The National Catholic Bioethics Center
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A Catholic Guide to End-of-Life Decisions ©2011

An Explanation of Church Teaching on Advance Directives, Euthanasia, and Physician Assisted Suicide

At Central Medical Hospital, a woman rests in bed with a serious illness. Her name is Anne. Anne is a Roman Catholic who wants to make decisions about her medical treatment in the light of her Catholic faith. As would anyone in her condition, Anne has questions about the teachings of the Church.

What are the Church's teachings on end-of-life decisions and how difficult will it be to follow them? Must she endure a great deal of pain? What if she is no longer able to make medical decisions for herself? Anne wants to make certain decisions ahead of time in order to relieve her family of the burdens of determining what care might be most appropriate for her.

A time of serious sickness is naturally distressing for the one who is ill and for the family and friends of the one who is stricken. Making sound moral decisions in the face of such circumstances may be especially difficult when we consider the emotional strains that are natural when someone we love undergoes great suffering.

This pamphlet describes how someone might approach end-of-life decisions in light of the teachings of the Catholic Church. We consider the redemptive nature of suffering, the important difference between morally obligatory and optional means of conserving one's life, the moral and legal status of Advance Medical Directives and Durable Power of Attorney, and the spread of euthanasia advocacy in America today.

The Redemptive Nature of Suffering

As a woman of religious conviction, Anne receives great consolation from her faith in God. She receives pastoral care from the hospital chaplains and Communion from the Eucharistic ministers. A priest has given her the Sacrament of Anointing and, should it become necessary, he is ready to administer Viaticum. In the past several weeks, however, Anne has begun to experience more pain. As her doctor performs new tests and prescribes additional medications, Anne experiences a greater degree of suffering.

Suffering at times may be a profoundly distressing experience that raises deep and troubling questions about the meaning of life and even the nature of God. How can a merciful God allow us to experience the suffering of illness? It should be comforting to reflect on the fact that God Himself entered into human suffering through His Son who suffered and died so that we could overcome death.

Suffering and death entered the world with the sin of our first parents, but Christ's obedience to the Will of His Father can now infuse these afflictions with redemptive power.

By virtue of our being made one with Christ in Baptism, we can join our suffering to that of Our Savior on the Cross at Calvary and thereby assist in His work of salvation for the entire world. The suffering of illness and dying brings the Catholic a grace-filled opportunity to offer prayer for oneself, for loved ones, and for the whole human race. Christ is with us during our illness and shares in our suffering as we share in His.

For those who have lost their faith in God, the suffering and helplessness of serious illness make little sense. Some may even come to contemplate suicide or euthanasia. Why should one endure the pain of illness when death is the end of all meaning and purpose? Others who accept the existence of God wrongly believe that He does not care whether we shorten our lives. The immorality of harming the great good of human life, however, should be apparent even to those without faith. The testimony of Sacred Scripture and the constant teaching of the Catholic Tradition speak against ever directly intending one's own death. The Catholic, with a deep faith in Jesus Christ, may not be able to understand his suffering, but he knows he can offer it up as a powerful prayer.

Obligatory and Optional Medical Means

Anne's doctor has informed her of a serious turn in her case. Anne has discussed the situation with her physician and considered the risks and benefits of the proposed treatment. She is aware that the suggested surgery is likely to enable her to live longer, but in her case the risk of developing serious complications is higher than normal and there is little likelihood of recovery. After talking it over with her family,

Anne has decided to forgo the surgery. Had Anne been younger, or someone upon whom others depended, she may very well have decided to undergo the treatment—despite its difficulties and poor prognosis. The most fundamental moral norm in dealing with end-of-life decisions is that we may never directly take innocent human life, including our own.

"Life, health, all temporal activities are in fact subordinated to spiritual ends."
- POPE PIUS XII

One of the most important moral distinctions for end-of-life decisions is that between what is morally obligatory and what is morally optional. What is morally obligatory we are bound to perform; what is morally optional we may include or omit at our own discretion. Moral theologians use the terms "ordinary" and "extraordinary" to make this distinction, in keeping with the words of Pope Pius XII: "Normally one is held to use only ordinary means—according to the circumstances of persons, places, times and culture—that is to say, means that do not involve any grave burden for oneself or another. A stricter obligation would be too burdensome for most people 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."

