

# Ethics, Patients, Medical Treatment and Christian Spirituality

## Ética, Pacientes, Tratamento Médico e Espiritualidade cristã Ética, Pacientes, Tratamiento Médico y Espiritualidad cristiana

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**ABSTRACT:** The present work aims to present guidelines on developing ethical clinical treatment options, provided the necessary social guarantees are in place to prevent abuses, based both in general ethics – which is more than an attitude based on reason, but also recognizes subjective values as being important, and sees patients necessarily as persons who need to be understood from a subject-centred approach complemented by a perspective based on rational human nature which is the foundation of a person's subjectivity – and Christian spirituality, which knows Christians find consolation in their faith in the promised blessed life after death.

**PALAVRAS-CHAVE:** Ethics. Medical treatment. Spirituality.

**RESUMO:** Este trabalho pretende apresentar diretrizes sobre o desenvolvimento de opções clínicas de tratamento baseadas na ética, dadas as garantias sociais necessárias para impedir abusos, com base na ética geral – que é mais do que uma atitude baseada na razão, mas reconhece também valores subjetivos como sendo importantes, e vê os pacientes necessariamente como pessoas que necessitam ser compreendidas de uma perspectiva centrada na pessoa, complementaram por um ponto de vista baseado na natureza humana racional que é o fundamento da subjetividade – e a espiritualidade cristã, que sabe que os cristãos encontram consolo em sua fé na vida eterna prometida após a morte.

**DESCRITORES:** Ética. Tratamento médico. Espiritualidade.

**RESUMEN:** Este trabajo presenta pautas para el desarrollo de opciones clínicas éticas de tratamiento, con las necesarias garantías sociales para prevenir abusos, basadas en el ética general – que es más que una actitud basada en la razón, pero también reconoce valores subjetivos como siendo importantes, y considera a los pacientes necesariamente como personas que necesitan ser entendidas desde un acercamiento centrado en la persona complementado por una perspectiva basada en la naturaleza humana racional que es la fundación de la subjetividad – y en la espiritualidad cristiana, que sabe que los cristianos se consolan en su fe en la vida eterna prometida después de la muerte.

**PALABRAS LLAVE:** Ética. Tratamiento médico. Espiritualidad.

### From persons to ethics

Everybody understands in a general way what is meant by the terms *ethical*, *unethical*, *moral* and *immoral*: “An immoral action is contrary to the over-all good of person(s) and thereby gives rise to a moral obligation to avoid it. This obligation or moral necessity is derived from our self-understanding as persons and directs us to choose to perform or omit an action. Moral necessity is unconditioned or absolute because it cannot be set aside, regardless of the circumstances, the inconvenience or consequences. A genuine moral duty is universal since it holds for all persons,

situations and cultures. Rape and perjury are immoral everywhere. This is so because morality is essentially related to the core of our personhood where human dignity and solidarity originate. From an ethical perspective all persons are equal and should be treated as such without discrimination” (Ford, 2002, p. 16-17).

We understand that “the meaning of *good* is pivotal for ethics.... Its meaning is not derived from another notion because *good* is a basic or primary notion but it is still relative to the concept of person employed. Whatever is truly *good* for the person is a *good of the person*, and *evil* is opposed to the *good of the*

*person*. The *object* of a good human action is the good that is freely chosen and which specifies the act's morality. The *object* refers to the action's subject matter including its objective purpose, i.e. what the action is naturally suited to bring about. Clearly the true interpretation of a particular action's object is crucial for its morality” (Ford, 2002, p. 17).

Feelings and intuitions may often be right but they cannot definitively determine what is truly good or bad: “the concept of the human person is the *referral point* for the moral evaluation of the object of human acts in relation to the good of person(s) affected...

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In the light of a person's dignity, essential nature, integral human experience, and relationships to other persons, animals and the environment, right reason is able to discern that the objects of some acts conflict with the true good of person(s) and hence judges them to be immoral. Reason judges a deliberately chosen action in itself is immoral if the nature or kind of action, humanly understood, is inherently opposed to the good of person(s), regardless of additional factors *extrinsic* to the action itself such as circumstances, customs or motives" (Ford, 2002, p. 21).

