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Catholicism and the "Right" to Die

by

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In numerous Western countries debates about the "right to die" are rapidly assuming the pitch and fervor that similar debates about abortion reached two decades ago. In the late 1960s/early 1970s, as the "baby boom" generation entered their childbearing years characterized by less of a generosity in giving life than had marked their parents, abortion-on-demand was legalized in virtually every Western country. Now, as baby-boomers and the median age of those countries' populations both grow older, calls for "death with dignity" are heard with greater frequency. This phenomenon is further abetted by improvements in medical care which now permit the sustaining of life in circumstances hitherto deemed terminal.

For all the calls for "death with dignity," however, the notion still remains an ambiguous one. Unfortunately, it has been that ambiguity which has allowed the idea of "death with dignity" to encompass ever more radical proposals, reaching the point of outright killing. If Catholic thought is to contribute to the shaping of the contemporary debate, then it is imperative that we demand the clarification of terms and bring our ethical wisdom to bear upon issues quite literally of life and death.

The debate over the right to die can be divided into three categories. The first category encompasses issues related to continuing to use such medical interventions which the Catholic tradition termed "extraordinary means" to preserve life where reasonable medical judgment clearly would declare that the proposed regimen is hopeless and the dying process has irreversibly set in. A second category would include all efforts aimed at directly effecting the death of the patient. A third category — perhaps the most controversial and, not coincidentally, the place where much debate is today centered — deals with the question of removing artificially supplied nutrition and hydration. Each of these categories will be examined in turn.

The fewest moral issues appear to be raised by the first category: questions of employing extraordinary means to preserve life where the patient is, in the view of competent medical judgment, irreversibly dying. The Karen Ann Quinlan

case illustrates both these types of questions and the problems surrounding them well. Quinlan was a young woman from New Jersey in a coma. Her breathing was ostensibly being maintained by a respirator. Her parents contended that, but for the heart-lung machine, Karen Ann Quinlan would die. Artificially maintained respiration, they argued, was merely prolonging Quinlan's dying process and they asserted that if it was removed, Quinlan would stop breathing and die. The respirator, Quinlan's parents claimed, constituted an extraordinary means of preserving life, a treatment which they as Catholics maintained could be removed. Their local bishop joined them in that position. The New Jersey Supreme Court eventually sanctioned removal of the respirator. (This essay will not consider the criteria by which the Court approved discontinuing the use of the respirator.) To everyone's surprise, when the respirator was withdrawn Quinlan began breathing on her own and survived, albeit in a comatose state, for several years following her removal from the respirator.

On the basis of the facts and prognoses which were generally available prior to the removal of the respirator, most Catholic theologians deemed withdrawing the device justifiable. The Catholic tradition affirmed that extraordinary means of preserving life are not morally obligatory when all reasonable medical evaluation believes that the patient is irretrievably in the process of dying. Once the process of dying has become irreversible the use of extraordinary means ceases to be morally demanded. Technology, after all, makes it possible to preserve the illusion of breathing and heart action even in a corpse, and no one would assert that Catholic theology requires that. In most places in the United States, removing such extraordinary means is acceptable (though some physicians exhibit a certain hesitancy in such cases, usually motivated more by a fear of lawsuits or malpractice accusations in litigious American society).

The fact that Quinlan continued breathing after removal from the respirator also provides a salutary lesson both for physicians and moral theologians: medical judgments, no matter how diligently arrived at or concurred in by how many specialists, are tentative. They should represent a reasonable analysis of the particular case, but they do not share in Divine omniscience. Despite the best assessment of competent medical professionals, the outcome of the Quinlan case reminds us that God alone is Lord of Life.