Generally, a medical procedure that carries with it little hope of benefit and is burdensome is deemed "extraordinary" and is not obligatory. For example, a person may judge in good conscience that the pain and difficulty of an aggressive treatment for terminal cancer is too much to bear, and thus decide to forgo that treatment. Whether a particular treatment is excessively burdensome to an individual patient is a moral question that often requires the advice of a priest or someone well-trained in moral theology. Individual patients and their families should seek the guidance of the Church whenever there is any doubt about the morality of a particular course of action.

Most medical treatment received during the course of one's lifetime is routine and does not raise serious moral questions. Sometimes, however, medical circumstances require considerable reflection about what procedures are appropriate for a given medical condition and time of life. When aggressive and experimental methods are recommended by a physician, the Church teaches that we are free to pursue such treatment whenever there is a reasonable hope of benefit to the patient. We are also free, however, to refuse treatment that is of dubious benefit or when its burdens are clearly greater than its benefits. For example, I might want extraordinary moral means used to extend my life in order to receive the sacraments of the Church, or to see friends or relatives one last time, or to be reconciled with somebody from whom I've been estranged. The use of extraordinary moral means always remains optional, but the moral obligation to conserve life obliges us simply to act in the most reasonable manner.

Specific Moral Teachings of the Church

By refusing aggressive treatment for her condition, Anne realizes that she faces the possibility of death in the near term. She will continue to receive morally obligatory care for her illness even though recovery for her is unlikely. Anne knows that she may not refuse any morally obligatory means of preserving her life. She knows, for example, that she may not refuse food and water as long as they provide her a benefit.

To make sound moral decisions patients must receive all relevant information about their condition, including the proposed treatment and its benefits, possible risks, side-effects, and costs (Ethical and Religious Directives for Catholic Health Care Services [ERD], National Conference of Catholic Bishops, November 1994, #27.) They must also know of any other morally legitimate options that are available. It is the patient, in consultation with the doctor, who ultimately must decide the course of medical treatment. Normally, the patient's judgment concerning treatment should guide others in their decisions unless it is medically unwarranted or contrary to moral norms.

When patients act with free and informed consent, they may use the most advanced medical techniques even when these are experimental or involve a certain measure of risk. The patient may also interrupt such methods when they fall short of expectations of benefit, but such a decision should take into account the reasonable wishes of the patient's family and the advice of one's doctor. The patient may also consider the expense the treatment may impose on the family and the community at large (ERD, #57).

When death is imminent one may refuse forms of treatment that would only result in a precarious and burdensome

prolongation of life. There is a presumption in favor of continuing to provide food and water to the patient, but there is a stage in the dying process when even these may no longer be obligatory because they provide no benefit. Normal care always remains morally obligatory, but refusal of additional treatment when death is imminent is not equivalent to suicide. It should be seen instead as an expression of profound Christian hope in the life that is to come. An instruction not to provide such treatment, when communicated ahead of time to family and friends, may give great comfort to loved ones during emotionally stressful times.

Giving Instructions for Future Care

Anne is blessed to have family and friends who love and care for her and who visit often. Not all the patients at Central Medical are as fortunate. Should it happen that Anne is no longer able to make decisions on her own, there are family members and friends who are capable of making decisions on her behalf. Anne must decide, however, whether or not to designate a particular member of her family to serve as her "proxy" or "agent." There is also the question of whether she should specify which medical procedures she feels will be most appropriate for her in the future should she be unable to make her wishes known.

An "Advance Medical Directive" and "Durable Power of Attorney for Health Care" (or "Health Care Proxy") are legal documents that take effect if the patient becomes incompetent. Even though these documents can be written without the assistance of an attorney, some states give them considerable legal weight.

An Advance Medical Directive specifies what medical procedures the patient wishes to receive or to avoid. (An Advance Medical Directive sometimes is called "A Living Will," but because of its association with the advocacy of euthanasia, we have chosen to avoid this phrase.) Durable Power of Attorney specifies a particular individual (variously called a "proxy," "agent," or "surrogate") to make medical decisions on behalf of the patient (or the "principal") when the patient is no longer able to do so. When neither of these instruments is drawn up, the task of making important medical decisions usually falls to the family. Most states have laws governing the use and implementation of the Advance Medical Directive and Durable Power of Attorney.

All hospitals and health care facilities are required by law to provide written information to the patient about the right to accept or refuse medical treatment and the right to formulate an Advance Directive and/or designate Durable Power of Attorney (“Patient Self-Determination Act of 1990”). The health care facility must also provide written policies stating how the patient’s Advance Directive or Durable Power of Attorney will be implemented. Individuals should remember that they do not have to sign any Advance Directive given to them by the hospital.

