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Instruction for Healthcare Administrators

by Most Reverend John J. Myers, J.C.D., Bishop of Peoria

Questions concerning the end of human life provoke uncertainty today in the healthcare field and contradiction in the legal field.[1] With increasing urgency such questions call for our attention, both because of their frequency and because of the rapidly changing legal environment. Soon The Patient Self-Determination Act of 1990[2] will take effect. This Act requires, among other things, that all healthcare facilities participating in the Medicare or Medicaid programs declare in writing their policies for the implementation of any advance directives, such as living wills or durable powers of attorney for healthcare, which their patients may present to them.

An advance directive is a legal instrument which becomes operative within existing personal relationships. Personal interdependency unites the physicians and the entire team of health professionals with the patient and the patient's family and friends as well as with the healthcare facility and the Catholic Church in whose healing mission Catholic facilities share. Each in its own way contributes to the good of the patient.

The Catholic healthcare facility is not a passive and indifferent site for the patient-physician relationship. Driven by its mission, the facility takes an active role in the delivery of healthcare. The Catholic facility's mission is a participation in the healing mission of the Church, an extension of the healing mission of Christ.

Informed by Christ's own view of human life, the Catholic facility joins the physician's medical expertise to its own human expertise with a view to the relief of suffering. Ideally, the patient and the physician operate within the vision of human life proposed by the facility. Still, it may happen that a patient or physician seeks a course of treatment which is at odds with the teaching incorporated in the policies of the Catholic facility. This situation has already been addressed with respect to abortion and sterilization. *The Ethical and Religious Directives for Catholic Health Facilities*[3] have clearly articulated the Catholic position on these questions. Euthanasia frequently opposed by Church teaching,[4] is directly condemned in the *Directives.*[5] Still, there is need to address explicitly the situations which may be created by advance directives, since there may be some doubt concerning which principles apply.

As Catholic healthcare facilities seek to formulate their policies in this regard, I wish to offer guidance by reflecting upon the Catholic moral

tradition and the role of the Catholic healthcare facility in the physician-patient relationship.

I. The Contemporary Situation

Surely all dedicated to healthcare wish to provided the benefits modern medicine makes available to those whose health is weakened and who require the assistance of medical technology. It is precisely this will to do good for others that creates the hesitancy many experience when they apply even minimal life-sustaining technology to those unfortunate persons who yet live bodily, while their higher human faculties appear to have slipped away.

The questions which confront one facing this situation cut to the deepest presuppositions about the meaning of human life: What limit is there to what must be done to preserve my life? May I refuse to preserve my life in what I consider to be an inhuman and undignified state? Has technology failed to preserve our humanity even as it preserves our lives? Such questions touch upon many complex issues: the gift of life, the inevitability of death, the fact of suffering, the power of technology. Our response to these questions must be founded upon the same Christian understanding of human life which makes the care of the sick and the suffering a concern of the Church.

As theoretical, these questions are vexing enough; facing an actual situation where one must determine the future of another person, who may be severely debilitated, raises these questions with their full gravity. They provoke not only doubt, but also fears and expectations of protracted suffering. Death seems to be the only release from an apparent slavery to technology, which preserves life but cannot restore health. I have great personal concern for those actually facing these problems, as well as for those who fear to face them. This moves me to offer guidance founded upon both a belief in the sanctity of human life and the recognition that death is inevitable and need not be opposed through measures which impose terms of life to be feared more than death itself.

For many people, a general climate of anxiety accompanies any contact with the medical profession. It represents both a science, that they may not understand, and an art, that may seem to treat the body, which is not extrinsic to the person,[6] as a thing. Some find medical procedures humiliating, and therefore fear the cure as well as the illness. We naturally shrink from imagining ourselves suffering any debility, but there is also growing anxiety at the prospect of chronic dependence upon the medical profession. People especially fear a technologically achieved preservation of their lives in a debilitated state.