Though reason is able to discern with certitude what acts are morally good or bad, sometimes reason is unable to judge with certitude that an action is immoral. Non-objective, subjective factors in a person may subconsciously play a role in the development of personal and subjective bias in the determination of reason's judgement. Subjective factors include preferences, love or emotions. Parental love could hinder a parent from realising that their son or daughter is engaged in a potentially damaging relationship. This does not happen in a simple mathematical calculation of two plus three equals five because the evidence is too clear to allow subjective factors a determining role. It is part of human nature that subjective factors may unduly influence reason in a genuine search for objective moral truth when the evidence is not entirely clear. Culturally entrenched prejudice or bias may also influence the moral judgements of a majority of citizens of a nation.

### Patients as Persons

Persons do not exist in the abstract without names, gender, age, family ties, a religious faith, a cons-

science, a nationality, a culture, or personal beliefs. Patients are persons who need to be understood from a subject-centred approach complemented by a perspective based on rational human nature which is the foundation of a person's subjectivity. Persons experience themselves in bodily activities like walking, playing sport, eating and drinking. At a far deeper level they experience themselves in rational acts of affirming the truth, of conscience, making free choices, of love and of desiring happiness. The patient's perspective is crucial and unique as it is an expression of an individual person as a rational subject. A person's subjectivity may be powerfully or only slightly influenced by the spirituality typical of their religious faith, be it Buddhism, Christianity, Islam, Judaism, or a system of secular beliefs and personal values.

Medical treatment is to serve patients who should not be subjected to the duress of enduring technological interventions against their wishes. Competent patients who have been informed of what is involved in *cardiopulmonary resuscitation* (CPR) and its success rate of about 1 in 7 walking unaided out of a hospital may morally refuse to have CPR if they have a cardiac arrest. This does not imply that life itself has no value but that CPR, in some circumstances, would be disproportionate to its benefits for the patient.

Many medical treatment decisions for an otherwise healthy person are doubtless objectively ethical, e.g. life-saving removal of a cancerous tumour. Other decisions may be in a moral grey zone, e.g. whether or not the surgical removal of a cancerous tumour in the bowel is warranted for an elderly and weak patient. The proportion of benefit over harm may not always be evident to both health

professionals and patients alike. In such grey zones considerations arising from the patient's subjectivity may rightly have a major influence in the final decision.

### Patients' Consent

Catholic tradition does recognise a competent patient's right to decide, in accord with moral principles, when continued medical treatment, as distinct from palliative care, is unwarranted or too burdensome and should be withdrawn. Doctors should respect this eminently human and personal decision. Consequently society should have a legal system that allows patients sufficient scope for the proper exercise of their rights.

Ahead of his times, Pope Pius XII recognised the rights of patients and made it clear that doctors derive their rights and duties to treat from patients themselves: "The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general, he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission (Pope Pius XII, 1957, p. 1030; Pope Pius XII, 1957-1958, p. 395-397)."

Since that time more credit and respect has rightly and universally been given to patients' conscientious judgements and morally responsible exercise of free choice in their healthcare. Doctors for some time have realised they may not treat competent patients without their informed consent. Patients have the right to refuse unwanted medical treatment. This requires that patients be given the relevant information before they make decisions — there is a difference between an 80% and a 20% chance of a cure following surgery.

## Understanding Patients' Burdens

The meaning of 'burdensome' should not be limited to what is physically painful. It should also include the observance of a psychological burden, which draws on one's self-understanding over time — from the present into the future. The sick themselves, not others, are the experts on how they feel and personally experience different kinds of burdens caused by their illness or treatments. As Dr Eric Cassell says suffering is "a specific state of distress that occurs when the intactness or integrity of the person is threatened or disrupted. ... Suffering is related to the severity of the affliction, but that severity is measured in the patient's terms and is expressed in the distress they are experiencing, their assessment of the seriousness or threat of their problem, and how impaired they feel themselves to be." (Cassell, 1999, p. 531-534). Cassell (1991) stresses that the patient's perspective is important and unique on account of its essential link to each person's subjectivity: "Because suffering is individual in its origins and expressions, truly to know why and how someone suffers it is necessary to know the person in his or her particularity. But that ... total knowledge of a person is impossible. Suffering is necessarily private because it is ultimately individual." (Cassell, 1991, p.31).

