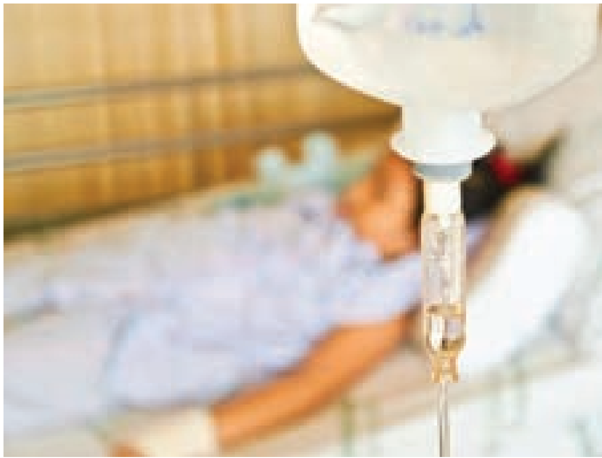

Nutrition and hydration is ordinary and proportionate care, not medical treatment. Thus it is obligatory. A person has a right to receive it and his or her caregivers have a duty to provide it. Without being provided nutrition and hydration, a person will die of starvation and/or dehydration.

There are four conditions when artificial nutrition and hydration (ANH) might not be morally obligatory:

1. When it would be impossible to provide
2. When a patient may be unable to assimilate the nutrition and hydration
3. When ANH may be excessively burdensome for the patient or may cause significant physical discomfort or complications
4. When death is imminent, meaning that the dying process has started and death will occur in a short period of time

Medical Futility

Medical futility is a condition that indicates that further treatment *will not offer reasonable hope of benefit* for the patient. By definition, this treatment would be considered extraordinary or disproportionate to the patient's illness. Medical futility will not change the ultimate outcome of the illness, which is death.

When the time arrives to consider whether or not to continue treatment, it is extremely important that you specifically ask the attending physician if you or your loved one is clinically in a condition of medical futility.

Withholding and the Withdrawal of Treatment

Life is a fundamental good and the basis of all other goods. However, the duty to preserve life is not an absolute one since human persons are mortal — subject to death. When a person's medical condition has reached the point of futility or when the burdens far outweigh the benefits of treatment, he or she can be *allowed* to die with full Christian and human dignity.

Advanced Directives

The Church supports the use of advanced directives, which allow individuals to name an agent to make health care decisions for them if they lose the capacity to make or express their own choices.

Advance directives give us a way to ensure that the decisions about the care we receive when we cannot speak for ourselves are made in accord with our faith. This information will give you the tools you need to construct a living will that reflects Catholic moral teaching.

For Catholics, morally correct medical decisions are based on our respect for the sanctity and dignity of life and acknowledge our dependence upon God as the Lord and Giver of life. Our decisions must be rooted in the recognition that each of us is the steward of this gift given to us by God.

For More Information:

Ethical and Religious Directives, Fifth Edition, United Stated Conference of Catholic Bishops (November 2009), www.usccb.org

National Catholic Bioethics Center, www.ncbcenter.org

Additional Resources

Address to the Participants in the International Congress on Life-Sustaining Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas, St. John Paul II (March 20, 2004), w2.vatican.va

Catholic Bioethics and the Gift of Human Life, Third Edition, William E. May (Our Sunday Visitor, 2013).

Declaration on Euthanasia, Congregation for the Doctrine of the Faith (May 5, 1980), www.vatican.va

The Prolongation of Life: Address to an International Congress of Anesthesiologists, Pope Pius XII (November 24, 1957).

Our Sunday Visitor is the largest English-language Catholic publishing company in the world. Come to osv.com with all your Catholic questions, concerns, and needs.

OurSundayVisitor

Bringing Your Catholic Faith to Life

1-800-348-2440 • Fax: 1-800-498-6709 • www.osv.com

By Steven Bozza

Copyright © by Our Sunday Visitor, Inc.
No part of this pamphlet may be reprinted or reproduced in any form.

Inventory No. P1772
Nihil Obstat: Msgr. Michael Heintz, Ph.D.
Censor Librorum
Imprimatur: ✠ Kevin C. Rhoades
Bishop of Fort Wayne-South Bend

ISBN 978-1-68192-011-5
Shutterstock 11/15

Frequently Asked Questions

End of Life Issues

For Review Only. Copyright Our Sunday Visitor, Inc.

For Review Only. Copyright Our Sunday Visitor, Inc.