The questions we face today are not independent of this climate of anxiety. These fears are not to be discounted lightly. Still, we have no reason to feel helpless in the face of such fears, as though we were governed by them rather than the truth of Christ. Christ offers hope. For while death

is certain, in Him it is not final; while suffering is universal, in Him it is not empty. The meaning of suffering and death in our life and the lives of those we serve depends upon their meaning in the life of Christ Himself.[7] Christ is the Victor over every kind of evil and we symbolize His triumph by the Cross upon which He suffered. Death is not the solution to human suffering. Rather, Christ is the solution to both suffering and death. Christ Himself reveals the truth of human life,[8] intended for all men and women of all traditions.[9] This truth, though not simple and sometimes not fully clear, is our guide through difficult times and difficult questions; we return to it continually in order to bring light to our darkness.

II. The Catholic Heritage

At the heart of the Revelation of Christ is the truth that all human life is created out of love and in the image and likeness of God. From the first through the last moment of earthly existence and beyond, the human person never loses this fundamental dignity nor the cradle of divine love in which it is created. Human life, which comes from God, belongs to Him still, so that we are not our own: we are to glorify God in our bodies[10] and serve the Creator before any creature.[11]

Human life and health, therefore, are to be preserved in the service of God. In this context, our common theological tradition has spoken of a **duty** to preserve life and health. This duty has never been understood to be an absolute duty, as if bodily life were the highest good. Rather, in full recognition of the need for earthly life to be completed and perfected in a higher life (which is also a bodily life), the fulfillment of this duty to preserve life and health has been recognized to have limits. Life and health are never to be neglected or attacked, but they need not be defended by any and all means.

For centuries, the question of the means which preserve life and health was relatively simple, for the unsophisticated state of medicine created few dilemmas. As medicine increased in complexity and proficiency, theological reflection upon the meaning of bodily life and the duty to preserve it advanced also. Our developing tradition of theological reflection has articulated several principles which help us to understand the role medical science is to play in our lives.

III. The Theological Tradition

The elements of the theological tradition appear in two forms. The writings of the theologians present reflections upon Revelation. These writings enjoy the authority that they secure for themselves through the strength of their own arguments. Second, the statements of the Magisterium present *normative interpretations* of Revelation.These statements enjoy varying degrees of authority, evidenced in their form of expression, but they must always be regarded as authoritatively giving direction to and frequently setting necessary limits to any further discusison.

In matters of healthcare, both forms of the tradition have appeared. Scholastic theologians developed a consistent doctrine for addressing questions related to life and health. Additionally, the Magisterium has endorsed some elements of this common theological tradition. Relative to patient self-determination with respect to advance directives, two magisterial documents are of primary importance: "Address to an International Congress of Anesthesiologists," November 24, 1957, by Pope Pius XII;[12] "The Declaration on Euthanasia" by The Sacred Congregation for the Doctrine of the Faith.[13]

A. Patient Self-Determination

Pius XII concisely formulates the fundamental consideration: "Natural reason and Christian morals say that man (and whoever is entrusted with the task of care of his fellowman) has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health."[14] The patient's duty to preserve his or her life and the right to the means necessary provide the point of departure in any matter of patient self-determination. This is so without prejudice to the corresponding rights and duties of healthcare professionals, as Pope Pius indicated.

The Ethical and Religious Directives for Catholic Health Facilities, as well as standard medical practice, recognize that the initiation, continuation, or interruption of any medical procedure deemed permissible requires "the consent, at least implied or reasonably presumed, of the patient or his guardians."[15] The need for consent recognizes that the patient is director of the actions that will be undertaken in behalf of his or her life and health. Nevertheless, "the right to refuse medical treatment is not an independent right, but is a corollary to the patient's right and moral responsibility to request reasonable treatment."[16] In other words, the private choice of the individual is not the only factor in the morality of the situation. There are objective dimensions of all situations which contribute to determining the morality of any choice which is to be made. Chief among these objective elements, according to Catholic theology and medical practice, is the duty to preserve life. This duty belongs both to the individual and, in a different way, to the healthcare facility, as Pope Pius taught.