In the subjective domain, the sick themselves, not others, are the experts on how they feel and personally experience different kinds of burdens. Cassell adds: "Suffering involves some symptom or process that threatens the patient because of fear, the meaning of the symptom, and concerns about the future. The meanings and the fear are personal and individual, so that even if two patients have the same

symptoms, their suffering would be different." (Cassell, 1991, p. 31).

Depending on their condition and circumstances, patients vary in their capacity to cope with different kinds of pain. Importance should be given to the informed views of competent patients in assessing their pains and sufferings. They could morally refuse on reasonable grounds to have treatment withdrawn if it is ineffective or burdensome. Furthermore, the general duty to have reasonable medical treatment also needs to be interpreted in the light of the religious beliefs of patients, be they Christian, Judaic or Islamic, etc — as will be discussed in more detail later in this article.

## Duty of Reasonable Care and Treatment of Patients

A person's wellbeing includes one's health understood as whatever pertains to the prevention, diagnosis, treatment and rehabilitation, for the physical, psychological, social, spiritual and personal wellbeing of the patient. (Pontifical Council for Pastoral Assistance to Health Care Workers, 1995). In health care, the basic moral principle is that healthcare professionals are bound to provide the medical treatment that is reasonably required in the circumstances to restore health or to save life. It is the responsibility of healthcare professionals, in dialogue with their patients, to interpret the duty of reasonable care in individual cases. In the past it has traditionally been axiomatic that all means possible should be employed to cure or save life. This rule of thumb is no longer a useful guide for doctors and patients alike in our time, at least in the developed world where contemporary high-tech medicine is available. Doctors normally have a moral duty to provide, and patients to accept, *ordina-*

*ry* or *proportionate* means of health-care. Some 50 years ago Pope Pius XII stated that the use of ordinary means for the preservation of life and health was morally necessary. His explanation of the morally relevant meaning of *ordinary* and *extraordinary* means in relation to patients and others is balanced and still relevant today: "...normally one is held to use only ordinary means — according to circumstances of persons, places, times, and culture — that is to say, means that do not involve any grave burden [*charge extraordinaire*] for oneself or another. A stricter obligation would be too burdensome for most men and would render the attainment of the higher, more important goods [*biens*] too difficult. Life, health, and all temporal activities are in fact subordinated to spiritual ends [*des fins spirituelles*]" (Pope Pius XII, 1957, p. 1030; Pope Pius XII, 1957-1958, p. 395-397)."

In other words, the informed and competent patient does have a right to draw the line in a morally responsible way between ordinary and extraordinary medical treatment.

The use of the term 'spiritual ends' includes activities that touch the spirit, not simply matter or the body, and may concern what is religious, divine or relate to the mind. Thus it may refer to a person striving to achieve the spiritual purpose of a fully human Christian life by doing God's will through acts of faith, hope, prayer and love of God and neighbour, and living a virtuous life, including reading, raising a family, working etc. To achieve all this presupposes persons are capable of living a rational and free self-conscious life, the preservation of which would be a priority for sick persons' treatment. There is, then, no duty to use extraordinary or disproportionate means of treatment. Admittedly it is not always easy to draw the line in in-

dividual cases. However, the provision of treatment ethically excludes deliberately choosing to cause the death of a patient by positive deeds or by undue omission of warranted treatment, even for the purpose of alleviating pain or suffering — this would be euthanasia.

Treatment should continue until a confident prognosis indicates that the patient's condition is incurable and that further treatment is disproportionate to the benefits expected. Treatment is futile when, given due time, it cannot restore health or function, cannot cure illness, disease or relieve distress. Multi-disciplinary communication is important for making the right decision for treatment and giving advice to patients. Attention should be paid to the knowledge and advice of nurses and carers in hospitals and nursing homes because they know their patients well. Discerning clinical judgement is required to see if it is justified to withhold or withdraw life saving treatment. It may at times be justified to cease medical treatment, initiate palliative care and let nature take its course, even if death occurs, rather than to intervene and prolong a life of suffering. Such withdrawal of burdensome treatment in terminal cases is good medicine and in the patient's best interests. Life support should not be withdrawn from incompetent patients without the agreement of their legally recognised representatives, who, as trustees, provide a social guarantee that their interests are duly protected.

