both ‘action’ and ‘omission’ in its definition, as Pope John Paul II said: “Euthanasia, in the strict sense, is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering.”\textsuperscript{180} The stress therefore put in ‘the intention of the will’ and in ‘the method used’ which the Vatican mentioned in the \textit{Declaration on Euthanasia}:

\begin{quote}
By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia’s terms of reference, therefore, are to be found in the intention of the will and in the method used.\textsuperscript{181}
\end{quote}

Euthanasia means the death of someone may be carried out by either a voluntary or involuntary action. Thus, the moral tradition has generally distinguished different terms of euthanasia:


\textsuperscript{180} John Paul II, \textit{Evangelium Vitae}, n. 65.

\textsuperscript{181} \textit{Declaration on Euthanasia} (1980), section II.
- **Voluntary active euthanasia** is an intentionally administering medication or treatment to end the patient’s life, done at the direct request of the person being killed. It is precisely voluntary because the killing is intentionally performed at the request of the patient with full, informed consent; and the patient is believed by the doctor to have a good reason to be killed due to his or her present or foreseeable mental condition and the quality of life.\(^{182}\)

- **Involuntary active euthanasia** is an intentionally administering medication to cause patient’s death without the patient’s request and full, informed consent. In this situation, the patients never express their wishes nor offer any solid evidence that their lives should be taken. If someone practices mercy killing on another person without explicit request, it becomes murder.\(^{183}\)

- **Non-voluntary (Passive) euthanasia** is withholding or withdrawing life-sustaining medical treatments from a patient with the intent of causing death. The term is applied to the killing of patients who do not have the capacity to comprehend what is happening to them, e.g. a very severely disabled or a patient in a persistent vegetative state.\(^{184}\)

The distinctions of these various terms make euthanasia one of the most pressing issues in bio-medical ethics today.

### III.7.2. Proponents of Physician-Assisted Suicide and Euthanasia

The advocates’ arguments of PAS and euthanasia are based on the general contention that individuals should be granted the right to die, when and how they wish whether death is imminent or not; and, physicians, “as agents of the patient’s best interests, should assist either by directly killing the patient or by assisting the patient in suicide. Euthanasia and assisted suicide are beneficent acts of relieving human suffering.”\(^{185}\) The basic line of supporting PAS and euthanasia can be summarized as follows.

Firstly, people who support euthanasia believe that in a secular democratic society, especially one of great and increasing cultural, religious and moral pluralism where individual rights are respected, everybody should have moral authority over their own lives and should be free to choose the means to end it when and how they wish.\(^{186}\) Helga Kuhse when suggesting that

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people are incapable of making such judgements about their own lives, denies the humanity and common-sense we all share:

It would be foolhardy to suppose that a general moral consensus can be developed on such morally controversial questions as voluntary euthanasia and medically assisted suicide; and, to the extent that it will not be possible to show that a particular moral viewpoint is the proper moral viewpoint, this entails that it will be inappropriate for public policies to enforce any one particular moral point of view. What is to be done? It seems that at least one option is open to us: to adopt a public policy approach that is based on mutual respect of freedom or autonomy. This is not a morally arbitrary approach. Personal autonomy or freedom is a very important moral value, and central to what it means to be a person and a moral agent.\(^{187}\)

Autonomy, or the self-determination or the ‘right to die,’ is the centrepiece in the moral defense for euthanasia. The respect for a person’s autonomous choices, then, creates the importance of respect for an individual’s dignity which is another principal argument for PAS and euthanasia. Advances in medical technology have increased medicine’s capacity to prolong life to the point where personal dignity may be severely compromised. Michael Manning said:

…our technological advances have done little or nothing to help ameliorate the psychological fear and existential anxiety experienced by all at the approach of death, more acutely by some than others. Indeed, the fear of being trapped on life-support machinery is clearly a new and modern fear. These advocates claim that we act out of compassionate concern for our fellow humans when we end their pointless suffering at their own request.\(^{188}\)

