

The Ethics of Care of the Dying Person



I. A Catholic Ethical Framework

1. The Catholic tradition has developed, through many centuries of reflection, a rich strand of thought and practice on what constitutes a good death and on the ethics of care for people who are dying. In recent times this has been articulated by popes and by Vatican documents including: *Declaration on Euthanasia* (1980); *Evangelium Vitae* (1995); *The Catechism of the Catholic Church* (1997); and 'On Life-Sustaining Treatments and the Vegetative State' (2004). This authoritative teaching provides guidance for Catholics on the ethics of treatment and care towards the end of life.
2. The same teaching is presented in several documents of the Catholic Bishops' Conference of England and Wales including: *Cherishing Life* (2004); *The Mental Capacity Act and 'Living Wills': a practical guide for Catholics* (2008); and *A Practical Guide to The Spiritual Care of the Dying Person* (2010).

The governing principle

3. The life of every human being, as made in the image of God, possesses an intrinsic worth or dignity which must be given strict respect in accordance with the fundamental requirements of justice.

Basic guidelines

4. The governing principle means we should not refuse medical treatment or ordinary care motivated by the thought, 'I no longer have a worthwhile life'. Such refusals deny the intrinsic worth of life and they make death the object of the refusal. They are suicidal. If a refusal by a proxy decision-maker is based on the judgment, 'he/she no longer has a worthwhile life', this is euthanasia.
5. Euthanasia is 'an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering' (*Evangelium Vitae*, 65). Euthanasia (sometimes euphemistically termed 'assisted dying') involves the unjust and morally unacceptable killing of a human person, it endangers and fails to respect the equality of people with disability and it harms the common good of society.
6. Due respect for my life generally obliges me to accept ordinary care and non-futile, non-burdensome medical treatment. However, due respect for my life

is compatible with the judgment, ‘this medical treatment is no longer worthwhile’,

- either because it no longer serves its purpose (is **futile**),
 - or because it is excessively **burdensome**: the burdens may be physical, psychological, social, or economic,
 - or because it promises **too little benefit relative to the burdens it entails** (even if those burdens are bearable).
 - Note that judgments about what counts as excessively burdensome are relative to *my* sensitivities, sensibilities, physical condition and social situation, so they are necessarily made by me if I am competent. In the case of previously competent but now incompetent patients, judgments about what is excessively burdensome should take account of reliable testimony to their previously expressed statements about what they would find burdensome. In the case of patients who have always been incompetent account should be taken of reliable testimony to their sensitivities.
7. In 2004, Pope John Paul II made it clear that clinically assisted nutrition and hydration is ordinary care and ‘in principle obligatory’. In contrast, since the 1993 Bland judgement, the law in the United Kingdom has permitted some profoundly disabled patients to be deprived of clinically assisted nutrition and hydration even if it is successfully sustaining their life and is not burdensome to them. This withdrawal of basic sustenance, without overriding reason, amounts to unjust killing. Nevertheless, the in-principle ethical obligation to provide clinically assisted nutrition and hydration may not apply in some dying patients if it would not succeed in prolonging life or in alleviating their symptoms relative to the burdens it entails.
 8. Our responsibilities and relationships with others and the central importance of our relationship with God require that we should seek to remain conscious throughout the process of dying, where we would normally be conscious. There are appropriate reasons for use of sedatives, even though this may lead to some clouding of consciousness/ drowsiness. Exceptionally, for example, if someone were in severe intractable pain that could not be alleviated in any other way, it would be permissible to sedate that person to the point of unconsciousness. Given advances in palliative medicine, this should rarely be necessary. It is quite common that people slip into unconsciousness naturally as part of the process of dying, but it is not right deliberately to deprive a dying person of consciousness without a serious reason.