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JOHN R. CAVANAGH, M.D.

Only a few days after I began my internship, I was confronted with a duty for which there probably can be no adequate medical school preparation. I received a call to go to the Sisters' Infirmary to pronounce a patient dead. I was not at all sure what the requirements were and was, shall I say, expecting something for which I was unprepared. My misgivings were soon forgotten as I entered the Infirmary. I am not sure just what I had expected, but the scene I encountered was one that has remained a beautiful memory to this day. Could I, I wondered — have turned into the chapel by mistake? There were nuns chanting the litany, their voices intoning the prayers in perfect unison. There were nurses in white, and student nurses in blue, kneeling and joining in the prayers. The assembly was in a semi-circle, and I perceived quickly that it was not formed around an altar, but was centered around a canopied bed on which reclined an elderly woman. On her face was the placid look of sleep. In her right hand was a rosary. I was so affected that for a moment my mission was forgotten and my misgivings totally allayed. I dropped to my knees and joined in the prayers for the dying. But one of the nuns soon recalled me to reality by tapping my shoulder gently and saying: "Doctor, Sister has been dead about ten minutes."

I have not seen many such scenes during my thirty years of practice, but I have not forgotten the beauty — the dignity — of this deathbed scene. True, I had not witnessed the actual death. I have never doubted, however, that the beauty and the dignity that I did witness were simply a prolongation of what was taking place as the woman died. It was apparent that the old nun had been at ease when she died — at ease spiritually, mentally, and physically.

Is this always the case? Obviously not. But let us examine the situation, at least from the medical viewpoint.

Dr. Cavanagh is a Fellow of the American Psychiatric Association and the American College of Physicians. He has served as president, secretary and is at present treasurer of the Guild of Catholic Psychiatrists; he is editor of their *Bulletin*. Dr. Cavanagh has published numerous articles and is author of the books, *Fundamental Marriage Counseling* and *Fundamental Pastoral Counseling*. He serves on the Board of Governors of the Catholic Physicians' Guild of Washington, D. C.

THE ACT OF DYING

The clinical picture presented by the dying patient is quite variable. Death may occur suddenly, but this is quite rare. The rapid occurrence of death is more frequent. In most cases, however, the death process is likely to last hours, days, or even months if the patient's fluid intake is maintained. The mental state of the moribund patient is also quite variable. He may be totally unconscious from the onset of his terminal illness as for example following a large cerebral hemorrhage. He may, however, retain complete consciousness with a clear sensorium up to moments before death. Recovery of complete clarity after periods of disturbed unconsciousness is not infrequent just prior to death. Perhaps the most common reaction is a gradual loss of consciousness, a gradual process of going to sleep. A final "sleep" seems to be the normal process of dying. It is only when some disease process is present that the onset of this sleep is disturbed.

Traditionally we have heard much about the "agony" of death, but there is very little to confirm this opinion. The labored breathing, the "death rattle," the muscular contortions of the dying individual may give this impression. These, however, are merely physical responses of the dying organism. Mentally, when the patient feels that death is near, and this is usually the case, his state of mind is peaceful. Our nature is such that we bear anxiety poorly. The anxiety of "not knowing" is overcome. Now he knows. Dying is easy for the dying.

All competent observers agree that there is no such thing as "death agony," except in the imagination. The contortions of the dying body, it is true, are sometimes distressing sights. They seem to be evidence of suffering, but it is seeming only. And yet many who are quite ready or even eager to leave this world dread the act of leaving.[1]

Clark agreed with this statement:

> One of the most common of these errors is the notion that pain and dying are inseparable companions. The truth is they rarely go together. Occasionally, the act of dissolution is a painful one, but this is an exception, and a rare exception, to the general rule.[2]
>
> The testimony of the dying, so long as they are able to give any testimony, is that their sufferings do not increase as the termination of life approaches, but on the contrary grow less.[3]

Sir William Osler described himself as "a student for many years of the act of dying." In 1888 Osler raised his voice of authority to combat the all-too-common notion that people who die suffer very much. Osler wrote:

> We speak of death as a king of terrors. Yet how rarely does the act of dying appear painful, how rarely do we witness agony in the last hours. . . . A friend who passed deep into the valley but to return spoke of the dream-like delicious sensation of the profound collapse in which he almost died. Shelley, when he said, 'Mild is the slow necessity of death,' was closer to the truth than was the idea of Newman in the *Dream of Gerontius*, who pictured death as a fierce and restless fight.[4]

He then continued:

> I have careful records of about five hundred death beds, studied particularly with reference to the modes of death and the sensations of the dying. The latter alone concerns us here: 90 suffered bodily pain or distress of one sort or another; 11 showed mental apprehension; 2 positive terror; 1 experienced spiritual exaltation, and 1 bitter remorse. The great majority gave no sign one way or the other.[5]
>
> The truth is, an immense majority die as they are born — oblivious.[6]

Philip is also of the same opinion:

> But of whatever kind and degree the previous suffering may be, and

by whatever cause produced, the last act of dying, in the common sense of the word, is still but the extinction of the sensibility, and consequently the termination of all suffering; and, as might from its nature have been foretold, so calm in general is this last act, that the most anxious observer often finds it impossible to ascertain the moment at which it takes place.[7]

Worcester quotes others as agreeing with him. I must say that my own experience is in accord with his statement:

> Many other physicians who have made it their practice to stand by their dying patients have stated that they never have had reason to believe there is any consciousness of suffering. Such has been my own experience.[8]

Thus it appears that most of the "agony" of dying is in the minds of those surviving and undoubtedly represents their own fear of death. The process of dying itself may prepare us for a peaceful death.

No one, certainly, would dispute the assertion that death *ought* to be peaceful. But is it so, in our society today? Bear in mind the picture of the deathbed scene of the old nun while I contrast it with the account given by Dr. Thomas T. Jones of Durham, North Carolina, of the death of one of his patients. The man was already dying of a major stroke when he underwent surgery for a gangrenous perforated appendix. Dr. Jones made the last of several visits to the patient.

> The son came from the room and urged me inside. This scene met my eyes: The surgeon was doing a 'cut-down' to restart an infusion; the nurse with mouth gag and suction apparatus was aspirating secretions from the throat; while the patient, already deeply cyanotic, began to have a series of convulsions and died.
>
> A picture of that moment remains with me, as I am sure it remains with the members of the family who were present, huddled in one corner of the room. They were barred from approaching the bed by oxygen tank, suction apparatus, tubes for suction, catheterization and infusion, as well as by members of the staff at the bedside who had completed the 'cut-down' and now were attempting artificial respiration.
>
> But the patient was dead. He was 92.[9]

Today the dying patient is so frequently surrounded by oxygen tanks, oxygen tents, nasal tubes, catheters, intravenous needles, and other gadgets that he looks like some complicated experimental animal. Farrell was prompted to say this about today's deathbed scenes.

> I submit that the deathbed scenes I witness are not particularly dignified. The family is shoved out into the corridor by the physical presence of intravenous stands, suction machines, oxygen tanks and tubes emanating from every natural and several surgically induced orifices. The last words, if the patient has not been comatose for the past forty-eight hours, are lost behind an oxygen mask.[10]

An anonymous widow, writing in the January, 1957 issue of the *Atlantic Monthly* said this of her husband's deathbed scene:

> The glaring, merciless rays from a powerful ceiling light displayed what was a human form, now portrayed in ghastly hue, in hunched position, with two tubes one in each nostril, eyes half open, breathing a noise of horror, while the oxygen tank at one side bubbled merrily, and the nurse stood counting the heartbeat, taking the pulse, I saw, I reeled, I froze to my depths. . . .
>
> When the first doctor came on duty I accosted him and begged that they cease this torture. He explained that except under the most unusual circumstances, they had to maintain life while they could. Very well, I thought, if it has to be so, so be it.

The *Atlantic*, in its prefatory comment concerning the article, said that our big metropolitan hospitals have "made of dying . . . an ordeal which has somehow deprived death of its dignity."[11]

What has brought about this change? Are we, as physicians, so strongly influenced by our feelings of omnipotence that we cannot give up our efforts even when death is clearly inevitable? Do we forget that when we were born, it was appointed for us to die? Do we take the death of a patient as a personal affront? Do we fail to make a distinction between "life-giving" and "life-prolonging" measures?