At these times, for the person who is terminally ill and experiences severe pain or suffering, PAS or euthanasia may represent the most compassionate and dignified option.\(^{189}\) This is one of the main pro-euthanasia arguments which are based on ‘mercy killing’. No person should be forced to endure suffering and those who relieve an individual’s suffering by euthanasia and PAS out of respect for autonomy and compassion are acting ethically.\(^{190}\)

Thirdly, those who advocate legalization of euthanasia and PAS would commonly appeal to the distinction between ‘killing’ and ‘letting die’ as ambiguous in many cases. The proponents

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for active euthanasia and PAS have argued that the distinction between allowing a terminal patient to die (by withholding or withdrawing treatment) and causing or hastening a patient’s death through a physician’s direct and intended intervention, lacks moral force.\textsuperscript{191} James Rachels and those who favour euthanasia argue that since death is the outcome in either case, there should be no moral difference between killing and allowing to die.\textsuperscript{192} In other words, once we decide not to prolong a patient’s dying process, whether we actively intervene to cause his death or passively allow him to die makes no moral distinction. According to Rachels, because there is no moral discrimination between killing and letting die, our present acceptance of allowing to die ought to be extended to active killing, when such killing would be more merciful.\textsuperscript{193}

\textbf{III.7.3. The Anti-Physician-Assisted Suicide and Euthanasia Perspective and the Teaching of the Catholic Church}

Nowadays, the spread of assisted suicide and euthanasia is especially disturbing those who are working against the legalisation of voluntary euthanasia. In considering the typical arguments raised by the pro-euthanasia groups, the opponents of voluntary active euthanasia and PAS ultimately reject the claims:

- Individuals should have an autonomous freedom to choose when, where and how they should die; and

- Killing someone is morally equivalent to allowing them to die.\textsuperscript{194}

Among the major arguments concerning the public debate of euthanasia and PAS, perhaps the most troubling issue is the concept of autonomy.\textsuperscript{195} Most people agree that to challenge or to interfere with an autonomous person, especially when his or her actions are not harming anyone else, is considered “not only to be bad social form but also disrespect of human dignity.”\textsuperscript{196} Therefore, it is easy to appreciate the significant place of autonomy in efforts to endorse PAS or euthanasia as a moral practice and legal policy. However, regarding the argument of autonomy many bioethicists rebut this assertion. Daniel Callahan, a philosopher widely recognized for his innovative studies in biomedical ethics, holds that euthanasia

\textsuperscript{191} Cf. Tran, \textit{Advancing the Culture of Death}, 66.
\textsuperscript{192} James Rachels’ most sustained argument for euthanasia and against the moral significance of the distinction between killing and allowing to die is in \textit{The End of Life: Euthanasia and Morality} (New York: Oxford University Press, 1986), 106-28.
\textsuperscript{193} Cf. Rachels, \textit{The End of Life}, 108.
\textsuperscript{194} Tran, \textit{Advancing the Culture of Death}, 70.
\textsuperscript{195} This concept was discussed in section \textbf{II.2.3. Autonomy}.
cannot be properly classified as an autonomous act of managing one’s private affairs. Since euthanasia involves at least one other person, it must be regarded as a form of public action and so be assessed with its social dimensions and implications. In the view of societal ethics, the risk of sanctioning euthanasia is simply too great, and Callahan expresses this idea very impressively in these words: “the history of the twentieth century should demonstrate that killing is a contagious disease, not easy to stop once unleashed in society.” Furthermore, also according to Callahan the very right of self-determination upon which euthanasia depends is actually contradicted when we give another the freedom to end his or her life. To give up one’s freedom permanently is a contradiction to freedom. As he says: “If I am by right master of my fate, I cannot transfer my right of mastery to another, nor can any other person receive it from me.” Life is the fundamental condition, which makes freedom and self-determination possible. To protect freedom or autonomy, we must protect life.

