End of Life Issues

This outline is available for download at www.RespectLifeMissouri.org

Welcome & Opening Prayer for Life

Facilitator opens meeting with a "thank you" to all who have attended, introduction of new members, and a prayer. It is important that all participants feel welcomed and participate within their own comfort level.

Opening Prayer

Opening Prayer for the Sick

Praised be God, the Father of our Lord
Jesus Christ,
The Father of mercies,
and the God of all consolation!
He comforts us in all our afflictions
And thus enables us to comfort those who are
in trouble,
with the same consolation
we have received from him.
Email us at prolife@usccb.org

Presentation – End of Life Issues

NOTE: The Powerpoint presentation is available online for download.

- The presentation file has been updated into the same PDF format as this session outline so it should be just as easy to access. If no laptop/projector is available, a printout of individual slides can also be copied/printed and used as both a presentation and as a handout for participant notes.
- The content in the slide presentation is designed to be straight-forward but also to allow flexibility.
- The comprehensive nature of the written facilitator notes below has been provided to allow for diversity among groups, for an extended and on-going education, and for later reference on the topic**. Therefore, it is possible that all the content included in the facilitator notes will *not* be covered in a single session. Please review the information below for each slide and then create a presentation that is your own based on the needs of your particular group.**
- If necessary, the Respect Life Office can answer any questions or provide guidance on any topics in the slide deck. Please contact the Respect Life Office at (816) 756-1850 or francis@dioceskcsj.org if you cannot access the on-line files.

Slide 1 Introduction End of Life Issues

Slide 2 Topics for Discussion

- Discuss a few "end of life" stories that have been in the news during our own lives
- Define common terms we have all heard
- Better understand the facts and the myths
- Clarify the Catholic Church's teaching on "end of life" issues
- Decide what we will do to support the sanctity of life for our brothers and sisters in Christ who are at the end of their natural lives

Slide 3 Dr. Jack Kevorkian

Jack Kevorkian, who passed away on June 3, 2011, was an American pathologist and right-to-die activist. He was most noted for publicly championing a terminal patient's right to die via physician-assisted suicide; he claimed to have assisted at least 130 patients to that end. He famously said that "dying is not a crime." On the November 22, 1998, broadcast of 60 Minutes, Kevorkian allowed the airing of a videotape he had made on September 17, 1998, which depicted the voluntary euthanasia of Thomas Youk, 52, who was in the final stages of ALS. After Youk provided his fully-informed consent on September 17, 1998, Kevorkian himself administered a lethal injection. All of his earlier clients had reportedly completed the process themselves but during the videotape, Kevorkian dared the authorities to try to convict him or stop him from carrying out assisted suicides. This incited the prosecuting attorney to bring murder charges against Kevorkian, claiming he had single-handedly caused the death.

Between 1999 and 2007, Kevorkian served eight years of a 10-to-25-year prison sentence for second-degree murder. He was released on parole on June 1, 2006, due to good behavior.

Slide 4 Patricia White Bull

On Christmas Eve, 1999, the family of Patricia White Bull in Albuquerque, New Mexico received an unexpected gift. After 16 years in a supposedly irreversible "vegetative state," Mrs. White Bull began to speak.

"Don't do that," she blurted out when nurses were trying to fix her nursing home bed. Then she started speaking her children's names, catching up on family developments, and eating foods she had not been able to swallow for many years. Her mother says her sudden recovery is a Christmas miracle from God

Slide 5 Terri Schindler-Schiavo

The Terri Schiavo case was a seven-year long legal case that revolved around whether Terri Schiavo, diagnosed as being in a persistent vegetative state (PVS) for several years, could be disconnected from life support. As early as 1993, Terri's husband, Michael, as her guardian, had entered a do not resuscitate order for her but was convinced by the nursing home staff to have it rescinded; in 1998 he petitioned the Sixth Circuit Court of Florida to remove her feeding tube under Florida statutes. He was opposed by Terri's parents, Robert and Mary Schindler, who argued that Terri was conscious. Michael later transferred his authority over the matter to the court, which determined that Terri would not wish to continue life-prolonging measures.

On April 24, 2001 Schiavo's feeding tube was removed for the first time and then later reinserted several days later as legal decisions were made; increasing media attention led to involvement by politicians and advocacy groups, particularly those involved in the pro-life movement and disability rights, including members of the Florida Legislature, the United States Congress, and the President of the United States. In March 2005 President Bush returned to Washington D.C. from a vacation to sign legislation designed to keep Schiavo alive, making the case a major national news story throughout that month. In all, the Schiavo case involved 14 appeals and numerous motions, petitions, and hearings in the Florida courts; five suits in federal district court; Florida legislation struck down by the Supreme Court of Florida; a subpoena by a congressional committee to qualify Schiavo for witness protection; federal legislation; and four denials of *certiorari* (a Latin word meaning "to be informed of, or to be made certain in regard to") from the Supreme Court of the United States.

The local court's decision to disconnect Schiavo from life support was carried out on March 18, 2005, and Schiavo died at a Pinellas Park, Florida hospice on March 31.

Slide 6 Rom Houben

Rom Houben, a 46-year-old car crash victim, has recently come forward with his horrific experience of coma misdiagnosis. Doctors believed that Rom was in a coma when in fact he was conscious but unable to speak or move. For 23 years, he tried continually to alert his doctors about the fact that he was actually awake but was unable to ever make a sound.

