A Compassionate Death: Palliative Sedation and Analgesia at the End of Life in Catholicism

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by
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**Introduction: The Crossroads of Faith, Medicine, and the End of Life in Catholicism**

The sun is setting as I get dropped off by my Uber driver and walk towards Pope St. John XXIII National Seminary. The gray concrete exterior is surrounded by serene green pastures, a fitting scenery for a place of learning and contemplation. An elderly gray-haired reverend notices me waiting outside and opens the door for me, as the entrance is restricted by card-swipe access. The door opens to a hallway spanning left and right, and faces a small lobby area with sofa chairs and an artificial fireplace. I sit down comfortably and review my prepared sheet of questions. A few minutes pass and Reverend Yavarone walks down the hallway towards me and I stand up to greet him. I then follow his lead down the hallway to the seminary library, surrounded by glass windows on all sides. We enter into a study room, and take our seats.

Every weekday, Reverend Yavarone drives from his communal home in Back Bay, Boston, where he lives with his fellow oblates of the Virgin Mary, to Pope St. John XXIII National Seminary for his daily lectures. The seminary is known for being home to one of the oldest seminarian populations in the U.S., as it the only Catholic seminary to offer a graduate-level program designed for priesthood candidates aged 30 years and above, called “second-career vocations” or “delayed vocations.” There, Rev. Yavarone teaches a course on Catholic Bioethics. On Sundays, he leads mass at St. Francis Chapel in the Prudential Mall on Boylston Street in Boston. The chapel is surrounded by commercial stores in the midst of a bustling city center. When he is not teaching or serving at the chapel, Rev. Yavarone speaks in public forums on Catholic bioethics. Every year, he is invited to speak at the Annual Divine Mercy Medicine, Bioethics, and Spirituality Conference held at the College of the Holy Cross in Worcester, Massachusetts.
My meeting with Rev. Yavarone was my first in-person interview and marked the beginning stages of my fieldwork on the subject of palliative sedation and analgesia at end of life in Catholicism in the U.S.

What is the relevance of end-of-life care issues in the U.S. today? As the U.S. population of the elderly is growing exponentially, the country is faced with the inevitable dilemma of how to best care of the elderly. As of 2015, the number of people 65 and older in the United States accounts for 14.9% of the population, 1.6 million more than the 2014 figure (“FFF: Older Americans Month”). In 2060, the U.S. Census Bureau projects that people 65 and older will comprise of nearly one in four U.S. residents. Accompanying the debates over how to best care for the country’s elderly is end-of-life care, which in itself is composed of many controversial elements as I will later explore. To further complicate end-of-life discourse, a vast majority of non-profit healthcare facilities in the U.S. are self-described Catholic hospitals, and thereby adhere to the Ethical and Religious Directives (ERD’s) for Catholic Health Care Services written by the United States Conference of Catholic Bishops. According to the Catholic Health Association of the United States, Catholic healthcare organizations comprise of more than 600 hospitals and 1,600 long-term care facilities out of 5,534 total registered hospitals and 15,219 total nursing homes, which makes it the largest group of nonprofit healthcare providers in the country (“Fast Facts on U.S. Hospitals, 2018”). To put that figure into perspective, one in six patients in the U.S. is cared for in a Catholic hospital every day.

As Catholic healthcare facilities are becoming more widespread, so are controversies over faith-based medical care that may conflict with patients’ wishes and cause misunderstandings between doctor and patient. A non-profit organization that advocates for civil liberties called the American Civil Liberties Union, or ACLU, is spearheading the opposition to
Catholic hospitals, alleging that Catholic hospitals that follow Catholic ERD’s “use their religious identity to discriminate against, and harm, women” in cases of refusing to perform abortions or providing reproductive services (“Why Is the A.C.L.U. Targeting Catholic Hospitals?”). These controversies over issues such as women’s right to abortion and others, shed light on the growing clash between Catholic faith-based medicine and its liberal opponents who argue for a neutral and non-faith-based form of care in Catholic hospitals.

Aside from reproductive rights, the topic of end-of-life care—specifically the way in which palliative care is provided to terminally ill or elderly patients—also incites disagreement between Catholic and non-Catholic healthcare advocates. In Catholic end-of-life care, particularly in Catholic hospices, providers adhere strictly to the ERD’s. The ERD’s mandate that Catholic healthcare facilities take extra precaution to ensure that providers use “ordinary or proportionate means” of preserving life, while strictly prohibiting any form of euthanasia or actions that intentionally induce death (Catholic Church). More importantly, Catholic ERD’s mandate that patients should be kept “as free of pain as possible so that they may die comfortably and with dignity” (CC). As such, patients should also “not be deprived of consciousness” so that they may prepare for their deaths (CC). The requirement for Catholic providers to ease the pain of their patients on the deathbed with palliative drugs such as morphine and other opioids challenges doctors and nurses to avoid potentially hastening the death of the patient, as these drugs may cause lethal respiratory depression. The Catholic ERD’s recognize this dilemma, stating that “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” (CC). This principle is also known as the principle of double effect, which states that an action is permitted if it has the potential to cause harm as a “double
effect,” such as hastening the death of a patient, as long as it is intended to bring about a good end, such as relieving extreme pain.

How do Catholic hospitals navigate the principle of double effect in the administration of palliative opioids in the context of our nation’s opioid crisis? How do Catholic and non-Catholic hospitals and hospices avoid “stealth euthanasia” when administering palliative drugs, and adapt to the shift towards acceptance of physician aid-in-dying? How does the approach of Catholic hospices in pain management differ from that of non-Catholic hospitals and hospices? How will faith-based medicine maintain its basic moral principles as Catholic hospitals continue to merge with non-Catholic healthcare organizations? These are the questions that I will seek to address and illuminate in this thesis.

Methods

This thesis focuses on the issues surrounding the administration of palliative drugs, specifically morphine and other opioids, in end-of-life care in Catholic and non-Catholic hospices in the U.S. I was able to collect interview data from first-hand participants in morphine administration such as hospice doctors and nurse practitioners, as well as professors and researchers of Catholic and Protestant Christian theology and medical bioethics by means of in-person and Skype interviews.

Over a period of four months, I contacted various Catholic hospices by researching hospice webpages listing public contact information. I also called direct lines to hospices’ informational desks, and was transferred to the appropriate contact persons for interview inquiries. Additionally, I emailed hospice administrative staff explaining my thesis and the importance of their contribution to my research. I utilized LinkedIn, a social media platform for
professional use, to search for healthcare professionals, including doctors and nurse practitioners, and messaged them directly to request interviews.

Similarly, to interview Catholic priests and seminary professors, I researched Catholic churches in the Boston area, and emailed the work email addresses of church staff with interview inquiries. On multiple occasions, Catholic priests and church staff would respond with a referral to a more experienced colleague in the field of bioethics who would be willing to be interviewed.

After receiving responses from email inquiries or over the phone, I would then send a more detailed email asking for the interviewee’s availability to schedule a 45 minute to one hour interview either in person (if in the Greater Boston Area) or a Skype phone call. I also provided my interviewees with the digital consent form and information sheet to be signed and returned to me at earliest convenience. If interviewees requested an in-person interview, we would then negotiate an appropriate meeting place, date, and time for the interview.

At the agreed upon time, I would call or meet my interviewees in person. During interviews, I would have a prepared set of questions tailored to my interviewee’s position and experience on the subject of end-of-life care and palliative sedation and analgesia. However, most of my interviews were fluid, and would progress as a natural conversation in different directions led by the interviewee.

In conjunction with my interviews with experienced Catholic and non-Catholic healthcare practitioners and Catholic priests and authorities on Catholic bioethics, I also searched online research databases for relevant studies and primary resources for Catholic teachings that affirm or further illustrate the points made by my interviewees. Additionally, I researched news articles on controversies surrounding Catholic hospitals and hospices adhering to the ERD’s, as well as latest developments on the U.S. opioid crisis.
Significance of Work and Definitions

I first became interested in the field of medical anthropology in my sophomore year of undergraduate college, when I took a medical anthropology course entitled, Medicine, Body, Culture taught by Professor Anita Hannig. In that course, I learned that Western biomedicine is only one, albeit the most widely used, form of ethnomedicine, or traditional medicine, that exists in the world. Through cross-cultural analyses of various fieldworks and anthropology texts, the course exposed me to a wide range of cultural notions of the human body, medicine, and healing among different societies—including those of Chinese and Papua New Guinean peoples, and compared them to those that we have in the U.S. For the first time, I understood the relevance of culture in medicine and the necessity of the field of medical anthropology to illuminate different worldviews and foster cross-cultural understanding. The following year, I took an experimental anthropology course on the Anthropology of Death and Dying, also taught by Professor Hannig, which focused on the ways in which different cultures view death and dying, and how their conceptions of death are revealed in their different funerary and burial customs. This course exposed me to the variety of ways in which cultures cope with the end of life stage. In the final leg of the course, my peers and I shifted from studying death and dying in unfamiliar cultures to our own. We read the required text, “Being Mortal,” by Atul Gawande, which addresses the failure of the Western biomedical profession in the U.S. to prepare people for the inevitable reality of aging and death.

While reading “Being Mortal,” I first became aware of the complexity of aging and dying in American culture, and how doctors and other healthcare providers have trouble reconciling their professional responsibility to save lives with the inevitability of death. Doctors’ inability to come to terms with the limitations of Western biomedicine leads them to perform extreme
procedures that provide patients with false hope, and often result in the patients’ diminished quality of life or even shortens patients’ lives. In addition to reading “Being Mortal,” my peers and I learned about the Death with Dignity movement in the U.S., or the advocacy for the legalization of medical aid-in-dying in the U.S. In this section of the course, my peers and I debated issues such as the level of autonomy patients should have over their end of life decisions, and whether or not doctors should be allowed to prescribe medications intentionally to hasten the deaths of their patients.

Altogether, these two courses shaped my interest in medical anthropology, and more specifically, in the culturally-shaped notions of aging and death in the U.S. that manifest in the ways in which doctors care for patients at end of life. After taking the Death and Dying course, I was left intrigued by some remaining questions, including, how can doctors better prepare their patients for the end of their lives? and how much should patient autonomy play into doctors’ decision-making? Additionally, I wanted to explore the roles of faith and religion in end-of-life care, as religion is closely related to people’s conceptions of death. With guidance from my advisor, Professor Hannig, who is now conducting fieldwork in Oregon on the effects of the Death with Dignity Act for her next research endeavor, I decided to pursue a thesis project on the subject of palliative sedation and analgesia at end of life in Catholic hospitals and healthcare organizations.

Palliative sedation, by definition, is the use of drugs called sedatives to relieve extreme suffering by making the patient calm, unaware, or unconscious (“NCI Dictionary of Cancer Terms”). Palliative sedation is typically performed on patients who are in the end-of-life stage, either in palliative care or hospice, and have symptoms that cannot be alleviated by other treatment. It is meant to make patients more comfortable, and not to hasten death. Examples of
sedatives include Xanax (or alprazolam), Valium (or diazepam), and Ativan (or lorazepam). Palliative analgesia, on the other hand, involves the use of analgesics, a different class of drugs from sedatives. Analgesics are designed to relieve pain without the side effect of loss of consciousness. They include narcotics such as morphine and other opioids, and nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and naproxen (“Analgesics”).

Palliative sedation poses a unique problem in Catholic faith-based medical care, as it induces a state of unconsciousness in the patient, which the Catholic Church considers immoral and unethical as it deprives a patient of his or her ability to partake in sacraments, and effectively removes patient autonomy. The use of analgesics, most commonly morphine, in end-of-life care is also problematic in Catholic healthcare, as it holds the potential to cause respiratory depression and subsequently hasten the death of patients.

The term for this dilemma in healthcare is neatly summed up in the principle of double effect. The principle of double effect, or the doctrine of double effect, is historically rooted in Catholic moral theology and holds that an action is morally permissible only if it meets four specific conditions. The four conditions of the principle of double effect include: first, that the action in itself must be either morally good or neutral; second, that the bad result of the action must not be directly intended; third, that the good result must not be the direct result of the bad result; and fourth, that the good result must be proportionate to the bad result (“The Principle of Double Effect”). The principle of double effect is often used in Catholic and even non-Catholic discourse to justify the practice of palliative sedation and analgesia, and is used by physicians and other healthcare providers to guide their decisions in end of life care.

Plan of Work
In the following chapters, I will cover the various facets of palliative sedation and analgesia in Catholicism and relevant controversies in Catholic faith-based medicine in the U.S.

In Chapter 2, I will explain the way in which Catholic believers perceive suffering in Catholicism—specifically, the Catholic belief in “redemptive suffering,” and how redemptive suffering can be achieved by the refusal to receive pain medications at end of life. I will contrast this with the non-Catholic view of suffering, as described by my interviewees, as “useless” and a bad that must be overcome by advances in pain relief with analgesics and sedatives. I will end the chapter with a discussion of how the non-Catholic view of suffering is related to the growing opioid epidemic in the U.S., and how the epidemic has affected the practice of administering opioids in Catholic and non-Catholic hospices and hospitals.

In Chapter 3, I will describe the major points of controversy in Catholic faith-based medical care, specifically on the subjects of abortion and the death penalty. I will relay specific cases of conflict between the Catholic Church and non-Catholics over Catholic hospitals’ refusal to perform abortions or provide reproductive services. I will also explore the growing acceptance, both legal and social, of physician aid-in-dying, and how this shift poses concerns for Catholic healthcare providers and organizations. Finally, I will address the increasing partnerships and mergers of Catholic hospitals and secular healthcare facilities, and how this trend may potentially undermine adherence to Catholic ERD’s in Catholic hospitals.

In Chapter 4, I will be quoting my interviewees on the principle of double effect of opioids and more generally, the principle of double effect as a whole, and how clinicians adhere to the principle of double effect in practice. I will then discuss the alleged overemphasis of this concept in end-of-life care. I will also relate the principle of double effect to the practice of palliative sedation, and how practitioners decide when sedation is appropriate for a patient. I will
then address the way in which intention of healthcare practitioners plays into the principle of double effect, as well as the roles of family members and healthcare proxies in deciding the plan of care for patients who are unable to communicate due to cognitive or other disabilities. Finally, I will explore the importance of patient autonomy in making end of life decisions, and how palliative sedation and analgesia may undermine patient autonomy.

In Chapter 5, I will define “extraordinary” and “ordinary” means of intervention by quoting one of my interviewees, a Catholic seminary Professor of Bioethics. I will also present notable landmark cases in the death with dignity movement, which have helped to define these terms in the U.S. legal system. Lastly, I will explore the case for palliative sedation and analgesia as a means for “stealth euthanasia” by citing clinical studies and quoting my interviewees who have direct clinical experience with administering morphine and other opioids.

In my conclusion, I will review the major findings from my research and attempt to answer the questions presented above. I will also explain the implications of my findings in the practice of palliative sedation and analgesia at the end of life in hospice and hospitals.
Chapter Two: Escaping Pain: Redemptive Suffering and America’s Opioid Crisis

In this chapter, I will first delve into the concept of redemptive suffering with an anecdote from one of my interviewees. Then, I will contrast this view of suffering with the mainstream view of suffering represented by America’s growing opioid crisis, as described by my interviewees. Finally, I will transition into the way in which America’s view of suffering is manifested in the nation’s growing opioid epidemic and how this epidemic is affecting the prescription of palliative drugs including opioids in hospice and palliative care.

When I first decided to pursue this thesis project, I knew going into it that I wanted to explore the interplay between religious faith, specifically the Christian faith, and medicine at end of life. I soon realized after speaking with my advisor, Professor Hannig, that this subject was far too broad to be studied for a thesis project. Instead, Professor Hannig suggested that I focus on researching end-of-life care in Catholic hospitals in the U.S., which would allow me to scale down the level of my research. Professor Hannig herself had been conducting ethnographic research on medical aid-in-dying in the U.S. and specifically was researching the response of Catholic hospitals to the legalization of aid-in-dying in Oregon. After digging into end-of-life care in Catholic hospitals, I discovered that one of the major points of controversy in Catholic health care is the practice of palliative sedation and analgesia, or the use of opioids in Catholic hospices. This discovery prompted my interest in palliative sedation and analgesia at end of life in Catholicism.

Redemptive Suffering in Catholicism

In the early stages of my research, I typed “Catholic hospice” into the search-bar of LinkedIn, a social media networking site that allows users to expand their professional networks and find employment opportunities. One of the first names that came up was that of Bobi
Martinez, a Catholic Mission Coordinator at Americare Hospice & Palliative Care, a Catholic organization located in Arizona. Martinez expressly consented to me using her real name in my thesis. I decided to keep interlocutor’s real names in my thesis unless they did not consent to using their real names, as it better allows me to explain their unique and individual motivations and backgrounds that shape their perspectives on the subject matter. After finding Martinez on LinkedIn, I looked up the Americare Hospice & Palliative Care webpage where it describes itself as a “Phoenix Diocese-approved Catholic organization dedicated to serving people of all faiths.” Under a section titled, “What Sets Us Apart,” it writes, “our healthcare team adheres to the strictest ethical and moral principles to uphold the value of human life at every stage” (“Americare Hospice & Palliative Care”). Seeing that Americare Hospice fit the bill for a Catholic healthcare organization, I sent a message to Martinez on LinkedIn, describing my thesis and requesting an interview with her. Martinez responded that same day, and we quickly established a phone interview day and time.

I asked Martinez to introduce herself and describe to me her responsibilities as a Catholic Missions Coordinator. She explained that she wears a variety of caps with various responsibilities:

When people meet me they don’t really understand what my role is. In Arizona, we are the only official [Diocese-approved] Catholic hospice. My role as the Catholic Mission Coordinator is to oversee all the sacred support for Catholic families and patients. Right now, that accounts for half of our patients. I also go out to give talks at parishes, community groups, and assisted living facilities, and mortuaries – anywhere where people want me to talk about hospices in general and how Catholic hospice is different. I also help keep us connected and report back to the Diocese here so that we can help them know year to year that we are who we say we are. Our mission is still continuing, according to ethical and religious directives of the Church. We have an official decree from the Diocese of Phoenix and Bishop Olmsted. That is not a one-time thing—you have to be continually be worthy of that. It’s an ongoing thing that we need to show that we deserve to have that. Besides that role, I also wear the liaison cap—I go out and talk to Catholic families that are being referred to us. I might go and talk directly in hospitals, homes, and group homes to help bring people on service and answer questions from them. I’m also a certified Grief Recovery Specialist.
As a Catholic Missions Coordinator, Martinez manages patient relations and serves as a liaison between Americare Hospice & Palliative Care and the local Catholic community. Additionally, she specializes in Grief Recovery, helping patient’s families in the grieving process. As our conversation progressed, Martinez began recounting her personal experiences with seeing patients receiving morphine and other opioids at end of life. I was surprised when she mentioned that she had witnessed one patient requesting that his morphine be withheld in order for him to offer redemptive suffering for his son.

One instance I can relay is that one patient was offering his redemptive suffering for his son who was not living a good life and had been making very poor choices and the son knew that that dad is offering his suffering for him. I remember in that instance, that son kept trying to tell a nurse, “You need to force him to take more pain meds.” And that’s when we had to say “We can’t force him to do that, this is his choice. He’s taking as much as he wants, and we have to respect that. He’s able to make that decision.” That’s the only time that maybe there’s been sort of a debate and that’s usually because it’s difficult for that child to watch because he knows it was for his benefit.

Although the practice of planned redemptive suffering for the purpose of atoning for a relative’s sins is not unheard of, it is a unique practice even in Catholic hospices. In Martinez’s words, “Sometimes we are unique as a hospice because we have had a handful of patients who have said I have paid to do some of my purgatory or I never want my pain better than a 5 or 6.” Many hospitals and hospices use a pain scale, ranging from 0-10, with 0 representing no pain and 10 being the worst pain you can imagine, to inquire a patient’s level of suffering and prescribe treatments as needed.

This concept of redemptive suffering is mentioned in the Catholic ERD’s, in which the U.S. Conference of Catholic Bishops writes, “The mystery of Christ casts light on every facet of Catholic health care,” including, “to see suffering as participation in the redemptive power of Christ’s passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ” (Catholic Church 2009:6).
Notably, the ERD’s do not explicitly describe redemptive suffering as an act of penance or substitute for purgatory, as suggested by Martinez’s anecdote of the father. Rather, the ERD’s mention redemptive suffering as a way to help patients come to terms with their suffering by seeing the “redemptive power” of suffering. In ERD #61, it specifically states, “patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering” (Catholic Church 2009:32).