About the distinction between active killing and allowing to die, some people in the medical community may prefer to call it a distinction between active euthanasia and what we might call ‘passive euthanasia’. Generally speaking, opponents of PAS and euthanasia maintain that there is a clear moral distinction between merely allowing to die and actually causing or deliberately hastening someone’s death. In the definition of ‘euthanasia’ in the Vatican’s Declaration on Euthanasia, the phrase “which of itself or by intention causes death” is necessary in order to affirm that not taking steps to prolong life when such steps are morally required is just as much the cause of death as a lethal injection would be. Likewise, refusing treatment with the intention to end one’s life is suicide. ‘Intention’ makes the difference. This is straightforwardly the case of PAS and euthanasia. These practices both incorporate intentions that the patient die (either at the hands of the physician or at his or her own hand with physician’s help). Thus, euthanasia and PAS really incorporate lethal intent and totally contrast with terminal sedation (and other practices such as honouring a patient’s refusal or withdrawal of life-prolonging medical interventions) where lethal intent is absent.

With her teachings, the Catholic Church firmly opposes the practice of PAS and euthanasia. Since the very early days, the Church has condemned the killing of innocent human life or
suicide. Catholic believers view human life as a gift of God’s love, “which they are called upon to preserve and make fruitful.” Intentionally causing one’s own death, through suicide or euthanasia, is equally as wrong as murder.\textsuperscript{203} The classic prohibitions against suicide are maintained for euthanasia: It fails to fulfill one’s responsibility to God, violates one’s own natural desire to exist, betrays self love, and injures one’s own community.\textsuperscript{204} Nonetheless, until Vatican Council II, there were not comprehensive statements about euthanasia made by ecumenical councils or popes, except Pope Pius XII. He condemned the policy ‘eugenic euthanasia’ of the German National Socialists as a violation of God’s sole dominion over innocent life, and as a refusal to accept unitive suffering with Christ. He wrote:

Conscious of the obligations of Our high office We deem it necessary to reiterate this grave statement today, when to Our profound grief We see at times the deformed, the insane, and those suffering from hereditary disease deprived of their lives, as though they were a useless burden to Society; and this procedure is hailed by some as a manifestation of human progress, and as something that is entirely in accordance with the common good. Yet who that is possessed of sound judgment does not recognize that this not only violates the natural and the divine law written in the heart of every man, but that it outrages the noblest instincts of humanity? The blood of these unfortunate victims who are all the dearer to our Redeemer because they are deserving of greater pity, “cries to God from the earth” (Gen 4:10).\textsuperscript{205}

More radically than ever, Pope John Paul II found it necessary to issue teachings on euthanasia and PAS as these practices have become more widespread. The Congregation of the Doctrine of the Faith’s \textit{Declaration on Euthanasia} is the first and fullest direct statement on the subject ever made by the Magisterium.

It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a fetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly, nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity.\textsuperscript{206}

\textsuperscript{203} Cf. \textit{Declaration on Euthanasia} (1980), section I.
\textsuperscript{204} Kevin O’Rourke, “Value Conflicts Raised by Physician Assisted Suicide,” \textit{Linacre Quarterly} 57, no. 3 (August 1990): 44.
\textsuperscript{205} Pius XII, \textit{Mystici Corporis Christi}, Encyclical Letter (1943), n. 94.
\textsuperscript{206} \textit{Declaration on Euthanasia} (1980), section II.
John Paul II himself has placed the stamp of his magisterial authority on the condemnation of euthanasia with his encyclical *Evangelium Vitae*:

Taking into account these distinctions, in harmony with the Magisterium of my Predecessors and in communion with the bishops of the Catholic Church, I confirm that euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person. This doctrine is based upon the natural law and upon the written word of God, is transmitted by the Church’s Tradition and taught by the ordinary and universal Magisterium.\(^{207}\)

That is the reason why “Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way.”\(^{208}\) It is also clearly stipulated in the *Charter for Health Care Workers* of the Church:

Medical and paramedical personnel – faithful to the task of “always being at the service of life and assisting it to the end – cannot cooperate in any euthanistic practice even at the request of the one concerned, and much less at the request of relatives. In fact, individuals do not have the right to euthanasia, because they do not have a right to dispose arbitrarily of their own life. Hence no health care worker can be the executive guardian of a non-existent right.\(^{209}\)

Health care workers, however, are invited to acknowledge the truth that if care is administered properly at the end of life, only the rare patient should be so distressed that he or she desires to commit suicide. Medical professionals must clarify all issues for their patients: Do people who ask to be put to death truly seek death? Are their patients only appealing for appropriate medical treatment to alleviate their pain and depression? Have their patients lost control of exactly what they need due to their suffering? Most importantly, these questions express the need of the human heart for the warmth and love of those who care for them. “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.”\(^{210}\)

\(^{207}\) John Paul II, *Evangelium Vitae*, n. 65.

\(^{208}\) United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, n. 60.


IV. END-OF-LIFE ISSUES IN VIETNAM: AN OPPORTUNITY TO LIVE OUT THEIR CATHOLIC IDENTITY

IV.1. The Situation of Health Care in Vietnam

This section is going to start with what aspects of health care in Vietnam are good and then deal with deficiencies, especially outside the major cities.

Vietnam, the easternmost country on the Indochina Peninsula, has made great progress in health care since 1990s, and is currently working to develop a universal health care system, which will cover all residents and provide them with basic health care. Since its origins, the Communist Party of Vietnam has professed a commitment to providing fair access to health care services, even during periods of war and extreme poverty.¹

The overall quality of health care in Vietnam is regarded as good as reflected by Health Partnership Group. In 2011 the average life expectancy of Vietnamese reached 73 years and the child mortality rate has shown a declining trend over time. The national rate fell from 15.8 per 1,000 live births in 2010 to 15.5 in 2011.² Vietnam continues to make progress towards achieving the health Millennium Development Goals (MDGs) of the United Nations, such as prevention and control HIV/AIDS, malaria and other diseases; reduction by 50% in the proportion of people without regular access to basic hygiene and safe water.³ In 2005, Vietnam’s Ministry of Health launched a palliative care initiative that uses the World Health Organization public health strategy for national palliative care programme development. With international financial and technical support, the initiative has made significant early progress. A rapid situation analysis in 2005 led to national Guidelines on Palliative Care in 2006, radically improved opioid prescribing regulations in 2008, the training of more than 400 physicians in palliative care by early 2010 using three curricula written especially for Vietnam and the initiation of palliative care services in some hospitals and in the community.⁴

Although Vietnam’s economy is in the midst of a global financial crisis and economic recession, the Government has managed to maintain an increasing investment in health care

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³ Health Partnership Group, Joint Annual Health Review 2012, 26.
sector to improve the people’s health. The state budget share of GDP spent on health in 2007 was 2.36%, declining to 2.30% in 2008, then back up to 2.77% in 2009 and 3.09% in 2010. Along with these impressive achievements there are numerous difficulties and challenges in health care services in Vietnam. Commercialization of health care services in public hospitals since the late 1980s has brought about a lot of changes to Vietnam’s health care system. The health sector began charging fees and privatized drug sales and thereby a large part of the fiscal burden of healthcare was shifted from the state onto individuals. The benefits of commercialization of health care have not been shared equally. The main beneficiaries of commercialization continue to be affluent social groups, while most of the people may be at high risk of falling into poverty when encountering major medical expenses. Moreover, in reality the poor and the exempted groups still find services unavailable without an informal fee, known as ‘under table’ or ‘envelope’ payments, to doctors, nurses, midwives and other healthcare staffs.

