

The Catholic living will and healthcare surrogate: A teaching document for evangelization, and a means of ensuring spirituality throughout life

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The living will is a document that allows a patient to give instructions about the medical care they desire to receive at a future time. If consistent with Catholic teaching, it becomes a very effective tool for evangelization. A truly Catholic living will addresses five key principles: (1) the desire for pain relief, (2) assessing treatments as either ordinary or extraordinary, (3) providing nutrition and hydration, (4) prohibiting euthanasia, and (5) providing for spiritual care. The Catholic living will is not only individualized and patient-centered, it also avoids the dangers of a secular living will which deny patients proper end-of-life care.

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INTRODUCTION

The living will, as we know it today, is a written document that allows patients to give instructions about medical treatments that they desire to be administered or withheld at a future time. The living will is one type of an advanced directive. This declaration becomes active only when patients become incapacitated and can no longer speak for themselves. Ideally, a complementary directive referred to as a healthcare proxy, or durable power of attorney for healthcare should accompany it. This document authorizes surrogates to make decisions for patients when the patients are no longer able to make decisions for themselves (National Catholic Bioethics Center 2011).

The living will was first developed and introduced by the Euthanasia Society of

America in 1967. Living wills were not popularized until they were embraced and promoted by syndicated advice columnist Abigail Van Buren (Dear Abby), herself a member of the Euthanasia Education Council (Senander 1996).

Cognizant of the origin of the living will, patients and physicians must seek guidance from the Church to ensure that these documents are in accord with Church teaching. There are defects and problems associated with many living will documents. It is for this reason that a living will to be used by Catholics should address the following five principles: (1) the desire for pain relief, (2) assessing treatments as either ordinary or extraordinary care, (3) providing nutrition and hydration, (4) prohibiting euthanasia, and (5) providing for spiritual care. The

inclusion of these five principles provides assurance that the living will document is consistent with magisterial teaching. It is also an effective means of spreading Church teaching on the dignity of human life and end-of-life care. A Catholic living will thus becomes a means of evangelization, even when one is incapacitated and unable to verbally communicate.

RELIEVING PAIN

The management of pain and the relief of suffering is a major focus of medical care and it is especially important in caring for patients struggling with a terminal diagnosis and those in the active stages of dying. Church teaching is very supportive of the goal that patients should be kept as free of pain as possible so that they may die comfortably and with dignity (U.S. Conference of Catholic Bishops 2009, n. 61). Additionally, the Church offers guidance about the moral implications of giving pain medication that might alter the level of consciousness or shorten the patient's life. Pope Pius XII stated that if there are no other ways of making a patient comfortable and it does not prevent them from carrying out their religious and moral duties, such an application of pain medication would be acceptable, since the intention is to relieve pain and not hasten death. He warned, however, that it is not right to deprive the dying of consciousness without a serious reason because patients not only need to satisfy their moral duties and family obligations, they also have to prepare themselves with full consciousness for meeting Christ (Congregation for the Doctrine of the Faith 1980).

The Church also teaches us about the redemptive nature and mystery of suffering. This is most helpful because for many patients the end of life can be a time of questioning and fear: questioning a God

who allows suffering or experiencing fear of an unknown future. True compassion for patients at this difficult time necessitates a response. Pope John Paul II in his apostolic letter *Salvifici Doloris* explains the "why" of suffering by looking at the ultimate source of the meaning of everything that exists, divine love. Love is the fullest source of the answer to the question of the meaning of suffering.¹ "For God so loved the world that he gave His only Son, that whoever believes in Him should not perish but have eternal life" (Jn 3:16). This introduces us to the heart of God's salvific work: a love that conquered suffering, a salvific love.²

This time of suffering especially in the last moments of one's 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 (Congregation for the Doctrine of the Faith 1980). Many patients will view this time as the last opportunity to unite their suffering with the suffering of Christ and may wish to moderate their use of pain medication. Healthcare personnel should explore the patient's goals of care regarding pain management and honor these.

ASSESSING TREATMENTS AS EITHER ORDINARY OR EXTRAORDINARY CARE

The concept of accepting proportionate or ordinary care or declining disproportionate or extraordinary care has been taught by the Church for hundreds of years (Cronin 2011). The Church offers solid counsel in making difficult end-of-life decisions. These decisions must be evaluated thoroughly. There needs to be adequate information given as well as a clear understanding by the patient as to whether the end-of-life treatment proposed will do one

of the following three things: (1) serve as a bridge to recovery from an acute medical problem, (2) alleviate discomfort and suffering from an on-going condition, or (3) offer little hope of benefit and may actually add burden to the patient's care.