Make certain that your Advance Directive forbids any action that the Catholic faith considers to be immoral, such as euthanasia or physician-assisted suicide. A Catholic hospital, in any case, will not follow a directive that conflicts with Church teaching (ERD #24). Once a directive is made, copies should be distributed to the agent and anyone else the patient deems appropriate. One should periodically review the provisions of an Advance Directive and, when there is a revision, all previous copies should be destroyed.

The usefulness of an Advance Directive, which gives specific instructions for care, is limited because of its inflexibility. If circumstances change significantly between writing the Advance Directive and its implementation, the instructions may be of little value to those acting on a patient's behalf, or may even hinder their freedom to make good decisions. There may also be a problem of interpreting the document when it is not clearly written. An Advance Directive oftentimes does not allow for adequate informed consent because one must make a decision about a future medical condition which cannot be known in advance. When drawing up an Advance Directive, therefore, one should focus on general goals rather than on specific medical procedures.

Assigning Durable Power of Attorney is preferable to an Advance Directive because it leaves decisions in the hands of someone whom the patient has personally chosen. A proxy agent also can be more sensitive and responsive to the decision-making that is necessary for a given case. When assigning Durable Power of Attorney one should choose an agent of good moral character—someone who is known to be

capable of making sound decisions under stressful circumstances. The agent should know the teachings of the Church and possess the practical wisdom to apply them to changing circumstances. An agent, of course, must also survive the patient. One may designate alternate agents in case one's first choice, for some reason, is unable to act.

A good agent makes decisions for the patient in light of what the patient would choose if able to do so. The proxy, therefore, should be very familiar with the moral convictions and wishes of the principal. When there is an Advance Directive from the patient, this should be the guide. When there is not, the agent must act on the oral instruction that has been given. Sometimes, however, acting in the best interests of the patient means ignoring instructions that are obviously unwarranted or clearly immoral. No agent is bound to carry out actions that conflict with morality and the faith.

The Specter of Euthanasia

Anne shares her hospital room with a woman whose condition is similar to her own. Recently a stranger visited her roommate and the two of them had a long discussion together. After he left, Anne was surprised to learn that the man was an advocate of euthanasia. Apparently he knows of a doctor who has already helped some sick people to kill themselves. He is trying to convince Anne's roommate to do the same.

Human life is an inviolable gift from God. Our love of God and His creation should cause us to shun any thought of violating this great gift through suicide or euthanasia. We read in Wisdom: “God did not make death, nor does He rejoice in the destruction of the living. For He fashioned all things that they may have being” [1:13]. St. Paul teaches us: “If we live, we live to the Lord, and if we die, we die to the Lord” [Romans 14:8].

"God did not make death, nor does He rejoice in the destruction of the living."
WISDOM 1:13

When formulating any Advance Directive and discussing end-of-life issues we should avoid using the expression “quality of life” because it is used by advocates of euthanasia to suggest that some lives are not worth living. “While illness and other circumstances can make life very difficult, they cannot diminish the inestimable worth of each human life created by God. ”Life itself is always a good, and is a quality that can never be lost. Still, we need not cling to this life at all costs, since the life to which we have been called in Christ is incomparably better.

Euthanasia has been defined by Pope John Paul II, in The Gospel of Life, as “an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering.” Supporters of euthanasia often justify it or physician-assisted suicide on the grounds that the pain of terminal illness is too great for the average person to bear. They hold that it is more merciful to kill the suffering patient. The Pope, as representative of Christ on earth, holds that “euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person.” It is a fundamentally unreasonable act.

Conclusion

The prospect of intractable pain may be frightening, but such extreme distress rarely occurs. The physician almost always can minimize or eliminate the pain that may accompany terminal illness. Most people, in fact, die peaceful deaths. Although it is certainly preferable to die in a conscious state of prayer, no one should feel obliged to forgo medications and pain relief even though they may bring about disorientation or produce unconsciousness. The Church does not oblige the Catholic to forgo medical treatment for pain even when such treatment may deprive the patient of full consciousness or indirectly shorten life. This is an application of the principle of double-effect (see glossary). The Church asks only that appropriate conditions exist before such medication be taken.

Hope of The Resurrection

We hope that these explanations of the moral teachings of the Catholic Church have been helpful to you. Christians should approach death with the joyful anticipation of seeing face to face their Blessed Lord whom they have loved and diligently served in this lifetime.

In order to prepare themselves to see God face to face, Catholics should try to confess their sins to a priest before death. Remember as well that the living have an obligation in charity and justice to pray for the repose of the souls of the faithful departed—especially for family members, friends, and those most in need of prayer.