Many coma tests were performed on Rom prior to doctors deciding that he was unconscious, yet somehow they inaccurately assessed his brain function and declared him brain-dead when he was fully conscious.

Dr. Steven Laureys, the neurological expert who saved Rom, revealed the story in a scientific paper that was published recently. Thanks to advances in technology since Rom was first diagnosed as being in a perpetual vegetative state, Rom was able to eventually type information into a computer that revealed his state of consciousness.

Dr. Laureys believes there are probably many people around the world who have been diagnosed as being in a coma when they may actually be conscious.

Slide 7 Definitions

euthanasia -- from the Greek words meaning "good death," is something we do or fail to do which causes, or is intended to cause, death, in order to remove a person from suffering; sometimes called "mercy killing."

assisted suicide -- an act by which one assists another in taking his or her own life; a physician, for example, who engages in "assisted suicide" would, upon the patient's request, provide the deadly drugs for the person to use.

Slide 8 Definitions (cont'd)

palliative medicine/therapy – used in terminal illness when the possibility of a clinical cure no longer exists; seeks to alleviate the person's symptoms and accompany him or her to death.

advanced medical directive – a written legal document by which an individual expressly indicates how he or she wishes to be treated in the event of a critical or terminal situation.

Slide 9 Definitions (cont'd)

vegetative state – a clinical condition of complete unawareness of self and environment, but heartbeat and breathing are maintained unassisted; accompanied by one distinguishing clinical feature: sleep-wake cycles in which the person occasionally opens his/hers eyes.

coma -- a clinical condition of complete unawareness of self and environment for at least one hour; differs from a vegetative state because there are no sleep-wake cycles.

brain death – determination of death using neurological criteria; complete and irreversible cessation of all brain activity.

Slide 10 Questions to Consider

1. **Is the withholding or withdrawing of medically assisted nutrition and hydration always a direct killing?**

   In answering this question one should avoid two extremes:

   First, it is wrong to say that this could not be a matter of killing simply because it involves an omission rather than a positive action. In fact a deliberate omission may be an effective and certain way to kill, especially to kill someone weakened by illness. Catholic teaching condemns as euthanasia "an action *or an omission* which of itself or by intention causes death, in order that all suffering may in this way be eliminated." Thus "euthanasia includes not only active mercy killing but also the omission of treatment when the purpose of the omission is to kill the patient."

   Second, we should not assume that all or most decisions to withhold or withdraw medically assisted nutrition and hydration are attempts to cause death. To be sure, any patient will die if all nutrition and hydration are withheld. But sometimes other causes are at work -- for example, the patient may be imminently dying, whether feeding takes place or not, from an already existing terminal condition. At other times, although the shortening of the patient's life is one foreseeable result of an omission, the real *purpose* of the omission was to relieve the patient of a particular procedure that was of limited usefulness to the patient or unreasonably burdensome for the patient and the patient's family or caregivers. This kind of decision should not be equated with a decision to kill or with suicide.

   The harsh reality is that some who propose withdrawal of nutrition and hydration from certain patients do directly *intend* to bring about a patient's death, and would even prefer a change in the law to allow for what they see as more "quick and painless" means to cause death. In other words, nutrition and hydration (whether orally administered or medically assisted) are sometimes withdrawn not because a patient is dying, but precisely because a patient is not dying (or not dying quickly) and someone believes it would be better if he or she did, generally because the patient is perceived as having an unacceptably low "quality of life" or as imposing burdens on others.

   When deciding whether to withhold or withdraw medically assisted nutrition and hydration, or other forms of life support, we are called by our moral tradition to ask ourselves: What will my decision do for this patient? And what am I trying to achieve by doing it? We must be sure that it is not our intent to cause the patient's death -- either for its own sake or as a means to achieving some other goal such as the relief of suffering.

2. **Is medically assisted nutrition and hydration a form of "treatment" or "care"?**

   Catholic teaching provides that a person in the final stages of dying need not accept "forms of treatment that would only secure a precarious and burdensome prolongation of life," but should still receive "the normal care due to the sick person in similar cases." All patients deserve to receive normal care out of respect for

their inherent dignity as persons. Science, even when it is unable to heal, can and should care for and assist the sick."

Almost everyone agrees that oral feeding, when it can be accepted and assimilated by a patient, is a form of care owed to all helpless people. Christians should be especially sensitive to this obligation, because giving food and drink to those in need is an important expression of Christian love and concern. But our obligations become less clear when adequate nutrition and hydration require the skills of trained medical personnel and the use of technologies that may be perceived as very burdensome -- that is, as intrusive, painful or repugnant. Such factors vary from one type of feeding procedure to another, and from one patient to another, making it difficult to classify all feeding procedures as either "care" or "treatment."

Perhaps this dilemma should be viewed in a broader context. Even medical "treatments" are morally obligatory when they are "ordinary" means--that is, if they provide a reasonable hope of benefit and do not involve excessive burdens. Therefore 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 obliged 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.

We must therefore address the question of benefits and burdens next, recognizing that a full moral analysis is only possible when one knows the effects of a given procedure on a particular patient.

3. What are the benefits and burdens of medically assisted nutrition and hydration?

Benefits

According to international codes of medical ethics, a physician will see a medical procedure as appropriate "if in his or her judgment it offers hope of saving life, reestablishing health or alleviating suffering."

Nutrition and hydration, whether provided in the usual way or with medical assistance, do not by themselves remedy pathological conditions, except those caused by dietary deficiencies. But patients benefit from them in several ways.