The concept of redemptive suffering is widely taught in the Catholic Church. Its application in end of life care, however, is not. When I brought up the above anecdote to Rev. Mark Yavarone, a Professor of Bioethics at Pope St. John XXIII National Seminary, he was surprised by the idea of redemptive suffering being controlled by the dosage of morphine administered to a patient. He commented,

I agree with the concept of redemptive suffering—it is in Saint Paul’s letter to the Colossians. It says, “In my own flesh fill up what is lacking in the suffering of Christ” and he definitely did see that in himself that he was united with Christ in his sufferings. But it's one thing to say “I'm going to take the suffering that has come into my life because of this disease which for some reason can't be cured or can't be alleviated and offer it together with the suffering of Christ to the Father” and another thing to say “I'm going to increase my suffering because I think I need to atone for more of my sins” or something like that so I would look at it more as accepting the suffering that comes to us as a share in the suffering of Christ than making ourselves suffer. There is an idea of penance and as you see in the Acts of the Apostles it says, “While they were praying and fasting the holy spirit said set aside Paul and Barnabas for the work that I want them to do.” Fasting or going without food for a day is a kind of increasing in your suffering but it's not something that causes damage to your health. In fact, I've been reading some interesting stuff that an occasional fast can be good for you so there can be that aspect of voluntary penance but not in a way that causes some kind of lasting harm.

Rev. Yavarone’s response clarifies that suffering can be offered together with Christ’s suffering as a way to be unified with Christ in suffering. However, increasing suffering willingly is a different act and does not necessarily constitute redemptive suffering. Willing forms of suffering, such as fasting, are an exception to this rule, but Rev. Yavarone points out that fasting may actually contain health benefits and therefore is not harmful.
To further explore St. Paul’s idea of suffering, similar to St. Paul’s letter to the Phillipians is St. Paul’s letter to the Colossians in the New Testament of the Bible, in which St. Paul recounts his many sufferings since coming to faith:

“Indeed I count everything as loss because of the surpassing worth of knowing Christ Jesus my Lord. For his sake I have suffered the loss of all things, and count them as refuse, in order that I might gain Christ and be found in him, not having a righteousness of my own, based on law, but that which is through faith in Christ, the righteousness from God depends on faith; that I may know him and the power of his resurrection, and may share his suffering, becoming like him in his death, that if possible I may attain the resurrection from the dead” (The Bible, Phil. 3:8-11)

St. Paul explains to the Colossians that the things he once gained as a Hebrew and Pharisee he now considers loss, when compared to the knowledge of Christ. He speaks of suffering in the context of the loss of his previous gains, but rejoices in his suffering as a way for him to “become like [Christ] in his death” and “attain resurrection from the dead” (The Bible, Phil. 3:10). He therefore imbues meaning into the act of suffering, comparing it to and even considering it a way to “share [Christ’s] suffering” as a means of becoming more Christ-like (The Bible, Phil. 3:10). This description of suffering forms the basis of the perspective of suffering in Catholicism.

Despite St. Paul’s acceptance of and joy in suffering, the Catholic Church does not teach that choosing suffering is a requirement of faith. In the *Evangelium Vitae*, or “The Gospel of Life” a papal encyclical written by Pope John Paul II, he writes that “while praise may be due to the person who voluntarily accepts suffering by forgoing treatment with pain-killers in order to remain fully lucid and, if a believer, to share consciously in the Lord’s Passion, such ‘heroic’ behavior cannot be considered the duty of everyone” (*Evangelium Vitae* par. 65). As such, forgoing pain relief in the hopes of sharing in Christ’s suffering, while commendable, is not the broadly encouraged for all Catholics to do at their end of life. In Rev. Yavarone’s view, the
alleviation of pain and suffering in and of itself is not bad. He agrees with the teachings of Pope John Paul II, stating,

suffering is not good in itself but it's also not something to be avoided at all costs. So, by all means, take an aspirin. I tell my congregation—use anesthesia because suffering is not a good in itself. If in order to end suffering, a person wants to be killed or wants to kill themselves then we’d have a problem with that. I would disagree with that not because suffering in itself is a good thing but that directly killing a person is a bad thing. So, in a nutshell, I don't think suffering is a good thing and I don't think we should increase our own suffering, but I also don't think it's something that needs to be avoided at all costs.

Rev. Yavarone explains that suffering is only considered good if intentionally offered to God along with Christ’s suffering. Otherwise, suffering by itself is bad and can be avoided by appropriate means such as taking pain medication. The only exception, however, is ending a person’s life in order to avoid suffering.

During my interview with Bobi Martinez, Martinez recommended that I visit the website of the National Catholic Bioethics Center (NCBC) for additional resources on Catholic bioethics for end-of-life issues. I decided to try my luck at interviewing the NCBC staff bioethicists, emailing the listed email address for general inquiries with a request to interview a staff bioethicist at the NCBC. To my surprise, I received a response with a referral to Dr. Jozef Zalot, a staff bioethicist at the NCBC. Dr. Zalot has extensive experience in the field of Catholic bioethics, having served Regional Director of Ethics and Spiritual Care for Mercy Health-Cincinnati. In this role, he reviewed and drafted ethics policies and even taught a nurse ethics education program. Additionally, he served as a Lecturer at the Athenaeum of Ohio/Mount St. Mary’s Seminary where he taught courses in Medical Ethics. I quickly set up a phone interview with Dr. Zalot, which took place early morning the following day. When I asked Dr. Zalot to explain the Catholic view of suffering, he responded:

Particularly within the Catholic Christian traditions, there is great value in suffering. Good can come of suffering if you relate your suffering to the sufferings of Christ. For example, suffering can be a source of growth. It can serve as a witness of courage to others. John Paul the Second
was not in good health for the last ten years of his life but he accepted his condition and went on doing the work that he believed God called him to do—a great witness of courage. It can serve in other’s good—Jesus’s suffering, Martin Luther King’s suffering, Jesus—God suffered for us. Did that bring about any good? Well certainly the Catholic perspective is going to say yes. So, in the Catholic perspective, again, suffering is not desired. I’m not going to say, “I hope you suffer today.” But when you suffer with the eternal perspective in mind, which the church presents or composes, there is meaning. In my own life, there are times where I’ve suffered and in the midst of it sucks but there is an underlying belief that there is something to it. I don’t understand what it is right now but after the suffering ends you reflect back on it and say, “Oh, ok there’s a lesson.” And I’ve learned some very important lessons in my own life which I wouldn’t have if that suffering had not occurred. Again, it’s not a good thing. We’re not advocating self-suffering either—doing things to yourselves. We recognize that it is part of the human condition and it exists for a reason and it’s how we grow.

Dr. Zalot recognizes that, while the Catholic Church does not teach that suffering as something to be actively sought, it teaches that suffering can be a source of “personal growth” for the believer. In Catholicism, suffering is seen as a tool used by God to both shape the believer and “witnessing” to those around him or her. Suffering, although bad in and of itself, has the potential to bring about good, such as in the cases of Martin Luther King, and most significantly for Catholics, the sacrifice of Jesus Christ. What, then, enables the Catholic believer to endure suffering? Dr. Zalot, explains that this endurance can only be achieved with the “eternal perspective” in mind—or the hope inherent in the belief that one will ultimately be free of pain and suffering in heaven. As Pope John Paul II puts it, “the certainty of future immortality and hope in the promised resurrection cast new light on the mystery of suffering and death, and fill the believer with an extraordinary capacity to trust fully in the plan of God” (Evangelium Vitae par. 67).

In one of my final interviews, I spoke with Dr. Michael J. Balboni, who holds a PhD, ThM and MDiv. Dr. Balboni is an accomplished Christian theologian, Instructor of Psychiatry at Harvard Medical School, and palliative-care researcher at Dana-Farber Cancer Institute. I was referred to him by one of his colleagues at Park Street Church, a Protestant Christian congregation in Boston. Although Dr. Balboni is not an expert in the Catholic faith, he has
extensive experience in researching and authoring many papers on the influence of spirituality and religiousness on the outcomes in palliative care patients. He also leads a targeted ministry for Christian doctors and other healthcare providers. One question that I posted to Dr. Balboni is how he views the notion of redemptive suffering in the context of end of life. He explained to me the Protestant Christian view of suffering, which is similar to the Catholic view of suffering:

Many believe that there is a redemptive aspect within pain and suffering and that the redemptive aspect is that those who are suffering can—and many do—discover a hope and a faith despite the difficulty. And some discover that in some mystical way their suffering is connected to God’s suffering within the world and it actually makes a difference—it actually changes things, which changes things in their own life. It changes things in the lives of others. Again, we don't glorify suffering. Christians don't glorify suffering. You see that even as Christ suffered his suffering actually had a redemptive power within it and Christ is the model for all suffering.

Altogether, Pope John Paul II, Martinez, Dr. Zalot, and Dr. Balboni agree that suffering holds redemptive value and opportunity for growth, while recognizing that suffering in itself is bad. Especially at the end of life, Catholic believers have an opportunity hope for eternity spent in heaven, rather than dwelling on the momentary pain and suffering in their current life. The acceptance of their lives coming to an end is an act of obedience to God’s will and timing. Death is only seen as another form of suffering that can be offered up to God in order to achieve redemption and personal growth. The meaning that accompanies suffering at the end of life is unique to the Catholic faith, as Pope John Paul II argues that the secular worldview that ignores the existence of God is void of any meaning in death. This point of contention also ties into the discussion of suffering in the context of the opioid crisis in the U.S. today.

*The Inability to Accept Suffering in American Culture and Western Biomedicine*

A common theme that I encountered in my interviews with my Catholic interlocutors is the growing rejection and refusal to accept suffering in American society today. Catholic Mission Coordinator, Bobi Martinez, commented,
I think what’s unfortunate is our culture now looks at suffering as useless—it’s something to be eliminated at all costs. I think that most healthcare settings, most physicians, most hospices talk to families learn that most people, human beings in general, see suffering as having no worth. As Catholics, we don’t see any suffering as useless; we see suffering as redemptive; we see that it isn’t something to be eliminated. What I believe has happened is we’ve gone to such an extreme that we’re willing to eliminate people, or the person, to eradicate the suffering.

Martinez believes that American culture, as a whole, views suffering as meaningless and useless, and therefore encourages people to go to great lengths to alleviate suffering, such as by using opioids. In the *Evangelium Vitae*, or The Gospel of Life, written by Pope John Paul II, he denounces the secular worldview of life, in which “‘the values of being are replaced by having…The so-called ‘quality of life’ is interpreted primarily or exclusively as economic efficiency, inordinate consumerism, physical beauty and pleasure, to the neglect of the more profound dimensions—interpersonal, spiritual and religious—of existence” (*Evangelium Vitae* par. 23). Pope John Paul II laments the loss of meaning achieved through suffering in the materialistic world. He claims that suffering, “an inescapable burden of human existence but also a factor of possible personal growth, is ‘censored,’ rejected as useless, indeed opposed as an evil, always and in every way to be avoided” (par. 23).

The view of life in materialistic terms feeds into the secular worldview that life is defined by pleasure and health, is challenged when one faces the end of life stage. Pope John writes that those who have adopted this materialistic worldview will view suffering as an “unbearable setback, something from which one must be freed at all costs” (*Evangelium Vitae* par. 64). Death, then, can adopt one of two meanings for the dying individual. In the case of the nonbeliever, death is considered “‘senseless’ if it suddenly erupts a life still open to a future of new and interesting experiences” (par. 64). For the Catholic or Christian believer, death is imbued with hope, serving as a “‘rightful liberation’ once life is held to be no longer meaningful because it is filled with pain and inexorably doomed to even greater suffering” (par. 64). In this
view, the suffering that accompanies death pales in comparison to the suffering of continued life. As such, the suffering of death is embraced by the dying person.

In my interview with NCBC staff bioethicist, Dr. Jozef Zalot, he shared a similar perspective on suffering in American society as whole:

Again, going back to our individualistic, relativistic society today. We’re looking out for ourselves. “I want what I want.” Anything that’s against me getting what I want needs to be eliminated. Suffering is seen in that way. Suffering is a bad thing. Now, the Catholic Church is not going to say “rah rah rah let everybody suffer.” It doesn’t say that. And by the way, suffering is not just physical. It can be mental, spiritual—there’s this whole range of suffering. Suffering, while certainly not desired, admittedly is part of the human condition. Everybody suffers at various points during their lives, and the question is, what do you do with it? What do you do about that? And from a humanistic, atheistic perspective, suffering is pointless. It’s absurd, what’s the point of it? I mean, go kill yourself because there’s no meaning to it.

Dr. Zalot agrees with Martinez in that American society rejects suffering as useless. He also argues that this viewpoint is rooted in the individualism in American society, which emphasizes the individual’s right to not suffer. Because suffering is viewed as useless, as Dr. Zalot explains, it may validate the individual’s right to end their own life in order to end suffering. This violates the act of dying for the Catholic believer, as it is considered holy and sacred, described by Pope John Paul II as “the supreme act of obedience to the father” (Evangelium Vitae par. 67). This “obedience” is characterized by a willingness to die in God’s timing “at the ‘hour’ willed and chosen by him,” which fittingly marks the end of a lifetime of obedience and submission to God’s will (par. 67). The suffering that accompanies death, is just another form of suffering, which although is “an evil and a trial in itself, can always become a source of good” (par. 67).

The prospect of death becomes more tangible when a person is reaching a chronological old age. Therefore, Pope John Paul II teaches that the aging person, rather than seeking “to be delivered from old age and its burden” (Evangelium Vitae par. 46) should continue to place his or her faith in God and recognize the fleeting nature of life compared to the eternal promises of
heaven written in the Bible. On the cultural shift towards seeing suffering as useless, Pope John Paul II wrote in the *Evangelium Vitae*,

“In a social and cultural context which makes it more difficult to face and accept suffering, the temptation becomes all the greater to resolve the problem of suffering by eliminating it at the root, by hastening death so that it occurs at the moment considered most suitable. Such a situation can threaten the already fragile equilibrium of an individual’s personal and family life, with the result that, on one hand, the sick person, despite the help of increasingly effective medical and social assistance, risks feeling overwhelmed by his or her own frailty; and on the other hand, those close to the sick person can be moved by an understandable even if misplaced compassion. All this is aggravated by a cultural climate which fails to perceive any meaning or value in suffering, but rather considers suffering the epitome of evil, to be eliminated at all costs. This is especially the case in the absence of a religious outlook which could help to provide a positive understanding of the mystery of suffering.” (par. 15).

Although Pope John Paul II, agrees that suffering is not a good in itself, he denounces today’s culture which “fails to perceive any meaning or value in suffering, but rather considers suffering to be the epitome of evil, to be eliminated at all costs.” Pope John Paul II’s argument that society views suffering as meaningless and evil, and aims to eliminate suffering entirely, is one explanation for America’s opioid crisis—in which Americans are overdosing on opioids to escape the reality of suffering. Martinez remarked,

I find that when I’m talking to people and hearing their questions, that what they’re asking me is very much centered around this narrative that suffering is an evil that must be eradicated at all cost. And I think if you really look at it, that’s something that’s really coming up now—the opioid addiction and extreme problem we have in our society where so much of our culture is medicated at this point. We are addicted to medication, strong opioid medication, and how that’s altering them in their bodies and affecting them and kind of feeding into this idea that all pain is useless and we need to just eradicate it at all costs.

Martinez’s concern for the nation’s growing opioid epidemic is not unfounded. In 2015, over 52,000 Americans died of drug overdoses, most of which were caused by opioids including OxyContin, Vicodin, heroin, and fentanyl (“Opioid Consumption Data”). This number is nearly four times the number of drug overdoses in 1999. To put that number into perspective, drug overdoses are now deadlier than car accidents and gun violence. The growing opioid epidemic in the U.S. calls into question the degree to which Americans rely on medication to ease their pain.
In the 1990’s, doctors began to categorize pain as “the fifth vital sign,” which pushed them to prescribe opioids to treat the problem (Simon 2017). In 2012 alone, it is estimated that health care providers wrote over 250 million prescriptions for painkillers according to the Center for Disease Control and Prevention (“CDC Newsroom”). The opioid epidemic has been attributed to a multifaceted campaign on the part of pharmaceutical companies in which doctors are fed propaganda by hospitals and state medical boards that patients would be suffering for no reason due to a fear of addiction.

Andrew Koldodny, a New York psychiatrist and opioid addiction specialist who cofounded an organization called Physicians for Responsible Opioid Prescribing, describes the opioid epidemic as “an out-of-control epidemic, not caused by a virus or a bacteria. This epidemic has been caused by a brilliant marketing campaign that dramatically changed the way physicians treat pain” (Fauber 2012). In 2007, Purdue Pharma and Cephalon, after an investigation by the U.S. Justice Department, was fined $635 million for misleading doctors by claiming that its product, the narcotic painkiller OxyContin, was less addictive and potentially abused than other pain medications (2012). In addition to the misleading advertising of pharmaceutical companies, there is a cultural explanation for Americans’ reliance on opioids.

The Washington Post reports that Americans are more likely than their European counterparts to believe that “life is perfectible,” or that pain can be completely eradicated which is one explanation for why Americans appear to abuse opioids to a greater extent (Humphreys 2017). Statistics show that US per capita opioid consumption is significantly higher than other developed nations in Europe (“Opioid Consumption Data”). For example, United Nations data shows that Americans are prescribed six times the number of opioids per capita as are citizens of Portugal and France, despite the easier access to healthcare in these countries. In the case of
hydrocodone, a specific opioid, Americans are calculated to consume more than 99% of the world’s supply of this opioid (“Opioid Consumption Data”). Aside from the cultural view that “life is perfectible,” one explanation for the opioid epidemic that has been proposed is that America has a greater aging population and therefore requires more opioids to relieve pains associated with aging. However, the U.S. population only ranks 42nd in the world for the largest population of citizens 65 years or older and countries ranking above the U.S. consume a much smaller figure of opioids than the U.S (“Opioid Consumption Data”). The more likely explanation for America’s opioid consumption, however, is the aggressive marketing of pharmaceutical companies that manufacture opioids, paired with the relative inactivity of the U.S. government in regulating these companies.

It is important to note that the number of opioid prescriptions does not directly correlate with the number of drug overdoses, which suggests that prescription of opioids is not solely to blame for the opioid epidemic. One area that was the first to be hit in the opioid crisis in the states is central Appalachia, in West Virginia (Lilly 2018). In central Appalachia, opioids first began as simple prescription drugs used for symptom management in blocking pain and reducing stress. Soon, however, the drug use grew to include grinding up the opioids to snort or inject for a temporary high. However, since 2012, the number of opioid prescriptions has gradually decreased, yet the death rate from drug overdoses by illegally-purchased drugs including heroin and fentanyl seems to be ever-increasing (“Opioid Consumption Data”). More recently, in October 2017, President Trump escalated the urgency of the opioid crisis, declaring it “a national public health emergency,” and extending it to his platform for stricter immigration policies by claiming that “an astonishing 90% of heroin in America comes from south of the border—where we will be building a wall” (Merica 2017).
What bearing then, do palliative drugs have on the growing opioid epidemic in the U.S?

Without a doubt, one source of the opioids contributing to the opioid crisis is the prescription drugs given to hospice and homecare patients. Martinez shared,

Unfortunately, sometimes we’ve had drug diversion cases. Someone lives in their private home and maybe their child or spouse or some sort of relative is taking their drugs and using them for themselves. And they try to say that “Oh my mom ran out of her medicine, you need to deliver more.” We are very careful of monitoring that because that has happened a few times. Other times, it’s usually not an issue where someone is asking for an extreme amount of medication.

