EUTHANASIA

In recent years increasing attention has been given to death and dying. It may be a consequence of the growing violence in our society, which has resulted in an early death for many people. It can also be attributed to the scientific progress which has led or promises to lead to the cure of diseases that formerly resulted in death. This same scientific progress has enabled the medical profession to keep people alive, even if only barely so, for a relatively long period of time, although there is no hope of survival or recovery. Finally, there has also been a growing trend in state legislatures to consider what are euphemistically described as "death with dignity" laws. At least one objective of such laws is to establish when death legally occurs so as to allow the removal of vital organs for transplantation.

In the face of these events, physicians, moralists and many other concerned persons have begun to re-examine the precise definition of death, and the criteria for determining when efforts to prolong life may legitimately cease.

The physician's interest springs from his concern for the patient and the patient's family. Family and friends are concerned with keeping their trusts of love, companionship or friendship with the patient. The moralist and the private citizen are concerned about the bases on which decisions are made, who takes responsibility for them, and how, in a comfortable society, people will be able to understand the meaning of death and the final events in a dying person's life.

In some cases, attempts to achieve a contemporary understanding of death and dying are but a subterfuge for efforts to permit legal euthanasia or mercy-killing. In some places people are being encouraged to sign agreements that will allow physicians to withdraw the support systems that maintain life in a critical situation. Behind much of this is the "quality of life" ethic, according to which the lives of certain persons are considered of inferior quality because of some defect or disadvantage, because of the burden that such persons place on others, or because it is deemed too costly for society to provide care and sustenance to keep them alive.

Scientist Dael Wolfle has briefly stated the questions that physicians and health care specialists are presently raising:

"Is society ready to analyze death and the prolongation of life in terms of cost-benefit analysis, or to consider shifting the use of expensive facilities from the hopelessly ill to those whose future holds more promise? What about the customary reluctance to administer powerful but addictive drugs until 'near end'? What do we think of the 'senseless prolongation' of life? Birth is no longer blindly accepted, but increasingly is planned and timed. Does this development and the growing acceptance of abortion indicate a readiness to consider euthanasia? The taboo against the discussion of such questions will have to relax, and seems already to be doing so. A society increasingly concerned about the quality of life cannot omit the final chapter from its concern" (Science 19 June 1970).

In developing guidelines for the current public discussion concerning death and the criteria for deciding whether to prolong life, the following principles should serve as the basic presuppositions:

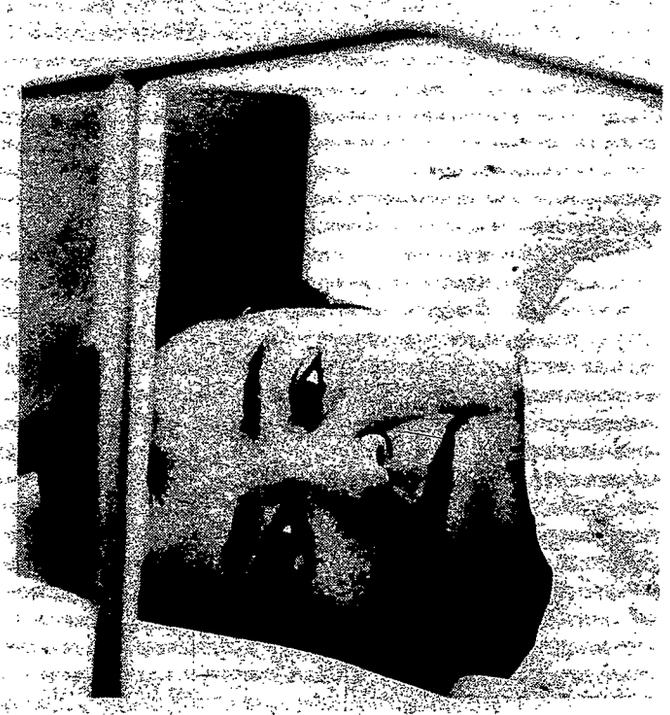
1. The life of each person is sacred because God has created each of us. We are not the absolute masters of our existence or of the decisions affecting life or death.

2. Death is not merely a physical or social phenomenon, but also an important spiritual event for each person. It is not merely the end of earthly existence, but the beginning of eternal life.

3. An important aspect of the care of the dying is spiritual preparation for death. Clergy, family, friends and the medical profession all have a role to play.

4. The life of every person is valuable, and society should do all that is necessary to maintain life and restore health to those who are critically ill.

In light of these principles, and of particular problems resulting from the quality of life ethic,



there are three specific issues to deal with:

First, a consideration of proposed "death with dignity" laws in the various states, and the philosophy underlying such laws.

Second, an updating of our understanding of the principles concerning the use of ordinary and extraordinary means to prolong or perserve life.

