Into Your Hands
Iona Institute NI
24 March 2018

A Happy Death: Ethical Care of the Sick and the Dying

Ethical Care – Some General Principles

- First – Non-maleficence
  - Do No Harm
- Second – Beneficence
  - Do Good
- Third – Within the bounds of what is possible
- Fourth – Respecting the Human Person
  - Body
  - Soul

End of Life Care

- Problem of an ageing society
- Western Society is getting older
- No country in the developed world has an above replacement birth-rate (2.1 children per woman)
- Modern medicine means longer lives
- Previously fatal conditions are now survivable, e.g. heart disease, diabetes, stroke, pneumonia
- More elderly people depend on fewer children and grandchildren to do the caring

How can we care?

- PCBE – Are people willing, able and resourced?
- Family & friends need to make sacrifices
- Health & social care professionals need to support patients' real needs
- Societal support generally is available but not always
- Personal, ethical issues
- Social, civic & political issues also
- Impact of changing/deteriorating family structure

Ethical Practice

- Most care is guided by the carer's pre-existing ethical stance
- Conscientious & competent care often comes from already generally good people "muddling through"
- Firm ethical boundaries are still needed
- Danger of misguided compassion unfettered by rational principle
- Clear case for a Natural Law / Virtue Ethics approach

Ethics and Law?

- Great deal of overlap, especially in extreme situations
- Much of what happens in the sick room is beyond legal scrutiny
- For example "M", dying, 78 years old, multiple chronic illnesses, great deal of pain - prescribed powerful analgesia, fatal in too great a dose
- Law might not look for or find evidence of overdose – he depended on the ethical sense of his carers.

Human Worth?

- Does it depend on simply being human?
- Does it depend on some additional factor?
- In some contexts, we value one more than another
- Personism – a capacity to attribute value to one's own life
- Possible principles that might guide us:
- Autonomy, Utility, Quality, Equality.

Human Worth?

- Autonomy – my own power to choose and judge
- Utility – my usefulness or productivity, whether economic or social
- Quality – my ability to exercise human capacities & enjoy the use of them
- Equality – my worth is equal to that of any other human being, simply in virtue of our shared humanity

Equality

- These are valuable aspects of human life
- Equal value is based on shared human nature alone
- Guarantees decent treatment in the face of our equal vulnerability
- To sickness
- Old age
- Dementia
- Death

Ethic of Equality

- Defends “the floor of human dignity”
- Even the most diminished are not denied the care to which all of us are entitled
- Particularly applies to dementia
- Temptation to devalue a life with little or independent function
- Especially where the burdens on a social/economic “high-utility” carer are very great

Terminal Illness

- An illness which cannot be effectively treated
- Which clinicians are morally certain will lead to the patient's death
- Given the totality of the circumstances (available medical care, affordability etc.)
- The death of the patient is not at issue
- What care is to be provided?
- What care may be omitted?

Some Ethical Fallacies

- Vitalism – keep physical organism functioning at all costs
- Spiritualism – free the spirit by terminating the organism
- Physicalism – Only physical life exists; if it is too painful, degrading, humiliating it should be ended
- All share the refusal to recognise death as a natural part of life

Care for the Dying

- Nutrition – To be provided as long as the patient is capable of taking it in
- Hydration – to be provided as long as the patient can take it
- Artificially – if needs be
- Medication – to control symptoms
- Surgery – to extend life, with the patient's informed consent
- Analgesia – whatever kind or quantity needed

Patient Autonomy

- Respecting their entitlement to decide their own treatment
- Accepting their acceptance of the inevitability of death
- Refusal intentionally to end their life
- Respecting their refusal of treatment
- Especially burdensome or excessively painful treatment

Analgesia

- Pain relief – enables tolerable quality of life in the dying
- Can be given in very high doses in terminal cases
- Central question is the intention of the one administering
- Which will determine the drug chosen and the dose
- Palliative care specialist is best qualified to do this

Informed Consent

- Patient and/or next of kin must be told the advantages and dangers of any proposed treatment
- Given the opportunity to consent or refuse
- Have that decision respected
- Should the patient be told that they are going to die?
- Should all the next of kin be told?