Cases like this are not isolated. Hospice and home-care, being places where large amounts of opioids are given to patients, are the perfect platform for drug diversions that can go unnoticed under government radar. Kaiser Health News reports, “Hospices have largely been exempt from the national crackdown on opioid prescriptions because dying people may need high doses of opioids” (Bailey 2017). In one case in Mobile, Alabama, a hospice nurse discovered a patient at home, “holding his abdomen, complaining of pain at the top of a 10-point scale. The patient was dying of cancer, and his neighbors were stealing his opioid painkillers, day after day” (2017). In an independent investigation, Dr. Leslie Blackhall of the University of Virginia Palliative Care Clinic, she found that most Virginia hospices do not mandate training to combat the misuse and theft of drugs (2017). A lack of training leads to cases of nurses who participate in drug diversion. This past June, a hospice nurse in Albuquerque, New Mexico, pled guilty to diverting oxycodone pills by recommending prescriptions for patients who did not need them and stealing the drugs to sell illegally (2017). Despite the policy efforts that are being made to counteract this problem on a national scale, the ones who ultimately suffer from this crackdown are the patients themselves. Placing stricter policies on opioid medications will only affect the care for the patient, and may cause greater suffering as a result.

One of my interviewees, a nurse practitioner in palliative care, Mr. Daniel Johnson, commented on the effect that the opioid epidemic has had on the prescription of pain relieving
drugs in his practice. He explained that, overall, palliative care is largely unaffected by the epidemic as it is careful to avoid patients who have histories of medication abuse.

Palliative care is not addiction medication. We have a different program called addiction medicine if you don't have a life-limiting illness. We are a palliative care service so we will treat chronic pain but we will not see patients that are addicted. No matter how many narcotics they get, if they have a life-limiting illness, we will do the best we can to work with them but without that [a life-limiting illness] they do not qualify for a service. We have a number of other services that will better meet their needs to help them with addiction so I think that's important. Patients that are manipulative and have addiction and have complex pain in the absence of a life-limiting illness—we will not see those patients. You need to draw clear boundaries with those patients. We will not escalate them and as a practice we use IV meds when needed but our plan is to transition.

As Mr. Johnson explained, palliative care takes measures to avoid aggravating existing addictions by referring patients who are not suffering from terminal illnesses to addiction medicine. Mr. Johnson also said that he has observed a cultural shift away from aggressive opioid use to a minimalistic approach in opioid use.

20 or 30 years ago everyone was saying that everyone has the right to pain control and pain is the 6th vital sign. Using opioids aggressively was the focus. And now we're on this other end of the spectrum where people are dying—they’re overdosing and in chronic pain. Now everyone is saying no opioids are inappropriate for chronic pain and we need to be level and careful with our prescription. So there's been the kind of this back-and-forth within medicine. But within palliative care our mission is the same; our job is to control and minimize suffering and we respond to patient’s symptoms. We don't give them too much, we don't give them too little so that it’s not effective. We want to maximize their quality of life and their function as best as we can to match their goal, so that doesn't change. The opioid epidemic doesn't change our mission; however there is a reality out there that we need to be aware of.

Mr. Johnson recognizes that there has been a general shift in the culture of medicine in the U.S., from using opioids aggressively to reducing opioid use as much as possible. Despite this shift, as Mr. Johnson explained, palliative care is mostly unaffected by the opioid crisis because they are focused in their mission to minimize suffering, he also notes that palliative care providers need to be careful to avoid are patients who are untruthful or manipulative when reporting their histories of opioid use. He went on to describe a case of a patient who claimed to have been on a higher dosage of opioids and was given too high of a dose as a result. In general,
however, the palliative care team aims to minimize and cut down on opioid prescriptions as much as possible.

During my clinical rotation, I had a patient who came in for surgery had poor absorption, so we had to do everything. She was one that had been a chronic pain-er before she had cancer and so she was super opioid-tolerant. And so we prescribed a PCA with a basal dose of pain control to match her old dose. We even decreased it by 15%. So they put her on that and after about 4 hours she got over-sedated and they had to use the reversal medication on her. And it was clear that what she claimed was taking at full, she was not taking because there was no reason for her to have gotten so sedated if that was her full medication; so we could have killed this lady. She could have died from the medication we put her on if they had noticed later. When people come to see us that have [been on opioids] for 20 years, who have been on insane numbers of opioids, it's insane. And our first job is to do no harm in healthcare and so we try to feel out where this pain is, how severe is their pain, are they taking as prescribed all their medications they’re prescribed, etc. because diversion is a huge issue. And we get Addiction Medicine on board with us and say “Hey this prescribing has gotten out of control we need to pull them back,” and almost every time our practice has been able to cut their dose by half at least by the time they leave. I can't speak to what happens after they get back to their primary care whoever been had been prescribing the high dose. I don't know what happens when they go there but we know that [drug diversion] is a reality. We need to be cautious so we need to have that at the back of our mind. For those [medications] that have high addiction potential, we need to be very firm handed and draw clear lines that we will only do what is safe and appropriate for [patients].

As Mr. Johnson described, the opioid crisis still affects the way in which practitioners approach the use of addictive medicine in palliative care. However, palliative care is limited in its ability to dampen the use of opioids of their patients, as they may return to their original doses once they are discharged from the clinic. The difference between palliative care and hospice, as Mr. Johnson put it, is that in palliative care, patients may still choose to treat their disease rather than solely managing the symptoms of the disease. Once patients have exhausted their options, only then do they elect to be moved to hospice, where they receive more heavy-handed opioid dosages to manage their symptoms.

In palliative care, patients can still seek treatment for a disease while managing symptoms before they've made decisions for end-of-life or comfort care. So a lot of times and majority of the time, I’m dealing with symptoms of patients that want to continue treatment. And if they decide that their pain control is more important and that's what they want to be the focus rather than more days on this Earth, then we will transition them to comfort care or hospice-oriented care and then more aggressively treat their pain with the anticipation that their disease process will end their life within 6 months or so. Then we can be more heavy-handed with the prescribing because the intent is not to keep them alive longer—it’s the control their symptoms.
Because palliative care, unlike hospice, does offer hope for recovery, it is more limited in its use of pain-relieving opioids. As such, palliative care is not as involved as hospice is in the opioid crisis.

Conclusion

In this chapter, I began the discussion of suffering as perceived in Catholicism, specifically, the function of redemptive suffering in helping patients come to terms with pain at the end of life. In some cases, redemptive suffering is used by patients as an act of penance and form of purgatory, although intentional suffering is never encouraged by the Catholic Church. As Pope John Paul II writes, hospitals and clinics “should not merely be institutions where care is provided for the sick or the dying. Above all they should be places where suffering, pain and death are acknowledged and understood in their human and specifically Christian meaning” (Evangelium Vitae par. 87). The Catholic Church teaches its members that there is inherent meaning in suffering when offered with Christ’s suffering, and that death is a holy act of “obedience” to God. On the other hand, my Catholic interlocutors raise concerns over the non-Catholic perspective of suffering—that it is useless and therefore should be exterminated by all means. This view of suffering, in their eyes, has culminated in America’s opioid crisis—in which people abuse of prescription drugs, some of which are diverted from Catholic and non-Catholic hospices and hospitals. America’s opioid crisis marks a cultural shift in the U.S. from the aggressive use of opioids to a minimalistic approach to prescribing opioids, as Mr. Johnson described. In the following chapters, I will proceed to explore how Catholic and non-Catholic worldviews clash in specific healthcare debates, and how both Catholic and non-Catholic healthcare facilities negotiate palliative sedation and analgesia in the context of their divided views of suffering.
Chapter Three: Morals & Medicine: Abortion, Medical Aid-In-Dying and Other Debates

In this chapter, I will take a broader view of Catholic faith-based medical practices in the U.S. and how Catholic healthcare organizations have come under fire for refusing to perform operations that violate the Catholic ERD’s. Specifically, I will cover the issues of abortion and the death penalty that have incited harsh opposition on the part of Catholic authority figures. I will also explore how this opposition is manifested in Catholic hospital policies, and describe specific cases in which these policies have negatively affected patients and drawn backlash from the American Civil Liberties Union. I will then address the legalization of physician aid in dying, previously called physician-assisted suicide, in the U.S., and the problem it poses for Catholic hospitals and hospices. Lastly, I will consider the effects of increasingly common mergers between Catholic and non-Catholic healthcare organizations on faith-based care.

Abortion and the Death Penalty

As the sun was setting outside, I noticed the brightly lit green pasture outside of the seminary begin to darken through the glass panes of the seminary. Just then, a bell began to chime signaling the end of the hour, and I watched as pairs of seminarians walked out towards the parking lot of the seminary. Rev. Yavarone paused for a moment and said matter-of-factly, I really believe that good morals is good medicine. So, for example, let's say you have a Catholic Church and they refuse to do abortions—I don't see that as just Catholic doctrine being lived out. My view would be that medicine is supposed to heal. There really is no evidence that it's going to help the woman long-term. She is still going to be a mother but she's going to be a mother of a child who is dead. So, abortion really isn't really a service, and in refusing to provide it, the Church isn't refusing to provide a service; they are simply choosing to offer only what is in the best interest of the patient. That's my framework, but that's not the way the secular world looks at it.

For Rev. Yavarone, the role of Catholic-based healthcare is to act in the best interest of the patient—regardless of religious ideology. Rev. Yavarone believes that the refusal of Catholic hospitals to perform abortions is simply good medical practice—and does not conflict with the
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physician’s duty to heal the patient. The subject of abortion in the Catholic view is important because it grants us insight into the foundational ethics of Catholic medical care. By exploring the conflicts between the Catholic church and what many Americans claim to be female reproductive rights in their right to abortion, we can better understand the beliefs of the Church that underlie the use of palliative analgesics and sedatives in Catholic hospices.

Recently, in a letter written by Pope Francis released by the Vatican, he writes, “I wish to restate as firmly as I can that abortion is a grave sin, since it puts an end to an innocent life” (Hume 2016). Pope Francis’s views on abortion are consistent with the Catholic Church’s stance on abortion as a fundamental sin. The Vatican’s strong opposition to abortion and other reproductive procedures such as tubal ligations and sterilization, are reflected in the Catholic ERD’s. Catholic hospitals’ strict adherence to the ERD’s have been met with controversy in mainstream American media. In 2016, talk-show host Samantha Bee in her late night satirical news show “Full Frontal with Samantha Bee,” directly challenged Catholic hospitals’ refusal to perform abortions. In one of her many segments on Catholic hospitals, she states, “Catholic hospitals provide excellent care until your medical needs conflict with their dogma” (Bee 2016). Bee highlighted a news story of a Catholic hospital in Arizona, who terminated a pregnancy to save a mother’s life, after which Bishop Olmstead stripped the hospital of its Catholic affiliation. The nun who approved the operation, Sister Margaret McBride, was later excommunicated.

Opponents to the Catholic Church’s position against abortion claim that abortion is necessary in some cases to preserve the mother’s health, and therefore condemn the Catholic ERD’s for strictly prohibiting abortions. As such, Rev. Yavarone’s claim that abortion does not constitute healing is challenged by these exceptions to the rule. Previously, Catholic hospitals have faced criticism for their handling of situations in which mothers are forced to choose
between getting an abortion and potentially dying in the birthing process. For example, in 2015, the ACLU of Michigan filed a lawsuit in the case of a pregnant woman who had a miscarriage and was denied medical treatment by a Catholic hospital, in accordance with their religious directives. The mother was taken to Mercy Health Partners in Muskegon, Michigan—the only hospital in her county, when her water broke only 18 weeks into her pregnancy (“Tamesha Means v. U.S. Conference of Catholic Bishops”). Because of its Catholic ERD’s, the hospital told Tamesha, the mother, that there was no course of treatment and sent her home twice— withholding information from her that would suggest that terminating her pregnancy was the safest course of action. When Tamesha returned a third time in excruciating pain and with an infection, the hospital was about to send her home once again when she began to deliver and eventually had a miscarriage with medical assistance. The lawsuit by the ACLU contended that the U.S. Conference of Catholic Bishops (USCCB) should be held responsible for the trauma and harm that Tamesha experienced during this ordeal. Tamesha’s case is not isolated—there have been many other cases of pregnant women being refused medically-induced abortions by Catholic hospitals despite risk to the mother’s health and wellbeing.

In the U.S., all hospitals that advertise themselves as Catholic must adhere to the ethical and religious directives in their medical practice to be considered a legitimate Catholic healthcare institution. As written in the ERD’s, ERD #45, “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted (Catholic Church 2001:25). Every procedure whose sole effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo.” Later, in ERD #46, the USCCB then clarifies that “Operations, treatments, and medications that have their direct purpose the
cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child” (2001:26). This exception, in the case of needing to preserve a mother’s life at the risk of losing the child’s, was re-affirmed by Marie Hilliard, Director of Public Policy at the National Catholic Bioethics Center. In an interview with The Guardian, she stated, “If the directives are properly applied, there should be no compromise of the wellbeing of humans” (Rezac 2016). However, it is unclear how each Catholic healthcare institution interprets these two directives, as in the case of Mercy Healthcare Partners.

Ultimately, Yavarone’s response to the case for women’s right to abortion is that the argument for a mother’s right to terminate her pregnancy is null because the practice of abortion is not meant to heal but to terminate a child’s life. In this framework, Yavarone does not dispute the fact that medicine is meant to heal the patient but rather takes the view that regardless of the Church’s religious opposition to abortion, the fact is remains that abortion is neither a good nor valid application of medicine.

The subject of abortion is tangential with that of the death penalty—as both practices are opposed by the Catholic Church’s pro-life position. In Pope John Paul II’s 1995 encyclical Evangelium Vitae, he wrote that “By his incarnation the Son of God has united himself in some fashion with every man [and] this saving event reveals to humanity not only the boundless love of God [but] also the incomparable value of every human person,” suggesting that the innate value of life outweighs the call for the death penalty (Evangelium Vitae par. 2). On the 25th anniversary of the Catechism of the Catholic Church, Pope Francis addressed participants on the subject of the death penalty, firmly stating that the death penalty—no matter how it is performed—“is, in itself, contrary to the Gospel” (“Pope Francis: The Death Penalty is Contrary
to the Gospel”). Pope Francis restated the Vatican’s position against the death penalty, because “remaining neutral today when there is a new need to reaffirm personal dignity would make us even more guilty” (“Death Penalty is ‘Contrary to the Gospel’”). Therefore, he said, “it is necessary to reiterate that, no matter how serious the crime committed, the death penalty is inadmissible, because it attacks the inviolability and dignity of the person.” The Vatican only allows an exception to the rule against the death penalty, “if this is the only possible way of effectively defending human lives against the unjust aggressor” (CCC, no. 2267). On the other hand, however, if “non-lethal means are sufficient to defend and protect people’s safety from the aggressor, authority will limit itself to such means, as these are more in keeping with the concrete conditions of the common good and are more in conformity to the dignity of the human person” (CCC, no. 2267).

Aid in Dying

To Reverend Yavarone, the church’s refusal to support abortion and the death penalty is not a mere matter of religious ideology, but the maintenance of a just society. He said, “My basic thing is not so much what’s a threat to Catholic doctrine, but what’s a threat to a just society because that’s what the Church is trying to do when she teaches.” When asked to respond to the growing shift towards acceptance of aid in dying in the U.S., Rev. Yavarone replied,

I am very concerned about [medical aid in dying.] There is a lot of euthanasia that goes on in this country. I have heard some doctors refer to it as “stealth euthanasia” where for example, they'll give a person a dose of morphine that's so high that what that dosage in itself tends to do is stop the breathing of the person—and everybody calls it relieving a person's pain. But saying that it's okay in law—either euthanasia or assisted suicide—is an additional step in the wrong direction.

For Rev. Yavarone, the debate over legalization of aid-in-dying is a central part of his ministry. Rev. Yavarone speaks annually at the Medicine, Bioethics, and Spirituality Conference held at the College of the Holy Cross, on beginning of life to end of life issues including IVF, three-parent embryos, adult vs. GERM stem-cell research; and end of life issues such as ordinary
vs. extraordinary means of preserving life, euthanasia, and physician-assisted suicide. Rev. Yavarone’s primary concern in the subject of aid in dying, is that the legalization of aid in dying will only encourage more illicit practices such as “stealth euthanasia,” or the intentional hastening of death under the guise of medical treatment at end of life.

In a 2006 article by Romanus Cessario, OP, on “Catholic Considerations on Palliative Care,” Cessario cautioned that “while the WHO [World Health Organization] definition of palliative care contains no provision that contravenes the Catechism of the Catholic Church, n. 2279, one should not assume that the implementation of these provisions will remain ‘unambiguously pro-life’” (Cessario 2006:639). He commented on the mission statement of the National Hospice and Palliative Care Organization, pointing out that “as it now stands, the NHPCO mission statement leaves itself open to allowing palliative care that would contravene the moral law, especially inasmuch terms like ‘quality of life,’ ‘values,’ and ‘decisions’ invite judgments ordered toward assisted suicide or euthanasia” (2006:639). In a recent article in the Ethics & Medics journal titled, “The Rise of Stealth Euthanasia,” the authors made the claim that “many hospice and palliative care physicians are urging, and actually performing, euthanasia by stealth. They administer sedatives that in themselves do not cause immediate death, but knowingly cause the conditions that result in death. This misuse of terminal sedation with intent to end life is properly termed ‘stealth euthanasia’—it is not active euthanasia or passive euthanasia, but a combination of both” (Capone 2013:2). As palliative and hospice care is becoming a standardized form of care, many including Cessario and the authors of the article worry that there will be more opportunities for physicians to practice “stealth euthanasia,” or euthanasia under the guise of proper medical care, while appearing to follow the principle of the double effect. The evidence for stealth euthanasia consists of personal stories of family members
who claim to have watched their loved ones die due to intentional negligence on the part of healthcare practitioners in hospice and palliative care. In one example, in another article in Ethics & Medics titled “A Planned Death for My Father,” the author told the story of his or her father, who was intentionally deprived of nutrition and hydration while in hospice in an assisted living facility and died as a result. The author recalls pointing out the hospice’s deliberate act of euthanasia, “As the employees of father’s assisted living facility came by on their regular rounds, I told them that my father was being killed. They acknowledge that I was right. They were very aware of what was happening” (Anonymous 2013:3).

Stories like these incite fear in both Catholics and non-Catholics who are concerned for the potential for intentional killing by the hands of doctors and nurses in hospice. Rev. Yavarone is concerned that the legalization of aid-in-dying may encourage more cases of stealth euthanasia, in what he calls the “slippery slope” argument. The “slippery slope” argument, which Rev. Yavarone says is one of his strongest arguments against medical aid-in-dying, contends that the legalization of voluntary euthanasia will pave the way for acceptance of non-voluntary euthanasia, and culminate in involuntary euthanasia, or the outright killing of a person. Although Rev. Yavarone’s position against the legalization of aid in dying is rooted in his Catholic faith—the belief that God should be given the authority over a person’s death—he explained that the “slippery slope” argument is rooted in logic and more appropriate for the “public sphere.” When asked why he opposes the legalization of aid in dying, he said,

For one thing, there is the slippery slope argument that if you start with voluntary euthanasia—from there you go to non-voluntary where the person is killed without their consent. Usually it starts with people who are unconscious or in a coma. In the Netherlands, they’ve had euthanasia and assisted suicide for a longer period of time, and there are more people put to death without their consent than there are with their consent. And then from non-voluntary, you actually move to involuntary, where a person has expressed they don't want this and it done to them anyway. And that has happened—people who have expressed “I don't want to be killed” have been directly killed. So you have the “slippery slope argument,” and you have the argument that life is a good and the state has an interest in protecting life. So if you die, it should be because of
something that is wrong with you, like your disease kills you, and not because of something that someone does to you. Because if there are other lives that are inconvenient or that involve suffering, why not take those lives too? I think it also erodes trust that patients have in their doctors because instead of looking at a doctor as someone who's going to heal them, they start to look at the doctor as someone who is trying to heal them up to a point. But if they can't heal they might kill. In fact, there are some people in the Netherlands now who refuse to be admitted into a hospital unless there is a written contract saying that no one will try and kill them. So you can use all of those arguments. For Christians and Catholics you have the additional argument that God is the author of life, and God is the Lord of our lives and of our deaths and not us, and that's an even more powerful argument to be made—you can use the “slippery slope” argument in the public forum where you are may be dealing with the only people who don't believe in God or who aren't Catholic or Christian.