It is psychologically more difficult to withdraw futile treatment once it has commenced than to withhold it. Carers may feel they cause death by withdrawing treatment whereas patients really die from their underlying terminal pathology. When the withholding of treatment is morally justified, its withdrawal is also justified bearing

in mind the reasonable wishes of the competent patient. These traditional moral principles should also be used to guide the care and treatment decisions of incompetent patients.

Healthcare professionals and the State are not morally obliged to provide futile treatment or go beyond the bounds of reason to provide every possible medical treatment. The availability of medical resources, personnel, family and state finances, and the prospects for the patient's recovery all enter into the complex judgement of the duty of reasonable treatment in the circumstances.

### Use of Drugs to Alleviate Pain

It is ethically permissible to use the required drugs to alleviate pain or suffering of patients even if it results in lessening consciousness, and in the case of those approaching death, shortening life. There is a world of moral difference between directly choosing to cause death and performing a medical procedure required to alleviate a patient's suffering, even though, as a side-effect, life may be somewhat shortened, but not deliberately taken.

John Paul II confirmed his predecessor's teaching on the use of pain-killing drugs: "Pius XII affirmed that it is licit to relieve pain by narcotics, even when the result is decreased consciousness and a shortening of life, 'if no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties'. In such a case, death is not willed or sought, even though for reasonable motives one runs the risk of it: there is simply a desire to ease pain effectively by using the analgesics which medicine provides." (John Paul II, *Evangelium Vitae* 65).

When taken as medically prescribed, morphine is safe and patients soon develop tolerance to it, including a gradual increase in doses as may be required from time to time. If terminally ill patients are in great pain that cannot readily be alleviated by morphine, they may need some sedative. They could be asked if they want to be sleepy most of the time or for some periods during the day. They may then be appropriately sedated, allowing for conscious periods for meals and for renewed awareness that they are still loved until death comes naturally.

### Medically Administered Nutrition and Hydration

Doctors, nurses, carers and ethicists agree that medically administered nutrition and hydration (MANH) should be offered to all competent patients and conscious patients who are mentally impaired who cannot eat and drink for as long as they need it. 'In all cases, the judgments about care due to patients should be based on the relevant medical and ethical criteria, not on the quality of the patient's life or state of consciousness' (Australian Bishops' Committee for Doctrine and Morals/Bishops' Committee for Health Care and Catholic Health Australia, 2005). The situation of patients on MANH needs to be reviewed periodically because many patients can make a successful return to oral feeding. When the condition preventing a patient from eating or swallowing is treatable by surgery or curable over time, MANH is morally obligatory. Though MANH does not cure a pathology, it sustains life for patients who can assimilate it and can prevent suffering from dehydration, hunger and thirst. Some sick and/or elderly patients, who at first agreed to have MANH, with the passage

of time, may find MANH is causing them much suffering and distress. They could morally refuse on reasonable grounds to have a feeding tube inserted or to have MAHN withdrawn in order to avoid undue burdens or suffering. It would be inhuman to refuse to offer MANH to any patients who want it. Needless to say it would be unethical to force feed competent patients against their reasonable wishes.

A case could be argued that it would be ethical for competent patients, distressed by the thought of MANH continuing after they have become irreversibly unconscious, to decide in advance to have MANH withdrawn if that time eventually comes (John Paul II, 2000). Other moralists would disagree and morally oppose this practice. If a patient's lawful agent requests that MANH be withdrawn in circumstances that clearly fall outside a Catholic hospital's policy, it would be necessary to inform the person that a Catholic hospital could not ethically comply with such a request.

### Patients in Post-Coma Unresponsiveness and MANH

It is more respectful to speak of patients in a *post-coma unresponsiveness* (PCU) than in a *permanent vegetative state*. This is the terminology preferred by Australia's National Health and Medical Research Council, which when referring to patients in PCU, has recently stated that 'awareness cannot be reliably excluded' by any tests (Australian Government, National Health and Medical Research Council, 2004). For some time there had been no agreement among Catholic moral theologians and ethicists on whether there was always a moral duty to continue to provide MANH to patients who had been diagnosed with moral certainty to be in an irre-

versible unconscious state as a result of a severe stroke or trauma. Some held it was morally permissible to withdraw MANH from patients in an irreversible unconscious condition, but there was agreement that it was morally wrong to give these patients a lethal injection.