Guiding Rule

- Thou shalt not kill
- But needs't not strive
- Officiously, to keep alive
- Respect that life has a natural end
- Do nothing intentionally to hasten it
- Do not impede it when it is inevitable
- Accept that it might be hastened by reasonable care

Recognition of Death

- Medical experts can recognise that death has occurred
- Crudely – lack of pulse or spontaneous breathing
- More recently: Neurological criteria
- Assumes that the brain has an integrative function for the body
- Lack of brain function = lack of bodily integration

Brain Death?

- Brain Stem – Breathing, heart beat
- Cerebellum – Movement, animal functions
- Cerebrum – Higher functions, rationality?
- Irreversible cessation of all activity
- In all THREE sectors
- Scientific conclusion – Church accepts it as that but makes no technical determination

Euthanasia

- Ethical principles that apply to one end of life apply to the other
- Human life is a continuum, and not radically divisible
- Looked at the status of new life, embryonic life, & infant life
- So, what about old life, sick lives, expiring lives?

Euthanasia – Terminology

- Greek root – Eu = happy

  Thanatos = death
- Sometimes called mercy killing
- Two conditions are central:
- Method and Intention
- By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.

  CDF 1980

Simplest Case

- Terminally ill patient, with no hope of recovery
- Asks for lethal poison or procedure
- Intends to have their own death brought about
- Requires or requests the assistance of medical or nursing practitioners to do so
- Usual justification is that it is in "the patient's best interests"
- And/or entailed by respect for patient autonomy

Alternative Cases – Non-voluntary Euthanasia

- Death where the patient might reasonably be surmised to have wanted that outcome
- Long term coma (aka "Persistent Vegetative State" or "PVS"), next of kin's decision
- Where an advance directive or "living will" so directs
- The patient's consent at the time is impossible to obtain and must be presumed
- Very often decided by litigation, e.g. Schiavo case, Ward of Court decision in Irish Republic, Bland etc.

Involuntary Euthanasia

- Killing is often carried out without regard to the patient's wishes
- Or against the patient's last known wishes
- Justified by the patient's "best interests"
- As identified by next of kin
- Possibility that euthanasia is to assuage family or friends emotional distress
- Consent might be coerced or cajoled

Active vs. Passive

- Active euthanasia – a deliberate action intended solely or principally as its immediate goal to bring about the death of the sufferer
- Passive euthanasia – withdrawing treatment or support in order to allow the natural process of death to occur
- Terms often used to blur the distinction between killing and allowing to die
- NB a deliberately chosen omission is also an act

Allowing to die?

- Terminal cancer, chemotherapy could delay death by six to 12 months. Patient opts for palliative care only. Morally acceptable?
- Structural brain/CNS injury, results in long term coma. Patient contracts pneumonia. Aggressive treatment is avoided, symptoms are managed. Patient dies. Euthanasia?
- Long term comatose patient – self sustaining in terms of breathing, respiration & circulation. Feeding is by NG tube, then later by peg feeding. May we withdraw this nutrition & hydration to allow the patient to die?

Non-terminal Illnesses

- Incurable but non-terminal pain?
- Physical pain or disability?
- Psychological or emotional pain?
    - Nancy (alias Nathan) Verhelst
    - Gender dysphoria
    - Born into a family of boys
    - Mother wanted a boy
    - Was consistently rejected by her family
    - Sought “gender reassignment surgery”

Non-terminal Individuals

- Nancy (alias Nathan) Verhelst (cont’d)
    - Radical, double mastectomy
    - Surgical construction of a penis
    - Synthetic male hormones administered
- He/she was very unhappy, after six months of counselling was killed by lethal injection
- Both the counselling and the killing were undertaken by Dr Wim Distelmans
- The deadline for review of the case has passed & no action has been taken