In a 1993 article published in *Journal of Medical Ethics*, author J. A. Burgess similarly explains the “slippery slope” argument with reference to the Holocaust. He quotes William Reichel and Arthur J. Dyck, saying, “If euthanasia were legalized, might we not then regard certain individuals as unworthy of life? Such a concept laid the foundation of the euthanasia movement that began in Germany before the National Socialist movement and before Hitler’s rise to power” (Burgess 1993:167). One example mentioned by Rev. Yavarone and used often by proponents of the “slippery slope” argument is that of the Netherlands, one of the first nations to legalize medical aid-in-dying via the “Termination of Life on Request and Assisted Suicide (Review Procedures) Act” in 2002. The law states that euthanasia and physician-suicide are exempt from punishment if the attending physician follows criteria of due care—including factors such as the patient’s request, patient’s suffering, information provided to the patient, and more.

Recent studies have presented evidence that the legalization of physician aid-in-dying in the Netherlands has become more and more permissible in recent years, which suggests that the “slippery slope” argument may be correct (Lerner 2015). In a recent issue of *JAMA Internal Medicine*, the author presented recent findings by the End-of-Life Clinic in the Netherlands, which show that of 645 people who applied to the clinic in a 1-year period, 162 requests were approved by physicians. Of those whose requests were approved, 6.5% were approved based on
reports that they were tired of living. 3.7% requested assisted death only due to psychological suffering (2015). An even more alarming finding was that 49.1% of those whose requests were approved admitted that part of their reason was simply due to suffering. The author suggests that ageism may also have factored into the physicians’ approval, as 53.7% of approved requests were by patients 80 years and older. Furthermore, statistics show that 1 in 30 people died by euthanasia in 2012 in the Netherlands, which is triple the rate in 2002 when medical aid in dying was first legalized (2015).

On the other side of the debate, deniers of the “slippery slope” argument reject the existence of the “slippery slope” as argued with the example of the Netherlands. In an article published in Current Oncology, the author admitted that “It is indisputable that the Dutch laws regarding euthanasia and doctor-assisted suicide have become more permissive, but those who invoke the slippery slope argument fail to realize that those changes are insufficient to demonstrate the existence of a ‘noxious’ slippery slope” (Benatar 2011:206). The author points out “the hidden assumption” in the slippery slope argument that “instances of euthanasia that the Netherlands now permits are morally wrong.” (2011:206). He argues that these instances of euthanasia may not be morally wrong because psychological suffering should be considered as equally valid as physical suffering in legitimizing aid in dying. Moreover, the author claims, alternatives to aid in dying may be even more morally abhorrent—“for some people, the prospect of continuing in a minimally conscious or unconscious state for the rest of their biological life is a fate worse than death” (206).

The issue of legal acceptance of aid-in-dying is particularly challenging to Catholic doctors in the U.S. who feel it is a violation of their conscience to participate in the hastening of death of a patient. Rev. Yavarone shared what he had witnessed at the conference—when a
physician asked the audience of Catholic medical practitioners, “How many people [here] have been asked to violate their conscious in the name of giving healthcare to one of your patients?”, more than half of the hands [in the room] went up, so that's something that can really happen. There are conscience protections in the law but there are people who are working very hard to erode those because they would say, for example, “Abortion is a service and whoever wants to end it should be able to,” and that if you are a person who can do it then you should be forced to do it.

Yavarone’s concern for society’s acceptance of medical aid-in-dying, was similarly expressed by Bobi Martinez. Martinez’s role as a Catholic Missions Coordinator at AmericanCare Hospice puts her at the forefront of patient-interaction, as she often works to reassure patients and their families that the hospice does not perform any stealth euthanasia. When I asked Martinez to share her experience with the subject of aid in dying, her tone of voice noticeably shifted to one of worry and concern.

People ask me how many times we don’t get patients or families because we refuse to do something like [aid in dying] and I can honestly say that it has happened but we can only count the total number of times on one hand. If you watch the media or you see what was being said, you would think everyone is for assisted suicide and deciding where and when they want to die, and it really isn’t the case. We actually have people and even self-described atheists choose us because they know we are not going to do anything to hasten their death.

For Martinez, the acceptance of physician aid in dying poses a concern for people—both Catholic and non-Catholic—who are fearful of the potential abuse of power by a doctor by intentionally performing stealth euthanasia on their patients. Therefore, Martinez claims, many are seeking care in Catholic hospitals and hospices because they feel more comfortable entrusting their care to doctors who practice according to the Catholic ERD’s. Martinez expressed her surprise at this, saying,

It is very interesting for me when someone who says they have no faith are still very concerned about [stealth euthanasia] and will choose a Catholic hospice because they trust us. They have done a lot of secular studies that when people are saying they want to die—“Please kill me, I want physician-assisted suicide,”’ people are actually crying out for help, and that 99% of the time, they are not truly asking for you to kill them. They are actually asking for help, for something they are not getting—emotional, spiritual. Maybe their symptoms aren’t well managed and they’re are in chronic suffering—in a desperate place. And what really matters is how we
respond to those people. If we respond with the support and help that they truly need, those people stop asking to die. It’s really a cry for help, not truly that they want to die. We aren’t respecting the dignity of that person at all [if we] look at them as something to be eliminated. Their suffering is what we should be trying to alleviate.

Martinez argues that, often times, those who request a physician-assisted death many not actually mean what they are asking. Rather, she says, they may really be asking for emotional and spiritual support to help manage their suffering. In this line of argument, the physician must respect the dignity of the patient by providing the support that he or she needs rather than conceding to the patient’s request to die. Martinez argues that the inherent dignity of the person is being violated when doctors view patients as “something to be eliminated” rather than looking for other ways to help the patient overcome their suffering and suicidal thoughts.

In an article published in the Journal of General Internal Medicine, researchers studied the factors that are at play in motivating an individual to request aid in dying. The study found that there are multiple interacting factors that contribute to a desire for hastened death—the three general issues that were found included “the effect of illness (e.g., physical changes, symptoms, functional losses), the patient’s sense of self (e.g., loss of sense of self, desire for control), and fears about the future” (Pearlman 2005:234). Interestingly, the study found that none of the participants who were interviewed attributed their desire for a hastened death to depression or lack of access to care. Rather, the participants were motivated by their loss in bodily function and loss of sense of self, which researchers say point to “the threats of dying to the social construction of life’s meaning” (2005:234). The researchers also noted that these threats are “especially salient among individuals living in a secular culture” (234). These results suggest that Martinez may or may not be correct in her statement that patients request aid-in-dying due to lack of spiritual support, because patients credit their desire to die to a “loss of sense of self,” which may or may not be aided by spiritual support.
Martinez later shared with me the testimonies of her patients, some of whom experienced institutional pressure from their insurance companies to essentially end their lives instead of receiving palliative care. She explained that because the practice of aid-in-dying is now legal in some states, it is being implemented in the plan of care for elderly patients by insurance companies. The companies push their patients to request end of life drugs, as opposed to palliative drugs and palliative care, in order to save costs.

We have people who have moved to Arizona to escape because they see how [aid in dying] is being implemented in the plan of care. We had someone recently say that they had a palliative procedure that they wanted just to help them feel better—not to cure them but maybe prolong their life a little—denied by insurance. In that same rejection letter, the insurance said that they would cover end of life drugs if they wanted to do assisted suicide. To me, that’s a horrific sign of where we’re going as a culture—when you are going to say no, it costs too much and you’re going to die anyway, we will cover the drugs that will kill you if that’s what you’d like to do.

As I continued to speak with Martinez over Skype, she raised concerns not only for the patients themselves who request aid-in-dying, but also for Catholic healthcare practitioners who risk their careers by refusing to take part in medical aid-in-dying. She explained that lawmakers must make proactive legislation to protect the rights of healthcare workers in refusing to participate in aid-in-dying. Martinez is active in the efforts to pass protective legislation, and even testified in state courts to help pass SB1439, a law in Arizona that explicitly protects the healthcare practitioner’s right to refuse participation in aid-in-dying.

This past spring, I worked with the Arizona Catholic Hospice to testify before the legislature to pass the law—even though assisted suicide is not legal in Arizona. We were able to get SB1439 passed. It’s a law that basically prevents people from trying to legislate through lawsuits; that no company such as a Catholic hospice—no company or anyone in the healthcare field—a nurse, a doctor, can be sued, demoted, fired, reprimanded, or have anything done to them if they refuse or participate in ending a patient’s life. There is a provision part of the Affordable Care Act that is supposed to protect against that, and earlier this year in Arizona we noticed that because of the possibilities of changes or repeals whatever was in the healthcare bill, we really needed something solid because the whole west coast now has physician-assisted suicide. Year after year, there is a push here in our state trying to get it on the ballot or into law. We are constantly fighting that and we have some of our staff, some of our nurses, that come from other companies where they were demoted, reprimanded, or fired for not participating in something that would end someone’s life. That was a huge victory for us to have that put into law here.
When I later looked up SB 1439, I found that it is indeed listed under Title 36, Arizona Revised Statues, in chapter 11.2, and was passed on March, 24, 3017. The bill states that “a person may not discriminate against a health care entity on the basis that the health care entity does not provide, assist in providing, or facilitate in providing any health care item or service for the purpose of causing or assisting in causing the death of any individual, such as by assisted suicide, euthanasia or mercy killing” (SB 1439, 2017). The bill protects the rights of the health care provider from institutional punishment for refusing to participate in medical aid in dying, stating that “A health care entity is not liable in any civil, criminal or administrative action for declining to provide any health care item or service for the purpose of causing or assisting the death of any individual” (SB 1439, 2017).

When it comes to issues like aid-in-dying, the National Catholic Bioethics Center at the forefront of helping Catholic healthcare facilities navigate these issues by ensuring that they stay informed on bioethics based on Catholic teachings. The National Catholic Bioethics Center (NCBC) was established in 1972 in St. Louis, Missouri. On their website, the NCBC lists its mission statement to “promote and safeguard the dignity of the human person, thereby sharing in the ministry of Jesus Christ and his Church” (“About Us”). The NCBC seeks to help Catholics in healthcare professions or otherwise involved in health care to “understand how the moral teachings of the Church apply to developments in health care and the life sciences.” The NCBC helps to facilitate conversations between Catholic dioceses and healthcare institutions on a wide range of ethical issues in medicine, science, and biotechnology. When I asked Dr. Jozef Zalot, Staff Bioethicist at the NCBC, if he is concerned about the rights of Catholic healthcare practitioners to refuse to participate in aid-in-dying, he shared his encounter with a Catholic
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palliative care doctor who had moved from California to Ohio after physician aid-in-dying was legalized in California.

Actually, a little background—it’s funny you bring that up with the nurse and the hospice in Arizona because just last week, I had a two-hour conversation with a palliative care doctor who was practicing in California, but because of the legalization of assisted suicide and all of the other things that that brings, [she moved]. In other words, people think it’s just—“OK, you’re legalizing assisted suicide.” Well that is fostering a whole cultural shift towards under-treatment of patients. [For example], you’re in the early stages of this illness and [the doctor] doesn’t want to deal with the symptoms of all of this—so “let’s talk about ending your life right now.” There is a whole shift in medicine towards under-treatment, or prescribing suicide to the patient. So [the doctor] left California for that very reason, and she grew up in Ohio, so she’s in Ohio right now but she’s thinking about going back because she feels called to be a witness to that. What assisted suicide is doing—what the legalization of assisted suicide is doing, is putting a lot of pressure on doctors. It’s souring the whole waters in terms of end-of-life care because if you’re a physician who supports assisted suicide and I know that, am I really going to feel as if I’m getting the best quality end of life or palliative care that I can get? I’ve asked people—“Has the legalization of assisted suicide affected the quality of end of life care?” and people said, “Yes, it has.”

Dr. Zalot agrees with Martinez that the legalization of aid-in-dying is concerning for Catholic healthcare practitioners, but is more concerned that the legalization of aid-in-dying is undermining the entire medical field and the quality of care for patients at end of life. As he explained, the acceptance of physician aid-in-dying embodies a cultural shift towards “under-treatment” of patients on the part of physicians who defer to hastening the dying process to avoid treating the symptoms of the patients. Even if patients do not request aid-in-dying, they may be fearful of its effects on the quality of care that they receive in hospice and become distrustful of doctors who support the movement. Moreover, Dr. Zalot believes that the legalization of aid in dying is violating the very sanctity of life of patients—in addition to undermining Catholic faith-based care. When asked if he believes the legalization of medical aid-in-dying is a potential threat to Catholic healthcare, he answered,

I don’t know if it would threaten Catholic healthcare. As far as I know right now, there are no Catholic hospitals that are doing [physician aid-in-dying]. Catholic hospitals, or people I’ve talked to are very clear that “we do not do this, and we will not do this.” Does it undermine the sanctity of life and that understanding within the culture? Absolutely. I think that’s where the real danger is because in our culture, in our society, people have an understanding that what is legal is ethical and you see this in terms of any numbers of things, like abortion. People think that just
because something is legal, it’s okay to do. That’s one of the effects that the legalization of assisted suicide has. It’s creating a mentality, creating a culture where—“Oh this must be good, this must be okay.” Assisted suicide is presented by supporters in very good light although there are many arguments against it—both theological and philosophical. I think that’s the biggest challenge of it—the culture shift. And what components of assisted suicide are seeking to do is change people’s perceptions of [aid in dying]. “You’re not actually committing suicide, you’re not actually killing yourself, its death with dignity.” It’s the language that’s used, and it’s amazing some of the things that are in the assisted suicide laws. That’s where the real challenge is. It affects the culture so people come to think that this is a good thing. And then palliative care and hospice are undermined because society is saying well, “Just go kill yourself,” and then it puts pressure on patients at the end of life to do this themselves, and so I don’t see assisted suicide as undermining Catholic teaching—that’s going to stay; that’s going to remain. It’s just another one of the symptoms of the individualistic and relativistic culture that we live in. “It’s all about me. There’s no right and wrong, it’s just about me and what I want to do.” And I think that’s where the real threat lies.

Dr. Zalot blames the media portrayal of medical aid-in-dying in the U.S. for the shifting cultural values that accommodate the legalization of aid-in-dying. He claims that the wording American media uses to describe aid in dying, such as “death with dignity” is creating a façade for the real killing that takes place in hospitals and hospices. Martinez echoed this criticism of the media, saying, “most people—surprising if you watch the media or you see what was being said you would think everyone is for assisted suicide and deciding where and when they want to die and it really isn’t the case.”

One of the largest organizations that advocate for physician-assisted dying legislation is the Death with Dignity National Center. On their website, their mission statement reads “The mission of the Death with Dignity National Center is to promote Death with Dignity laws based on our model legislation, the Oregon Death with Dignity Act, both to provide an option for dying individuals and to stimulate nationwide improvements in end-of-life care” (“About Us”). On their website, the organization deems terms such as “Physician assisted suicide” as an “inaccurate, inappropriate, and biased phrase which opponents use to scare people about Death and Dignity laws” (“Terminology of Assisted Dying”). The organization also rejects the term “euthanasia” to describe aid in dying, claiming that they are actively opposed to euthanasia as it
“refers to the act of deliberately causing the death of another person who may be suffering from an incurable disease or condition.” On the flip side, Dr. Zalot and Martinez argue that the phrase “death with dignity” creates a false impression of aid in dying as a legitimate practice that is in favor of the dignity of the person.

Sitting in a J.P. Licks near the Longwood Medical Area where Michael Balboni works as an Assistant Professor of Psychology at Harvard Medical School, I asked Dr. Balboni to share his experience on the subject of physician aid-in-dying. Dr. Balboni wears multiple caps—he is an accomplished researcher, professor, and Protestant Christian minister whose focus is on the cross-over of faith and medicine. His ministry consists of advising Protestant doctors and other healthcare practitioners on how to reconcile their faith with their practice. In response to my question on medical aid-in-dying, he said,

I don't advise any clinician to participate in physician-assisted suicide and I think that's directly leading into being involved in a cause-and-chain effect of someone committing suicide. I think that's bad for medicine; it's bad for doctors and nurses to be involved in such a way. They are to be present for the patient and not to be involved in extinguishing the patient, which seems to be going directly against the very central aspect of what their roles are. I think it'll undermine the patient-clinician relationship over the long-term and it will be more difficult for patients over the long-term to trust their caregivers. I am also very concerned that there is no philosophical division between the physician-assisted suicide and euthanasia. I understand there are differences, but as soon as we allow physician-assisted suicide within one generation, we will have accepted euthanasia. As we see in other countries like Belgium going to involuntary euthanasia, I think it’s absolutely terrifying. I don't think we as a society would resist [involuntary euthanasia] as soon as we start going down that path. I would advise clinicians to really resist and refuse to be participate in this. It’s not legal in Massachusetts but I certainly know clinicians who have been asked by their patients to help them, but it would be an illegal act. Even if it were legal, I think there are very strong reasons for doctors and nurses to refuse to play any role in hastening anyone's death through physician-assisted suicide.

Dr. Balboni points out that there is a fine line between physician aid-in-dying and euthanasia, referring back to Rev. Yavarone’s “slippery slope” argument. Similar to Dr. Zalot’s concern for aid-in-dying’s effects on the overall practice of medicine, Dr. Balboni argues that aiding a patient’s death is fundamentally opposite to a healthcare practitioner’s responsibility to
help the patient. This paradox is potentially harmful to the patient-caregiver relationship, as it will gradually erode patients’ trust in their doctors.

In my final interview for my thesis, I had the opportunity to interview a nurse practitioner in palliative care based in Chicago, who connected with through a personal contact. Mr. Daniel Johnson is in his first year as a practicing nurse practitioner (NP) in palliative care, but previously worked as a registered nurse (RN) for four years in an oncology unit. After working as an RN for four years, Mr. Johnson decided to pursue a doctorate to become a nurse practitioner, deciding in his final year before graduating that he wanted to pursue a specialty in palliative care. He currently works in a non-Catholic hospital that, in his words, cares for “some of the sickest patients in the area” as an NP specializing in palliative care. During his NP program, he worked for over 300 hours in Catholic-affiliated hospitals, so he can speak on both Catholic and non-Catholic healthcare settings. After exchanging a few emails, we were able to schedule a phone interview around his busy work schedule, right before he was to leave for a ski trip vacation. When we first began our conversation, Mr. Johnson mentioned that although he does not have any formal education in bioethics, he has a deep interest in bioethics and hopes to eventually pursue a Master’s in Bioethics and chair an ethical committee in the hospital. He also shared his interest in anthropology as he is “always trying to figure out what the culture of the specific family [of the patient] is and how to match that physically to be most effective.”

When I ask him to comment on physician aid-in-dying and his knowledge on the subject, he insisted that the practice only applies to a small fraction of patients. He said,
distress. Except for those that have very real pain that are like, “I'm done with this pain. Just give me the pain meds, I'm done being in pain.” I don't see those patients saying “Give me a pill to kill me.”

Mr. Johnson explained that most patients at the end of their life seek to maximize the time they have left to repair relationships with families and come to terms with their imminent deaths. The only exception to this rule, in his experience, are patients who are in extreme pain and are therefore desperately seeking a way out of the pain. Only patients in an extreme state of pain will request aid-in-dying.

What I know and what I've heard is that only patients that are aggressively seeking that—only those patients—are actually achieving [physician aid-in-dying]. And in these cases it's actually just the physicians prescribing a medication for the patients to take on their own. You have to ask very specifically and you even have to go through some sort of sort of psych eval in order to be given that prescription and be seen by that doctor from a legal perspective. I've never met any provider that purposefully hastens death by prescription of the medication. We might withdraw support if someone decides enough is enough. We let someone off hemodialysis knowing that they would die within two weeks and we do a number of things to allow people to die but it can't be coming from our prescriptions. Someone with 10 out of 10 cancer pain isn't able to say “I'm done” like someone that's on dialysis. So there is kind of that sadness and something that feels like unfairness, but that's life. And I have seen a couple patients that have begged me to die, as a nurse, and some of them—I wish that the Lord could take them in that moment, but a couple others have bounced back and had really sweet moments in their life before ending. So we're also really careful; and another thing palliative care does is role-of-care discussions, end-of-life discussions in the context of treatment options—‘What do you want for your life and for your treatment?’ And we don't allow patients to make those treatment decisions if they are in severe pain because we know that the pain will interfere with that decision-making. So pain as a driving force for wanting to die is understandable but we need to do our best to control the pain before we allow patients to make those decisions.