Another challenge in health care services is that urbanization and industrialization are happening quickly, thus creating huge pressure on big cities. Overcrowding in Vietnamese hospitals is a significant issue with it not being uncommon in some state-run hospitals for two or three patients to literally share one bed. The reason is most of the best health workers have incentives to move from rural or poor urban areas to major cities, such as Hanoi and Ho Chi Minh City (formerly known as Saigon). Health care facilities in these capital areas are better equipped and have more modern equipment to provide good health treatments that health centers in other provinces do not have. This disparity has caused many health care problems especially for the poor and the ethnic minorities who mostly live in isolated and remote areas.

In addition, the Vietnam demographic is that of a populous country entering an ageing stage very fast. The Population Census in 2009 indicated that Vietnam’s population would continue to rise, on average, about 900 thousand people per year. Furthermore, the population age structure has changed dramatically with the population in the age group of 60 years and older increasing from 8.0% in 1999 to 9.4% in 2010. A high proportion of the elderly population will necessitate rising needs for health care services in the immediate future. For example, while communicable diseases have seen a declining trend, non-communicable diseases continue to increase in prevalence. This study finds that more often people at the age of 60 or

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older are suffering cardiovascular diseases, diabetes, cancer and chronic lung diseases. This will heavily influence the demand for geriatric health services, palliative and end-of-life care.

Besides those difficulties, there remain other issues such as, low salaries for health care professionals, insufficient government subsidies, outdated medical equipment. All of them make the health care system of Vietnam largely underdeveloped and both the quantity and quality of hospitals, clinics and medical workers have not kept pace with Vietnamese society’s expectations.

IV.2. The Challenges for Vietnamese Catholic Health Carers

From the description of the above situation of health care provision in Vietnam, though we can see that the Vietnamese people’s health status continues to improve, the Communist Party, the National Assembly and the Government of Vietnam must make much more of an effort to develop and consolidate their health care system. Attracting, training, supporting health care workers at all levels is actually one of the most vital elements for success. In fact, there are some factors that cause difficulties in appealing to, retaining health care professionals at grassroots level facilities, especially in disadvantaged areas and in some specialties. These factors may be: low income, unsatisfactory remuneration and salary supplements, very difficult working conditions in rural and mountainous areas, severe work pressures, too few staff, and medical workers with few opportunities for training,…

There is not enough room here for detailed consideration of all these issues, but this section is trying to focus on the challenges for Catholic health carers, especially when they deal with the patients near the end of their lives.

IV.2.1. The Objective Difficulties

First of all is the religious issue. Vietnam’s Catholic Church was established by missionaries in the 16th century and grew during French colonial rule (1787-1954) in Vietnam. After five centuries developing, Vietnamese Catholics are about 8% of more than ninety-one (91) million inhabitants in a predominantly Buddhist country. However, the Catholics represent a...
vital force for the culture, history and society of the nation, according to teachings of the Catholic Bishops’ Conference of Vietnam:

As the Church in the heart of Vietnam nation, we are determined to stick to the destiny of our homeland, following the national tradition and integrating in the current life of our country. The Council teaches that "the Church goes forward together with humanity and experiences the same earthly lot which the world does." (*Gaudium et Spes*, n. 40) So we have to go forward together with our people, share the common life with our nation, because this homeland is the place where we are called to live as God's children, this country is the womb carrying us in the process of implementing the vocation as children of God, this nation is the community that God gives us to serve as citizens and members of God's People.9

Nowadays, though many barriers still remain because of historical and political reasons, Vietnamese Catholics now are able to partake in all sectors of the country. For instance, the Catholic Church in Vietnam has recently been allowed to take a limited role in health care that the Communist government used to prevent or interfere with in the past. Moreover, when public hospitals are heavily subsidized, financial resources from the State budget are in shortage, private hospitals and foreign invested hospitals have more shares in the marketing of health care services in Vietnam. This also provides a chance for Catholics to pay their contribution. It is true that Catholic bishops of Vietnam continue to ask for more freedom and request Catholic involvement in health care, education and charity work as a contribution to social development.