First, for all patients who can assimilate them, suitable food and fluids sustain life, and providing them normally expresses loving concern and solidarity with the helpless.

Second, for patients being treated with the hope of a cure, appropriate food and fluids are an important element of sound health care.

Third, even for patients who are imminently dying and incurable, food and fluids can prevent the suffering that may arise from dehydration, hunger and thirst.

The benefit of sustaining and fostering life is fundamental, because life is our first gift from a loving God and the condition for receiving His other gifts. But sometimes even food and fluids are no longer effective in providing this benefit, because a patient has entered the final stage of a terminal condition. At such times we should make the dying person as comfortable as possible and provide nursing care and proper hygiene as well as companionship and appropriate spiritual aid. Such a person may lose all desire for food and drink and even be unable to ingest them. Initiating medically assisted feeding or intravenous fluids in this case may increase the patient's discomfort while providing no real benefit; ice chips or sips of water may instead be appropriate to provide comfort and counteract the adverse effects of dehydration.

As Christians who trust in the promise of eternal life, we recognize that death does not have the final word. Accordingly we need not always prevent death until the last possible moment; but we should never intentionally cause death or abandon the dying person as though he or she were unworthy of care and respect.

Here we offer some brief reflections and cautions regarding the kinds of burdens sometimes associated with medically assisted nutrition and hydration.

Physical risks and burdens

The risks and objective complications of medically assisted nutrition and hydration will depend on the procedure used and the condition of the patient. In a given case a feeding procedure may become harmful or even life-threatening.

If the risks and burdens of a particular feeding procedure are deemed serious enough to warrant withdrawing it, we should not automatically deprive the patient of all nutrition and hydration but should ask whether another procedure is feasible that would be less burdensome.

Psychological burdens on the patient

Many people see feeding tubes as frightening or even as bodily violations. Assessments of such burdens are necessarily subjective; they should not be dismissed on that account, but we offer some practical cautions to help prevent abuse.

First, in keeping with our moral teaching against the intentional causing of death by omission, one should distinguish between repugnance to a particular procedure and repugnance to life itself. We should not assume that the burdens in such a case always outweigh the benefits; for the sufferer, given good counseling and spiritual support, may be brought again to appreciate the precious gift of life.

Second, our tradition recognizes that when treatment decisions are made, "account will have to be taken of the *reasonable* wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter." The word "reasonable" is important here. Good health care providers will try to help patients assess psychological burdens with full information and without undue fear of unfamiliar procedures. A well-trained and compassionate hospital chaplain can provide valuable personal and spiritual support to patients and families facing these difficult situations.

Third, we should not assume that a feeding procedure is inherently repugnant to all patients without specific evidence. In contrast to Americans' general distaste for the idea of being supported by "tubes and machines," some studies indicate surprisingly favorable views of medically assisted nutrition and hydration among patients and families with actual experience of such procedures.

Economic and other burdens on caregivers

While some balk at the idea, in principle cost can be a valid factor in decisions about life support. For example, money spent on expensive treatment for one family member may be money otherwise needed for food, housing and other necessities for the rest of the family. Here, also, we offer some cautions.

First, particularly when a form of treatment "carries a risk or is burdensome" on other grounds, a critically ill person may have a legitimate desire "not to impose excessive expense on the family or the community." Even for altruistic reasons a patient should not directly intend his or her own death by malnutrition or dehydration, but may accept an earlier death as a consequence of his or her refusal of an unreasonably expensive treatment. Decisions *by others* to deny an incompetent patient medically assisted nutrition and hydration for reasons of cost raise additional concerns about justice to the individual patient, who could wrongly be deprived of life itself to serve the less fundamental needs of others.

Second, we do not think individual decisions about medically assisted nutrition and hydration should be determined by concerns such as national budget priorities and the high cost of health care. These social problems are serious, but it is by no means established that they require depriving chronically ill and helpless patients of effective and easily tolerated measures that they need to survive.

Third, tube feeding alone is generally not very expensive and may cost no more than oral feeding. What is seen by many as a grave financial and emotional burden on caregivers is the total long-term care of severely debilitated patients, who may survive for many years with no life support except medically assisted nutrition and hydration and nursing care.

The difficulties families may face in this regard, and their need for improved financial and other assistance from the rest of society, should not be underestimated. While caring for a helpless loved one can provide many intangible benefits to family members and bring them closer together, the responsibilities of care can also strain even close and loving family relationships; complex medical decisions must be made under emotionally difficult circumstances not easily appreciated by those who have never faced such situations.

On a practical level, those seeking to make good decisions might assure themselves of their own intentions by asking: Does my decision aim at relieving the patient of a particularly grave burden 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?

Rather than leaving families to confront such dilemmas alone, society and government should improve their assistance to families whose financial and emotional resources are strained by long-term care of loved ones.

4. What role should *"quality of life"* play in our decisions?

Financial and emotional burdens are willingly endured by most families to raise their children or to care for mentally aware but weak and elderly family members. It is sometimes argued that we need not endure comparable burdens to feed and care for persons with severe mental and physical disabilities, because their low "quality of life" makes it unnecessary or pointless to preserve their lives.

But this argument -- even when it seems motivated by a humanitarian concern to reduce suffering and hardship -- ignores the equal dignity and sanctity of all human life. Its key assumption -- that people with

disabilities necessarily enjoy life less than others or lack the potential to lead meaningful lives -- is also mistaken. Where suffering does exist, society's response should not be to neglect or eliminate the lives of people with disabilities, but to help correct their inadequate living conditions. Very often the worst threat to a good "quality of life" for these people is not the disability itself, but the prejudicial attitudes of others--attitudes based on the idea that a life with serious disabilities is not worth living.

