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From the Catholic Hospital Association: A Statement on the Dying Patient

To everything there is a season, and a time to every purpose under the heaven. A time to be born and a time to die.

Ecclesiastes III, 1 & 2

Catholic hospitals, along with all other hospitals in the United States, are now struggling with many problems that are created by newer technology. One problem which has caused difficulty is the unnecessary prolongation of a patient's dying. A Catholic institution, or indeed any institution with an equal belief in the Judeo-Christian tradition, fully recognizes that the act of dying represents simply a change from one life to another. Dying is not a change that is so terrifying that it must be put off with every means possible regardless of its inevitability; rather it is a process that should be made as comfortable as desired by the patient, and when inevitable, not prolonged.

The non-prolongation of death, while respecting the sanctity of life, is one of the most difficult problems faced by the physician and other health care personnel at this time. The difficulty of the problem is evidenced by the voluminous literature addressed to the many allied subjects of "patients' rights," "extraordinary means," "death with

dignity," "no heroic measures," "living wills," and others. In all of this, the basic question is: "What are the rights and what are the obligations of patients and those who provide their care?" The question has serious moral, legal and socio-economic implications. Any answer proposed must give adequate consideration to each of these components. Even so, the question remains basically one of health care and the answer must be provided within that framework. The dilemma and its resolution reside in the basic framework of the patient-doctor relationship.

The principles with which one resolves the dilemma are not changed because of the degree or etiology of the patient's illness. Even so, it is the application of these principles in the trying circumstances surrounding the care of the critically and terminally ill that causes difficulty.

Each competent patient has the legal and moral right to choose what will be done to and for him. This right is inalienable. Thus, it is the patient's right to decide if, when and to what extent he will accept care. In the exercise of this right, the sick patient, if he chooses, seeks the help of the medical community. He, as it were, enters into a contract, albeit unwritten, with the health care team to provide this needed service. In entering into this contract, however, he does not thereby surrender any of his rights to decide what he will accept and, more importantly, what he will refuse, the corollary being that those who provide the patient's care may not abrogate in any way this right of the patient to decide for himself.

Responsibility of Parents, Guardian

Obviously, there are circumstances, quite limited in scope, where others may be assigned the exercise of this patient's right. The parents of minor children must speak for them. A legal guardian may be assigned for an incompetent adult patient and thus may legally act for the patient. Members of the health care team caring for the patient are not assigned this fundamental right by the patient or others nor should they be.

Because the patient has this right, the physician whom he asks for help assumes an obligation. This obligation binds that physician to provide the means and option for the best available care to the patient. The physician may proceed with this care only if the patient voluntarily accepts it. When an adult patient presents himself with acute appendicitis, this whole process normally moves very efficiently and the patient is soon cured of his problem. Quite often, however, medicine cannot offer a cure but only control. If a new found diabetic

presents himself, the problem is explained and the patient informed what is available to control the disease. Again, the patient ordinarily accepts and the physician can proceed with the care. However, should the patient refuse, the physician is not permitted to proceed. Sometimes only comfort and symptomatic relief can be offered to a patient. Thus, a patient with advanced degenerative arthritis of the spine can be offered some relief of pain and stiffness, but not much more. But also in the case of symptomatic relief, as opposed to cure or control, the patient still must decide to accept or reject the treatment offered.

And finally, what of the patient in the terminal stages of a fatal disease, such as advanced metastatic carcinoma? This is the situation in which the rights and obligations of both patient and health care team are most frequently contravened. To infringe the patient's right to note his condition under such circumstances by not telling the truth or to offer false hope to a patient by treating with useless medications or procedures is to commit an act which may be morally and ethically wrong. Such a practice might, on occasion, be valid for the sake of the patient but even under these circumstances the responsibility for it is not thereby lessened. Even in those cases where the patient for his own sake cannot be told of his condition, such a decision must be shared with the patient's nearest responsible relative. Consultation with the family and with others is needed to be certain that withholding such information or continuing to give such useless treatment is an appropriate decision. In a patient with metastatic carcinoma, and with other terminal patients, one must eventually face the time when the patient reaches the state of inevitable and imminent death where neither cure nor control of the disease is any longer possible.

The obligation of all of the members of the health care team remains unchanged. The physician must still explain the problem to the patient and offer the help of the health care staff to help the patient get his affairs in order, to prepare himself for the inevitable and to keep him as comfortable as possible. It is, though, the patient who must choose his course. Here again, the health personnel cannot choose with impunity to deceive the patient or the physician to prescribe those treatments which will not or can no longer help the patient's condition.

Evaluating Patient Care

Deciding the patient's death is imminent and evaluating the care the patient is receiving at that time, should be done with great caution, and only should be done after appropriate consultation with experts in the hospital in either a formal or informal setting. When the patient

is terminal, however, it should be discussed with all members of the health care team so that there will be full understanding of why certain drugs, such as cancer chemotherapeutic agents, or certain procedures have been discontinued. If the patient is conscious, the patient must be the one to make the decision to accept or reject the proposed modification of the medical regimen after all aspects have been discussed with him. If he is not conscious, the family must be included in the discussions before the decisions are made to discontinue no longer appropriate therapy. It must be stressed that such actions, when at all possible, be preceded by consultation with appropriate members of the hospital staff. Obviously, this will include not only physicians, but other members of the health care team working with the patient and also members of the spiritual ministry within the hospital.

If there is any doubt of the imminence of the patient's death and if there is any hope whatsoever of improvement as a result of therapy, then all appropriate care must be vigorously pursued. In the end, however, the responsibility for the conclusion that a patient is inevitably and imminently dying, remains with the physician caring for the patient. When such a decision has been made, only treatment that is appropriate to the dying state should be started or continued. Not only does the terminally ill patient have the right to determine what care he will or will not accept, the health care team has an equal right, as well as an obligation to offer that patient only that care which is appropriate to his condition.

Thus, recently developed technological procedures that permit almost unlimited prolongation of certain physiological functions should be used only when they contribute to the prolongation of a patient's life. They should not be used when they contribute to prolongation of dying. Explanation of this difference should be made in an appropriate manner to the patient when possible but also to the next of kin.

When changes have been made in the therapeutic regimen to make it appropriate to the terminal state of the patient, other members of the health care team must be informed of the changes and the reasons for them.

At no time in these considerations should the dignity of the patient be disregarded. The right of the individual to die without dehumanization is as inalienable as his right to accept the treatment that will be offered. The patient's and staff's recognition of the hope that is possible through faith, allows the patient to maintain his dignity and the health care team to accept the inevitability of death with dignity.