When death is inevitable, are we medically or morally justified in prolonging life just for the sake of keeping the patient alive for a few hours or even a few days? Must we use every possible "life-prolonging" measure in the irreversibly ill patient? Must we never pull out the tubes, take out the needles, or remove the oxygen tent as long as the subject breathes? Should we not remove these instruments which have ceased to have value and make up the bed and allow the family to share the terminal hours of consciousness, if any remain? Centuries ago Hippocrates forbade the administration of remedies to those beyond hope.

Before going ahead, a few definitions may help to clarify the situation. First, death itself: What is it?

DEATH

Death is viewed by the theologian, the philosopher, the lawyer, and the physician each in his own frame of reference. The pastoral theologian thinks of death primarily in terms of the administration of the last rites; the philosopher considers it in terms of separation of body and soul, the lawyer in terms of its naturalness, and the physician frequently thinks of it as a defeat. For our present purpose the main concern is with somatic death as it is understood by physicians. Robbins, a pathologist, defines somatic death in these terms:

> Somatic death refers to the death of the organism. For medico-legal purposes, it is said to occur when cardiac function ceases.[12]

Father Lynch gives a satisfactory definition of somatic death which agrees in its terminology with our thesis:

> Real medical death may be defined as the cessation of essential vital function beyond every reasonable hope of resuscitation.[13]

Father Lynch's definition is quite valuable for ordinary use. It covers eventualities such as temporary cessation of the heart beat which may be encountered in cardiac surgery.

Medical death is the concern of the physician and on this basis decisions concerning discontinuance of treatment and performance of autopsies must be decided. Theologians and philosophers have a common but differently oriented interest in the separation of body and soul. The theologian is concerned with the duration of the process since the last rites will be effective only as long as the body and soul are united. Most theologians seem to agree that the sacraments may be administered up to two hours after medical death. The philosopher states that we cannot be sure of separation of body and

soul until incipient putrefaction is evident. I prefer not to enter this discussion.

THE PHYSICIAN AND THE DYING PATIENT

In spite of the fact that every physician must have had many patients die while under his care, how many has he actually seen die? Probably not many. Is his failure to attend the dying a wish to deny the reality of death which arises out of its affront to his feeling of omnipotence? Dealing as he does, in association with the clergyman, with the intricacies of human life — with birth, life, marriage and death — he must, to sustain his own ego, develop great confidence in his diagnostic and therapeutic ability. This buttressing factor is outraged by the inevitable death of his patient. The physician's frustration at not being able to help and a reluctance to face the emotional scenes so frequently encountered in the death chamber incline him to separate himself from them. As a result of this and, I am sure, other factors, the dying patient is too frequently left in the care of internes, nurses, and auxiliary help.

If the physician thus severs himself from the dying patient, he is missing an important part of his therapy. Besides the comfort that his presence may give to the patient, it may also be a source of reassurance to the family. It will increase their confidence that everything is being done to ease the departure of a loved one. For the family this may be their first experience with death. They will need reassurance which only the physician can give. The clergyman, who is more frequently present on these occasions than the physician, cannot give the same type of help which the physician can give. The frequent questions of "how long?," "Is he suffering?," "Is there anything more which can be done?," "Is he dead?," can only be answered by the physician. The clergyman may offer comfort and hope concerning a life after death, but the physician must accept his full responsibility up to the moment of physical death. Worcester agrees with this opinion:

> Even when only watchful waiting is needed, the physician must not underrate the help that his mere presence may afford in steadying and comforting both the dying patient and the family. When apparently doing nothing, he yet may be doing much.[14]
>
> In the practice of our art it often matters little what medicine is given, but it matters much that we give ourselves with our pills. Until the doctor has had the sad experience of standing by to the very last those nearest and dearest to him, he can only imagine the heartache of his dying patient's family and their sore need of sympathy; nor until he himself has been nigh unto death can he more than imagine the comfort that the firm clasp of a friendly hand can give to one in such extremity.[15]

Medical students and nurses should be taught more about the dying process. They should be encouraged to continue their attendance to the moment of death. It is true that the physician may fulfill his legal obligation by informing the next of kin concerning the impending death of the patient and then instituting such measures as he deems adequate to care for the patient. I wonder, however, if he fulfills his moral obligation unless he makes frequent visits during the dying process and does not plan

to be present at least until consciousness is completely and finally lost?

