Care of the Dying and Proportionate Means

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When a person is considered to be in the last phase of life, then more than ever, it seems, issues to do with the meaning of life and the purpose for our existence become evident. Dying is a most important phase of a person's life as we are led through growing disability to surrender the things of this life and to prepare for the life to come. As Christians we believe that it is not an end but a transition to a new beginning.

In the dying process not only the dying person, but those around them become acutely aware of the human condition. We believe that we are essentially made in the image and likeness of God for the purpose of communion with him and with free will. We accept the biblical story of mankind in which we are affected by sin and that that fallen nature is characterized by suffering, war, oppression, poverty, vain striving, disappointment and death. Death is part of the human condition: we are born dying - "the wages of sin" *Rom* 6:23 (cf *Gen* 2:17).

At the same time however, we believe that we are redeemed by Christ's life, death and resurrection and called to communion with Him.

That belief in resurrection humanises the dying process by giving us hope. It humanises the dying process by allowing us to accept that life is in transition, that we are called to be with God, and therefore death is both tragedy and gain. Before us we have Christ's example in which in prospect of his own death at Gethsemane he expressed his complete and free submission to the will of the Father. His death transformed us through the sacrifice he made for our sins. For us then death is the end of our earthly pilgrimage in which we look forward to life in complete communion with Him. For that reason we are not obliged to use every possible means to prolong life but can accepts its inevitability in prospect of the life to come.

Christ's suffering, death and resurrection also provides insight into the mystery of suffering. We know from experience and from the biblical account of the fall that suffering is an inescapable burden of human existence. Christ has also shown that suffering in others provides the opportunity to love as he did in response to those he encountered. Christ's own suffering also shows us how best to respond in acceptance of the divine will for us. His suffering, especially his cry of abandonment on the Cross also indicates the human reality of extreme suffering both in its effect on us which disables rational function and our need for the support of others. Empathy diminishes suffering.

The experience of suffering for us is thus a factor of personal growth as we find that our love of others increases our capacity to suffer and that love responds effectively to

suffering through empathy, We also come to realise that suffering dehumanises, and love humanises both victim and carer.

The Catholic Catechism teaches that life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good.[1]

The Catechism also teaches that though morality requires respect for the life of the body, it does not make it an absolute value. It rejects a neo-pagan notion that tends to promote the *cult of the body*, to sacrifice everything for its sake, to idolize physical perfection and success at sports. By its selective preference of the strong over the weak, such a conception can lead to the perversion of human relationships.[2]

Instead the Catholic tradition teaches that everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for his honour and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of.[3]

Suicide contradicts the natural inclination of the human being to preserve and perpetuate his life. It is gravely contrary to the just love of self. It likewise offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations. Suicide is contrary to love for the living God. [4]

Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.[5]

Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.

This distinction is a very old distinction that had its origins prior to modern medicine. It used to be called the distinction between *Ordinary and Extraordinary Means*. The

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[1] *Catechism of the Catholic Church* St Paul's Publications 1994 n. (n .**2288)**
[2] Ibid. n. 2289
[3] Ibid. n. 2280
[4] Ibid. n**.** 2281
[5] Ibid. n. 2278

distinction pre-dates modern medicine, health insurance and universal public health care systems. What it meant was that a family should do what a family ordinarily could do to care for a dying person. It freed them of obligations to take extraordinary means, those things that were beyond what a family could ordinarily provide. They were not obliged to provide expensive, difficult professional intervention.

Possibly the earliest recording of the distinction was in the writing of a Spanish Sixteenth century theologian, Francisco De Vitoria, in his seminal work *Relectiones Theologicae*[6] where he distinguished between natural means of preserving life – food, rest, etc., and the limited therapeutic interventions of the time.

Another Sixteenth Century theologian, Domingo Soto also made a similar distinction when he wrote in relation to battlefield amputations (given that general anaesthesia was unavailable at the time):

> "Given that in the amputation of a limb or in cutting open the body there is very great pain, certainly nobody can be obliged to undergo this because nobody is held to preserve their life with so much torment. Nor should that person be deemed someone who commits suicide."[7]

In recent times that distinction has come to mean:

- Ordinary - all interventions which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience."
- Extraordinary - all interventions which cannot be obtained or used without excessive expense, pain, or other inconvenience for the patient or for others or which, if used, would not offer reasonable hope of benefit for the patient."

The notion of "burdensome treatment" has been explained through the use of examples to include treatment that is: painful, frightening, hazardous, repugnant, disruptive for the patient, repugnant, financially too burdensome to the patient, family, hospital or health service, or would require the use of facilities which are urgently needed by patients who would benefit more.

The following are some examples where the distinction applies:

- Mrs Attwood, 85, has had a brain tumour surgically removed but is left with some brain damage including the area that processes olfactory sensation. She complains that all food tastes and smells utterly repugnant to her, "like vaseline". She asks her priest whether she is obliged to keep eating when it is so repugnant to her.

- Mr. Heine, 88, is a survivor of Nazi concentration camp medical experiments. He is a diabetic and has a lesion of his foot that has become infected and is

[6]Cf. Peter Clark "Tube Feedings and Persistent Vegetative State Patients: Ordinary or Extraordinary Means?" *Christian Bioethics*, Volume 12, Issue 1 May 2006 , pages 43 - 64
[7] Ibid.

gangrenous and he has developed septicaemia. Amputation of the limb below the knee is recommended as a life-saving measure. He refuses. Part of his refusal seems to be linked to a fear of doctors from his earlier experience, part is repugnance at the thought of losing the limb.

- Mr. Arthurs of Nullawil in the Mallee region of Victoria (Australia) has a prostate malignancy and has started chemotherapy to be followed by radiotherapy. His wife has advanced ischaemic heart disease and can no longer make the 400 kilometre round trip to Melbourne with him. He asks whether he can refuse the treatment so that he can stay home to look after his wife through her last illness. He does not want to be away when she dies and judges that the burden for her in being without him for long periods would be too great.

- Mr. Multugera, 68, of the Jagara (Australian indigenous) people has lived all his life in the East Kimberley region of Australia. He is an artist and had a missionary school education, but has led a tribal existence isolated from most aspects of modern industrialised society. A tribal elder, he has never visited a settlement of more than a few hundred people. He has been brought into a clinic to see the visiting doctor who comes once a month. He has episodes of chest pain, sweating and weakness. A cardiograph shows evidence of advanced heart disease warranting an angiogram and probably open heart surgery or a heart transplant. This can only be done by sending him by air ambulance to a major centre such as Perth or Adelaide. This would take him out of his family, tribal and cultural context and he refuses to go.

- Gary is a long term prisoner with a history of violence that has continued in prison. He has frequently self-mutilated. On one occasion he cut-off his penis. Psychiatric assessment holds that he is not mentally ill so he has remained in an ordinary prison. The prison reform society has lobbied strongly for surgical restoration of his penis. Plastic surgeons judge that he would not be compliant through the long series of operations and rehabilitation, and so indicate that it would not be appropriate as there is little prospect of long term benefit.

- Mary has been on dialysis for eighteen years. Recently she has developed ischaemic heart disease and as a result she suffers from severe angina for the duration of each dialysis session of five hours, three times per week. Initially she was treated with analgesics but there is a limited range available to those on dialysis because most have metabolites that are not removed by the dialysis and she has now become tolerant of those that she can take to the point that there is no available means of controlling her pain while on dialysis short of general anaesthesia. That is considered inappropriate on such a frequent basis. She has informed her doctor that the treatment has become too burdensome and opts not to continue.