The second challenge is about culture. As influenced by Buddhist theology and Confucian philosophy, most Vietnamese people are highly family oriented. Very often two or three generations reside in one household where elders are the leaders who have the strongest influence in decision making and are respected and sought after for advice. As parents grow older, children are expected to take care of them to compensate for the gift of birth and upbringing. Related to this culture, Vietnamese people may feel shame in their community if they accept outside help with caring for their ageing parents. It is, therefore, culturally very difficult for elderly Vietnamese to wish to be sent to residential facilities or nursing homes.10 Likewise, they seem to display stoicim towards pain and may suffer in silence. They may not

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9 Catholic Bishops’ Conference of Vietnam, *Pastoral Letter to All Priests, Religious and Lay People of the Whole Country* (Hanoi: CBCV, 1980), n. 9. This is the first national episcopal plenary assembly held in Vietnam after the Communist took over the whole country in 1975.

choose to disclose their feelings and pain to medical staff or other people in fear of losing face and honour, and a strong desire to go home or even die at home. This choice derives from a number of cultural beliefs that are likely to affect decisions at the end of life for Vietnamese patients and their families. These beliefs include: an aversion to dying in a hospital because of the belief that souls of those who die outside the home wander with no place to rest, the perception that consenting to end-of-life support for a terminally ill parent contributes to his or her death and is an insult to one’s ancestors and parent... This culture issue is really a big challenge for health workers in general and specifically for Vietnamese Catholic health carers in properly performing their work.

One more difficulty which should be noted here is that palliative care or the care for the patients at the end of life stage has a very short history in Vietnam. According to the statistics in 2007, there were an estimated 24,000 AIDS death, 150,000 new cancer diagnoses, 80% at an advanced stage, and at least 70,000 cancer deaths. Recognizing a very high level of unmet need for pain and symptom control, psychological support, and training for end-of-life care clinicians to help the cancer and HIV/AIDS patients, Vietnam’s Ministry of Health just began its palliative care initiative in 2005. The truth is that there is a lot of confusion for Vietnamese health care workers when they deal with some palliative care or end-of-life issues, such as: the ethics of pain management, advance directives, the morality of withholding and withdrawing medically administered nutrition and hydration, physician-assisted suicide, euthanasia. Vietnam as yet has no long-term strategy for palliative care. This country has only a small fraction of the number of trained palliative care staff and clinicians it needs. Also there is not yet a national palliative care organization that could provide a discussion forum for development plans and continuing education for its members, as well as promote palliative care research. Even when facing dilemmas in their work of caring for patients at their end of life, health carers of Vietnam do not have any ethics committees to guide or give them appropriate instructions. In short, despite rapid progress, many challenges must be overcome to meet Vietnam’s great need for palliative care.

IV.2.2. A Personal Suggestion

With the objective difficulties given, I wonder if we could use the challenges as opportunities to face the very serious ethical issue within Vietnam’s health care system. Being a Catholic priest, I believe that the health care professionals may find in palliative care or end-of-life issues a chance to further live out and enhance their Catholic identity in a communist country.

It is admitted that the extraordinary advances of science and technology in the very vast field of health and medicine have produced many achievements in curing, but the demands of facing sickness, debilitation, weakness from old age, and especially their deaths require more than skilled techniques of medicine. “The activity of those engaged in health care is a very valuable service of life. It expresses a profoundly human and Christian commitment, undertaken and carried out not only as a technical activity, but also as one of dedication to and love for one’s neighbor.” Thus, on one hand palliative care clinical and training centers must be established at major regional and provincial hospitals to provide clinical training in palliative care for professional health carers, and on the other hand more voluntary workers should be encouraged to get involved in caring for the patients with refractory distress or approaching their very end stage. This is really a good chance for Catholics to be Christian witnesses when most Vietnamese patients, because of cultural belief, receive palliative or end-of-life care in the home. When my mother was dying, I saw that there was nothing anyone in our family could do but give loving care and presence. In this way, we helped her to be stronger to face the sufferings and finally die a peaceful death. This is certainly possible to implement in Vietnam, starting from the parish community, where Catholics are living in the midst of non-Christians. With the activities of Caritas, Legio Mariae or Cursillo... Vietnamese Catholic health carers, both professionals and volunteers, can visit and care for terminally ill patients at homes, help them to hopefully know the meaning of pain and suffering, and make them feel that they are always loved and cared to the end of their lives. In fact, “institutions are very important and indispensable; however, no institution can of itself replace the human heart, human compassion, human love, and human initiative, when it is a question of helping others in their sufferings.”