Images: Shutterstock.com

Making health care decisions is never an easy task. Today there are many options available to ease human suffering and prolong life. There are also many voices advocating for medical choices that do not embrace the Christian vision of the human person. And so, health care decisions have become more difficult and heart wrenching to make.

The central question we must always ask ourselves is, *"Are my actions or inactions causing my death or the death of one in my care?"* We also need to keep in mind that our duty to preserve life is not an absolute one. Death is inescapable. Our task is to know when it is morally acceptable to allow death to occur.

By gaining insight into some common terms and protocols used in end of life health care, you will be better able to ask the right questions to your medical team, enabling you to make end of life decisions that uphold human dignity and are consistent with Catholic moral teaching.

Pain Management

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. 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.

— United States Conference of Catholic Bishops, *Ethical and Religious Directives,* 61

The Catholic Church has been very clear over her history that no one should die in pain and that we can take medications to help relieve pain even if by doing so a person's life may be shortened. The intent in this case is not to cause death but to ease pain.

The guiding ethical principle in pain management is the principle of double effect. Briefly defined, the principle of double effect is when one act that is good *in itself* has two effects: the *intended* good effect and the *unintended* and foreseen evil effect. The good effect must outweigh the evil effect, and there cannot be any other options available.

An example of how the principle of double effect is applied in cases of pain management is in the administration of morphine. The relief of pain is a good act in and of itself. Thus the intended good effect is to ease pain. However, morphine depresses respiration. In terminal cases, this unintended and foreseen evil effect may cause death sooner rather than later. The possible death is not the intention. The alleviation of pain is the intention that is of the utmost importance.

Do Not Resuscitate Orders

A do not resuscitate order, commonly known as a DNR, is an order that in the event of cardiac arrest sudden respiratory failure no cardiopulmonary resuscitation (CPR) is to be administered. It is morally acceptable to place a DNR order on yourself or someone in your charge if CPR will be of no significant benefit to the patient or a significant burden to him or her, or if the type of resuscitation that needs to be used is overly burdensome to the patient.

In today's times, it is important to state what a DNR isn't. Some medical facilities have expanded the meaning of a do not resuscitate order to mean that nothing at all is to be done to sustain a patient in a life threatening condition. In reality, a DNR does not mean to suspend all medications, nutrition, and hydration. This instance has to be considered as part of a larger discussion regarding the withholding and withdrawal of medical treatment, which we will do later in this pamphlet.

Ordinary or Proportionate Care

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.

— United States Conference of Catholic Bishops, *Ethical and Religious Directives,* 56

Traditionally, the term "ordinary care" is used to describe a medical treatment that has been proven to be successful and common in treating an illness. Ordinary care is not overly burdensome to the patient and it offers, in the judgement of the patient, reasonable hope of benefit to him or her.

Today the term "proportionate care" is used more often because it is more precise in that it allows one to better assess the benefits and burdens that a particular treatment offers a particular patient. As the bishops have stated, patients or their caregivers have a moral duty to use ordinary or proportionate care.

Extraordinary or Disproportionate Care

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

— United States Conference of Catholic Bishops, *Ethical and Religious Directives,* 57

Extraordinary or disproportionate care (again, "disproportionate care" is a more precise term) is used to describe a medical treatment that has not been proven successful in treating an illness, is overly burdensome, or in the judgement of the patient does not offer reasonable hope of benefit to the patient.

It is important to note here that the key phrase in all the definitions of ordinary or proportionate care and extraordinary or disproportionate care is "reasonable hope of *benefit*." Many bioethicists choose to use the term "reasonable hope of *recovery*," which subsequently is used to justify the removal of lifesaving treatment prematurely.

Benefits and Burdens

It is impossible to outline a complete list of benefits and burdens since any identifiable benefit or burden is subject to change over time through technology, the availability of medical or pharmaceutical interventions, the illness one is experiencing, and financial resources. However, we can identify some types of common burdens:

- **Great effort:** A medical intervention that is too difficult or impossible to use.
- **Great pain:** When there is pain associated with a medical intervention that is more than what the person can reasonably bear even with palliative care.
- **Great expense:** When there are costs associated with a medical intervention that have the possibility to cause financial ruin for patients or their families.
- **Great dread:** Patients may have a great fear or dread of a particular medical intervention. This fear or dread may be caused by the reality of disfigurement or mutilation the intervention may cause or by the anticipated pain associated with the procedure.

Nutrition and Hydration

I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act.

— St. John Paul II, March 20, 2004, Address to the participants in the International Congress on Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas, 4

For Review Only. Copyright Our Sunday Visitor, Inc.