Deliberate Acts

At the opposite end of the spectrum from the kinds of situations represented by the Quinlan case lie issues contained in our second category: deliberate acts aimed at causing a patient's death. Petition drives have been or are underway in various States to conduct public referenda authorizing doctors to effect a patient's death or to provide the patient with assistance in procuring his own death. In 1990 Dr. Jack Kevorkian attracted national attention in the United States with his "suicide machine," a device which used intravenous means to introduce a pain-killer followed by lethal drugs into the bloodstream of a person who wanted to kill himself. Kevorkian attached the instrument to an Oregon woman in a suburban Detroit park (Kevorkian chose Michigan because he maintained that certain technicalities in State law facilitated his "assisted" killing of the woman).

The woman had supposedly been diagnosed with incipient Alzheimer's disease and, deciding that she did not want to go through the progressive degeneration Alzheimer's usually represented, chose to kill herself early. Episodes of direct euthanasia have also been reported for several years in the Netherlands.

Justification of direct euthanasia is clearly a growing phenomenon in the United States. One measure of this trend was the need perceived by the Administrative Committee of the National Conference of Catholic Bishops to issue a statement on euthanasia September 12, 1991, two months before the general meeting of the U.S. Episcopate in November, because "[c]urrent efforts to legalize euthanasia place our society at a critical juncture."¹ The very fact that electoral initiative drives to place physician-assisted suicide questions on various State ballots is yet another index of this trend. Still another is the appearance in recent years of physicians anonymously confessing to "helping a patient die" in professional journals. Books by euthanasia advocates like Derek Humphry and Jack Kevorkian have become best sellers. Twenty years ago, the typical phenomenon of "mercy killing" was a distraught or disturbed spouse or other relative who entered a hospital and shot the patient. Today, the notion of physicians using their medical arts to achieve the same result in more antiseptic conditions is discussed in respectable professional circles, despite the clear injunctions of the Hippocratic Oath: "I will give no deadly medicine to anyone if asked nor suggest any such counsel." Indeed, in those states which reimposed capital punishment after 1976 and prescribed the form of execution to be lethal injection, a special cadre of technicians had to be trained because physicians judged the inducement of death to be ethically inconsistent with their calling. We are now succeeding at moving death row from the prison to the hospital, or even to the home.

It is not unreasonable to assume that pressure for physician induced death will grow in coming years, particularly as the numbers of AIDS cases increases. The rising numbers of people living longer, the possibility of living longer with potentially major diseases like Alzheimers, and the abandonment by many families of custodial care for family members (especially older ones) may also encourage such pressures and even expand them to include inducing death on recommendation of an incompetent patient's next-of-kin, caregiver, physician, and/or the State. Decreasing financial resources from State- or privately-sponsored health insurance programs also must be factored into this march of the lemmings.

Beyond doubt, no competent Catholic moral theologian could justify such practices in any way. The sanctity and inviolability of innocent human life is a fundamental principle of Catholic morality. Innocent human life may not be directly attacked. Life itself is sacred. It does not acquire that sanctity because it meets some additional, external criteria such as health, a certain level of intelligence, ability for social interaction, etc. Nor is life the simple possession of the person living: the human person is gifted with life by God and cannot unilaterally dispose of that life. The Catholic tradition is clear in its condemnation of suicide and murder.

It is the loss of this sense of the sanctity of life which marks much of the

contemporary "death with dignity" debate. A full-fledged war for the mind, heart, and culture of modern man is being waged between those who adhere to a "sanctity of life" ethic and those who would substitute a "quality of life" ethic in its place. For the latter, life itself is simply a biological phenomenon, the merit of whose continued existence must be measured against some extrinsic criterion like health or "future potential." Support for physician-induced death is one example of this ethic. Another is the support in various medical circles for denying ordinary treatment to handicapped newborns because their subsequent lives are judged by others not to be worth living, e.g., refusal to remove intestinal obstructions or to close spinal fistulae in Down Syndrome infants. Still another example is the proposal to declare all anencephalic babies dead so that their organs can be more expeditiously stripped for transplantation. Some suggest that a major flaw in the "Americans with Disabilities Act" (which became effective in 1992) is its ban on removing treatments from people with disabilities.² It is not alarmist to say that, in this assault on the Christian principle that one may not destroy innocent life for any reason, one of the fundamental pillars of Occidental culture, one which undergirds not just ethics but medicine and law as well, is at stake. We ought to think long and hard while we are still standing at the crest of this slippery slope.