This being said, our moral tradition allows for three ways in which the "quality of life" of a seriously ill patient is relevant to treatment decisions:

1. Consistent with respect for the inherent sanctity of life, we should relieve needless suffering and support morally acceptable ways of improving each patient's quality of life.
2. One may legitimately refuse a treatment because it would itself create an impairment imposing new serious burdens or risks on the patient.
3. Sometimes a disabling condition may directly influence the benefits and burdens of a specific treatment for a particular patient. For example, a confused or demented patient may find medically assisted nutrition and hydration more frightening and burdensome than other patients do because he or she cannot understand what it is. The patient may even repeatedly pull out feeding tubes, requiring burdensome physical restraints if this form of feeding is to be continued. In such cases, ways of alleviating such special burdens should be explored before concluding that they justify withholding all food and fluids needed to sustain life.

These humane considerations are quite different from a "quality of life" ethic that would judge individuals with disabilities or limited potential as not worthy of care or respect. It is one thing to withhold a procedure because it would impose new disabilities on a patient, and quite another thing to say that patients who already have such disabilities should not have their lives preserved.

The Church must emphasize the sanctity of life of each person as a fundamental principle in all moral decision-making.

Slide 11 “Quality of Life”

Discuss which quality of life issues on the slide should be considered when determining whether a life should be ended.

Slide 12 Questions (cont’d)

5. Do persistently unconscious patients represent a special case?

Even Catholics who accept the same basic moral principles may strongly disagree on how to apply them to patients who appear to be persistently unconscious -- that is, those who are in a permanent coma or a "persistent vegetative state" (PVS). Some moral questions in this area have not been explicitly resolved by the Church's teaching authority.

On some points there is wide agreement among Catholic theologians:

1. An unconscious patient must be treated as a living human person with inherent dignity and value. Direct killing of such a patient is as morally reprehensible as the direct killing of anyone else.
2. The area of legitimate controversy does not concern patients with conditions like mental retardation, senility, dementia or even temporary unconsciousness. Where serious disagreement begins is with the patient who has been diagnosed as completely and permanently unconscious after careful testing over a period of weeks or months.

Some moral theologians argue that a particular form of care or treatment is morally obligatory only when its benefits outweigh its burdens to a patient or the care providers. These moralists hold that the chief criterion to determine the benefit of a procedure cannot be merely that it prolongs physical life, since physical life is not an absolute good but is relative to the spiritual good of the person. They assert that the spiritual good of the person is union with God, which can be advanced only by human acts, i.e., conscious, free acts. Since the best current medical opinion holds that persons in the persistent vegetative state (PVS) are incapable now or in the future of conscious, free human acts, these moralists conclude that, when careful diagnosis verifies this condition, it is not obligatory to prolong life by such interventions as a respirator, antibiotics, or medically assisted hydration and nutrition.

While this rationale is convincing to some, it is not theologically conclusive and we are not persuaded by it. While particular treatments can be judged useless or burdensome, it is morally questionable and would create a dangerous precedent to imply that any human life is not a positive good or "benefit." Life is always and everywhere a basic good of the human person and not merely a means to other goods.

At a practical level, we also need to be concerned that withdrawal of all life support, including nutrition and hydration, not be viewed as appropriate or automatically indicated for the entire class of PVS patients. There is currently an absence of conclusive scientific data on the causes and implications of different degrees of brain damage, on the PVS patient's ability to experience pain, and on the reliability of prognoses for many such patients.

6. Who should make decisions about medically assisted nutrition and hydration?

"Who decides?" In our society many believe this is the most important or even the only important question regarding this issue; and many understand it in terms of who has *legal* status to decide. Our Catholic tradition is more concerned with the principles for good *moral* decision-making, which apply to everyone involved in a decision. Some general observations are appropriate here.

A competent patient is the primary decision-maker about his or her own health care, and is in the best situation to judge how the benefits and burdens of a particular procedure will be experienced. Ideally the patient will act with the advice of loved ones, of health care personnel who have expert knowledge of medical aspects of the case, and of pastoral counselors who can help explore the moral issues and spiritual values involved. A patient may wish to make known his or her general wishes about life support in advance; such expressions cannot have the weight of a fully informed decision made in the actual circumstances of an illness, but can help guide others in the event of a later state of incompetency.

When a patient is not competent to make his or her own decisions, a proxy decision-maker who shares the patient's moral convictions, such as a family member or guardian, may be designated to represent the patient's interests and interpret his or her wishes.

Health care personnel should generally follow the reasonable wishes of patient or family, but must also consult their own consciences when participating in these decisions. A physician or nurse told to participate in a course of action that he or she views as clearly immoral has a right and responsibility either to refuse to participate in this course of action or to withdraw from the case, and he or she should be given the opportunity to express the reasons for such refusal in the appropriate forum. Social and legal policies must protect such rights of conscience.

Finally, because these are matters of life and death for human persons, society as a whole has a legitimate interest in responsible decision-making.

7. Are there medical situations in which it is moral to withhold nutrition and hydration?

Yes. For example, a patient in the last stages of stomach cancer is already dying from that condition. Such a dying patient, or others who can speak for the patient, may decide to refuse further feeding because it causes pain and gives little benefit. The administration of nutrition and hydration in this case would pose a burden on the stomach cancer patient that is disproportionate to its benefit. By contrast, the “vegetative state” is not in itself a case of imminent dying, and the reception of nutrition and hydration itself does not generally constitute a burden for him or her.