As Mr. Johnson described, rare cases of aid-in-dying can only be performed after a lengthy process that includes a psychological evaluation. In addition, the act of dying is not directly facilitated by the doctor or NP; rather, the doctor usually prescribes a lethal pill that the patient then takes on his or her own. It is important to note that not all cases of patient death facilitated by a doctor or NP are categorized as medical aid-in-dying. Mr. Johnson shared that he has participated in withdrawing life support from patients, which effectively ends their lives. However, this practice is limited to patients who are some form of life support, such as those on
Patients with extreme cancer pain but are still independently living must actively seek aid in dying in order to hasten their deaths. Mr. Johnson qualified this by saying that doctors and nurse practitioners take caution to ensure that patients are qualified to make their treatment decisions. Patients who are extreme pain do not qualify to make these decisions, as their decision-making may be influenced by their desperation to escape their pain.

*Nonprofit vs. For-Profit Hospices & Catholic and Secular Conflicts of Interest*

Another palpable worry that many of my interviewees expressed is the gradual undermining of Catholic authority in Catholic healthcare institutions by non-Catholic healthcare organizations as a result of hospital mergers. Bobi Martinez, the Catholic Missions Coordinator at Americare Hospice, explained that hospices carefully brand themselves in a way that attracts more patients. Because the Catholic brand carries favorable connotations of quality, non-Catholic hospitals are motivated to partner with Catholic hospices to brand themselves as Catholic. Similarly, hospices market themselves as nonprofit because the label suggests better care. According to Martinez, however, the label of for-profit and not-for-profit hospitals grants very little insight into their actual models of care.

Some hospices market that they are nonprofit or not-for-profit so people think they must be better. Unfortunately, that’s not true. I always try to encourage people not to take that at face value. In the end, it’s a way to market their hospice. All Medicare-certified hospice companies are paid exactly the same for the exact same basic benefits for people with Medicare. I noticed there are some good nonprofit hospices but there are also some really bad ones. You can’t take that as a criterion. They know that they can make more money off of people—for example, by taking patients and making sure that they medicate and do clockwork—orchestrate their death so they can make more money—so they won’t be on service longer and cost more to take care of. Other hospices might market themselves as a nonprofit hospice but they don’t have respect for life or natural death. Usually, almost every single way that you can enumerate how we are different always points back to that respect and regard for life until natural death. We do not decide when someone leaves this Earth; that is for God to decide alone. Our job is to manage your pain, help you feel the best you can, and give the best physical, emotional, and spiritual support to you and your family and trusting in God’s will of when your time is through.
Martinez went on to explain that partnerships between Catholic and non-Catholic hospitals and corporations make it increasingly harder for Catholic hospitals to maintain their Catholic standards of care.

That’s a thing with Catholic hospitals that a lot of people figure is a big struggle for Catholic hospitals and corporations—that there are so many partnerships that are formed when they are building these building—wings or trying to go into business with people, and trying to also not violate any Catholic teachings or allow anything to happen in their hospitals that is immoral or not according to guidelines. Unfortunately, that’s what we are seeing across the country, a lot of Catholic hospitals are no longer really Catholic because of these partnerships and what they are allowing to go on inside the facilities.

As a result of these partnerships and the undermining of Catholic authority in these formerly Catholic hospitals, Martinez claims that many nominally Catholic healthcare institutions are no longer following Catholic ERD’s. In her own experience, Americare Hospice once refused to partner with a nonprofit Catholic hospital in order to maintain their ability to provide care that adheres to the Catholic ERD’s.

We do not have that problem [of undermining Catholic authority] because we are individual entities with privately-owned companies. There are about 80 of us in the state of Arizona. There is a big hospice here that markets itself as a nonprofit to Catholics but they do not follow the ERD’s, and they hasten death and they do things that are inappropriate. They tried to formulate a contract with us to create a villa inpatient unit and we declined. There were a lot of people from the outside that asked why we did that, saying, “They’re the biggest one and that’s going to get you so much business.” For me it was very apparent that they were trying to formulate relationships so they could use it as a marketing tool. We have the ability as a publicly-owned private company to say, “We don’t need you, we don’t want to partner with you.” Even here in Arizona, we’ve seen a hospital that was once Catholic that is no longer Catholic, and they partnered with that organization. We get no referrals for patients out of that hospital and, unfortunately, they still will tell patients in that hospital that aren’t informed that they are a Catholic hospice. No, they’re not—they were stripped of it officially years ago. But people that aren’t informed wouldn’t know that. So, they’ve misrepresented themselves. It’s been a big struggle and it all came about by creating these relationships with other corporations, other doctors, other entities that do not abide by Catholic teachings in their care and their philosophy and that’s where you get into really big trouble. People don’t understand how much Catholic healthcare has shaped the healthcare system that we have in our country and that we’re slowly whittling away that in many areas.

Although Americare Hospice was able to remain autonomous by rejecting a partnership this nonprofit organization, Martinez fears that these partnerships and mergers will gradually reduce the Catholic label as no more than a marketing tool.
I asked Dr. Zalot to share his experiences on this issue, as the Catholic NCBC often
called into discussions concerning the adherence to Catholic ethics in mergers between Catholic
and non-Catholic healthcare institutions. He explained that the wording of legal documents, such
as the merger agreements, is important to ensure that Catholic teachings are maintained in the
hospital following a merger. His work at the NCBC often involves facilitating these discussions,
as Catholic bishops who are called into bless the merger may ask the NCBC to make moral
analyses of disagreements during merger talks.

A lot of hospitals are partnering more with secular healthcare institutions—for example, they are
building a new wing or are sponsored by something. This is undermining Catholic authority and
can also lead to questionable practices. It’s a very big issue. The frustrations of healthcare today
and one of the things that makes it really fascinating at the same time is that partnerships between
Catholic and non-Catholic entities are ongoing. Normally what happens is, in a vast majority of
these cases, a Catholic hospital is going to merge with another institution, or a wing is going to be
built sponsored by whomever. Usually in the articulation agreements or in the merger
agreements, the language is very clear that in the Catholic facility or in the wing that is being
built that no procedures will be performed or consults given, whatever the case, that may violate
Catholic teaching. And it’s up to the non-Catholic entity to either agree to that or not agree to
that. Basically, in terms of these partnerships, what’s supposed to happen is that nothing that
violates Catholic teaching will happen within any of these facilities—that’s part of the merger
agreement. Also, in the vast majority of cases, the local bishop has to give his blessings [to the
merger]. He has to give his agreements to the deal and that’s actually what the NCBC does a lot is
bishops will contact us and say, “We’ve got this issue. Can you give me a moral analysis of it so I
can make a determination whether we move forward or not?” So there are supposed to be checks
and balances in play. But does the continuing merger between the non-Catholic entities pose
challenges? You know what, in some cases it is a threat, but does it pose challenges to maintain
Catholic identity in healthcare? The answer is yes, it does. And that’s a lot of the work that the
NCBC does, but at the end of the day, it’s up to the Catholic facility to say “We are not going to
participate in assisted suicide; we are not going to participate in anything else that violates
Church teachings.” By the way, when you look at the list of things, its really very short. I mean
there’s really only a very small number of things that Catholic healthcare will absolutely not
participate in.

Although Dr. Zalot admits that it is certainly a valid to worry over the effects of the
increasing number of partnerships of Catholic and non-Catholic healthcare institutions, he
believes that as long as the Catholic institution clearly state their terms of agreement in their
merger agreements, these conflicts should not pose a threat to Catholic healthcare. Furthermore,
because there are only a few matters—such as refusal to participate in abortion and medical aid-
in-dying—that are nonnegotiable, Dr. Zalot believes it is not difficult to ensure that these restrictions are maintained.

In one case study of a Catholic and non-Catholic merger, a Catholic hospital in Bronx, NY, Our Lady of Mercy Hospital (OLM) suffered from financial distress and was forced to seek a secular sponsor in order to maintain its operations (“Acquisition of distressed Catholic hospitals”). The Archdiocese of New York, the sole sponsor of OLM, was unable to provide the financial support that the hospital required and agreed to a merger with the nearby Montefiore Medical Center, a non-Catholic healthcare organization. As a part of the initial agreement, Montefiore agreed to adhere to the Catholic ERD’s in the first few years following the merger in 2008. Soon after, however, the OLM began to see its Catholic identity stripped away as religious displays—including statues, crosses, and artwork, were transferred to nearby Catholic parishes and the hospital was renamed the North Division of Montefiore Medical Center. Finally, the introduction of reproductive health services including sterilization, family planning services, and counseling solidified its complete departure from its Catholic identity. This case serves to show that Martinez and Dr. Zalot are correct to worry that these mergers may lead to an undermining of Catholic authority in formerly Catholic hospitals and hospices.

On the other side of the debate, talk show host Samantha Bee expressed on her show her concerns that American hospitals are becoming increasingly Catholic as a result of these partnerships. On the ACLU website, it reports that between 2001 and 2011, the number of Catholic-sponsored or affiliated hospitals increased by 16 percent, while the overall number of hospitals nationwide declined (“Miscarriage of Medicine”). In 2011, one in ten acute-care hospitals were Catholic-sponsored or affiliated, while 10 of the 25 largest hospital systems in the country were Catholic-sponsored. Although Catholic healthcare practitioners are concerned that
these mergers with non-Catholic hospitals will affect their ability to practice according to the Catholic ERD’s, non-Catholic healthcare practitioners who work for Catholic-affiliated healthcare facilities are also concerned about the restrictions on their ability to practice by the same ERD’s. In “Full Frontal with Samantha Bee,” Dr. Rupa Natarajan, a former resident OB-GYN at a Catholic hospital is quoted saying, “If a hospital is bought by a Catholic facility, it then has to adhere to the religious directives of the facility” (Bee 2016). These directives include not providing contraceptives, performing surgeries for sterilization, and performing abortions. Dr. Natarajan said that because of the hospital’s Catholic affiliation, she “wasn’t allowed to offer tubal ligations, [she] wasn’t allowed to offer contraception. And this is including women that had high risk medical conditions where they should not be getting pregnant again” (Bee 2016).

In another one of my interviews with a doctor, Dr. Williams, who practices in a large Catholic healthcare umbrella corporation that offers both home care and hospice services, she shared her experiences working for both non-Catholic and Catholic hospice providers. She denied the claim that Catholic hospitals and hospices approach care differently from non-Catholic hospitals and hospices, saying,

I have worked for a secular hospice provider and I would tell you that, on the whole, from my perspective, there is relatively little difference [between non-Catholic and Catholic hospices] and I think in the end of life realm, the principles are largely the same end—standard hospice care versus the Catholic realm. I do think there are some differences though; sometimes there are differences around the amount of autonomy in the patients’ decision-making—the idea that the patient has certain moral obligations around things like nutrition and hydration related to their religious objectives or religious beliefs and some of the other things in the ethical and religious directives. For example, around physician aid-in-dying, where it’s legal, that would be a clear difference in care provided by a Catholic hospice provider versus a secular hospice provider. Around the issues of sedation, it is a little less clear but one of the elements of the ethical and religious directives of the Catholic Church is that the patient should not be unduly deprived of their consciousness and so where there is an issue of sedation for existential distress, I think there are differences I think in terms of the approach.

Dr. Williams says that aside from differences in patient autonomy in decision-making, aid-in-dying, and palliative sedation, Catholic healthcare organizations are not as different from
non-Catholic healthcare organizations as some may believe. Interestingly, in my interview with Mr. Johnson, he shared that he had in fact noticed a difference in opioid usage between Catholic and non-Catholic hospitals. He had noticed, after working for over 300 hours in Catholic-affiliated hospitals and now working in a non-Catholic hospital, that the Catholic hospitals’ approach had been less aggressive in terms of symptom management. He describes this as non-Catholic hospitals being more “progressive” in their methods of treatment.

There were a couple things that I picked up on [while working for Catholic hospitals] and I don't know if it was because it was a Catholic institution or because it was smaller than the hospital I work for now. I don't know, but [the hospital I work for now] has the sickest patients in the area—it’s where you either go to die. What I saw [in the Catholic hospital] and what I felt was interesting was that in the Catholic hospital, they are so much less aggressive with their symptom management. They have ceilings of opioid dosages which they will prescribe—and of course they know there are exceptions with every rule—but at the hospital I'm at we're doing ketamine drips; we're doing palliative sedation—forefront things. The Catholic hospital is not even willing to think about or touch on these things, so I don't know why our work is so much more progressive.

Although Mr. Johnson claims that the Catholic-affiliated hospital where he worked was much less aggressive in its use of opioids for symptom management, Dr. Williams denies that this is the case for all Catholic-affiliated hospitals. When asked about the claim that non-Catholic hospices use methods of opioid administration to intentionally hasten the death of their patients in order to generate a larger patient turnover, she said,

I would tell you that that's unsupported and I think largely untrue [hastening death in non-Catholic hospices]. I think there are good hospice providers and not-so-good hospice providers—both Catholic and non-Catholic—and I think that when you hear things like that, that is a larger reflection of an organization's medical practice than it is their religious philosophy. So I can tell you where I was, when I worked in a secular hospice, the Catholic hospice actually had the reputation for being heavy-handed with morphine compared to the secular hospice I worked for. And you know it's always hard I think based on what you hear about people's impressions and anecdotes to know whether a given agency prescribing practices are appropriate or not because you don't have access to all of the medical facts in order to make that judgment. So I would always be very careful about ascribing to those kinds of labels but I think they cut both ways. I would say that we certainly utilize NCBC a lot here personally you know we call after them on different cases just to be sure we're in the realm of the ERD’s and typically we find their guidance to be very helpful and not really the direction that we would have gone in but it's always good to have them validate.
As Dr. Williams revealed, it is difficult to make the claim that Catholic or non-Catholic hospices are more or less aggressive in their use of opioids. Although Mr. Johnson noticed a difference in the aggressiveness of opioid use between Catholic-affiliated and non-Catholic hospitals, there is no way of proving the claim that Catholic hospices are generally more or less willing to use opioids.

Conclusion

In this chapter, I described how the Catholic Church’s positions on abortion and the death penalty stem from a fundamental view of life as innately valuable. Then, my interlocutors expressed their concerns over the legalization of aid-in-dying and how it may lead to the “slippery slope effect” towards non-voluntary euthanasia, in addition to undermining patients’ trust in their doctors out of fear of “stealth euthanasia.” As Martinez and Dr. Zalot revealed, the legalization of aid-in-dying is also concerning for Catholic providers who fear losing their jobs or being reprimanded for refusing to take part in aiding a patient’s death, which calls for legislation that protects Catholic providers from punishment. Finally, my interlocutors called attention to the increasing number of mergers between Catholic and non-Catholic healthcare institutions, in which both parties wish to maintain their autonomy in practice. However, as my interviewees demonstrate, it is unclear as to how different Catholic and non-Catholic healthcare facilities really are in their approach to care aside from a few key issues, suggesting that their differences may be overstated. In the next chapters, I will be delving into the practices of palliative sedation and analgesia in Catholic and non-Catholic hospitals and how the principle of double effect is used as a tool to ensure that no abuses take place.
Chapter Four: Unintended Evil: Applying the Principle of Double Effect in Catholicism

At the core of my research, I hoped to uncover how the practices palliative sedation and analgesia are reconciled with Catholic moral theology. In all of my interviews, both Catholic and non-Catholic interviewees used the “principle of double effect” to explain how palliative drugs are given with the intention of relieving a patient’s pain with the possibility of incurring unintended negative side effects. Although I understood the principle of double effect in theory, I wanted to know how the double effect is practically applied in a clinical setting. In this chapter, I will be quoting a nurse practitioner working in a Catholic hospice to explain the practical steps of applying the double effect in opioid administration. Then, I will quote a nurse practitioner working in non-Catholic palliative care on the ethics of palliative sedation. I will also uncover the importance of intention in prescribing drugs, the roles of healthcare proxies and family members in deciding patients’ plans of care, and how patient autonomy is maintained in end-of-life care.

Double Effect of Opioid Administration

I was first referred to Ms. Redding by one of my interviewees who works with her in the same hospice. I am keeping Ms. Redding’s identity confidential per her request. Prior to our interview, I had been seeking an interviewee who would be willing to share a clinical perspective of opioid administration in a Catholic hospice, and Ms. Redding was exactly the person I was looking for. Ms. Redding is a nurse practitioner at a Catholic hospice that she and her family founded over ten years ago. After sending her an email introduction to her work address explaining my project and the importance of her contribution, she kindly agreed to a phone interview that would fit into her busy work schedule. Skipping the formalities, I asked her to share with me how she initiates the process of administering opioids. She explained,
For our organization, we always use a psychoactive consent form. It’s a consent form that we have to initiate, explaining to the families of the patient that we initiate medications that would be appropriate for them such as morphine or Ativan. [The form explains that] there are psychoactive effects—in other words they may get a little drowsy, they may get a little confused, but it’s not intended to hasten any death. Our intention is never to hasten death, but we have to make family members and patients aware of the side effects of actually administering the medication.

Although the psychoactive consent form is thorough in explaining the potential side effects of morphine on the patient, there is still stigma that surrounds the use of morphine. Ms. Redding then described to me how her patients and their families are often hesitant to consent to opioid administration, due to the stigma against opioid abuse and its potential to hasten death.

Often times we have family members or non-denominational family members who are intimidated by the use of morphine because morphine has a stigma to it and a negative connotation. However, loved ones require it due to pain, [such as] cancer pain. A lot of the times they’re afraid that once the morphine is started, their loved one will decline and will eventually die, so we have to explain to them in terms of principle of double effect. [Then] they have an easier time understanding the use of morphine and its purpose, and they are more amenable to its use. So, as far as cases like that, I would say there’s been quite a few cases where family members are just hesitant to even let something like morphine be started.

In situations in which patients and their proxies are wary of the effects of morphine, Ms. Redding explains to them the principle of double effect to reassure them that morphine is carefully and systematically administered to avoid hastening death or other harmful side effects.

Although the principle of double effect is commonly used in both Catholic and non-Catholic hospitals in the U.S., it originates in the Catholic Church tradition and can be traced to the writings of Saint Thomas Aquinas, an Catholic priest and scholar from the 13th century ("The Principle of Double Effect").

I asked Ms. Redding to describe the four criteria of the double effect in administering opioids. She explained,

Our goal in hospice is to provide palliative care, or to provide symptom management. Even in a Catholic hospice, the use of morphine can be safely administered if it’s being done morally and ethically. One way to explain that is the principle of double effect.

The first criteria of the principle of double effect is that the nature of the act is itself good, or at least morally neutral. We will explain that symptoms logically speaking—we’ve got morphine receptors all over our body and part of what the morphine or opioids will do is it will
bind to those opioid receptors and inhibit the descending pathways so it doesn’t transmit pain to the brain. And when they understand it in those terms, that there is an actual property in the opioids, then it becomes more of a medical thing, not so much a stigma thing. So, the entire of the act of giving someone morphine with pain is good, or at least morally neutral.

The second criteria is that the agent intends the good effect and that the bad effect is a means to the good or the end to itself. In other words, we’re not giving morphine to cause respiratory suppression. We are giving morphine because we know it’s got inherent properties to treat the pain and relieve the pain with that side effect that we don’t intend of, of respiratory depression. And that’s when we always also explain dosages—that we would start low and titrate slowly, and we would give it upon assessment that they need it, and not around the clock, every hour on the hour on a high dose just because we think that they need it.

The third criteria is where you have to make sure the good effects outweigh the bad effects and that there is sufficient pain to justify causing the effects of respiratory depression. As an example, giving morphine to a patient for pain relief definitely outweighs the bad effect of respiratory depression. Again, to justify its use, we’re not using it to just treat a headache, we are using it for maybe cancer pain or the act of people dying. So that third criteria is met in the principle of double effect. The agent exercises due diligence to minimize the harm. We’re not giving morphine to cause respiratory suppression, and we would definitely start slow, at a low dose, and start slowly titrating it until it causes or it helps relieve the pain. So, there are some hospices that might just start it as 10 mg, every hour around the hour, on the clock until a patient dies. That is not applying the principle of double effect appropriately.

And lastly, in terms of educating patients of family members on the use of morphine, we always want to look at the intent. So you can apply principle of double effect as much as you want but if your intent is to shorten their life, hasten their death, then it is still not a morally justifiable act. So, we still have to look back and look at our intent of the families and if their intent is just to provide comfort and not cause/not hasten their death then its morally relevant to use morphine in that sense.