Insofar, then, as a healthcare facility is a moral agent, it must not blindly follow the directives of another person, but must fulfill each of its duties with conscious responsibility to its mission and to the moral teachings of the Church. Compliance with the wishes of a given patient is thus limited by the moral nature of the healthcare facility itself. **Accordingly, our Catholic policy is to respect and comply with all informed and conscientious requests for, or refusals of, medical assistance, unless it involves some moral irresponsibility for the facility, some failure in its duties to the well-being of the patient.**[17] Ultimately, responsibility for the moral uprightness of the facility lies with the Administrator. That is, without normally being personally involved in the patient-physician relationship, the Administrator

sees that the policies and customary practices of the facility are formed according to Catholic principles.

The conviction that the limits of our compliance are actually founded upon the truth of human life, and therefore, that they are genuinely directed toward the patient's best interests, gives us confidence to adhere to our principles and to refuse to comply. This does not mean that we impose our beliefs upon patients in violation of their decisions. Rather, we respect the right and duty of the patient to self-determination. At the same time we avoid complicity in activities contrary to our long moral tradition. And we recognize that we also act rightly by not allowing the beliefs of another to be imposed upon us.

B. End of Life Decisions

At the end of life, a patient may exercise the right to self-determination in more than one way. If the patient is competent, he or she retains the full authority to direct the plan of treatment. If incompetent, one of many possibilities may ensue. Advance directives are legal instruments, such as living wills and durable powers of attorney for healthcare, which specify the conditions under which they become operative. In the absence of an operative legal document, decisions may be made by other interested persons, usually families, friends or guardians, or at times by doctors, or through court processes.[18]

The limits of our willingness to comply with end of life decisions are supplied by our understanding of euthanasia: "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[19] Thus, euthanasia "in all its forms is forbidden. The failure to supply the ordinary means of preserving life is equivalent to euthanasia. However, neither the physician nor the patient is obliged to the use of extraordinary means."[20] Because it is not always clear in a particular case what constitutes euthanasia, the Church has presented an explicit and authoritative statement.

C. The Declaration on Euthanasia

The Catholic theological tradition developed a doctrine concerning the duty to preserve life by distinguishing between ordinary and extraordinary means. Ordinary means are normally deemed obligatory, while extraordinary means normally involve some grave burden or disproportion between themselves and the benefits they secure. Pius XII gave authoritative expression to such a distinction[21] and The Sacred Congregation for the Doctrine of the Faith developed, with slight linguistic revision, our understanding of the distinction in the 1980 "Declaration on Euthanasia."

At the outset it is to be noted, as the "Declaration" teaches, that the complexity of the situation may make it difficult to apply ethical principles. It is necessary to advert both to the principles and to the peculiarity of an

individual case. Accordingly, the judgment about the use of therapeutic means belongs "to the conscience of the sick person, or of those qualified to speak in the sick person's name, or of the doctors."[22]

The "Declaration" teaches:

> Everyone has the duty to care for his or her own health or to seek such care from others. Those whose task it is to care for the sick must do so conscientiously[23] and administer the remedies that seem necessary or useful.

The first consideration, as Pius XII also taught, is to preserve life[24] and health. The first obligation, the presumption, if you will, is that everyone care for his or her health. If a person is unable to fulfill this duty, he or she still has the duty to seek such care from others. In the event of sickness, others have the duty to care for the sick person and to administer necessary or useful remedies. The existence of each of these duties is not something which needs to be proven. These evident duties are the foundation of the discussion.

With this established, the Congregation considers whether it is "necessary in all circumstances to have recourse to all possible remedies." In brief, the reply is that there is no obligation to use extraordinary or disproportionately burdensome means. To clarify the meaning of these terms, the "Declaration" teaches:

> 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 result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

Thus, in a particular case, those means are deemed non-obligatory whose expected results for this given patient are disproportionate to the type of treatment, or to the degree of complexity or risk, or to the cost, or to the availability of the means in question.