8. May nutrition and hydration be withheld from patients in a persistent “vegetative state” because prolonged care for them may involve significant costs?

No, because in technologically advanced societies the costs directly attributable to the administration of nutrition and hydration are generally not excessive. To be sure, the costs and other burdens placed on families by the patient’s need for prolonged care may become very significant. However, this real problem must not be resolved by removing basic care so the patient will die. To act to end life because life itself is seen as a burden, or imposes an obligation of care on others, would be euthanasia.

Slide 13 Common Myths

Requests for assisted suicide represent a person’s true desire
Like other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression.

Terminal illness has to involve unmanageable pain
Taken together, modern pain relief techniques can alleviate pain in all but extremely rare cases.

Slide 14 Common Myths (cont’d)

Most terminally ill people seek suicide According to available data, only a small percentage of terminally ill or severely ill patients attempt or commit suicide.

Single events cause people to end their lives

Contrary to popular opinion, suicide is not usually a reaction to an acute problem or crisis in one's life or even to a terminal illness. Instead, certain personal characteristics are associated with a higher risk of suicide.

Slide 15 Groundhog Day Snowman Cartoon

Slide 16 Assisted Suicide Undermines Good Pain Management

During the Supreme Court's January 1997 oral arguments on its assisted suicide cases, Justice Stephen Breyer noted a remarkable fact from a report by the British parliament's House of Lords. The Netherlands, which has allowed assisted suicide and euthanasia for years, had only three hospices nationwide, while Great Britain, which bans these practices, had 185 hospices. He had placed his finger on one of the most insidious effects of legalization…

Once the "quick and easy" solution of assisted suicide is accepted in a society, doctors lose the incentive to pursue more difficult but life-affirming ways of truly caring for patients close to death. The converse is also true: prohibiting assisted suicide sets a clear limit to doctors' options so they can commit themselves to the challenges of accompanying patients through their last days.

Slide 17 Current Status of U.S. State Laws

In 1997, the U.S. Supreme Court ruled that state laws that criminalize physician-assisted suicide are not unconstitutional. That ruling did not make physician-assisted suicide a crime. It simply declared that criminalizing physician-assisted suicide is a matter that each state may decide for itself.

Those who advocate euthanasia have capitalized on people's confusion, ambivalence, and even fear about the use of modern life-prolonging technologies. Further, borrowing language from the abortion debate, they insist that the "right to choose" must prevail over all other considerations. Being able to choose the time and manner of one's death, without regard to what is chosen, is presented as the ultimate freedom. A decision to take one's life or to allow a physician to kill a suffering patient, however, is very different from a decision to refuse extraordinary or disproportionately burdensome treatment.

As the Vatican Congregation for the Doctrine of the Faith has said, "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." Moreover, we have no right "to ask for this act of killing" for ourselves or for those entrusted to our care; "nor can any authority legitimately recommend or permit such an action." We are dealing here with "a violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity" (*Declaration on Euthanasia*, 1980).

As the Second Vatican Council declared, "euthanasia and willful suicide" are "offenses against life itself" which "poison civilization"; they "debase the perpetrators more than the victims and militate against the honor of the creator" (*Pastoral Constitution on the Church in the Modern World*, n.27).

Legalizing euthanasia would also violate American convictions about human rights and equality. The Declaration of Independence proclaims our inalienable rights to "life, liberty and the pursuit of happiness." If our right to life itself is diminished in value, our other rights will have no meaning. Those who represent the interests of elderly citizens, persons with disabilities, and persons with AIDS or other terminal illnesses, are justifiably alarmed when some hasten to confer on them the "freedom" to be killed.

Evangelization/Catechesis

Slide 18 Catechism 2276-2277

"Those whose lives are diminished or weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible. Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable."

Slide 19 Pope John Paul II

Every individual, precisely by reason of the mystery of the Word of God who was made flesh, is entrusted to the maternal care of the Church. Therefore every threat to human dignity and life must necessarily be felt in the Church's heart; it cannot effect her but at the core of her faith in the Redemptive Incarnation of the Son of God, and engage her in her mission of proclaiming the Gospel of life in all the world and to every creature.

Pope John Paul II

On March 20, 2004, near the end of the Rome conference on the "vegetative" state, Pope John Paul II delivered an important speech in an audience with the attendees. This speech clarified and reaffirmed our moral obligation to provide normal care to these patients, including the food and fluids they need to survive. Here the Holy Father made several points:

1. No living human being ever descends to the status of a "vegetable" or an animal. "Even our brothers and sisters who find themselves in the clinical condition of a 'vegetative state' retain their human dignity in all its fullness," he said. "The loving gaze of God the Father continues to fall upon them, acknowledging them as his sons and daughters, especially in need of help." Against a "quality of life" ethic that makes discriminatory judgments about the worthiness of different people's lives, the Church insists that "the value of a man's life cannot be made subordinate to any judgment of its quality expressed by other men."

2. Because this life has inherent dignity, regardless of its visible "quality," it calls out to us for the normal care owed to all helpless patients. In principle, food and fluids (even if medically assisted, as in tube feeding) are part of that normal care. Such feeding, he said, is "a natural means of preserving life, not a medical act." This means, among other things, that the key question here is simply whether food and fluids effectively provide nourishment and preserve life, not whether they can reverse the patient's illness. Even incurable patients have a right to basic care.