Many advanced directives are designed to provide a predetermined list of options to help the patient choose what type of medical care they would desire at a future date and with a hypothetical medical condition. These advanced directives appear to be providing well-informed consent; however, they are forcing patients to decide on specific medical treatments in advance of the time of need and without full understanding of the medical situations that may arise. Many studies have shown that individuals have difficulty predicting what they would want in future circumstances (Sudor and Fried 2010). In addition, it has been found that patients' treatment preferences and values change when their health changes (Sudor and Fried 2010, 256). Rather than being beneficial to patients, these simplified, predetermined decisions limit ideal care and are a poor prediction of future desires.

It has been shown that a better way to address end-of-life medical decision making is to prepare the patients and their surrogates to participate with clinicians in making the best possible in-the-moment decisions (Sudor and Fried 2010, 257). In doing so, Catholic patients need to start by selecting healthcare proxies that are of good moral character and able to make sound decisions under stressful circumstances. They also need to know the teachings of the Church and be able to apply them to changing circumstances (National Catholic Bioethics Center 2011, 3). The patients need to articulate their values over time, to their healthcare proxies and, if possible, to their physicians. Surrogates need to make decisions in light of what patients would choose to do in a

given situation based on written or oral instructions and good judgment (National Catholic Bioethics Center 2011: 3).

Making in-the-moment medical decisions can be the most challenging for the physician and medical team caring for these patients. It can also, however, be the most rewarding through having taken the time to get to know the patients directly or through their healthcare surrogates, learning their life stories, and seeing Christ in these patients as they are being called home.

PROVIDING NUTRITION AND HYDRATION

This tenet of the living will is probably the most salient from the perspective of evangelization. Making a written request for the administration of food and water, even if given by artificial means is something that is generally not included in a standard living will and is unique to Catholic moral teaching.

The lack of agreement between the secular medical community and the Catholic Church over artificial nutrition and hydration (ANH) starts in part with a disagreement over the definition of terms. The Catholic Church fundamentally views ANH as *normal care* similar to the need for shelter, clothing or warmth. The provision of food and water is always normal care even though a medical act, such as the placement of a feeding tube, may be required for its administration. This medical act, like all others, should be guided by the principles of ordinary and extraordinary care. The secular medical and legal communities, however, do not view ANH as normal care but strictly as a medical treatment.

The American College of Physicians' *Ethics Manual* does not consider the artificial administration of nutrition and fluids as normal care but as a medical

intervention subject to the same principles of decision making as other treatments (American College of Physicians 2005). The judicial consensus upholds that competent adults can decline any and all medical interventions and since ANH is considered a medical treatment, patients may refuse ANH, even if death results (Ganzini 2006). This is in contrast to Pope John Paul II's statement in which he declared, "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 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."³ As can be clearly seen there is a vast difference between the Church's position on ANH as a natural means of preserving life and the medical and legal communities which consider it a medical intervention.

There is another fundamental difference that should be mentioned. The scientific approach considers life an instrumental good, a good *for* the person (May 2008, 279–285). Any standard therapeutic recommendation has to show a concrete improvement in quality or longevity of life. The Church considers life an instrumental good *of* the person, focusing on the dignity of the human person made in the image and likeness of God and making recommendations based on the sanctity of human life (May 2008, 285). The benefits to the patient derived from the approach of the Catholic Church would not necessarily be discernible or recognized by the secular medical community. Since the Catholic position starts from the presumption *in favor* of ANH until it is no longer useful or becomes burdensome, and the medical literature starts from the presumption *against* ANH unless there are

statistical, reproducible, and tangible benefits to support its use, there is little doubt this will be an on-going area of controversy and conflict.

The Church does understand that as a patient's medical condition declines and death approaches, there may come a time when ANH will have reached its proper finality and become excessively burdensome or cause physical discomfort. At this point ANH is no longer obligatory and can be discontinued (U.S. Conference of Catholic Bishops 2009, n. 58).