However Pope John Paul II on 20 March 2004, in his address to an International Congress of Catholic doctors and ethicists at the Vatican indicated the ethical way to go in this situation. He made it clear that patients in PCU were human beings with intrinsic value and personal dignity, with a moral right to "basic health care (nutrition, hydration, cleanliness, warmth, etc.) and to the prevention of complications related to confinement to bed." He emphasised that "the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, to the extent in which and as long as it is seen to achieve its proper purpose, which in the present case consists in providing nourishment to the patient and alleviation of his suffering. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission."

The Australian Catholic Bishops' Committee for Doctrine and Morals agreed it would be morally different 'if the patient is unable to assimilate the material provided or if the manner of the provision itself causes undue suffering to the patient, or involves undue burden to others' (Australian Bishops' Committee for Doctrine and Morals/ Bishops' Committee for Health Care and Catholic Health Australia,

2005). In this case the benefit of MANH would not be proportionate to its burdens or harm.

The Pope's teaching applies in principle and does not rule out the ethical use of professional judgement by doctors should other medical counter-indications arise. Doctors and health carers are to determine by careful clinical assessments whether patients are truly being nourished, their sufferings alleviated, prevented or even increased by the use of MANH.

The Pope's address is directed specifically to the care of patients in PCU. It would also apply in principle to other unconscious or incompetent patients who are not dying but are suffering from "advanced dementia, severe stroke, advanced metastases or advanced neurogenic disease" (Australian Bishops' Committee for Doctrine and Morals/ Bishops' Committee for Health Care and Catholic Health Australia, 2005). His speech, however, was not meant to modify the normal ethical practices of Catholic palliative care hospices and their staff for their patients as they approach imminent death. In these cases it suffices to keep dying patients comfortable by continuing normal palliative care such as using an intravenous drip and caring for their mouth hygiene by the use of ice cubes.

Pope John Paul II spoke of the obligation to use MANH, but made no reference to what patients in developed and developing countries could or would wish to be done to them. As mentioned above, Pope Pius XII had made it clear that doctors derive their rights and duties to treat from their patients. The following passages from the *Declaration on Euthanasia* are very valuable:

"It is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against

a technological attitude that threatens to become an abuse. ...A right to die [means] the right to die peacefully with human and Christian dignity. From this point of view, the use of therapeutic means can sometimes pose problems..."

"In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or the doctors, to decide in the light of moral obligations [principles] and of the various aspects of the case... In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the results that can be expected, taking into account the state of the sick person and his or her physical and moral resources... Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community" (Congregation for the Doctrine of the Faith, 1980).

The Australian Catholic Bishops' Committee for Doctrine and Morals agrees that MANH involves a medical decision: "The Pope's statement does not explore the question whether artificial feeding involves a medical act or treatment with respect to insertion and monitoring of the feeding tube. While the act of feeding a person is not itself a medical act, the insertion of a tube, monitoring of the tube and patient, and prescription of the substances to

be provided, do involve a degree of medical and/or nursing expertise. To insert a feeding tube is a medical decision subject to normal criteria for medical intervention" (Australian Bishops' Committee for Doctrine and Morals/Bishops' Committee for Health Care and Catholic Health Australia, 2005).

### Christian vision of human life

Special consideration needs to be given to the relationship of patients' consciences and freedom of choice to their spirituality, religious beliefs or lack thereof. I will touch on some beliefs of many Christians which could consciously or subconsciously influence their health-care decisions.

The Christian tradition is optimistic as may be gleaned from the following biblical texts: "God is love, and whoever remains in love remains in God and God in him"; (Jn 4:16) "Even were I to walk in a ravine as dark as death, I should fear no danger, for you are at my side." (Ps. 23:4) "Peace I bequeath to you, my own peace I give you, ... this is my gift to you. Do not let your hearts be troubled or afraid." (John 14:27)

Christ's teaching on the new life of faith and grace encourages believers to look forward to the glorious risen life that awaits them after death. St Paul wished to die to be with Christ: "I am caught in this dilemma: I want to be gone and to be with Christ, and this is by far the stronger desire — and yet for your sake to stay alive in this body is a more urgent need." (Phil. 1:23). The Greek verb means to be gone, to loose from moorings, to weigh anchor, to depart or to die, according to large dictionaries for this text.