3. This judgment does not change when the "vegetative" state is diagnosed as "persistent" or unlikely to change: "The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of minimal care for the patient, including nutrition and hydration."

4. Deliberate withdrawal of food and fluids to produce a premature death can be a form of euthanasia, that is, unjust killing. "Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission."

5. The Church's traditional teaching, that one is not obliged to impose useless or excessively burdensome treatments on patients, remains valid. The obligation to provide assisted feeding lasts only as long as such feeding meets its goals of providing nourishment and alleviating suffering. But to those who might too easily withdraw such feeding as overly burdensome, the Holy Father warns that " If a seemingly unresponsive patient might be able to feel the burdens of tube feeding, he or she may also be able to feel the suffering of being dehydrated to death.

6. We must not forget the needs of families caring for a loved one in a "vegetative" state. The rest of us must not abandon these families, but reach out to give them every possible assistance so they will not face their burdens alone. Respite care, financial support, the sympathetic cooperation of medical professionals and volunteers, and psychological and spiritual comfort were among the kinds of help the Holy Father urges society to provide.

By reaffirming these principles, the Holy Father is reminding us that here, as on issues such as abortion, embryo research and capital punishment, the Church's voice must be raised to insist that every human being is a beloved child of God, that no one is worthless or beyond our loving concern.

Slide 20 Pope John Paull II -- The Gospel of Life [Evangelium Vitae]

In his 1995 encyclical letter *The Gospel of Life (Evangelium Vitae)*, Pope John Paul II sounded an alarm. In the midst of a culture that congratulates itself on being enlightened and progressive on matters of human rights, he said, we are very much in danger of giving in to a "culture of death." Modern debates on abortion and euthanasia are a symptom and leading edge of something more profound and insidious -- an entire view of the world that will lead us to forsake our ideals of human dignity and equality and "revert to a state of barbarism"

For some answers let us consider recent developments on two issues that at first glance may seem quite different: human embryo research and assisted suicide.

These appear different not only because they deal with opposite ends of life's spectrum, but also because they involve very different claims. With human embryo research, the question that seems to need answering is: Is this really "human life" at all? Even if we can all agree to respect human life, isn't this little product of conception really just a conglomerate of a few cells, too undeveloped to have human status? Can the uncertain status of this entity really outweigh the needs of many persons for the life-saving treatments that embryo research may provide?

At the other end of the spectrum we seem to have almost the opposite argument. Sick and elderly people, it is argued, are full-fledged persons whose rights *do* matter. These are the very people whose need for treatments (for Parkinson's and Alzheimer's disease, for example) outweighs the merely "potential" interests of the embryo. And because they are persons who deserve respect, goes the argument, their wishes regarding how to end life deserve our respect and even our assistance.

Slide 21 Do We Have a Right to Die?

Some see the "right to die" as parallel to the "right to life." In fact, however, they are opposite. The "right to life" is based on the fact that life is a gift that we do not possess as a piece of property (which we can purchase or sell or give away or destroy at will), but rather is an *inviolable* right. It cannot be taken away by another or by the person him/herself. The "right to die" is based, rather, on the idea of life as a "thing we possess" and may discard when it no longer meets our satisfaction. The "Right to die" philosophy says there is such a thing as a "life not worth living." For a Christian, however, life is worthy in and of itself, and not because it meets certain criteria that others or we might set. Fr. Frank Pavone

Slide 22 The Principle of Double Effect

When an act has both a good and a bad effect, we should ask ourselves whether it meets four criteria.

1. The act itself must be good or at least morally indifferent; giving medication to relieve pain certainly meets this test.
2. The good effect must not be attained by means of the bad effect—we cannot claim, like Jack Kevorkian, that we may deliberately kill suffering people because once they are dead they can't suffer.
3. The bad effect must not be intended; we cannot give pain medication in order to end pain and cause death.
4. There must be a serious reason for pursuing the good effect; it would be irresponsible to risk hastening death to relieve an ordinary headache.

Taken together, these criteria have become known in Catholic moral reasoning as the principle of double effect.

Slide 23 What is the Catholic Churches Definition of a Dignified Death?

The teaching of Pope John Paul II about sickness and death came not only from his speeches, addresses, and encyclicals. He instructed just as convincingly with the witness of his own faith in the face of injury, suffering, hospitalization, illness and dying. He gave this catechesis for years.

He taught us that to understand death with dignity, first accept the dignity of life. Human dignity is an undeserved gift, not an earned status.

> *The dignity of life springs from its source*. We come to be by the loving action of God the Creator. "What is man that you are mindful of him, and the son of man that you care for him? You have made him little less than a god, and crown him with glory and honor" (Psalm 8:5).
>
> *The dignity of life is beyond price*. We have been ransomed not with perishable things such as silver or gold, but with the precious blood of Christ (1 Peter 1:18- 19).
>
> *The dignity of life is clear from our calling.* God's plan for human beings is that they should "be conformed to the image of his Son" (Romans 8:29).
>
> "For God created man for incorruption, and made him in the image of his own eternity" (Wisdom 2:23).