Nurse Redding’s four criteria conform to the principle of double effect as laid out by the Catechism of the Catholic Church. The Catechism states that the first condition is that “a morally good act requires the goodness of the object, of the end, and of the circumstances together. An evil [motive] corrupts the action, even if the object is good in itself” (Catechism of the Catholic Church, no. 1755). The second condition that the action must meet is that the evil effect(s) must not be directly willed, but only tolerated. On this condition, the Catechism states, “There are acts which in themselves, independently of circumstances and intentions, are always gravely illicit by reason of their object; such as blasphemy and perjury, murder and adultery. One may not do evil so that good may result from it.” (no. 1756). The third condition is that the good effect must be caused at least as directly as the bad. In other words, “an effect can be tolerated without being
willed by its agent; for instance, a mother’s exhaustion from tending her sick child. A bad effect is not imputable if it was not willed either as an end or as a means of an action. For a bad effect to be imputable it must be foreseeable and the agent must have the possibility of avoiding it, as in the case of manslaughter caused by a drunk driver” (no. 1737). The last condition that must be met is that the good effect must be proportionate to compensate for the bad effects.

A few weeks after my interview with Ms. Redding, I sent an email to another Catholic hospice and homecare provider, requesting to speak with a clinician who could also share their experiences with administering opioids. I received a response in my inbox the following morning from Ms. Jones, the CEO of the organization, who agreed to a phone interview with both her and one of the palliative care doctors in the practice, Dr. Williams. Ms. Jones’ and Dr. Williams’ real names will also be kept anonymous as they did not consent to using their real names. One week after scheduling our phone interview, I dialed into a conference call with Ms. Jones and Dr. Williams. Although Ms. Redding had clarified how the principle of double effect is applied in opioid administration, I wanted to know how it the principle is more broadly applied in hospice care. When I brought up the principle of double effect, Dr. Williams was quick to voice her opinion on the matter, saying that she believes the principle is overused and overemphasized in care, and that the link between opioids and hastening of death may be due to a confounding variable such as time.

My comment about the issue of double effect is that I think the principle of double effect with regards to pain and symptom management at the end of life is often over-utilized. There is good medical literature that shows that when opioids and benzodiazepines are used judiciously at appropriate medical standards and medical practices that they don't hasten death and that good pain and symptom management actually prolongs life—they don’t shorten life. I think people often either have experiences with providers who are not expert in the manipulation of opioids and benzodiazepines for pain and symptom management and perhaps have been subject to inappropriate prescribing and then come away with the conclusion that the attempt to manage the patient’s pain and symptoms resulted in their early death. We sometimes see that patients who are in such distress who are very near the end of life when caregivers have agreed to the active management of their symptoms are very close to death in any circumstance. So, there is a perhaps
temporal relationship between the administration of meds for symptoms and the patient's death but not necessarily a causal one. In other words, you take a dying man and you give him a dose of morphine and he dies. That does not mean that the morphine is responsible for the patient's death or that he would have lived any longer as opposed to if you had not treated him. That's where the medical literature shows that when you appropriately manage patients’ symptoms as compared to not managing patients’ symptoms, the patients actually get their symptoms managed live longer so for the vast majority of patients I would tell you that the principle of double effect doesn't apply.

Dr. Williams’s opinion that the double effect does not apply to most cases of patients receiving morphine and other opioids remains debated in clinical literature. In a 1997 article published in *New England Journal of Medicine*, Frances Glessner Lee, Professor of Medical Ethics at Harvard Medical School, writes that “the simple classifications of intent provided by the rule of double effect are not easily applied to the physician’s intentions in the clinical setting” (Quill 1997:1768). Lee brings up the issue of intent in applying the principle of double effect, arguing that it is difficult to classify the intent of doctors in order to ensure that the principle is properly met. One example that Lee uses to illustrate this problem is the practice of terminal sedation. He writes, “Although the overall goal of terminal sedation is to relieve otherwise uncontrollable suffering, life prolonging therapies are withdrawn with the intent of hastening death. Terminal sedation would thus not be permitted under the rule of the double effect, even though it is usually considered acceptable according to current legal and medical ethical standards.” The point that the authors make, just as Dr. Williams argues, is that the principle of double effect may hinder the physicians’ ability to relieve a patient’s pain, such by means of palliative sedation, because of its effect of hastening death. Although the terminal sedation is meant to relieve a patient’s pain, it requires that life prolonging therapies be withdrawn, which is considered a violation of the principle of double effect.

In the *Journal of Palliative Medicine*, Dr. Susan Anderson Fohr writes, “Unfortunately, in ethical articles discussing end-of-life issues, any discussion of relieving pain is invariably
followed, almost in the same breath, by a discussion of the double effect. Even when meant to encourage the use of opioids to relieve pain, these double effect discussions have the effect of reinforcing the misperception that cancer patients must die in pain unless medication that hastens death is administered” (Fohr 1998). She also writes that “Not only is it not necessary to rely on the PDE [principle of double effect] to justify giving adequate pain medication to dying patients, but such reliance on the PDE actually perpetuates the myth of the double effect of pain medication, directly contributing to the under-treatment of suffering at the end of life.” Anderson’s argument suggests that the overuse of the principle of double effect, especially in discussions of using pain relieving medications, may lead to the under-treatment of patients’ suffering and worsen their physical state.

Later in our interview, Dr. Williams clarified that although she feels the principle of double effect does not apply to the vast majority of medical cases, there are some situations in which the principle does apply, such as when the patient is at risk for respiratory failure.

There are some circumstances in which the principle of double effect applies and those [circumstances] may be people with significant respiratory diseases at baseline who may be very sensitive to the effects of opioids in an exaggerated way. That's frankly become a benefits and burdens discussion with the patient if it's possible and or with the family in terms of understanding what's important to them in terms of the of the trade-off for managing symptoms versus the possibility that that may be accelerated by medication—but that's a very rare circumstance.

Where does this concern with respiratory depression from opioid usage stem from? The first recorded human fatality from morphine overdose dates back to the 1850s. Englishman Alexander Wood performed one of the first injections of morphine to his wife, who thereafter died from respiratory depression (Dahan et al. 2010). Recent scientific studies have uncovered the link between opioid use and respiratory depression, such as in one study that showed that opioid ligands exert effects in vivo through interactions with multiple opioid receptors, including \( \mu \)-, \( \delta \)-, and \( \kappa \)- opioid receptors and that respiratory depression is mediated mostly by the \( \mu \)-opioid.
receptor (2010). In a study done with knockout mice, researchers found that mice lacking µ-opioid receptors did not exhibit respiratory depression after being administered opioids and other opioids as compared to mice with active µ-opioid receptors (Romberg et al. 2003). This study also confirms that opioid usage may cause respiratory depression in patients, which presents the need for the principle of double effect to decide which cases are appropriate for the use of opioids.

Who is to blame for the alleged over-use of the principle of double effect in medicine? Dr. Williams blames the medical community for over-emphasizing principle of double effect, as opioids do lead to respiratory depression and death in most cases. Because of the stigma against opioid usage, however, Dr. Williams believes that that over-emphasizing the principle of double effect can lead to poor medical care decisions that lead to patients’ increased suffering.

I would tell you that the circumstances in which the principle of double effect applies to the standard pain and symptom management set up is extraordinarily rare. We talk about it like it's commonplace [and] it scares the pants off people. We do a disservice then to patients and families because we let people suffer because of their preconceived notions and conceptions. So I think we worry about it a lot we talk about it a lot but in reality it's very rare.

Dr. Williams’s argument that the fear of hastening death by opioid use and can lead to unnecessary suffering of patients is affirmed by studies that have shown this to be the case. Dr. Timothy E. Quill writes in the Journal of Palliative Medicine, “the fear of hastening death, or being perceived to hasten death, is one of the many barriers to effective pain management” (Quill 1998:333). Quill cites studies about analgesic use immediately prior to death, which show that dying patients experience a ‘‘crescendo’ of pain just prior to dying, requiring rapidly escalating doses of analgesics,” proving that there is a need for increased dosages of opioids for pain management at end of life (1997:333). Quill also argues that clinicians may encounter different moral dilemmas under the principle of double effect when it comes to caring for dying patients. On one hand, “some patients in the same circumstances may be prepared for death and want to
hasten death by any means possible, the sooner the better” but because of the “moral prohibition against intentionally hastening death is at the core of the rule of double effect, the patient’s open expression of intention may make some clinicians more reluctant about acting” (333). On the other hand, “other clinicians may view sedating these patients to unconsciousness to escape from their pain, and then not giving them food or fluids, as a form of ‘slow euthanasia,’ which is clearly outside the boundaries of the principle of double effect” (333). Quill makes the point that the principle of double effect may cause physicians to question both the use or disuse of palliative sedatives as the physician may fear being accused of intending the hasten death or creating a slow and painful process of death by administering sedatives—both of which violate the principle of double effect.

In addition to the clinical perspective of the principle of double effect, I wanted to get an academic perspective on the practicality of using the principle. I asked Reverend Yavarone to comment on the application of the principle of double effect. He agreed with Dr. Williams that the principle is “over-used,” saying,

You know I tell my students I think the principle of double effect is a little bit over-used. It can be a helpful thing for understanding but I like to make it simple for the guys which is—whenever I do anything there's the kind of thing that I'm doing—eating, starting a car, teaching—there’s the intention that I have in my mind as a motive for doing it—I'm starting a car because I want to drive it to teach, I'm eating because I want to nourish myself. And there's the circumstances—where am I, what day is it, what's the temperature outside—in the circumstances that surround that action. I believe and the Church would say that in order for an action to be fully good all three of those have to be good.

Rev. Yavarone went on to say that the principle of double effect is not as complex as some perceive it to be. He broke down the principle of double effect with the following illustration:

Somebody’s suffering and I want to relieve their pain so I take a whole garbage can full of morphine and I take a garden hose and I dose them with it and they die. Now I may say that what I was trying to do was to alleviate their pain, but that action in and of itself causes death. I mean that high a dose of morphine is going to cause death. So my intention might be good, circumstances might indicate yes you can use morphine here, but the object—the kind of thing
that you are doing is actually kill the person—even if that is not your intention. So, one of the first things you have to look at is the dosage—“Is it a dosage of morphine that is appropriate for alleviating pain?” and if it is, then you're not killing a person by doing that action. Now your intention also has to be to alleviate pain as opposed to killing them, and the circumstances need to be appropriate for giving them morphine. If they just have a headache, just give them aspirin. That's the basic principle in a nutshell. You want to give them a dosage that's appropriate to alleviate pain, your intention needs to be good.

Although Rev. Yavarone’s simplification of the principle of double effect clarifies the root of the principle by emphasizing the importance of the intent behind the act of administering morphine to a patient, I was left pondering how feasible it is to know the intentions of the caregivers when administering morphine.

**Intentions of Healthcare Providers**

At the root of the principle of double effect in opioid administration, the intention of healthcare practitioners when administering morphine and other opioids is of utmost importance. Surrounded by the hushed bustling sounds of the J.P. Licks, I asked Dr. Balboni how he would explain the importance of intentionality of the doctor or nurse who is administering pain relief medication. He responded:

Intention is really important. Within American law, intention has always played a major role in trying to understand and even consider different levels of involvement when someone dies—particularly around the issue of killing. We recognize first-degree murder, second-degree murder, and it's all based around the intent of the individual who committed an act that led to the direct cause-and-chain effect of someone dying. I do think intent is really important and I think the purpose of the law of double effect is to give moral guidance to clinicians, because many do not want to be part of the cause-and-chain relationship that directly leads to someone dying. Within the Christian tradition, this goes back to at least Aquinas. There is a great worry of the culpability of being involved in caring for someone and doing things that actually end up leading to that person dying—and [providers] don't want that moral guilt on [them] as caregivers because then [they’ll] have to deal with that. Hindus and those that believe in karma feel the same way—“Why am I going to do something for this person that ends up being bad karma for me?”. It's different but it's similar in some ways, and within moral theology and philosophy, this is where there are these questions drawing to questions of intent. I think it was the purpose of the law of the double effect is to free clinicians to feel that they can directly intervene and act out of compassionate care for the patient in order to rightly relieve the pain and the suffering with that being their intent and not being the intent of actually killing. The double effect is where you don't intend that event and that event happens (such as the death of the person) and you're not morally culpable for those actions because you did not intend them—you intended another set of actions that were considered morally right and good, which is the relief of pain and suffering. I think within the secular perspective, it's deeply challenged but even within our own laws, most people recognize
that intent still matters in what happens when someone dies so I think it is still recognized by everyone as something important.

Dr. Balboni stresses that intention is important in medicine, just as someone who commits murder is held accountable because of their original intent to kill. He then makes the point that the principle of the double effect serves to prevent abuses by considering the intent behind an action. Dr. Balboni believes that, in addition to protecting the patient from intentional harm, the principle of double effect also functions to protect and free the clinician to practice care in a morally admissible way. Especially in end-of-life care, in which patients often die under the watch of their doctors, doctors need to maintain their guiltlessness in their patients’ deaths by means of the principle of double effect. Because of its universal application, this principle therefore applies to both Catholic and non-Catholic healthcare institutions, as it essential to a physician’s ability to practice care without the risk of being held accountable for a patient’s death.

I was curious about the way in which intentionality is established from a bioethics perspective, so I asked Dr. Zalot of the NCBC how one can know the intentionality of the healthcare practitioner who is administering palliative drugs at end of life. Dr. Zalot answered,

I think the only way to ascertain the intentionality is to ask the person. There’s really no other way. Ultimately, each one of us has our conscience—we have our free will and we have to make moral decisions. And ultimately one’s intentions are known only to that person and God. Can people die in terms of this or any other thing? The answer is yes. In terms of assessing the intentionality, we can ask and get a truthful answer. I suppose, maybe another way to do it is objectively look at the patient’s medical record to see if a healthcare provider is upping someone’s morphine or Ativan. If they are increasing the patient’s dose so that it is obviously beyond the bounds of what is the standard of care for pain relief, in that circumstance maybe you could say, “Your expressed intentions don’t match your actions.” But ultimately, it’s really, it’s a person stating what is [his/her] intention.

As Dr. Zalot concedes, there is no way of knowing a provider’s intention behind the administration of drugs without directly asking him or her. An indirect way of knowing the
intentionality of the provider is by monitoring the patient’s medical record to spot any inconsistencies in care or signs of inappropriate dosages, but this is an unreliable method.

I asked Ms. Redding to explain in clinical terms how her hospice ensures that caretakers in nursing homes are appropriately administering opioids to their patients. She explained that nursing homes are bound by a legal contract with their hospice that grants full authority to their hospice to direct the use of opioids. In her words,

There is a contract that we have. And I wouldn’t say a lot of our patients are in facilities; a portion of them are in group homes where they have unlicensed personnel—not nurses—that provide the care. They are just caregivers. With the skilled living facility, the contract shows that we have the professional responsibility as a hospice to direct the care, which includes pain management—the orders for morphine and how it’s being given. It is being given by us, not their doctor, not by their nurses. Its given by us. And as nurses, they have to follow those orders. So there are some cases in which we may not trust or be as certain as how they would give it, so the instructions by the doctor on the morphine order are very specific. It may say “Give five milligrams every four to six hours for pain rated as 2 to 4 by patient.” “If anything is rated from 4-6 then you can give maybe 10 milligrams of morphine after 4-6 hours.” If it’s rated as severe from 8-10, then there might be a different dose that the doctor will give. So it’s very specific so that there’s not a lot of judgment on their end as to what they think they should be giving. It’s very regimented but covers the patients pain as well.

Although Ms. Redding asserts that the contract and strict instructions for administering morphine prevents abuses from taking place, it remains unclear how nurses and doctors can be held accountable for their actions. I asked Mr. Johnson to share how, in his hospital, doctors and nurse practitioners are held accountable in their use of opioids and the factors behind deciding how much opioids should be given to a patient. Mr. Johnson noted that the level of opioids given to patients in each department can vary depending on the culture of care in that department. The approach of care in each department is largely controlled by the attending physician in charge, as they are responsible for educating the residents and interns in the department.

In palliative care, we all work incredibly independently and I don’t work in hospice, but I can say I work pretty closely with that team. For me, I get my caseload of patients for the day and unless I have questions I'm on my own; I don't need any oversight; I don't need any physicians to sign off on anything. Our roles are interchangeable in our hospital. So there is going to be difference in prescriber preferences and comfort and because our attendings do provide a lot of in-services, that's who we bounce questions off of, and they provide a lot of education. An attending within a
system can be more aggressive or more liberal, and everyone working with him could be as well because that's how they're learning and that's where they're getting their education from. I think it is a cultural thing that's largely defined by the attendings and even just the experiences of the other practitioners and providers in the room. Let's say I practice for 15 years and I had become very comfortable and I know that some medications are more effective then treating pain they rather just simply opioids, then I would probably say to my co-workers, hey have you thought of robaxin and a ketamine cream, or a schedule of Tylenol and maybe some Ativan or Cymbalta. Depending on their types of pain and suffering, you can use other pain relief aside from opioids. I'm only there two days and maybe the next day, we rotate and we all kind of pickup where the other provider left off. I won't always see the same patients—I might see a patient the next day of one of my colleagues so there is a lot of room for us to hold each other accountable and to educate and say “Hey I felt like you got a little aggressive here and I ended up pulling back,” so I think it's largely determined by the culture of the team and the culture of the education. But saying that secular hospitals prescribe to hasten death is just nauseating. That is so against what we do and I think it's interesting that that can be a perception and I don't know what that's a reaction against. It is a fine line, of course; it's the principle of double effect. That's never the goal, however.

Although the attending physicians have the most power and influence in shaping care because of their responsibility as educators, ultimately, doctors and NP’s are autonomous when caring for their patients. The way that they keep on another accountable for their actions, as Mr. Johnson explained, is by constantly rotating care for different patients. Because they are not the sole providers for their patients, doctors and NP’s can make decisions to decrease or increase morphine doses as they see fit. This sharing of responsibility essentially creates a system of checks and balances that prevents providers from abusing their power, and reduces the importance of intentionality of doctors behind prescribing opioids to patients.

Role of Family Members and Healthcare Proxies

In situations in which patients are incapacitated or otherwise unable to speak, they rely on healthcare proxies and family members to make important plan of care decisions according to their wishes. I wanted to know—if and when family members make requests to inappropriately raise the dosage of morphine, how Catholic healthcare practitioners respond to these requests. Ms. Redding emphasized the importance of educating family members on the Catholic approach to care in these situations. She said,
It’s rare at [our hospice] because we are very proactive in explaining the position of how we approach pain management, and a lot of family members do agree with it. There aren’t very many who have said “Well this is what I want to do.” And maybe at the beginning they may have had that thought that this is what they want and then when we explain what happens if you do something like that, it maybe it dissuades them from [asking for that]. I think what families want is pain management—if anything they’re afraid that signing on with Catholic hospice means [their loved ones are] going to have to suffer. I think it’s a lot of reassurance that “No, we are using morphine just like any other hospice.” We’re just using it carefully, in a way that doesn’t shorten anyone’s life but doesn’t prolong it either. So, I don’t think we’ve had to turn anyone down—we might have had to educate them about it at first if they had that question and then that’s it.

As Ms. Redding explained, family members of patients are sometimes concerned that a Catholic hospice will refrain from using morphine and that cause their loved ones to suffer more. When appeasing patients’ family members, Catholic providers must strike a delicate balance between explaining the potential harm of using too many opioids, while re-assuring them that they will prescribe adequate amounts of morphine to prevent suffering of their loved ones.

What exactly is the process of appointing a healthcare proxy when the patient is unable to speak for him or herself? The process of appointing a proxy for a Roman Catholic consists of signing the “Roman Catholic Health Care Proxy form.” For many Catholics, it is important to appoint a person who can be trusted to make decisions that are consistent with their personal convictions and preferences. Notably, in the fourth clause of the form under “My wishes regarding healthcare decisions and express limitations on my agent’s authority,” it states “I direct my Attending Physician(s) and the Facility where I am a patient, provide me with proper medical treatment and care including, but not limited to: (a) appropriate pain relieving medicine in an amount to alleviate or suppress my pain, but not calculated specifically to cause or hasten my death” (“Offices & Services”).