It must not be overlooked that the Congregation begins with the certain duty to preserve life and health and then shows how to recognize means which are exceptional in the fulfillment of the duty. In other words, in the event of illness, our *first* response is that the duty to preserve life or health is to be fulfilled by means which are necessary or useful. If the use of those means is seen to be disproportionately burdensome according to the terms of the "Declaration", they need not be employed or may be interrupted. Let there be no mistake: **if a means is necessary or useful for the preservation of life or health, the obligation to use it exists unless it is shown to be disproportionately burdensome in the particular situation.**[25]

According to the teaching of the "Declaration", the obligation to use the means which are necessary or useful is more fundamental than the option not to use them. For the obligation to use life-preserving means depends upon the certain duty to preserve life and health. On the other hand, the option not to use the means depends upon their being shown to impose burdens disproportionate to their benefits. **Therefore, when it is not**

immediately clear whether the use of therapeutic means is disproportionately burdensome, it is not an entirely open question whether or not such means are to be employed. The presumption is that the necessary or useful means are to be employed unless there is evidence that the means are optional, according to the terms of the "Declaration".

The "Declaration" offers some clarifications to facilitate the application of these general principles:

> If there are not other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk . . .
>
> It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations . . .
>
> It is also permissible to make do with the normal means that medicine can offer. 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.[26]

The first two clarifications share the common presupposition of a case where "the normal means that medicine can offer" are not "sufficient." These clarifications state that in such a case, it is permitted to employ advanced medical techniques and it is permitted to interrupt them if the results are less than expected. The third clarification states that it is always[27] permitted not to have recourse to the advanced means at all.

The "Declaration" adds a separate clarification for specific circumstances:

> When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.

It must be emphasized that this "decision to refuse" depends upon the imminence of death "in spite of the means used."[28] The "Declaration" teaches that we do not determine that death is imminent by considering the state of the person independent of the use of the means. That is, if the means are effective to preserve life, death is not imminent. No one should apply the terms of this qualification to a case where death is not imminent *in spite of the means used.*

Also it should be noted that the phrase "burdensome prolongation of life" recalls an earlier passage in the "Declaration":

> Ultimately, the word *euthanasia* is used in a more particular sense to mean 'mercy killing', for the purpose of putting an end to extreme suffering, or saving abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years, of a miserable life, which could impose too heavy a burden on their families or on society.

The contrast between the parallel phrases (prolongation of a miserable life vs. burdensome prolongation of life)[29] points to a subtle distinction which

is precisely the heart of the matter. *It is euthanasia to intend to bring an end (through action or omission) to human life which is burdensome or miserable. It is not euthanasia to bring an end to a burdensome means of prolonging life.*

Finally, it should be restated that, in those cases where death is *not* imminent and the means which are available for use are effective in the conservation of life, there can be tremendous difficulty in determining in the particular case what means one is strictly required to use as opposed to those means one is permitted either to use or to refuse. It is not possible to identify a given technical means and to classify it as always and in all circumstances obligatory. The final decision is contingent upon the circumstances of the individual cases and rests with the consciences of the patient or those who act in the patient's behalf.'[30]

IV. Application of the "Declaration on Euthanasia" for Administrators of Catholic Healthcare Facilities

Applying the principles formulated in the "Declaration on Euthanasia" to end of life decisions is not easy. The principles have been stated by the Church to help individuals and institutions arrive at a correct formation of conscience. Still, it is difficult to see clearly all aspects of the question. No one should underestimate the intricacy and the peculiarity of individual cases. Allow me, then, to summarize the essential points relative to the "Declaration" for Administrators of healthcare facilities making policies and decisions concerning the implementation of end of life directives.

1. It is the function of the Administrator to ensure that the practices of the healthcare facility follow the guidelines of the "Declaration." Normally, this is done at the level of policy. In rare cases, the Administrator, with the counsel of trusted personnel, may be required to determine whether a given advance directive or other medical order here and now conflicts with stated policy or with Catholic teaching. Normally we can comply, but in the case of an evident violation, the Administrator refuses compliance. The Administrator may thus determine that an individual's request or directive is not in harmony with Catholic teaching, or that the individual has misunderstood or misapplied the principles. To make this judgment is not to accuse any person of wrongdoing or sin.[31] It is, rather, to point out an error of judgment and to refuse to involve the facility in an activity which violates the moral responsibility of the facility.