Dying often includes pain and suffering. Pope John Paul II admitted to his own personal sufferings, and proclaimed that these offered him a new source of strength for his ministry as Pope. We read in *Evangelium Vitae* (no. 67):

> "Living to the Lord ...means recognizing that suffering, while still an evil and a trial in itself, can always become a source of good. It becomes such if it is experienced for love and with love through sharing, by God's gracious gift and one's own personal and free choice, in the suffering of Christ Crucified. In this way, the person who lives his suffering in the Lord grows more fully conformed to him (cf. *Phil* 3:10; 1 *Pet* 2:21) and more closely associated with his redemptive work on behalf of the Church and humanity. This was the experience of Saint Paul, which every person who suffers is called to relive: 'I rejoice in my sufferings for your sake, and in my flesh I complete what is lacking in Christ's afflictions for the sake of his Body, that is, the Church' (*Col* 1:24)."
>
> "None of us lives to himself, and none of us dies to himself. If we live, we live to the Lord, and if we die, we die to the Lord; so then, whether we live or whether we die, we are the Lord's" (Rom 14:7-8). Dying to the Lord means experiencing one's death as the supreme act of obedience to the Father (cf. Phil 2:8), being ready to meet death at the "hour" willed and chosen by him (cf. Jn 13:1), which can only mean when one's earthly pilgrimage is completed."

Respect for the dignity and sanctity of life of patients includes concern for their spiritual needs. "The terminally ill in particular deserve the solidarity, communion and affection of those around them; they often need to be able to forgive

and to be forgiven, to make peace with God and with others." The sacrament of the sick, confession, and viaticum acknowledge and celebrate the very relationship with God through which we have received the dignity and sanctity of life, especially as a prelude to the final journey to our Father's house.

John Paul II never tired of praying for the help of the Mother of God, especially for the sick and dying. No summary of his catechesis is complete without turning our eyes to our Mother who stood vigil at the cross of her Son. "I entrust all of you to the Most Holy Virgin ... may she help every Christian to witness that the only authentic answer to pain, suffering and death is Christ our Lord, who died and rose for us."

Slide 24 Role of Catholic Healthcare Providers

Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal.

Directives

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

- A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive 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 judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

- There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.

- 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.

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

- Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. 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.

Slide 25 Role of Catholic Healthcare Providers (cont'd)

- 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. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

- The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

- Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

- Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

Slide 26 Role of Catholic Healthcare Providers (cont'd)

- Use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

- Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.

Slide 27 Is it Acceptable to Sign a "Living Will?"

Obviously, we cannot predict the future, or know in advance what form of sickness or disease we may be afflicted with in the years ahead. We do not know what treatments we will need or what will be available. The making of a "Living Will" presupposes that we know what kind of medical treatments we will want to use or avoid in the future. It speaks about treatments before we even know the disease; it turns a future option into a present decision.

Not every medical treatment is always obligatory. But to figure out which treatments are obligatory, morally speaking, and which are only optional, one must know the medical facts of the case. These facts are then examined in the light of the moral principles involved. But to try to make that decision in advance is to act without all the necessary information. Moreover, to make that decision legally binding by means of a formal document is not morally justified. ***Living Wills are both unnecessary and dangerous.***

Living Wills are also unnecessary because they propose to give rights which patients and doctors already possess. People already have the right to make informed consent decisions telling their family and physicians how they want to be treated if and when they can no longer make decisions for themselves. Doctors are already free to withhold or withdraw useless procedures in terminal cases that provide no benefit to the patient. Some people fear that medical technology will be used to torture them in their final days. But it is more likely that the 'medical heroics' people fear are the very treatments that will make possible a more comfortable, less painful death.

Moreover, if the living will indicates one does not want "to be kept alive by medications" or "artificial means" what does that mean? An aspirin is "medication," and drinking through a straw is "artificial." People can construe meanings for these words which the signer of the document never intended.

Slide 28 What are the alternatives to a "Living Will?"

At the same time, the obligation to respect human life in every condition is addressed to all of us, including patients. Catholics should beware of "advance directives" that reject assisted feeding across the board; rather, we should seek out more carefully worded documents that recognize the presumption in favor of such care when it does not impose undue burdens on the patient. Many state Catholic conferences have produced statements on this issue, or even sample forms allowing Catholics to specify their wishes in ways that reflect Catholic values and conform to any requirements of state law. Forms allowing the patient to name a trusted proxy decision maker, to made decisions when the patient can no longer do so, may be more helpful than a written declaration that tries to anticipate all future medical situations.

Hospitals and physicians, for their part, should not be obliged to comply with a request from patient or family that they believe is immoral. The Ethical and Religious Directives for Catholic Health Care Services state that a Catholic hospital "will not honor an advance directive that is contrary to Catholic teaching," and adds: "If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored".

Patients and families, like others involved in medical decisions, need to understand that while specific medical procedures may at times become useless or burdensome, this can never be said of human persons themselves. Caring for loved ones who may never be able to respond or thank us for our faithfulness could be the ultimate test of our commitment to a culture of life.

A safer route is to appoint a health care proxy who can speak for you in those cases where you may not be able to speak for yourself. This should be a person who shares your moral convictions, and who will be able to apply them to specific medical situations that may arise for you in the future.

Some are worried that they will have all kinds of treatment they don't want. But in the current climate, you are more at risk of the opposite, as more and more hospitals are refusing life-saving treatment to people who want it. Because of this, more and more people are signing documents, called the "Will to Live," that expressly indicate their desire for life-saving treatment, should the need arise

Outreach Planning

Slide 29 USCCB Pastoral Plan for Pro-Life Activities -- Join your Parish Respect Life Team!!