The Christian faith offers hope for believers and their loved ones

for the future and strength in the midst of present anxieties, fears and sufferings. Death and suffering, though tragic, are not absolute evils for Christians. Referring to people generally, Vatican II states: "Christian faith teaches that bodily death ... will be overcome when that wholeness which they lost through their own fault will be given once again to them by the almighty and merciful Savior (Pastoral Constitution of the Church in the Modern World, 1996)."

The Christian vision is well expressed in the following saying: "For a Christian, the moment of death is the moment of his being finally united forever to Christ (Pontifical Council Cor Unum, 1981)." However, sadly, as Professor Francis rightly Moloney laments "the theological commitment of Christianity to a life which extends beyond the limitations of this life is seldom heard in contemporary health care discussions (Moloney, 1995)."

### Influence of Christian Beliefs and Spirituality on Decision Making

People with a strong sense of a religious mission may want treatment that borders on being *extraordinary* in order to live longer and continue to fulfil a mission. Think of the heroic struggle of Pope John Paul II to live on to the very end to fulfil his mission of Shepherd of his world-wide flock — until he felt it was time to go 'to the house of the Father'. Likewise a dying mother may wish to show her love for her teenage children by opting for continued health care at home to share more quality time with them as they mature.

Others who are impressed by God's gift of life may wish to hold on to it in this world, even by choosing to have extraordinary life-saving treatment to prolong life as

long as possible. This would normally be morally permissible. It is possible some people whose spirituality is dominated by the fear of God or of the after-life in general may wish to delay death by actively seeking life-saving treatments.

People who have a strong and vibrant belief in God and the Risen Christ may be less inclined to want to have extraordinary or burdensome life-saving treatment than others in view of their desire to enter heaven! Likewise sick people with few prospects for a cure from a lethal disease may choose to forego costly extraordinary treatment to avoid using unavailable money or a substantial amount of the family savings. Again, some parents and grandparents, may opt for life-prolonging treatment, if available, in order to be there for their children or grandchildren. Others again may be inspired by St Paul who was willing to embrace a natural death, as we have seen, to join the Risen Christ in glory. Such patients may be reluctant to consent to undergoing extraordinary treatments.

Some people late in life may more readily prefer not to endure disproportionate means of treatment. Others may enjoy pursuing an intellectual life of reading, studying and following their family members and cultural interests would find it uncomfortable to have life prolonged by medical treatments that result in their life becoming burdensome to themselves and others, by perhaps being unable to pray or talk. Pope Pius XII agreed: "A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important goods too difficult... On the other hand, one is not forbidden to take more than strictly necessary steps to preserve life and health, as long as one does not fail

in some more serious duty" (Pope Pius XII, 1957).

In the light of this it would be difficult to justify an operation that could prolong life but most likely leave the patient permanently unconscious. Again a few exceptional persons may choose to moderate their use of pain killers in order to share in the sufferings of Christ.

Chaplains and pastoral care practitioners have an important spiritual role to play in helping the sick and elderly to think through their concerns, including reconciliation with family members and perhaps God. They may be able to help them resolve some conscientious conflicts as they prepare them to accept their eventual death, hopefully with serenity and peace. Dr Eric Cassell's research shows that there is preliminary evidence of impaired thinking in otherwise competent adults once they become very sick and hospitalized; their thinking has been found to be comparable to that of children younger than 10 years of age (Cassell, 2001. If this is so, pastoral care for the aged, sick and dying would be all the more necessary.

Many Christians give much importance to administration of the Sacraments of Reconciliation, of Anointing and of the Eucharist through which God's love and merciful forgiveness of sins is provided at the approach of death. Catholic chaplains should give timely help to prepare the sick and elderly who wish to receive these Sacraments. Such patients would receive greater spiritual benefit if they are still conscious.