Nutrition & Hydration — Various Stances

Between the extremes of removing useless extraordinary means of preserving life in the irreversibly dying and schemes for physician-induced death lies the problem of removing artificially supplied nutrition and hydration. Part of the complication surrounding this issue is that local Catholic conferences and/or bishops have taken various positions on this matter. The aforementioned September 1991 Bishops' Statement on Euthanasia, for example, studiously avoids the issue. Theologians have analyzed the issue in different ways.³

What is the issue? Comatose patients, by definition, do not dress up and come down for dinner. Like other people, persons in a coma need to receive food and water if they are to survive. The typical means used to feed and hydrate a comatose person is intravenously, or by naso-gastric tube or by gastrostomy. Given such a supply of food and fluids a person will survive; deprived of them, a person will die of starvation and dehydration, usually about ten days to a fortnight after the supply of nutrition and hydration has been removed.

This author would judge the removal of artificially supplied nutrition and hydration to be immoral. Proponents of withdrawing food and water argue that because these items are supplied artificially, they become extraordinary treatments and thereby removable when the patient is "dying." Such an analysis is faulty for various reasons.

The heart of the error lies in claiming that a patient in such circumstances is "dying." The patient is comatose, perhaps permanently so (again, with the *caveat* about the provisional status of medical prognoses which the Quinlan case should have taught us). But a coma is not, in itself, a terminal condition. If food and water are removed from this patient, he will die from starvation and dehydration, not from the coma. To say that the coma is the cause of death is to stretch the

notion of causality beyond credibility. If one wheels a comatose patient into a hospital courtyard in midwinter, he will undoubtedly die. Of course the coma prevents the patient from getting up and finding shelter, but it was not the coma which killed him. The same can be said about securing food: it is what is done and not done for him, and not his coma, which brings about death.

Likewise, the notion of "ordinary/extraordinary" has no place in this discussion because those terms refer to medical treatments, but extending the notion of "treatment" to encompass food and water merely because they are supplied artificially is not justifiable. Food and water do not become artificial just because they are supplied artificially. If that were so, then every woman who nourished her baby by means other than breast-feeding would have to be said to be "medicating" her child, a clearly ludicrous proposition, as one commentator has observed. Food and water represent minimal levels of requisite care demanded for every patient, just as heat or blankets would represent such minimal care: no one would claim that keeping the heat on in the sickroom of a permanently comatose patient constitutes "treatment."

Ultimately, however, resolving the question of artificially supplied nutrition and hydration requires returning to questions of theological anthropology. What is the human person? What is the relationship of the body to the person? The myriad of responses to those questions can basically be reduced to two models of the human person: the Judaeo-Christian and the Gnostic-Cartesian. For Catholicism, the integral person is a soul-body composite. Body and soul together form one person. The body is not something inferior to the person: it is the way human beings exist. Christianity witnesses to the human immersion in materiality by the Incarnation — the foundation of the whole sacramental structure of salvation — and culminates in the integration and redemption of the whole person, body and soul, at the Parousia. Over against this Catholic vision is the Gnostic-Cartesian view of the person. According to its advocates, the person is a being trapped in subpersonal matter, a materiality that is evil at worst, neutral at best. The body cannot be deemed essential to the person: it is a prison of the person, a shell, something separate from the person, one of the objects of Descartes' famous doubts. The real person is the indubitable act of *consciousness* that says "ego." Because I think, I am, not vice versa. Hence, if I do not think (or at least if my thinking is not demonstrable to others) I am not. Unconscious and comatose patients thus are transmuted into "vegetables" by an alchemy more base than what the medievals pursued.

