

CATHOLIC PERSPECTIVES: SUPPORTING ADVANCE HEALTH CARE PLANNING FOR THOSE WITH COMPLEX HEALTH SITUATIONS

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OBJECTIVES

- Deepen understanding and awareness of key Catholic moral teaching in response to advance care planning scenarios and questions
- Develop greater comfort in the topic of end of life decision making
- Understand resources available for use in supporting end of life decision making.
- Have the freedom to voice and address pressing questions on end of life decision making

THE THREE R'S

- What **R**esonates with you?
- What needs **R**evue?
- What do you **R**eject? (What is not aligned with your beliefs and values) – How do you articulate this?

**“WHEN HEALTH FAILS, A PERSON
IS EXPELLED INTO A STRANGE
LANDSCAPE FOR WHICH HE OR
SHE HAS NO MAP.”**

John O'Donohue



ACKNOWLEDGING THE MYSTERIES

- Why do bad things happen to good people? (Harold Kushner)
- Suffering and death are mysteries and require faith, hope, and the love of a supportive community
- Death is an act, “beyond our control, yet also a personal act in which the freedom of the person is intimately involved”.¹

ETHICS

- A system of values and principles which tie together in a reasonable and coherent way to make our society and our lives as civilized and enriching as possible.
- Answers two questions:
 - What do we value?
 - How should we live?

-Rose Mary Volbrecht, PhD

SANCTITY AND DIGNITY OF LIFE

- Imago Dei – we are made in the image and likeness of God.
- “Life is entrusted...as a treasure which must not be squandered, as a talent which must be used well.”
(Evangelium Vitae #52)
- In what ways can we experience the final days and moments on earth as growing in the depth and dignity of human life

DYING WELL

- “Life is a gift from God...Death is Unavoidable”*
- Any medical treatment at this critical point must aim at not simply prolonging life, but at reducing the human diminishments of the dying process, maximizing the values the patient treasured throughout life, and bringing comfort.
- Advances in technology may certainly help people live longer, but at a cost – modern medicine has enabled death and dying’s medicalization, a once deeply personal and communal experience. (Whole Person Care Initiative - returning to our common human and Christian roots)
- * CDF Declaration on Euthanasia

ISSUES IN CARE FOR THE SERIOUSLY ILL AND DYING

- Church witnesses to her belief that God created persons for eternal life. This is the basis of hope.
- Those who are dying should be supported by a respectful, loving, and supportive community
- Relief of pain & suffering is a primary purpose. Palliative care rooted here.
- Duty to preserve our life, but it is not an absolute duty, because persons are made for eternal life with God.

ISSUES IN CARE FOR THE SERIOUSLY ILL AND DYING

- May reject procedures that, in patient's judgment are insufficiently beneficial or excessively burdensome.
- Suicide and euthanasia are never morally acceptable options.
- Medicine's task is to care, even when it can't cure.
- Technology is evaluated relative to human dignity.
- Avoid two extremes:
 - Employing useless or burdensome means (Medical Vitalism or Life at all costs)
 - Withdrawing technology to cause death (We are stewards, not owners, of our lives)*

*Coleman, G.D. Subjectivism, Vitalism? Catholic Teaching Avoids Extremes. *Health Progress*, January – February 2014

HOW MUCH TREATMENT IS ENOUGH?

- Mainstream position rejects two extremes:
 - Vitalism
 - Persons are always morally obligated to use medical treatments unless the procedures are clearly useless for prolonging life. Biological existence is an absolute moral value.
 - Biological life at all costs
 - Libertarianism/Subjectivism
 - Persons are never morally obligated to use medical treatments; individual self-determination is the absolute moral value.

KEY QUESTIONS AND CONTEXTS

- Euthanasia
- Physician Assisted Suicide
- Considering Life Prolonging Treatments
- Medically Assisted Nutrition and Hydration (Tube Feeding)
- Pain Management and the Principle of Double Effect
- Surrogate Decision Making (Advance Directive)
- POLST

COMMON MISPERCEPTIONS

- Euthanasia
 - Action or Omission that by itself or by intention causes death in order to alleviate suffering. (ERD #60)
- Physician assisted suicide:
 - Where a terminally ill person (diagnosed with less than 6 months to live [also Hospice eligible], obtains a life ending prescription from a licensed physician after moving through a process spelled out in CA State statute (End of Life Option Act). The pills are intended to end one's life.