But what of the physician's role in caring for a patient whose life is ebbing away? Here again, some definitions are necessary. Let me give mine:

a) *Reversible illness:* One from which recovery is possible.
b) *Irreversible illness:* An incurable illness, one from which there is no possibility of recovery.
c) *Dying process:* The time in the course of an irreversible illness when treatment will no longer influence it. Death is inevitable.
d) *Act of dying:* The final phase of the dying process, frequently referred to as the "death agony."

The distinction between a reversible and an irreversible illness is usually not difficult. Once a diagnosis is established, the prognosis usually becomes clear. In the irreversible illness the recognition of the onset of the dying process may be difficult at first, but should soon become clear. In the case of the youthful, previously healthy patient, the recognition of this change may be impossible. It is in the case of the older patient with a chronic, fatal disorder that transition to the actual process of dying may usually be determined without difficulty.

It is my conviction that when death is inevitable — when the dying process is beyond doubt — the patient should be allowed to die in dignity unencumbered by useless apparatus. His family and friends should be in attendance at his bedside, not seated in some hospital alcove. His care should not, however, be left to attendants. His physician should be in frequent attendance as long as the patient is conscious or is likely to remain so.

When it is determined that the actual process of dying has begun, restorative measures should be discontinued because they are unavailing. The exception here should be the youthful, previously healthy patient, for whom treatment must be vigorously pursued up to the very act of dying.

Not unseldom, a patient who has an irreversible disease in the dying phase develops an intercurrent disorder such as pneumonia. This presents a somewhat different problem. Should the intercurrent disorder be treated vigorously with antibiotics and blood transfusions in the fatally ill patient? I think not. This situation should be treated as the basic condition would be treated, i.e., with only ordinary methods of treatment.

We must recognize that the choice of further treatment may not be that of the physician. The patient has the first claim on what is to be done and if he indicates that his choice is to employ every possible means to prolong life as long as a spark remains, his wishes must be given primary consideration. It is unlikely that he will do so. The second choice will be with the family who may wish to pursue treatment vigorously as long as life remains. If this is their desire, it must also be given serious consideration. The family, however, will usually be guided by the advice of the attending physician, who should bear in mind that the prolongation of life in the dying patient

by extraordinary means is neither morally nor medically indicated.

ETHICAL CONSIDERATIONS IN THE DYING

I should like to make my position clear. What I am suggesting is not euthanasia. Euthanasia is the employment of some direct means with the goal of shortening the life of the patient. Dr. Jones of Durham coined the word *agathanasia* from the Greek to describe "a good death," or "a death with dignity."[16] But to preclude any confusion with so-called euthanasia, I prefer my term, from the Latin —*Bene mori. Bene mori* means only that when death is inevitable, all the extraordinary means of treatment should be discontinued and only natural means should be employed. The patient should be allowed to die naturally, in dignity, and with proper decorum.

Moralists make a distinction between different classes of therapy. These are classified as *natural, ordinary,* and *extraordinary.* Natural means of preserving life include normal nursing care, feeding by mouth, giving fluids by mouth by spoon feeding if necessary, the relief of pain, insomnia and mental anguish. For practical purposes *ordinary* means would seem to be a slight extension of this so as to include common artificial procedures. Father O'Donnell states that the most commonly available technics of modern surgery and medicine should be classified as ordinary means.[17] Father O'Donnell also speaks of intravenous fluids as an ordinary means of preserving life.[18] Both of these statements of Father O'Donnell would need clarification in practice. As a matter of fact, he, himself states that all these terms are relative. In practice the intravenous fluid might be a *useless* means. We would have to ask ourselves many questions concerning its use, e.g., why is the fluid being given? Is there any chance it will reverse the dying process? Is the process reversible? Are there veins to be used? Must we cut down on the veins? Is it being done merely to prolong life when there is no hope of recovery? Does the physical condition of the patient warrant its use? How long will it prolong the life of the patient? What is the state of consciousness of the patient? What is the diagnosis? Father Kelly agrees that intravenous feeding, in itself, is an ordinary means, but states that "the mere prolonging of life in the given circumstances seems to be relatively useless." Father Kelly also points out that merely because a means is in the medical sense ordinary it is not necessarily obligatory.[19]