Care for Those Who Are Chronically Ill, Disabled, or Dying
Although euthanasia and assisted suicide can appear a reasonable and even compassionate solution to the suffering of individuals and families struggling with illness or the dying process, these are not real solutions—they do not solve human problems, but only take the lives of those most in need of unconditional love.

- Reach out to those in the parish family or broader community who are dying and keep company with them
- Provide support to the family, especially with difficult end-of-life decisions
- Encourage people to volunteer or provide other assistance to the local hospice program Encourage physicians and other health professionals to provide appropriate palliative care
- Foster prayers, at Mass and in homes, for those who are dying and their families to receive the respect and care they need and to be comforted by the peace of Christ develop
- Support programs of respite care for families caring for seriously ill members at home

Slide 30 Catholic Community Hospice – Raise awareness, volunteer, or get friends and family to volunteer!

Catholic Community Hospice
9740 W. 87th Street
Overland Park, KS 66212
1-877-621-5090
http://catholiccommunityhospice.com/

What is Hospice Care?
Hospice care is a choice to enhance the life of a loved one with a terminal illness. Thousands of people choose hospice care each year to focus on their quality of life. Hospice care is available in private homes, assisted living communities, care facilities and hospitals. Nurses manage the care, communicate with doctors and provide medications to relieve symptoms and control pain.

Catholic Community Hospice is a nonprofit organization that provides nursing, spiritual and emotional care for those with life limiting illnesses. Serenity, comfort, advice and skilled professional care are what Catholic Community Hospice brings to people of all ages at any stage of a life-limiting illness.

Serving patients of all faiths in the following counties:
KANSAS: Douglas, Shawnee, Jefferson, Wyandotte, Johnson, Leavenworth, and Miami.
MISSOURI: Jackson, Clay, Cass, and Platte.

What do volunteers do?

- Patient Care Volunteers provide companionship and support to patients and families in their own homes, nursing homes or assisted living facilities. They offer a listening ear, open mind and loving heart to the families in their care.
- Administrative Support Volunteers provide office support & clerical duties and other vital staff support.
- Bereavement Volunteers provide companionship and support to people who have lost a family member. This volunteer work may be accomplished through home visits or telephone contact depending on the need of the survivor. Additional training is provided.
- Special Project Volunteers provides assistance in community programs and events that raise funds and community awareness of hospice.
- 11th Hour Volunteers complete additional training in the physical and spiritual aspect of dying and are available upon request to provide additional support to patients and families during the final hours of life.

Who can volunteer?

- Be willing to become a vital part of Catholic Community Hospice's mission to provide compassionate care to patients and their families.
- Be at least 18 years of age.
- Attend a free 12-14 hour hospice training course.

- Complete a simple application and background check.
- Those who have recently lost a loved one are asked to wait at least 12 months before volunteering – particularly if they want to work with other patients.

Slide 31 Alexandra's House -- Raise awareness, volunteer, or get friends and family to volunteer!

PO Box 10034
Kansas City, MO 64111
Phone: 816-931-ALEX
http://www.alexandrashouse.com/

Alexandra's House is a community based, peer support peri-natal hospice program that provides active management and hope for families pregnant with or who have a baby with lethal anomalies and who is expected to die near or shortly after birth. Part of our services include helping to bring meaning to the families' suffering, birth planning, attending doctors visits, testing, photography sessions, hospital-based labor and delivery, coordination of memorial services and long-term bereavement care.

The following are just a few of the many ways you can participate in the efforts of Alexandra's House:

- Intercessory Prayer
- Knitting or sewing soft all white 15″X 15″ baby blankets
- Small plush toys
- Postage stamps
- Donations by mail

What else can we do?

Sign up to be a RESPITE volunteer! RESPITE, supported by The National Family Caregiver Support Program, provides assistance to the primary family caregiver, by providing supplementary care arrangements for the dependent relative on a needed basis. This may include care in the home, an adult day-care center, or a weekend in a nursing home or assisted living facility.

Start a YOUNG AT HEART group for the senior citizen community in your parish. This group can be used for fellowship and social events. Plan short trips, special Masses, or meals out at a local restaurant.

Begin a Bereavement group in your parish to work one-on-one with church members who have lost a loved one. Set up a system to assign a volunteer to meet with the bereaved parishioner for one year after the death of a loved one. Skills needed: compassionate, caring, loving and a good listener.

Pray for the sick of your parish. Begin a prayer chain or if you already have one invite others to join to pray for those who are in the hospital or terminally ill. Prepare meals for the family, allowing them to spend more time with their loved one.

Plan now! Speak with your family and medical doctor about your wishes for your health care, should you become unable to make these decisions.

Slide 32 Summary

- Discussed a few "end of life" stories that have been in the news during our own lives
- Defined common terms we have all heard
- Better understand the facts and the myths
- Clarified the Catholic Church's teaching on "end of life" issues
- Decided what we will do to support the sanctity of life for our brothers and sisters in Christ who are at the end of their natural lives

Closing Prayer

Slide 33 Closing Prayer for the Dying

Lord Jesus, our Redeemer,
you willingly gave yourself up to death
so that all people might be saved
and pass from death into a new life.
Listen to our prayers,
look with love on your people
who mourn and pray for their
brothers and sisters.
Lord Jesus, holy and compassionate;
forgive their sins.
By dying you opened the gates of life
for those who believe in you.
do not let our brothers and sisters be parted from you.
but by your glorious power
give them light, joy, and peace in heaven
where you live forever and ever.

Amen