EVANGELIUM VITAE

#65

- Euthanasia must be distinguished from the decision to forego so-called "aggressive medical treatment", in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience "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".
- **Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.**

VATICAN DECLARATION ON EUTHANASIA

- Today 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, denying the right to die peacefully with human and Christian dignity.
- [Modern medicine has “medicalized” dying whereas our heritage tells us that both birth and death are communal and profoundly human experiences.]

PHYSICIAN ASSISTED SUICIDE

- Also known as:
 - PAS; End of Life Option Act (CA law); Death with Dignity
- Proponents cite autonomy as primary goal (Libertarianism)
- “To live in a manner worthy of our human dignity, and to spend our final days on this earth in peace and comfort, surrounded by loved ones --- that is the hope of each of us. In particular, Christian hope sees the final days as a time to prepare for our eternal destiny.” – *USCCB Statement on Physician Assisted Suicide*

USE OR REFUSAL OF LIFE PROLONGING TREATMENTS

- The truth that life is a precious gift from God has profound implications for the question of stewardship over human life..We are not the owners of our lives and,, hence,, do not have absolute power over life..We have a duty to preserve our life and to use it for the glory of God,, but the duty to preserve life is not absolute, for we may reject life - prolonging procedures that are insufficiently beneficial or excessively burdensome.” Introduction to Part 5 of ERDs.

LIFE-PROLONGING CHOICES PRINCIPLES

- Morally obligated to use treatment that is
 - Available
 - Beneficial (from perspective of the patient)
- Moral option to use or to refuse to use treatment that is:
 - Ineffective, futile
 - Too burdensome (from perspective of the patient)

STANDARDS FOR BURDENS

- Burdens are evaluated from the patient's perspective
 - Grave pain or suffering
 - High risk of injury or mortality
 - Excessive financial burden
- Quantity of life
 - Keep alive
 - Procrastinate dying
- Quality of life
 - Help live
 - Promote living

A KEY MYTH:

SIMPLICITY

Simplicity

- Napoleonic Law vs. Anglo-Saxon Law
 - Maximalist vs. Minimalist
- Case and Individually Specific
 - There is no simple answer to these questions
 - What one person may find worth suffering through may be too much for another...and both may be valid

KEY MYTH

MAINTENANCE

- “Now that Grandpa’s hooked up to all these machines, we’re stuck. He never would have wanted this. Why didn’t we just listen to him in the first place?”
- Generally, the same moral and ethical considerations should apply to starting as to stopping a treatment.
- Whatever moral assessment justifies withholding a treatment should also justify withdrawing it.

MEDICALLY ASSISTED NUTRITION & HYDRATION

- “In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally...Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be excessively burdensome to the patient” (ERD #58)

PAIN MANAGEMENT – ERD #61

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

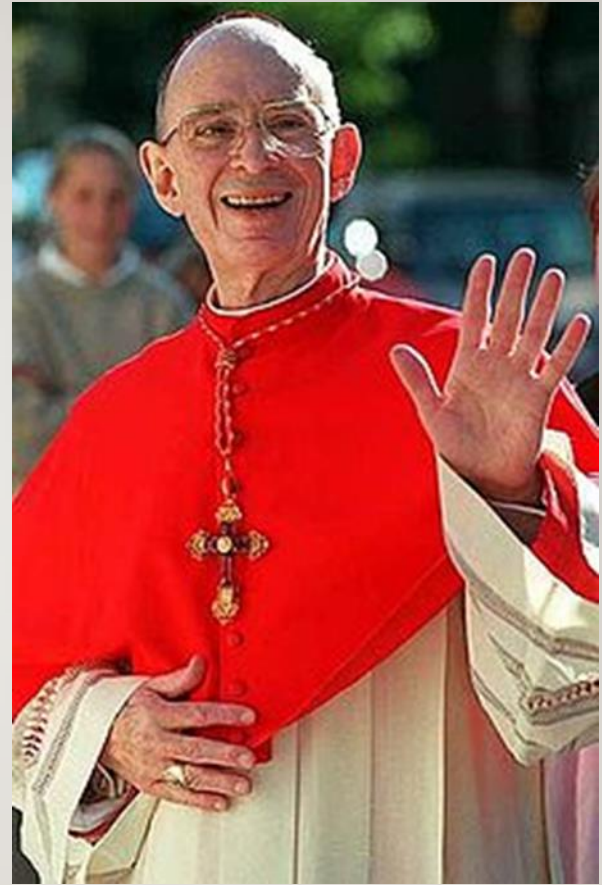
PAIN MANAGEMENT

- "If no other means exist, and...in this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine." – Pius XII (CDF's Declaration on Euthanasia)
- Medication capable of alleviating pain may be given to a dying person even if it indirectly shortens the patient's life, as long as the action is a good action, the intent is not to hasten death *and* the medication is titrated to the pain.