Extraordinary means are those not readily or usually available; they may be of an experimental nature; they are not likely to cure; they are unlikely to reverse the dying process, they are expensive; they are painful and may be repugant to the patient or his family. Father O'Donnell states that all modern moralists would agree that means which would involve extreme pain, danger of death, excessive expense, or great subjective repugnance would be classified as extraordinary. *In the dying patient only ordinary means of treatment need to be employed.*

EXTRAORDINARY METHODS

What are we to think when one of the extraordinary methods of treatment is instituted? Today when the life of the patient may be prolonged by the use of the artificial kidney, by the use of an "iron lung," by an artificial pacemaker for the heart, by a shunt of blood which by-passes the heart and even the lungs, we must sooner or later ask ourselves when shall we stop their use? Who shall give the order? When the patient's life is being maintained by any of these methods, would it be murder if their use was discontinued by the physician or insisted upon by the family? Would it be suicide if the patient insisted on stopping their use or actually interfered with their employment? Should the patient be asked whether they should be continued or discontinued? This would be equivalent to saying, "Are you prepared to die?" It would seem too much of a decision to ask the patient to make. Being asked to make such a decision would throw most families into turmoil and would be a potent source of future guilt conflict in those who made the decision. In any case in which such a decision is to be made, it should be made by the physician in charge of the case.

His decision should be based on the opinion that the continuation of such a procedure has no curative value and will only prolong the process of dying. There would not seem to be any question of euthanasia in such cases since these measures are employed only to forestall inevitable death. Such discontinuance, according to Marshall, would not be suicide if instituted by the patient "for suicide is the direct taking of one's own life either by a deliberate positive act, or by the omission of an ordinary means which is essential for the maintenance of life. To discontinue an extraordinary measure is not suicide." "Neither would such an act be murder," Dr. Marshall continues, "for murder requires that the act must be a direct positive act, or must involve the deliberate omission of some ordinary means to preserve life.[20] With these opinions I am in full accord. Such a decision would indeed be hard for most physicians; because they are in conflict with the tradition of medicine to maintain life as long as possible.

What about the use of sedatives in the dying patient? This need not be a source of concern when they do not *directly* contribute to shortening the life of the patient. The principles concerning this are clearly stated in Directive 23 of the *Ethical and Religious Directives for Catholic Hospitals* published by The Catholic Hospital Association:

> It is not euthanasia to give a dying person sedatives merely for the alleviation of pain, even to the extent of depriving the patient of the use of sense and reason, when this extreme measure is judged necessary. Such sedatives should not be given before the patient is properly prepared for death (in the case of a Catholic, this means the reception of the Last Sacraments); nor should they be given to patients who are able and willing to endure their sufferings for spiritual motives.[21]

Pope Pius XII carried this point further. The Italian Society for the Science of Anaesthetics had put to him the question as to whether it is morally

lawful to give sedation to relieve a patient of pain if the use of the sedation would at the same time shorten the patient's life. He replied in the affirmative, in an address on February 24, 1957, saying:

If there exists no direct causal link, either through the will of interested parties or by the nature of things, between the induced unconsciousness and the shortening of life . . . and if, on the other hand, the actual administration of drugs brings about two distinct effects, the one the relief of pain, the other the shortening of life, the action is lawful. . . .[22]

CONCLUSION

In conclusion, I would urge that we all promote the idea of *bene mori*, a dignified, pleasant death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life, is never justified. *Bene mori*, that is allowing the patient to die peaceably and in dignity, is always justified.

Shakespeare must have had something of this in mind when in *King Henry VI* he has Salisbury say concerning Cardinal Beaufort, "Disturb him not, let him pass peaceably."[23]

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