2. Perhaps the most troubling end of life decisions concern the refusal or removal of artificial nutrition and hydration. On the one hand, it is difficult to assert an obligation that a person live in a debilitated state for what may be a long time. On the other hand, it is unsettling to assert that a person may die of starvation under medical supervision. This issue does not admit of easy resolution, as evidenced by the ongoing medical, ethical, theological and legal debates. The fact that the "Declaration on Euthanasia" did not address this issue in particular does not mean that the general principles it

articulated do not apply to questions of artificial nutrition and hydration. On the contrary, in the absence of a **specific** treatment of this issue, it is imperative to understand how the **general** principles articulated in the "Declaration" apply to this question.

It should be noted that it is essentially irrelevant whether artificial nutrition and hydration are to be considered parts of normal care or forms of medical treatment. All means of preserving life or health, whether normal care or medical therapy, are subject to the analysis described in the "Declaration on Euthanasia." The moral obligation to use a given means does not arise exclusively from the nature of the means, for one must also consider the circumstances of the case. That is, even aspects of normal care, *under extreme circumstances,* may be extraordinary or disproportionate in a particular situation. It is not true morally to say that artificial nutrition and hydration must be applied under any and all circumstances. **The moral assessment of the case does not take away from, but rather depends upon, the physician's expertise.** Only in light of the circumstances of the particular case does it become possible to determine what is **necessary** or **useful** and what is **disproportionate.**

Food and water are always **necessary,** but a given means of artificial nutrition and hydration may not be necessary because other, more normal means for the provision of nutrients are sufficient. Food and water are always **useful** for a living being. Still, a given means of artificial nutrition and hydration may not be useful in cases where the body is chronically incapable of assimilating the nutrients[32] which are provided in this manner. In such cases, when artificial means fail to deliver nutrients in a manner in which they may be assimilated, artificial nutrition and hydration are, properly speaking, *useless.* Artificial nutrition and hydration are not useless in cases where they effectively deliver nutrients but fail to bring about some other, indirect benefit, such as the restoration of consciousness. Artificial nutrition and hydration are useful for the provision of nutrients and useless when they fail to provide nutrients; they are not useless when they fail to secure complete recovery from some symptom, pathology, or condition extrinsic to the need for nutrients.

3. The use of therapeutic means is optional, according to the "Declaration," when their use *imposes* burdens which are **disproportionate** to the benefits their use secures. It is essential to note that the proportion in question lies between the burdens the means *introduce* when used and the benefits the means achieve. When resorting to medical means, we are responsible for the burdens which our intervention imposes. If those burdens are excessive in relation to the achievements of the intervention, the medical means *may* be refused or discontinued. However, the use of means is not deemed disproportionate due to the presence of burdens or misery which arise *independent* of the medical intervention in question.[33]

Additionally, in cases where death is imminent in spite of the means used, one need not apply the same standards. For the "Declaration" teaches that under the conditions of imminent death in spite of medical intervention it

is not *necessary* to employ means which secure only a burdensome prolongation of life.

4. The "Declaration" teaches: "Those whose task it is to care for the sick must do so conscientiously and administer the remedies that seem necessary or useful." Catholic healthcare facilities, then, as professional medical providers, cannot avoid the duty to provide life-preserving means, including artificial nutrition and hydration,[34] to those for whom they are necessary or useful, unless their provision imposes burdens disproportionate to its benefits, according to the terms of the 'Declaration'." **That is, in cases where artificial nutrition and hydration are necessary or useful, Catholic healthcare facilities must apply such means in the fulfillment of their duties as described in and subject to the limitations specified in the "Declaration on Euthanasia." Limits to the fulfillment of the certain duty to preserve life arise when the use of the means is disproportionately burdensome in the situation or when death is imminent in spite of the means used.**

V. Conclusion

This analysis should throw light on the moral dimensions of your implementation of advance directives. I present this letter to assist you in understanding Catholic moral teaching and *to enable you to reject certain misunderstandings* of that teaching. It should not represent a departure from your customary practices, but should provide the intellectual and Catholic grounds for practices which respect and defend the sanctity of human life, despite the miseries and sufferings to which it is susceptible.