WHAT DOES OUR FAITH ASK OF US?

- Nourish Hope
- Listen and Speak with Compassion
- Support Dignity and Honor where you and your loved ones are at
- Sustain Meaning in the midst of suffering
- Enhance Relationships





Yesterday is gone. Tomorrow has not yet come.
We have only today. Let us begin.
- Joseph Cardinal Bernardin

PRIMER – MEDICAL DECISIONS WHEN THEY COUNT MOST

- Source for following 4 slides - Sacramento Coalition for Compassionate Care



A CENTURY OF CHANGE

Early 1900s:

Today:

Life expectancy

Cause of Death

Purpose of Medicine



Only 25%
of Americans ...

WHAT IS AN ADVANCE HEALTH CARE DIRECTIVE?

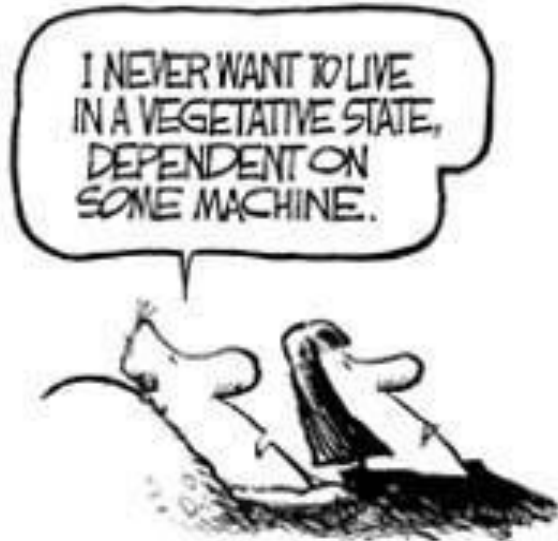
- A way to make your health care wishes known.
- Allows you to:
 - Appoint a decision maker.
 - Write down your health care wishes.
- Also known as or previously called...

ADVANCE CARE PLANNING IS A PROCESS

- Reflect
- Select spokesperson
- Talk about wishes
- Complete advance healthcare directive
- Distribute copies
- Review periodically (5 **Ds**)

WHO DO I CHOOSE AS MY AGENT?

- A person you trust to make the decisions you want
 - Familiar with your values
 - Willing and able
- Doesn't need to be a family member
- Select alternate
- Tell others who you chose, why



DECISION MAKING CAPACITY, AGENTS, SURROGATES, AND ALTERNATE DECISION MAKERS

- Each person who is decisionally capable is the primary decision-maker regarding his or her own care
- Decisional capacity is presumed unless it is clearly established that the patient lacks any of the following 3 abilities
- Ability to **understand** information relevant to the decision
- Ability to **consider** alternatives and make a decision
- Ability to **communicate** decision

FAMILIES' ROLE IN DECISION MAKING

Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions.. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values,, or if the person's intentions are unknown,, to the person's best interests.. In the event that an advance directive is not executed,, those who are in a position to know best the patient's wishes – usually family members and loved ones, should participate in treatment decisions for the person who has lost capacity to make health care decisions.” (ERD #25)

- Do you encourage parishioners and families to have these conversations?
 - Why or why not?



QUESTION AND DIALOGUE

5 MIN EXERCISE

- What resonates with you?
- What needs review?
- What questions do you think you will be asked when supporting someone through advance care planning? How will you respond?

RESOURCES

- Diocese of Sacramento: Whole Person Care website (www.scd.org/wpc)
- California Catholic Conference (www.cacatholic.org)
- Alliance for Catholic Healthcare (www.thealliance.net)
- California Coalition for Compassionate Care (www.coalitionccc.org)
- 5 Wishes (<https://www.agingwithdignity.org>)
- State of California Advance Health Care Directive
 - <https://oag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirectiveForm-fillable.pdf>
- Dignity Health's Mercy Faith and Health Partnership
 - Susan Taylor, RN