### Approach of Death for the Terminally Ill

Some people may find the prospect of death threatening and disturbing. It is difficult to cope with the thought of the gradual breaking

down of our vital organs and the disintegration of our bodies. We can hardly endure the thought of leaving our loved ones, letting go of our grip on this world and completely ceasing to be. Our sense of personal dignity rebels against death notwithstanding medical treatment's power to delay its inevitable approach. Indeed, Dr David Kissane goes so far as to speak of "demoralization as a 'dimensional' state of mind — that is, as a mental state ranging from a normal response to perceived helplessness to a morbid form of existential distress (Kissane, 2004, p. 21)."

However, Christians find consolation in their faith in the promised blessed life after death when the just will share in the resurrection of Christ and enjoy a blessed eternity.

To help people to prepare to accept death as well as possible, dying patients need to be informed in good time of their condition by their doctors. Patients have a right to prepare emotionally and spiritually to die naturally, in peace and with dignity, without being deprived of an opportunity to attend to their outstanding personal, family and religious duties. Patients' decisions about treatments at the end of life could also be influenced by their religious faith or personal beliefs. They ought to know there is no need to resist the approach of death and that they may in good faith let go and die. Chaplains or pastoral care practitioners should help the dying be sustained by their own religious faith or personal beliefs and to realise that they are under no moral obligation to accept burdensome life prolonging treatment.

In the care of the dying provision of patient comfort is *the priority*. This excludes forced feeding against the wishes of a competent patient. Sometimes patients lose their appeti-

te and this may well be part of the dying process, without any hint or suggestion of a suicidal intention. Failure to respect the dying process would show a lack of respect for the dying person who accepts the inevitability of death without any *intention* of suicide.

### Institutional Policies

All healthcare institutions and residential aged care facilities should observe State laws, including those prohibiting the deliberate performance of direct euthanasia. They should follow their own ethical guidelines for making medical decisions towards the end of life, making sure provision is made for the needs of patients from a variety of spiritual and religious backgrounds. Catholic institutions should follow their own published *Ethical Guidelines* which should be in accord with official Catholic teaching. Healthcare professionals should abide by their own institution's policies, recognising that there is always scope for the exercise of professional clinical judgements.

Governments have a responsibility to adequately fund the healthcare needs of all citizens of any religion or none. Integral healthcare, especially of the elderly and patients near the end of life, does require the assistance of qualified pastoral care practitioners. These ought to be publicly funded and

not be prevented by laws or policies from having reasonable access to patients who could benefit from their valuable spiritual or pastoral services.

### Conclusion

Christian doctors should exercise their own professional responsibilities to find concrete solutions to moral problems that arise in their lives as lay Christians. The Second Vatican Council was quite explicit on this point when speaking about the role of lay people (meaning in this context the non-ordained): "It is their task to cultivate a properly informed conscience and to impress the divine law on the affairs of the earthly city. For guidance and spiritual strength let them turn to the clergy; but let them realize that their pastors will not always be so expert as to have a ready (the Latin text adds *concretam*, concrete) answer to every problem (even every grave problem) that arises; this is not the role of the clergy; it is rather up to the laymen to shoulder their responsibilities under the guidance of Christian wisdom and with eager attention to the teaching authority of the Church" (Vatican II Documents *Gaudium et Spes*, 33/43).

Here the Church is effectively asking informed lay people — and with greater reason doctors — to exercise their own prudential judgement rather than be ever dependent on the advice of the clergy in

particular cases. This does not represent an abandoning of responsibility by pastors. It is merely placing it where it belongs, viz. in the informed and sincere consciences of upright lay members of the People of God. Doctors who have not received an adequate education in moral principles and who feel the need for some assistance should seek advice on how they may best remedy this situation.

The law should allow doctors, after having made thorough ethical assessment of the needs of dying patients, to develop ethical clinical treatment options, provided the necessary social guarantees are in place to prevent abuses. Fear of being sued encourages the practice of defensive medicine, hinders making correct clinical decisions and is not in the best interests of patients nor of the community.

The community and doctors should not regard the existence of incurable disease or the inevitability of death as indicators of failure. Education is the right way to deal with the community's culturally entrenched death *angst*. People need help to form a correct understanding of the right to refuse medical treatment in common law and national jurisdictions as well as the right to appoint an agent with an enduring power of attorney (medical). This would avoid dilemmas for family members, legal representatives and healthcare professionals alike.

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