When I asked Dr. Williams if she has ever encountered requests by family members or healthcare proxies to raise the dose of morphine to alleviate the patient’s suffering, and how she responds in these scenarios, she explained,
In those circumstances, I think you need to sit down and talk to people about the fact that for the given individual patient [that approach is inappropriate]. Most of my experience around this comes with people who typically have advanced respiratory disease where sometimes even small doses of morphine will affect their respiratory effort. First and foremost, you always search for alternatives, so is there another drug that will help relieve the patient's symptoms or help relieve the patient’s anxiety without increasing their risk of respiratory because if you have an effective alternative then you’ve solved your problem. If you have no effective alternative, then you need to have a discussion about what the benefits of the medicine are—which would be to relieve the symptoms of pain and anxiety, and the risk—the risk that the patient may die as a result of the other effects of the medicine—not the effects you intend—the unintended effects. The decision is based on the balance of what the greater good is for the patient. If the greater good is based on the idea that you want to relieve the patient’s suffering at the risk of accepting a higher possibility that the patient may die, that’s the decision to be made and that's very individual for people. That decision obviously is best made by the patient whenever possible because the patient is the one with the symptoms and the benefits and the burden decision are really ultimately the patient’s. The Church is very clear about that but that's not always possible sometimes. In that case, the conversation then takes place with a caregiver or the patient's surrogate and then you're making a decision based on what you know about the patient's values and wishes and beliefs. Most of the time in that circumstance. In my experience, most patients and families will opt for the relief of suffering—not always but most commonly.

Both Ms. Redding and Dr. Williams recognize the importance of educating patients’ families on the intended and unintended effects of morphine and pain medications. Ultimately, as Dr. Williams notes, doctors assume that the patient’s family and/or proxies are making decisions based on the patient’s values and beliefs. When I asked Dr. Zalot how doctors and nurses should handle a family member’s or healthcare proxy’s request to raise the dosage of morphine for their loved ones, he answered:

In terms of intentionality, ask them—“Why do you request or say “x””? If a proxy requests a large dose of morphine, Ativan, whatever, and it is quite obviously beyond the standard of care, certainly that’s going to give you an indication. [You then ask], “Do you recognize what you’re doing?” At least in my experience working in a healthcare system before coming to the NCBC, it is very clear that 99.99% of people who are acting as proxies really don’t have a clue, or a medical background, so they don’t really understand. This is understandable; they don’t understand how the medications work, and everything else. They may see someone in pain and say, “Well can you give them a big dose to make them comfortable?” They don’t understand the medical ramifications of it. If you are in a hospital setting or a hospice setting or whatever the case may be, if a proxy requests something that is very much outside of the bounds of standard of care, then that’s some indication that “Woah, what’s going on here?,,” and you could ask them “What is it that you’re trying to achieve from this request?”.
Dr. Zalot recognizes that the majority of healthcare proxies do not have any medical education or knowledge to make an informed medical decision. This lack of knowledge may often lead family members to make requests that are inappropriate.

*The Ethics of Palliative Sedation*

In addition to the discussion of the application principle of double effect in opioid administration is its application in the practice of palliative sedation, in which doctors and nurses administer enough opioids to completely sedate the patient into a state of unconsciousness. One of my interviewees, who works as a nurse practitioner in palliative care, Mr. Johnson, described his encounters with patients who underwent palliative sedation. He shared,

I've been with two patients who have undergone palliative sedation and it wasn't their choice. It was just up to their families and it felt like a simply the right thing to do, but I've done some thinking and some digging on the topic and it's interesting. I feel like about four years ago—I was doing some research into it just because I was curious—and at that time it didn't feel like there was such consensus about the appropriateness of palliative sedation. And taking on this new job [as a nurse practitioner] it was something that we were doing, and even now even those things that will arise on consensus if it is unacceptable thing to do. I still have a little unrest about it and there's going to be a case presentation of one of our patients that was a messy situation where we ended up doing palliative sedation within the next month and we will talk about how we feel about it.

Mr. Johnson noted that, in his own research, he has found that the appropriateness of palliative sedation appears to be debated, even among the medical community today. He says that the only way in which he can come to terms with the practice of palliative sedation is by applying the principle of double effect.

One of the things with palliative sedation and one of the reasons I've been able to stomach it a little bit more and have peace with the idea, is the idea that as symptoms increase, so does our opioids and our prescriptions and our coverage of those symptoms. So if you have more pain, we increase your pain meds. As symptoms increase, we increase our coverage. Sometimes the doctrine of double effect means that that sedates you. And at end-of-life—especially those with really bad cancer pain—sometimes we hold off on morphine drips until the family is there and the patient can get their goodbyes and have their moments of lucidity so they can have that. And we almost let them suffer a little more than we like so they can have their moment, and then we start increasing the morphine because we don't want them to be uncomfortable and the family doesn't want them to be uncomfortable. And when we do that they become more sedated. And through agitation, or through grimacing, we have a number of ways that we can tell their pain. So yes,
they are sedated by our medications, but we are letting their symptoms guide our prescription and our dosage knowing that it is making them sleep. But we're even careful that even if they are having some restlessness at end of life, we are more cautious with the morphine with the fear that they are having enough trouble to breathe and [morphine] will probably depress the respiratory section of the brain. So it is such a balance, but with these patients—especially those that are really, really suffering, death is okay. Death is the goal. We don't want to expedite it, but we're all going to die, and they've had years of suffering and pain so this is appropriate. It's their time to go and we will make them comfortable as it happens; and unfortunately as we make them comfortable, they have less urge to breath and it may lead to an earlier death than otherwise.

Mr. Johnson explained that according to the principle of double effect, it is acceptable for patients to become sedated as a result of pain medication, as it is an unintended side effect. The only exception, however, is when patients at the end of life would like to have moments of consciousness with family members. In these situations, doctors and nurse practitioners withhold morphine and opioids in order to give patients moments of clarity. Ultimately, Mr. Johnson stressed, the patient’s symptoms determine the level of opioids prescribed. Because the patients’ symptoms determine the number of opioids and sedatives prescribed to the patient, palliative sedation is always an unintended side effect. Furthermore, the potential to hasten death may not necessarily be a bad thing for the patient, as terminal patients have often come to terms with their deaths and even desire to die sooner.

Mr. Johnson admits that in Western biomedicine, treatment options can get out of hand and lead to palliative sedation as a result of the extreme circumstances. When patients reach the height of their symptoms, doctors and NP’s are forced to use palliative sedation in the best interest of the patients. He described:

Sometimes, unfortunately, we push so hard in Western medicine. Especially in oncology, we push and push until a lot of times the chemo radiation or the unintended side effects kill the patient. So, unfortunately, too often patients that say, “I want everything, I want to live,” and they end up crashing. They end up being on a med-surgery floor and getting infection and going septic, or going into respiratory distress, or having a GI leak, and there's an attempt to resuscitate them or transfer them to the ICU. They're intubated and then it's a “Now what we don't know what to do” situation. And when those patients don't improve, then the family all agrees—it's time, there's nothing else we can do; this patient’s dying. It's time to withdraw care.” And those patients are not active contributors to their decision-making because they're unable to. Other times, patients have dementia where they have a guardian and are not able to make their own
decisions. Some of the ones that have the most pain has been liver encephalopathy or end-stage liver where we can't get there ammonium down. They're confused or agitated, and you can tell that they're just in excruciating pain and uncomfortable, but we're not able to control the symptoms. That's actually the case that when I came on they did sedation. For over the month, they couldn't figure out the cause for liver encephalopathy. The patient was crying out, screaming and writhing in bed no matter how many opioids they gave her, and it was agreed that it was unethical leaving her like this and having her look like this. She was a young woman and so it's unfortunately the majority of time when we're doing this, we are causing [palliative sedation].

As Mr. Johnson’s description of the female patient shows, doctors and nurses are often forced to perform palliative sedation as a last measure if treatment options are not alleviating pain. This example illustrates the principle of double effect, in that the healthcare providers intend to alleviate the patient’s suffering, but unwittingly cause the effect of sedation or even hastening the death of the patient. How can doctors and NP’s be sure that death is the goal of the patient, or in other words, how can they be certain that patient autonomy is respected in planning care for patients at end of life?

Patient Autonomy in Palliative Care

I asked Ms. Redding how she and her colleagues treat patients who have cognitive disabilities that are unable to articulate their level of pain, much less make decisions regarding their care. Ms. Redding, explained that in these cases, nurses and doctors rely on non-verbal signs that reveal the level of pain of the patient—which they then use to adjust the level of morphine administered to the patient.

The way nurses are trained—the way physicians are trained is that pain reported by the patient is real and we have to respond to it. So if they are unable to articulate it due to Alzheimer’s, we are trained to assess pain using nonverbal cues—sometimes its patients moaning, sometimes its grimacing, sometimes its guarding a certain part of their body. Knowing the history of the patient, the medical history, we know where a pain could possibly come from. If they have Alzheimer’s but they also have a huge gaping wound in their sacrum area because they are bent down, they may not be able to verbalize that they have pain there but with that gaping wound we know there is pain there. So we’re medicating them for that but also assessing with this dose, given at this frequency, that they remain somewhat alert, not changing their breathing, but they look a little more comfortable—less grimacing, less moaning—so we can use nonverbal gestures to determine if our pain management is effective.
Ms. Redding explained that nurses often gauge the pain of the patient by paying attention to physical wounds that may be causing pain, or relying on nonverbal cues to know when the patient is experiencing pain. Despite these efforts, it is still a challenge to treat the pain of patients with cognitive disabilities brought on by Alzheimer’s disease and other age-related diseases. I similarly asked Dr. Williams to explain how she approaches care for people with Alzheimer’s. She explained that in situations involving patients with Alzheimer’s, the best approach is to rely on the caregiver to make a decision in place of the patient.

So that's one of the major hallmarks of Alzheimer disease—people in the more advanced stages of the disease lose their decision-making capacity because they lose their ability to understand and appreciate the current circumstances. Then you’re reliant upon their surrogate caregiver—their health care agent, or the person who legally has the power to be a decision maker, for them to really weigh those same burdens and benefits.

Dr. Williams, unlike Ms. Redding’s relies on caregivers and healthcare proxies to communicate the pain level and desire for treatment on the patient’s behalf. Their differences in approach show how respecting patient autonomy can be problematic and force doctors and nurses to use unorthodox means to care for patients.

In my interview with Reverend Yavarone, he explained how patient autonomy should not be the sole determinant in a doctor’s plan of care. Rev. Yavarone believes that respecting autonomy, although important in medicine, may not always serve the best interests of the patient, as patients may make requests that are harmful to their wellbeing.

Autonomy is important but it’s not everything. Every doctor—if he or she is a good doctor—is going to refuse certain things that the patient wants. So let's say an anorexic patient comes who's a healthy weight and they want liposuction. A good doctor is going to say no because even though [the patient is] autonomous, [he or she] is asking for something that isn't good for [him or her]. Any good doctor—if anyone comes to them and asks to remove a healthy limb—will refuse. And there is a rather rare mental disorder with people who have this kind of dysmorphia of the body they want to have something removed is healthy. A good doctor is going to refuse that. So autonomy isn’t like a God where “What I want to do with my health decisions, the medical profession should do it for me.” And for one thing, directly killing someone or helping them to kill themselves ends their life ends of the greatest good that we have in this world and it also puts an end to their autonomy—doesn’t let them make any more decisions. I do think there is also a possibility that sometimes a terminally ill person is depressed and they might not be so
autonomous as we think they are. In fact I could get the stats and talk about Oregon which is one of the states that has assisted suicide. [In Oregon,] only a very small percent of patients, and I think it was less than 10%, were made to go through a psychological evaluation before they availed themselves of assisted suicide. So the problem I see is that right now there is a very prevalent view in society and in the medical profession to some extent that autonomy trumps everything and it really doesn't it doesn't trump the patient's own good.

Rev. Yavarone is not alone in his view of autonomy as a double-edged sword. In an article published in *Medics & Ethics*, Paul Jennings writes that “during the 1900’s tension between physicians and patients grew as patients demanded more rights in decisions regarding health care, especially end-of life options. Patients’ rights to autonomous self-determination became the norm, and the authority to make medical decisions shifted from the physician to the patient or his surrogate” (Jennings 2017). Jennings then writes that, with this shift towards patient autonomy, patients “demanded procedures or operations which from the factual medical perspective of the physician were futile care that offered little or no benefit to the patient” (2017). Jennings, like Rev. Yavarone, argues that the deferring to patient autonomy can do more harm than good—such as when family members of patients request that doctors “do everything possible” to save their loved ones, even when this approach is not clinically sound.

One case study that Jennings recounts in the article is that of an eight-six-year-old woman with metastatic stage-four lung cancer who went into cardiac arrest. The patient’s surrogate, her daughter, asked doctors to “do everything.” The patient’s doctors administer CPR on the patient, but she quickly returned to a state of cardiac arrest. After the daughter refuses to give up on her mother, the hospital chaplain asked her if her mother “ever had a conversation with you about her wishes and what she would want if she were every in a situation where the physician has done everything to try to cure her but now needs to transition her to comfort care?” The daughter responded by crying and breaking down and refusing to give in, saying, “I hear what you are saying, but I still want her to be full code and everything done!” Jennings uses this example to
illustrate that often times, the patient or surrogate is not the “proper individual to make the
determination on medical futility. The physician is” (Jennings 2017). As such, patient and family
member autonomy should not always be the sole determinant of care, as it interferes with the
doctors’ ability to conduct proper medical care.

In an article released by the Institute of Catholic Bioethics, the authors express a similar
sentiment on patient autonomy. The article cites the Hippocratic Oath, the pledge made by
medical students to “use treatment to help the sick according to [their] ability and judgment, but
[they] will never use it to injure or wrong them” (“Hippocratic Oath & Autonomy”). At the core
of this pledge is the principle of beneficence, or the obligation of the physician to benefit the
patient based on his or her ability and judgment. Additionally, the oath requires that physicians
promise to not harm the patient, which underlies the principle of non-maleficence. However, the
Hippocratic Oath relies on the physician’s judgment, which is often subjective. As such, it does
place patient autonomy above the physician’s judgment. The Hippocratic Oath was challenged
by the American Medical Association in 1980, when the AMA changed the code to state that
“the physician shall respect the rights of patients, of colleagues and of other health professionals,
and shall safeguard patients’ confidences within the constraints of the law” (“Hippocratic Oath &
Autonomy”). This shift marked the pivotal moment after which patient autonomy began to take
precedence over the Hippocratic Oath. In The Principles of Biomedical Ethics, Beauchamp &
Childress write that “whether respect for the autonomy of patients should have priority over
professional beneficence directed at those patients is a central problem in biomedical ethics”
(Beauchamp 2012). In response to this problem, Daniel Callahan, an expert on bioethics, writes
that the only way to solve this crisis is by “replacing the current ‘ethic of individual rights’ with
an ‘ethic of the common good’” (“Hippocratic Oath & Autonomy”).
In my interview with Mr. Johnson, he explained that patient autonomy is achieved by adjusting opioid and morphine dosages according to a patient’s level of suffering. In this way, physicians are not making subjective decisions when prescribing morphine, but systematically relying on a patient’s suffering to make care decisions. Doctors and NP’s are trained to minimize suffering, so their goal is always to reduce the patient’s suffering. Therefore, if a patient were to request to not be given any opioids, he would make certain that that is their request because the patient’s suffering is considered unethical. In his own words,

a patient suffering is driving the boat. I think it's unethical to leave someone in suffering unless they want to. I want to be fully clear if they say no pain meds. When someone goes to end-of-life hospice or comfort care, it's up to them—they’re driving the boat. And so often these patients and families say, “No just make me comfortable please. Just make me comfortable.” We have to keep in mind—I’m dealing with someone some of the sickest patients in the area in the hospital I work at so I'm also dealing with patients that have had really, really long journeys and very frequently pain from cancer, wounds that aren't healing from dialysis and end stage renal. I'm dealing with people that the reason that they died with us is because they are not stable enough for their symptoms. Their symptoms are so severe that they need to stay in the hospital for a symptom control and we call that GIP, or general inpatient hospice. Sometimes there is a stigma against hospice, so often, palliative care manages their end-of-life symptoms and we don't have hospice involved. It's just us, and our job is to respect their wishes and with those wishes they may be sedated because we have prescribed levels of medications that cause that.

Respecting patient autonomy in end-of-life care is often difficult as patients cannot verbally express their wishes, or may be in a state of desperation due to their high levels of pain. Therefore, doctors and nurse practitioners like Ms. Redding and Mr. Johnson ultimately rely on a measurement of a patient’s suffering to “drive the boat,” or to determine the plan of care for the patient. Mr. Johnson’s responses grant us insight into how providing palliative care is a careful balance between respecting patient autonomy while making decisions based on the suffering of the patient as perceived by the caregiver.

Conclusion

As this chapter shows, the principle of double effect is a useful tool for doctors and nurse practitioners like Ms. Redding to ensure that morphine and other opioids are administered
appropriately. However, the emphasis on the principle of double effect remains contentious, as Dr. Williams explained. Both Dr. Williams and Rev. Yavarone agree that the principle of double effect is over-used, as there only a small fraction of patients who already suffer from respiratory depression may be further aggravated by high dose of morphine, resulting in a hastened death. As Mr. Johnson explained, the ethics of palliative sedation are heavily reliant on the proper application of the principle of double effect, in which sedation is never intended but a side effect of alleviating the suffering of the patient. Doctors and NP’s may even withhold morphine and opioids to give patients the opportunity to say their goodbyes to their loved ones. Regarding the intentionality of the person administering morphine to patients, Dr. Zalot admits that the person’s intent cannot be known directly questioned. The only other way of establishing intent of the practitioners is by examining records of care that clearly show malicious intent.

In situations in which patients are incapacitated or unable to verbalize their wishes, they rely on healthcare proxies or family members to make decisions in their place. Doctors and providers are thus responsible for educating the proxies and family of the patients to enable them to make informed and appropriate decisions. Lastly, as Rev. Yavarone puts it, “autonomy isn’t a God,” and doctors should make decisions in the best interests of the patient, even if they may go against the patient’s wishes.
Chapter Five: A Time to Die: Ordinary vs. Extraordinary Means and “Stealth Euthanasia”

In this chapter, I will shed light on the definitions of “extraordinary” and “ordinary” means of intervention as used in Catholic bioethics, and how these definitions apply to end-of-life care. I will present controversial cases that have challenged Catholic bioethics and helped to define these terms in the U.S. legal system. Finally, I will seek to address the potential for “stealth euthanasia” in the use of palliative sedatives and analgesics, as explained by my interlocutors.

What is “ordinary” and what is “extraordinary”?

In Catholic bioethics discourse, in tandem with the principle of double effect, is the discussion of extraordinary vs. ordinary means of intervention in care for patients at end of life, and the associated weighing of benefits vs. burdens. One of my interviewees, Reverend Yavarone regularly defines extraordinary and ordinary means in the public sphere to explain Catholic morally and ethically-guided medical care. Specifically, ordinary and extraordinary means of care is often used to decipher the difference between intentionally killing the patient and treating the patient’s symptoms. In Rev. Yavarone’s words,

The most basic thing is the difference between killing someone and allowing them to die. The Church says, and I would say, that reason can also arrive at this truth. It's not just a Catholic truth for Catholic people—that you should never kill someone even if they ask, but that you can allow them to die (people have been allowing their loved ones to die since the beginning of human history). So sometimes it's a pretty clear-cut difference and other times it's hard to tell. So there's a distinction that the Church makes between ordinary and extraordinary means of preserving life. Ordinary means would be means where the benefits are proportional to the burdens and you're talking about the benefits of the particular treatment in question. So, a ventilator in my mom's case was extraordinary means—it wasn't really offering her any benefits. She had had a stroke, she had been there for some time before she was discovered, she was brought into the hospital, and so as far as I could tell she was probably brain-dead. So, the ventilator wasn't offering any real benefit and that would be extraordinary means and could be discontinued at this point.