PROHIBITING EUTHANASIA

The immorality of euthanasia can be understood by natural moral law and predates Christianity. Hippocrates prohibited euthanasia in his original oath when he stated "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan" (Furton, Cataldo, and Moraczewski 2009). The Church confirms that euthanasia is a grave violation of the law of God. Pope John Paul II helps us to understand how euthanasia is a false mercy and indeed a perversion of mercy (Pope John Paul II 1995). Euthanasia has been defined as an action or omission, which of itself and by intention causes death, with the purpose of eliminating all suffering (Pope John Paul II 1995, 64). What is important to point out is that there are two components to euthanasia, an action or omission and an intention, which is to cause death. Both components are necessary in order for an act to be considered euthanasia.

Physician-assisted suicide (PAS), or as it has been more recently referred to, physician-assisted death, is a form of euthanasia in which the physician assists patients in killing themselves by supplying the means to terminate their lives (BioEdge 2013).⁴ PAS is gaining

acceptance through state legislative actions and ballot initiatives throughout the country. The proponents of PAS support their actions based on the principle of autonomy, and therefore believe that personal autonomy includes the right to PAS and euthanasia. Their premise is based on an understanding that people have the ability and right to control their own lives and that right includes determining the manner and time of their demise (May 2008, 264–265). The Church does respect a person’s right to make choices, however, those choices are not unlimited. Life is considered the most basic gift of a loving God, a gift over which we have stewardship but not absolute dominion (National Conference of Catholic Bishops 1991). Valid choices must acknowledge equal human dignity and respect for the sanctity of human life. Pope John Paul II has pointed out,

To claim the right to ... euthanasia, and to recognize that right in law, means to attribute to human freedom a perverse and evil significance: that of an absolute power over others and against others. This is the death of true freedom.⁵

PROVIDING FOR SPIRITUAL CARE

Our faith in the resurrection and divine life are strengthened through the sacraments. The sacraments of Penance, Anointing of the Sick and Viaticum are the healing sacraments that give peace, strength, and grace in preparation for death. The Anointing of the Sick provides the graces of peace and courage to overcome the difficulties accompanying serious illness (Catechism of the Catholic Church 1997, 1520). It unites a person more closely to Christ’s Passion and uses suffering as a participation in the saving work of Jesus. In essence, it “fortifies the end of our earthly life like a solid rampart

for the final struggles before entering the Father’s house” (Catechism of the Catholic Church 1997, 1520–1523). In addition the Church offers those who are about to leave this life the Eucharist as viaticum, food for the journey. Here, the Eucharist is the sacrament for passing over from this world to the Father (Catechism of the Catholic Church 1997, 1524).

Just as the sacraments of Baptism, Confirmation, and the Eucharist are the sacraments of Christian initiation, the sacraments of Penance, Anointing of the Sick and the Eucharist as viaticum complete the earthly pilgrimage (Catechism of the Catholic Church 1997, 1525).

CONCLUSION

A living will document that includes the five principles enumerated above reflects the fundamental teachings of the Catholic Church, thereby becoming a Catholic living will (National Catholic Bioethics Center 2011; Marker 2013⁶). The Magisterium has put forth valid teachings that are grounded in Faith and supported by Reason. A Catholic living will avoids the shortcomings and limitations of secular living wills, which deny patients proper end-of-life care. It also individualizes the document, making it patient-centered in accordance with Church teaching. The Catholic living will, along with the healthcare proxy, becomes a very effective tool for evangelization. It allows patients a final opportunity to pass on the Faith to others. They witness even when they can no longer express in words the truths about human dignity, the redemptive value of suffering and hope in eternal life. The Catholic Church will always guide our earthly life, as well as our journey from death to eternal life in Christ.

ENDNOTES

1. Pope John Paul II, *Salvifici Doloris* (February 11, 1984), n. 13.
2. Pope John Paul II, *Salvifici Doloris* (February 11, 1984), n. 14.
3. Pope John Paul II, Address to the Participants in the International Congress on "Life-Sustaining Treatment and Vegetative State: Scientific Advances and Ethical Dilemmas." (March 20, 2004), n. 4.
4. Oregon has changed the name of PAS to "physician-assisted death." Polls have shown that people are more likely to approve legalizing the practice when the word suicide is not used.
5. Pope John Paul II, *Evangelium Vitae* (March 25, 1995), n. 20.
6. The PMDD is based on Catholic principles and conforms to the legal requirements of each state.

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