Third, the application of these principles with regard to children.

A number of states are now considering death with dignity bills. The initial stated purpose of such laws is to allow people to determine in advance that no extraordinary means should be used to prolong their lives when they are terminally ill. To accomplish this, each person is encouraged to sign a "Living Will," which provides that extraordinary procedures need not be used to sustain life.

Behind the stated purpose is the expectation that the Living Will will condition the thinking of people to accept positive termination of life in cases of senility or incurable illness. Moreover, the existence of such a document gives the physician a measure of **encouragement** to take positive steps to end life.

Distinguishing between "ordinary" and "extraordinary" means has become commonplace in discussing the obligation to prolong life when a person is irremediably ill and death is certain.

Citing Pope Pius XII for his assertion of the principle, moralists and ethicians hold that we must take all ordinary means to preserve life, even if there is little hope of recovery. We are not obliged to use extraordinary means to prolong life when recovery is no longer possible, although we may do so.

Ordinary means are described as "all medicines, treatments and operations which offer a reasonable hope of benefit for the patient and can be obtained and used without excessive pain, expense, or other inconveniences."

By extraordinary means are meant "all medicines, treatments and operations which cannot be obtained or used without excessive expense, pain or other inconvenience, or which if used would not offer a reasonable hope of benefit."

Thus by extraordinary means we mean all medicines, treatments and operations:

— which will not cure the pathology, but will restrain its progressive destruction;

— which offer no sure hope of cure, and may involve a significant risk;

— which, if successful, render the patient incapable of certain functions;

— which are extremely painful;

— which are extremely expensive.

It is important to keep in mind that the criteria for "extraordinary means" are flexible and changing. We must avoid too rigid a categorization of such means. Means of preserving life that are looked upon as extraordinary at a given time or in given circumstances may become quite ordinary and commonplace in a short period of time.

In its tragic opinions of January 22, 1973, striking down state abortion laws, the Supreme Court cited "health reasons" that would justify ending the life of the fetus, not only during the first **six months** of pregnancy but also during the last three months when the child can usually survive with ordinary incubational care. The court listed the following reasons related to the mother's health that it held permit destroying the fetus:

— "Maternity, or additional offspring, may force upon the woman a distressful life and future."

— "Psychological harm may be **imminent.**"

— "Mental and physical health may be taxed by child care."

— "There is also the **distress , for all concerned,** associated with the unwanted child."

— "The additional difficulties and continuing stigma of unwed motherhood may be involved."

Each of these reasons can be applied to the newborn infant, as well as to the unborn child. In fact, it takes little imagination to reconstruct the list so that it could also be applied to an incurably ill person as well. Thus:

— The suffering of the incurably ill may force upon the family a distressful life and future.

— Psychological harm (**for** spouse, children, relatives) may be imminent.

— Mental and physical health may be taxed by caring for the sick person.

— There is also the distress, for all concerned, associated with the dying process of the patient.

— The additional difficulties and continuing stigma (of alcoholism, drug-use, loss of bodily functions) may be involved.

In summary, the following conclusions emerge:

1. The Church should see a **special** pastoral responsibility and mission in preparing people for death. This includes compassion and empathy, the availability of the sacraments, and fostering understanding of human suffering as associated with the suffering Christ.

2. Catholic hospitals, physicians, nurses and health care workers should be in the forefront of pastoral care of the terminally ill and the dying.

3. In determining when to cease using extraordinary means to prolong life, the patient has the primary right to decide. Physicians, clergy, family and friends should assist the patient in making the decision and should help the patient in the dying process.

4. Because of the dangers involved, and because of the multiple roles the physician plays (curing the patient, caring for the patient, overcoming disease, increasing the storehouse of scientific information), the physician alone should not make the decision about prolonging life.

At best, there will be a tragic element in every death. Suffering, sorrow, human regret and the sense of loss are not likely to be done away with completely. Physicians and health care workers should do all that is reasonably possible to ease suffering. The Church, through her ministers, should balance sorrow with Christian hope. Family and friends should help those closest to the dying person to cope with and overcome the effects of death.

In face of continued efforts to condition people to accept direct action to terminate the lives of the aged, chronically ill or terminally ill persons, and in light of so-called "death with dignity" bills that would legally permit killing such people, it is necessary to mobilize health care workers, lawyers and concerned citizens. A concerted effort should be directed to the following goals:

1. Emphasize the Christian understanding of death as the beginning of life; emphasize too the significance of suffering, compassion, and hope.

2. Educate people to understand the difference between direct action to kill someone (active euthanasia) and cessation of extraordinary procedures to prolong the dying process (passive euthanasia — non-use of the extraordinary means to prolong life).

3. Organize a small group, including lawyers and doctors, to carefully watch legislation that attempts to define the moment of death, or that is described as "death with dignity" legislation.