I offer this direction in order that you might maintain your catholicity in the face of a legal and social environment which embraces other principles. The Catholic Church has consistently exhibited a moral tradition independent of the legal and social circumstances within which it lives.

Today, the federal government provides for us an occasion to exercise moral leadership through articulating our principles upholding the sanctity of human life in contrast to the political and legal structures which, at times, would permit its neglect. Since the courts have not dealt finally with these questions, visible adherence to our principles has no small influence, for we draw upon a tradition older and a teaching more profound than the law. Catholic moral leadership in the field of healthcare is essential to defend and promote the non-sectarian truth of human life.

Given at my Chancery September 14, 1991, the Feast of the Triumph of the Cross.

References

1. I refer to clinical cases which receive legal scrutiny. For example: *Barber v. Superior Court*, 147 Cal.App.3d 1006, 195 Cal.Rptr. 484 (1983); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, N.E.2d 626 (1986); *In Re Westchester County Medical Center on behalf of O'Connor*, 72 N.Y.2d 517, 534

N.Y.S.2d 886, 531 N.E.2d 607 (1988); *Cruzan v. Harmon*, 760 S.W.2d 408 (MO. 1988); *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 255 Cal. Rptr. 297 (1986).

2. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, Sections 4206, 4751, enacted November 5, 1990.

3. United States Catholic Conference, 1971, revised 1975.

4. Most recently, the Administrative Committee of the National Conference of Catholic Bishops has issued a "Statement on Euthanasia," (September 11, 1991) rejecting euthanasia and assisted suicide: "Those who advocate euthanasia have capitalized on people's confusion, ambivalence, and even fear about the use of modern life-prolonging technologies . . . Being able to choose the time and manner of one's death, without regard to what is chosen, is presented as the ultimate freedom. A decision to take one's life or to allow a physician to kill a suffering patient, however, is very different from a decision to refuse extraordinary or disproportionately burdensome treatment."

5. *Ethical and Religious Directives, op. cit.*, No. 28, see below.

6. See *Gaudium et Spes* #14: "Though made of body and soul, man is one. Through his bodily composition he gathers to himself the elements of the material world; thus they reach their crown through him, and through him raise their voice in free praise of the Creator. For this reason man is not allowed to despise his bodily life; rather he is obliged to regard his body as good and honorable since God has created it and will raise it up on the last day."

7. For an extended reflection upon these matters see *Salvifici Doloris*, the 1984 Apostolic Letter of Pope John Paul II.

8. "The knowledge of Christ is a knowledge full of the simple truth about man and, above all, full of love." Pope John Paul II, "Address to University Students in Krakow," June 8, 1979, reprinted from *L'Osservatore Romano*, English Edition, in *The Whole Truth About Man*, (Boston: Daughters of St. Paul), 1981, p. 35.

9. See *Gaudium et Spes* #22: "The truth is that only in the mystery of the incarnate Word does the mystery of man take on light. For Adam, the first man, was a figure of Him Who was to come, namely Christ the Lord. Christ, the final Adam, by the revelation of the mystery of the Father and His love, fully reveals man to man himself and makes his supreme calling clear. It is not surprising, then, that in Him all the aforementioned truths find their root and attain their crown."

10. Cf. I Cor. 6:19-20.

11. Cf. Rom. 1:21-25.

12. *Acta Apostolicae Sedis*, 49 (1957), pp. 1027-1033; English version published in *The Pope Speaks*, Vol. IV, n. 4 (Spring, 1958).

13. *Acta Apostolicae Sedis*, 72, (1980), pp. 1542-1552; English text in *Origins*, August 14, 1980, Vol. X, n. 10, pp. 154-157.

14. "Address," November 24, 1957, *op. cit.*

15. *Ethical and Religious Directives, op. cit.*, No. 1.