Traditionally, medicine determined death as the cessation of heart-lung action. Death took place when the integrated functioning of the body had broken down irretrievably. The body's systems could no longer work together to maintain an integrally functioning human person. While the development of devices like the heart-lung machine have obscured this cessation of integrated function of death, that definition has nevertheless not lost its central significance: death occurs when the unified functioning of the body has irreparably broken down. In the case of artificial respiration, such treatment is extraordinary when the unity of the body has broken down beyond repair: while the respirator can mimic life, when no truly integrated functioning is present, removal of the

respirator will result in cessation of breathing. If the patient (e.g., Karen Ann Quinlan) begins breathing on her own, there is sufficient minimal integrated functioning present: the patient is alive.

On the other hand, removing artificially supplied nutrition and hydration will not result in death from an already existing collapse of the patient's integrated functioning because there is a sufficient level of mind-body integration to sustain life on its own, provided food is available. The only way that one could say that integration is lacking here is to equate the lack of integrated functioning with the lack of expressive consciousness. Such a conclusion necessarily involves adopting a Cartesian notion of the person (a concept irreconcilable with the concepts of Catholic theological anthropology), reducing the person to mere consciousness, indeed, to consciousness of which others must be aware (since we do not necessarily know whether a comatose person is self conscious). The dangers of such an impoverished notion of the person are apparent. Are newborn babies persons? Fetuses? The handicapped? The demented? The anesthetized? These are not irrelevant questions. Was the post-respirator Karen Ann Quinlan a person (albeit a very sick and impaired person) or a corpse?

There are numerous documented cases of patients declared to be in a permanent coma who have recovered. Coma is not *in se* a terminal condition. But depriving the comatose of food and water will certainly seal their fate by our own hand. Already, the removal of artificially supplied nutrition and hydration has been applied to patients who indicated, their caregivers have argued, some awareness of their environment by response to stimuli (a phenomenon not encountered among the dead). The new classification "persistent vegetative state" has been notoriously ambiguous. At least one state Supreme Court opinion has justified the removal of such feeding even if the patient has indicated no wishes in this regard before lapsing into coma, on the grounds that a proxy might determine that such starvation is in the patient's "best interest," a new variation on the concept of *lebensunwertes Leben*.

Present Needs

The Magisterium needs to address the question of artificially supplied nutrition and hydration clearly, definitively, and quickly. With the growing trend towards approving such action, with the arguable stakes in terms of Catholic theological anthropology, and with the very real influence of the practice of starving patients as supplying a wedge towards more explicitly direct forms of euthanasia, the Magisterium cannot continue to leave this subject in ambiguity. Catholic thought will have little chance to affect this debate if we start addressing it consistently only after the horse has left the barn.

Twenty years ago in the debate over abortion, warnings were sounded that allowing the destruction of the unborn would foster an ethos conducive to killing the aged, the ill, and the incapacitated. At that time such fears were branded groundless and unthinkable. But even a cursory survey of the medical and ethical literature reveals that what was "unthinkable" two decades ago is now quite ponderable. The paradox is that this century of tremendous technological

achievement has supplied us with the means of making life better for so many, or for destroying life itself. The history of this century testifies how adept we are at doing the latter. What is needed now is a mature ethical reflection on what we are technologically able to do. The Catholic Church's moral teaching on the meanings of death — *and life* — are indispensable to that task.

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 3. See Robert Barry, "Feeding the Comatose and the Common Good," *Thomist*, 53 (January 1989), no. 1: 1-30; John M. Grondelski, "Removal of Artificially Supplied Nutrition and Hydration: A Moral Analysis," *Irish Theological Quarterly*, 55 (1989), no. 4: 291-302. Cf. J. B. Balsam, "To Sustain Life or to Allow to Die?" *Angelicum*, 66 (1989): 264-81; Thomas O'Donnell, *Medicine and Christian Morality*, 2d ed., rev. (Staten Island, New York: Alba House, 1991), pp. 70-73.
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