Another more important thing to note is that to date, there are no ethics committees not only in any health care facility nor in the Catholic dioceses in Vietnam. This is the reason why

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health care workers find it very difficult and even stressful when facing ethical dilemmas regarding palliative care or end-of-life care. Vietnam’s Catholic Church should play more of an active role in the overall health care sector where she can continue to fulfill Jesus’ healing mission. It is also the best way to “be consistent with the Gospel” and “be aware of the current problems of the country.”

It is my personal suggestion that the Church in Vietnam should pay more attention to those who are working in the medical area, especially in caring for the old, the terminally ill and the marginalized (the HIV/AIDS patients, the lepers…). At the diocesan level, Vietnamese Catholic leaders, in collaboration with professional trainers, medical ethicists and theologians, can organize training courses, seminars, so that health workers may acquire necessary knowledge of the theological foundations, moral principles and the teachings of the Church related to emerging ethical issues in their career. Moreover, it is essential to establish ethics committees or consulting groups of some type to help and guide Catholic health carers to be aware of and learn strategies to handle these rising moral dilemmas in accord with the teachings of the Church without losing their jobs as health care professionals. This is clearly mentioned in the *Charter for Health Care Workers*:

The continuous progress of medicine demands of health care workers a thorough preparation and on-going formation so as to ensure, also by personal studies, the required competence and fitting professional expertise. Side by side with this, they should be given a solid “ethical-religious formation,” which “promotes in them an appreciation of human and Christian values and refines their moral conscience.” There is need “to develop in them an authentic faith and a true sense of morality, in a sincere search for a religious relationship with God, in whom all ideals of goodness and truth are based.” “All health care workers should be taught morality and bioethics.” To achieve this, those responsible for their formation should endeavor to have chairs and courses in bioethics established.

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CONCLUSION

It is true that the progress of science and technology in the last several decades in medicine has made a spectacular contribution to health care of people throughout the world. But not always does this progress serve the truth about humanity. It provides an excuse for many assaults on human beings, such as denying the human right to life from conception and including direct intervention in the dying process. Science and technology have their share in those assaults. As a result, people separated form basic values and moral duties, want to be the lord of universe, and more – want to claim total mastery over human life. This reality has placed the health care profession in an extremely challenging situation, especially when they deal with the patients at their very end-of-life stage. It is meaningful to note the words of Dr James Drane, a medical bioethicist:

Nations and states influenced by Catholic culture inherit from history a sound and reasonable religious perspective on the meaning of life and death. Such a perspective is critical when individuals or societies face the problem of how to legislate the care of fellow human beings approaching death. Without a religious perspective, death and dying lose their meaning. 19

This thesis firstly seemed to be pure research. It initiated from my own experience of the death of my mother and is motivated by the desire to fulfill the mission of my Catholic priesthood. However, the more I pay attention and effort to examining the issues of the very end of human life, the more I am discovering that they are some of the most important issues which the Church and society have great concerns about today.

Hopefully this research may contribute in a small part to helping Catholic health carers face the challenges in their profession as well as in living out their faith. Finally, when applying this research in my home country Vietnam, I believe that it will be useful for those working in the health care sector to become witnesses of Jesus Christ, who “took away our infirmities and bore our diseases.” (Mt 8:17; cf. Is 53:4) Furthermore, this would possibly make communists and non-Christians in Vietnam aware of the value of life which comes from God.

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