16. National Conference of Catholic Bishops Committee for Pro-Life Activities: "Guidelines for Legislation on Life-Sustaining Treatment," 1984.

17. For this reason, Catholic facilities have policies against direct sterilization and abortion, for example.

18. It should be clear that, in terms of our compliance with particular therapeutic requests, there is no essential difference whether they originate from the patient, or from the appropriate surrogate or proxy, or from some legal instrument.

19. "Declaration on Euthanasia," *op cit.*

20. *Ethical and Religious Directives, op. cit.*, No. 28.

21. "Address," November 24, 1957, *op. cit.* Pius spoke of means which are ordinary and those which involve grave burden according to the circumstances of persons, times, places and culture. In this way, Pius upheld the genuine, though relative, good of bodily life and health which all have a duty to preserve, without prejudice to other duties that may be more serious.

22. It must not be overlooked that after this decision has been made, there remains a moral decision for the facility. The healthcare facility must determine whether cooperation

in the patient's decision is morally responsible for the facility. Normally, there are no obstacles to our compliance. In the event, however, of a violation of Catholic teachings or principles, the facility may not comply. Responsibility here rests ultimately, though not normally personally, with the Administrator. To refuse compliance is not to judge the subjective moral dimensions of the patient's decision. It is a recognition of the moral nature of the healthcare facility and of the need for it to be morally responsible to its mission, to its patients, and to the teachings of the Church.

23. "Must do so conscientiously" seems to be an under-translation. The Latin text reads: *"omni cum diligentia operam suam praestare debent."* (The Italian text is equivalent to the Latin: *"devono prestare la loro opera con ogni diligenza.")* The official Latin text is clearly stronger than the translation.

24. A duty to care for health must also be, *a fortiori,* a duty to care for life.

25. As the "Declaration" goes on to clarify, this appies to "the normal means that medicine can offer" as opposed to "the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk." The latter category of means are considered normally optional, although occasionally, the extraordinariness of the circumstances of the case may warrant measures beyond what is strictly obligatory in the preservation of life. Such circumstances include pregnancy, alleged crime, alleged malpractice, and genuine uncertainty in the mind of the person or persons with whom the authority for decisions rests.

26. The Latin text qualifies the word for "burdensome" with the adverb *"nimis."* Thus, it is clear that this statement refers not to those techniques which carry *any* risk or *any* burden, but to those which carry risk or burden *disproportionate* to their results.

27. *"Semper"* (Latin) and *"sempre"* (Italian) are not translated into the English text.

28. The Latin text is more emphatic than either the Italian or English: *"Imminente morte, quae remediis adhibitis nullo modo impediri potest".*

29. This connection is obvious in the English and Italian *("il prolungarsi di una vita infelice"; "prolungamento precario e penoso della vita")* versions of the text. The Latin version supports the parallel, although the terms used are not the same: *"infelicis vitae prorogatio"; "precariam et doloris plenam vitae dilationem").*

30. In this context, let it be stated once more that the moral standing of the healthcare facility is not determined entirely by the wishes of the patient. After the patient has reached a decision concerning the course of treatment, the healthcare facility remains bound to assess the moral implications of its own cooperation in the decisions of the patient.

31. The complexities which make this issue difficult to understand may also contribute to reducing or removing altogether any culpability, should an individual commit an error of judgment.

32. Nutrition and hydration are here treated as if there were no difference in their provision. This is an editorial convenience. It must be recognized that it may be the case medically that the provision of caloric nutrients may create complications which the provision of water does not. At such times, their provision should be regarded as separate life-preserving means.

33. It may be helpful to consider the distinction between keeping alive someone who is unconscious and keeping unconscious someone who is alive. The former may be achieved through artificial nutrition and hydration, for example, while the latter is achieved through any means which *imposes* unconsciousness.

34. This classifies the means of artificial nutrition and hydration among "the normal means that medicine can offer" as opposed to "the most advanced techniques," in the terms of the "Declaration." Means of artificial nutrition and hydration which normally can be maintained through skilled nursing are certainly among "the normal means that medicine can offer," given the state of care which can be expected from a professional healthcare facility.