Non-terminal Individuals

- Any decision on police action or prosecution would have to come from the Euthanasia commission, chaired by Dr Wim Distelmans
- Another Belgian Case: Ann G (a pseudonym)
  - Anorexia nervosa sufferer for 25 years
  - Suffered sexual abuse from Walter Vandereycken
  - Dr Vandereycken is an international expert on Anorexia
  - Suspended by KU Leuven but continues in private practice
  - Ann G sought and obtained euthanasia

Ethical Principles I

- Life is an inalienable good
- Our natural inclination is to live
- Any other good whatever depends on our existing to enjoy it
- Any act of self destruction (even with the assistance of another) offends this principle
- We always already live in a nexus of social & familial relationships
- Self-destruction always harms the people to whom we are related

Ethical Principles II

- *Qui agit per alia, agit per se*
- My act of suicide is my responsibility
- My choice to assist another's suicide is a deliberate act on my part where I too will the end/telos of the act
- When I bring about another's death, at their request, the killing is my moral responsibility
- It is theirs, also
- Moral guilt here is shared but not thereby diminished

Theological Considerations

- Life is a gratuitous gift from God
- Refusal to accept that gift when already given is an offence against God's goodness – His "Sovereignty & loving plan"
- Its completion is not in time but in eternity
- Suffering can have a redemptive value
- Euthanasia like suicide counts as the deliberate killing of the innocent
- NB Voluntary sacrifice of one's life is a different case

Two Certainties: Death & Taxes

- Given that death is certain for each of us
- We are obliged to avoid it ordinarily
- We are obliged not to seek it
- We are not obliged to avoid it at all costs
- We can choose to accept it, when it becomes inevitable
- We may choose to forego extraordinary means
- We may choose only proportionate care

When we seek euthanasia, we…

- Harm family relationships – loved ones as agents of death
- Harm the therapeutic relationship – the doctor can no longer be assumed only to be a healer
- Reduce the patient to an economic factor only – euthanasia might be to preserve an inheritance/reduce costs
- Reduce the patient to the level of a non-rational animal
- Eliminate the suffering by eliminating the sufferer… decapitation for a headache!

Conclusion

Any Questions?

Email: Eamonn.Gaines@Gmail.com

References/Further Reading

- *Taking Care: Ethical Caregiving in our Aging Society* (Washington DC: President's Council on Bioethics, 2005) - https://bioethicsarchive.georgetown.edu/pcbe/reports/taking_care/index.html
- Respect for the Dignity of the Dying (Rome: Pontifical Academy for Life, 2000) - http://tinyurl.com/PAV-Dignity
- *Why the Concept of Brain Death is Valid as a Definition of Death* (Vatican: Pontifical Academy of Sciences, 2008) http://www.casinapioiv.va/content/dam/accademia/pdf/es31.pdf
- *The Signs of Death* (Vatican: Pontifical Academy of Sciences, 2006) http://www.pas.va/content/dam/accademia/pdf/sv110/sv110.pdf
- Communio : International Catholic Review – Collection on Death and Brain Death, 2013. http://www.communio-icr.com/collections/view/brain-death

Contributors: Robert Spaemann, Nicholas Tonti-Filippini & D. Alan Shewmon

References/Further Reading

Some Useful Resources:

Anscombe Centre - http://www.bioethics.org.uk/

Mercatornet - Ethical & Cultural Issues from a Human Dignity Perspective – http://www.mercatornet.com

Bioedge - Promotes human dignity in bioethics, evidence-based ethics in medicine & shows that medical excellence is not possible without ethical principles - https://www.bioedge.org

Bioethics Observatory – at the Catholic University of Valencia http://www.bioethicsobservatory.org

Liverpool Care Pathway - https://tinyurl.com/LiverpoolCare1 & https://tinyurl.com/LiverpoolCare2