Reverend Yavarone believes that the use of extraordinary vs. ordinary means is fundamentally based in reason and not limited to the Catholic sphere, as it also applies to non-
Catholic ethical medical care. When it comes to difficult decisions, such as deciding when is the right time to remove a loved one from a ventilator, it is useful to weigh the benefits in proportion to the burdens to decide what is “ordinary” and what is “extraordinary.” Rev. Yavarone qualified this by explaining that benefits and burdens are not standardized, and can vary between patients and their immediate environments. He explained,

[Extraordinary and ordinary means] would vary very much between patients. There is a difference between sometimes those words are used in the medical profession, where for them, extraordinary means would mean something very unusual so it wouldn't necessarily differ from patient to patient. If something is experimental or if it's not readily available they might call that extraordinary. But when we say extraordinary, we mean something different. So for example, when I was in the Philippines, there are places where an IV might be extraordinary because they just can't get one—they're just too poor or too far from the city where there would be a decent hospital so it would be so burdensome for them to get one. [In that case], the burdens would outweigh the benefits. They might have to sell everything that they have and perhaps even take a chance on the person dying to get from a remote place in the province to the nearest city on the nearest island that would have a hospital. Here [in the U.S.], a ventilator would pretty much be readily available just about any geographical place in the United States so there's a lot more that would be ordinary means here than would be in the Philippines and that's just part of the mercy of God. He doesn't ask us to do the impossible.

As Rev. Yavarone clarified, the circumstances surrounding the patient often determine which methods are “extraordinary” and which are “ordinary.” In the case of a patient living in a third-world country where life support technology is rare and would require the patient to go to extreme lengths to access, the burdens (accessing life support) would outweigh the benefits (extending the life of the patient) in the situation, and life support would be considered “extraordinary” means.

To expand on the definitions of extraordinary vs. ordinary means, Rev. Yavarone addressed the means of nutrition and hydration at end of life. Rev. Yavarone, and the Catholic Church, defines food and water as an “ordinary” means in any circumstance.

Food and water is a special case. Whereas something like a ventilator could be ordinary and some situations and extraordinary, [food is not]. We have a priest right now who's in his 50s who has multiple systems atrophy—a very terrible degenerative disease on the autonomic nervous system. He needs a ventilator and for a long time they would remove the ventilator and he would celebrate mass and he would only leave it on when he slept. So for him a ventilator was and still
is ordinary means. There may be a time in his own life where it is no longer offering any reasonable benefits so it can be withdrawn. So the point is that something like a ventilator can be ordinary at times and can be extraordinary at times. Food and water according to the Church—and again I think the Church is only teaching what's true—is in principle ordinary means. In other words, as long as a person can digest food and assimilate water you should give it to them even if you need to supply them by tube. So I would disagree for that example with the Terri Schiavo case from a few years ago. She was a woman who had a heart attack many years ago. She was still relatively young and her 30s and she was on a feeding tube and the feeding tube was working just fine she wasn't in any life-threatening situation. To make a long story short, the husband together with the courts decided it was okay to remove the feeding tube and she died I think about two weeks afterwards and the cause of death was starvation and dehydration. So food and water is a little bit different and in principle, it's ordinary no matter that a person state is. The only exception would be if a feeding tube is can't do what a feeding tube is supposed to do. Some people can't assimilate food anymore and so it doesn't make any sense to administer it; and some people—you introduce the feeding tube and the feeding tube immediately causes some kind of infection so there wouldn't be any point in giving it to the person.

As this chapter will later cover, Terry Schiavo’s case was unique in that the courts decided that food and water were extraordinary means and could therefore be removed. Rev. Yavarone disagrees with this decision, as the Church considers nutrition and hydration to be ordinary in any case.

I asked Dr. Williams to share how she applies the extraordinary vs. ordinary means to her practice. She shared that these terms are commonly used in hospice to determine the best course of treatment for each patient. So it's actually pretty common in terms of making determinations. We define extraordinary measures as those that don't offer any reasonable hope of benefit in the setting of the patient's particular medical problem. So the same treatments can be ordinary in one circumstance and extraordinary in another. If I have a treatment like putting you on a ventilator after you've had an allergic reaction that's caused you to have tracheal swelling for example—that’s an ordinary treatment because you have a temporary problem for which I have a high level of certainty that I can fix but in the interim I need to keep you breathing to keep you alive. That would be considered an ordinary treatment. But that same idea of putting you on a ventilator when you have a terminal cancer of which you are dying from respiratory failure—putting you on the ventilator is not going to halt the progression of your cancer. It is not going to halt the progression of your respiratory failure and so in that circumstance the intervention becomes extraordinary. We describe those things to patients and families; so obviously there is a need for a medical understanding of effectiveness in terms of making the decision about when something is ordinary versus when something is extraordinary. That’s really your job as a physician—to help people understand what the effectiveness of the treatment or the intervention is and what the likelihood is that that intervention will result in the outcome that they are hoping for, and from there to discuss the patient's decision about is this. The patient is the one who makes the decision of the degree of burden they can bear.
Dr. Williams explained that it is often up to the physician caring for the patient to determine whether the benefits outweigh the burdens of treatment. This determination requires a clinical understanding of the patient’s condition as well as the outcomes of each treatment. In addition to making this determination, the physician must also explain the benefits and burdens to the patients and their families, which can be a difficult task to achieve.

Ordinary means, as defined by the Catholic Church as “those which offer reasonable hope of benefit and are not unduly burdensome to either the patient or the family” (Saunders 2016). Extraordinary means, on the other hand, may be used by the patient but is not required or encouraged by the church—they are means which “do not offer reasonable hope of benefit and may be excessively burdensome to either the patient or the family” (2016). Although this definition appears to be straightforward, it comprises many aspects of consideration, including: “type of treatment, the degree of complexity, the amount of risk involved, its cost and accessibility, and the state of the sick person and his resources.” (2016). In response to ordinary and extraordinary means, Dr. Balboni argued that the definitions of these terms are not well-taught to Catholic congregation members and can often lead to confusion in deciding which treatment options are extraordinary and which are ordinary.

It's definitely a case-by-case sort of decision and to the degree that there is a lot of subjectivity, that subjectivity should be left up to the patient to decide what would be ordinary or extraordinary. I think there's a calculus between kind of the burdens of the treatment as well as the benefits so even within the United States it's not just going into the ICU that is intentionally extraordinary. There are much less highly technical sorts of medical things that could be considered extraordinary but the patient's not going to be any benefit from it they’re still dying and it is a case-by-case word decision. I think one thing the Catholic Church hasn't done a super job in is teaching its congregational members in how to think about those categories. We do see among a lot of Christians a lot of more intensive receipt of more intensive care within terminal illness versus those who are not very religious and so it seems that a lot of religious beliefs play a role in how these things are being played out. There is perhaps not enough discernment in recognizing, “Well I'm dying, family members dying; it's time to let go,” so Christians are less willing to make that decision versus their secular counterparts.
Dr. Balboni’s point is valid in that many of the definitions that the Church offer to define extraordinary and ordinary means rely on an assumption of morality. To further clarify these two definitions, however, Catholic theology has defined both terms by outlining five factors in each. In the case of extraordinary means, the first factor is the “impossibility factor,” which refers to cases in which it is impossible to attain the means of treatment (Wildes 1996). The second is the difficulty of the factor, or whether or not the factor requires excess effort on the part of the patient. The third factor is that of pain—or the level of pain that patients would experience with the treatment, such as the pain of enduring chemotherapy. The fourth factor is the financial expense of the treatment. If, for instance, the treatment would cost the patient and his or her family an amount of money that is beyond their means, then the treatment would be considered extraordinary. The last and fifth factor is the emotions of “fear and repugnance” which make the patient averse. Some Catholic moralists cite amputation as an example of this—or when patients may be repugnant to the idea of living with an amputated body part and therefore refuse the operation (1996).

Ordinary means are similarly defined by five factors. The first factor holds that the means of conserving life “must offer some hope of benefit if it is to be ordinary and considered obligatory” (Wildes 1996). If death is inevitable, such as when a person is already dying, then typically ordinary means such as food and water would no longer be considered ordinary as they do not offer any reasonable benefit to the patient. The second factor is the patient’s social status—which may dictate the financial burden that he or she may bear from receiving the treatment. The fourth factor is the notion of difficulty, which involves factors such as pain, cost, danger to life, fear—all of which determine the difficulty of the treatment. An ordinary means must be both “convenient and reasonable” to carry out (1996).
Along with defining extraordinary and ordinary means, Catholic priests rely on the determination of a benefits to burdens ratio or comparing proportionate to disproportionate treatment when determining the best course of treatment for a patient. The problem with this approach is that this language implies a “mathematical measurement” but fails to “retain all the nuances of traditional teaching” (Wildes 1996). Despite the objective standards that exist to determine the benefits vs. burdens ratio, such as the availability of treatment, this determination largely relies on the “prudent judgment of the patient with the help of family and physician” (1996).

An example of the blurring of the line between ordinary and extraordinary means is the issue of nutrition and hydration. Although Rev. Yavarone argues that nutrition and hydration should always be considered ordinary means, this definition may not apply to patients in end of life care. According to Pennsylvania bishops, “the patient in the persistent vegetative state is not imminently terminal” and nutrition and hydration in this case remains “an ordinary means to sustaining life and should be continued” (Wildes 1996). The bishops of the Maryland Catholic Conference similarly write that “a medical treatment should not be deemed useless, however, because it fails to achieve some goal beyond what is expected.” It is worth noting that, up until recently, the notion of ordinary and extraordinary means was not exclusively applied to end-of-life care. Traditionally, Catholic bishops have viewed these issues in light of the whole patient, and not individual medical interventions, such as nutrition and hydration. As such, Catholic bishops cannot definitively apply the definition of nutrition and hydration as ordinary to every case, as each patient case is unique, which I will explore in the next section.

*Landmark Case Studies*
One of the most polarizing cases on the debate of extraordinary vs. ordinary means of intervention is that of Karen Ann Quinlan, whose name has since become synonymous with “death with dignity” and a patient’s right to die. On April 14, 1984, after a night out with friends and consuming alcohol and sedatives, 21-year-old Karen Ann Quinlan stopped breathing and slipped into a coma. Doctors at the Catholic hospital where Quinlan was kept then diagnosed Quinlan as being in a persistent vegetative state, and her parents requested that their daughter be removed from the ventilator. After doctors refused the request, her parents took the case to court, where her case became the first “right to die” case in the U.S. In a landmark case, the New Jersey Supreme Court ruled in favor of Quinlan’s parents, stating that “no compelling interest of the state could compel Karen to endure to unendurable” after which Quinlan was allowed to be removed from life support. Quinlan went on to live for another 10 years independent of life support, finally dying in 1985 of pulmonary failure (“Top Ten Comas”).

During the entire ordeal, Quinlan’s parents, Roman Catholics, had consulted their priest on their daughter’s situation. The Quinlans and their priests deferred to “The Prolongation of Life,” a statement issued by Pope Pius XII in 1957, which obliged Catholics to use ordinary means, rather than extraordinary means, to extend life. In their view, the Quinlans and their priest viewed the respirator that kept Karen alive as “extraordinary means,” a view with which the doctors disagreed. The Quinlan’s attorney, Paul Armstrong, exclaimed in his opening statement that “The answer to the tragedy of Karen Ann Quinlan is to be found in the love, faith, and courage of her family, who ask only that she be allowed to return to God with grace and dignity” (Leopore 2017). Armstrong repeatedly used the word “dignity” to emphasize that Quinlan’s right to die was validated by her right to be treated with dignity. On the other hand, the doctors’ attorney, Ralph Porzio, argued that the “sanctity of life” is “the cornerstone of our
Western Culture” and went on to equate the “sanctity of life” with right to die. Porzio cited the Declaration of Independence, reminding the court that the first right listed in the Declaration of Independence is the right to life. Porzio even likened the approval of Quinlan’s right to die to “turning on the gas chamber,” recalling the horrors of the Holocaust to argue for the right to life. Ultimately, the court ruled on March 31st, 1976, that despite Quinlan’s “incompetence,” her right to refuse medical treatment is protected under the Constitution’s protection of liberty, and that her father has the right to refuse on her behalf (2017).

Another landmark right-to-die case that came years later is that of Terry Schiavo, who on February 25, 1990, underwent cardiac arrest and entered into a persistent vegetative state. Because Schiavo left behind no advanced directive, her closest family was given the task of deciding her medical care. Under Florida law, Michael Schiavo, Terry Schiavo’s husband, was given legal guardianship over Terry (Quill 2005:1630). After three years of trying traditional and experimental therapies, Mr. Schiavo came to terms with Terry’s diagnosis of an irreversible persistent vegetative state, and decided that his wife would not want to kept on a machine in her condition. Mr. Schiavo claimed that his wife had made statements to him years before saying, “I don’t want to be kept alive on a machine.” Terry’s parents, the Schindlers, did not accept the diagnosis and remained firm in their belief that she would improve with additional treatment. In 1994, Mr. Schiavo and the Schindlers faced off in court, when Mr. Schiavo refused treatment for his wife’s infection and her parents took legal action to require treatment. In 2001, the court ruled that clear and convincing evidence showed that Ms. Schiavo would have chosen to not be kept alive on life support. In 2003, Florida legislature created “Terri’s Law” to override the court decision to remove Schiavo’s feeding tube, and her tube was reinserted. The law was then ruled unconstitutional and voided. Finally, in March of 2005, Schiavo’s feeding tube was removed for
a third time—which led to Congress passing an “emergency measure” signed by the President to force federal courts to review her case and have the tube reinserted. The U.S. District Court in Florida denied this request and Schiavo later died 13 days after the tube was removed on March 31, 2005.

Terry Schiavo’s case differs from that of Karen Ann Quinlan in that the primary conflict in the case existed between two familial parties who each felt they were doing what she would have wanted. While Quinlan’s case decided that the person in a vegetative state has a right to die when the technology keeping him or her alive is deemed “extraordinary means,” Schiavo’s case reinforced the need to respect the patient’s wishes if she or he were able to voice them while arguing that nutrition and hydration are extraordinary means. Ultimately, the court in Schiavo’s found sufficient evidence to prove that Schiavo would not have wanted to be kept alive on life support and conceded that doing so would be unethical and illegal.

Both Quinlan’s and Schiavo’s cases serve to show the complexity of deciding which technologies are “extraordinary,” and which are “ordinary,” as well as laying the foundation for the Death with Dignity movement in favor of an individual’s right to death. In particular, Schiavo’s case called attention to a patient’s autonomy even when he or she is in a vegetative state. Because Schiavo’s husband was able to argue that she would have wanted to be let go, the courts decided in his favor to remove her from life support.

“Passive” or “Stealth Euthanasia” and “Mercy Killing”

One of the questions I sought to address in my thesis is how do Catholic healthcare practitioners navigate the use of palliative drugs with the potential of hastening death or for “stealth euthanasia”? Through my interviews with my interlocutors, I aimed to answer this question. Stealth euthanasia is especially relevant in end-of-life care, when doctors and nurses
have increased authority over the drug doses administered to a patient. In simple terms, it can be defined as the withholding or withdrawing of ordinary treatment, such as life-support, that may reasonably prolong the life of a patient. I asked Ms. Redding how she and her colleagues manage the responsibility of hospice care while keeping in mind the concern for stealth euthanasia. She responded,

Ethics is huge when it comes to healthcare and there’s a reason for that. The medical community has the ability to hurt patients, injure patients, and shorten one’s life. And then you’ve got patients that are vulnerable or in a vulnerable position because they have diseases, they’ve got impairment in cognition, and they are looking to the healthcare community to help either cure them or alleviate their symptoms. So there is this trust issue between patient and professional. There’s one party that’s vulnerable and one that’s got the power, and between that you have to have a balance. When it comes to end of life and at the very end with hospice, I think that is even more paramount that we are not providing stealth euthanasia under the guise of hospice. And unfortunately, some family members may perceive hospice to be just that—but in five states in the country physician-assisted suicide is legalized, and we really don’t have euthanasia legal anywhere in the country. They’re thinking hospice must be the answer to that [or to provide stealth euthanasia]—and unfortunately, it’s not. Hospice was never intended to shorten one’s life. It was intended to provide palliation. Palliation by nature is all about covering symptoms, managing symptoms, providing pain relief and comfort for the patient, not to cure but to provide relief. Religious healthcare may not be a theological—not about imposing values of the Christian or Catholic faith to our patients—because we employ people of all faiths and we care for people for all faiths here. It’s part of Catholic healthcare and its part of our requirement to be a Catholic hospice or Catholic hospital [to employ people of all faiths]. You have to be able to care for people of all faiths, minister to people of all faiths or no faith at all, and employ people of all faiths.

As Ms. Redding explained, a mutual trust must exist between patients and their caregivers in hospice, and that the purpose of hospice should always be to provide palliative care and not to shorten a patient’s life. Although there is always the possibility of doctors abusing their power to provide stealth euthanasia under the guise of hospice care, Ms. Redding asserts that hospice remains a place for no other purpose than for patients to receive palliative care, and that this principle is built on a trust between patient and doctor or nurse. In a Catholic hospice, in particular, Ms. Redding explained that Catholic faith is not a prerequisite for either caregiver or patient, but that it provides the ethical guidelines for care that can be understood by people of all faiths.
With healthcare, it’s not so much about doctrine or dogma, but so much more about ethical care—ethical medical care. When I explain to a lot of our nurses who may not be Catholic, they are completely understanding of how Catholicism or Christianity plays a role in what we do in hospice. They never feel like they have to be Catholic to understand it—they don’t feel like they have to believe in the same principles. What they do understand is Catholic healthcare forces you to provide good medical care because we’re supposed to abide by ethical parameters guided by our faith. Part of that includes what is considered proportional care, what is considered disproportional care, what is considered aggressive care, and what’s considered nonaggressive care. All of those terms are ethical terms—ethical terms that are safe guides to use and apply at the end of life or in healthcare in general. We explain to nurses in those terms—that when we are trying to decide at the end of life if this patient continue dialysis, or if this patient should continue IV hydration, we’re going to go through those parameters. First, let’s look at the principle of double effect—does it meet all of those requirements? Now let’s look at what is proportionate care versus disproportional care.

Ms. Redding went on to give an example of medical care guided by Catholic moral ideology in the case of a patient with a renal disease wherein doctors and nurses must weigh the difference between proportionate and disproportionate care. Only by following Catholic ethical guidelines can caregivers avoid situations of stealth euthanasia or other malpractice.

As an example, a patient might have renal disease, or kidney disease but the family want the IV hydration to be continued. A Catholic healthcare approach to this would be—“Well let’s look at whether the IV hydration is considered proportionate care.” At this point, because the patient is going into kidney disease or renal failure, there’s no longer an ability for the body to assimilate that extra fluid to come in and just pee it out. So, if you’re not peeing it out, it stays in the body and the patient becomes very swollen, and starts to have secretions collect in their lungs. They start to get very swollen and uncomfortable and maybe there is an increase of diarrhea and there’s all these burdens on the patient. We then decide, because of what the patient’s body is doing, that this patient is now suffering more from this treatment of IV hydration and the side effects and that the adverse effects are actually outweighing the benefit of the hydration. Good Catholic hospice ethical care would actually say it’s time to discontinue that so we discontinue it and this patient then may not have hydration. But at the same time, we didn’t push them with extra fluid that they didn’t need and cause harm. So all of those decisions are actually guided by the ethical principles that we are following through our faith. Our nurses recognize that [Catholic ethics] making them follow good medical care, and it’s not about religion.

Along the lines of stealth euthanasia, some may justify the practice by claiming to only be practicing “mercy killing,” suggesting that stealth euthanasia is in the best interest of the patient. I asked Reverend Zalot for his take on this argument, to which he responded,

The argument that mercy killing is justified by Catholic teaching is absolutely untrue. John Paul II wrote in his document called Evangelium Vitae—the Gospel of Life, in paragraph 66, “Even when motivated by the selfish refusal to be burdened with the life of someone who is suffering, euthanasia and assisted suicide must be called a false mercy and a disturbing perversion of mercy.
True compassion leads to sharing in others pain, it does not kill the person who is suffering we cannot bear.” And I think that’s a great insight in there—this idea of mercy killing—think of what you’re doing—you’re ending someone’s life, or you’re helping them to end their life. Is that real mercy? I personally don’t see how it can be. What you’re doing is, or the intent is, “Well, we’re going to end their suffering” but that raises a whole lot of questions about the meaning of suffering and everything else. But what you’re doing is you’re killing a person, and this whole understanding of mercy, or mercy killing, I should say, it doesn’t.

Reverend Zalot firmly denies the claim for “mercy killing,” as he believes Catholic doctrine teaches believers that real mercy is sharing in a person’s suffering, rather than ending it. When I asked Reverend Yavarone to respond to “mercy killing,” he expressed a similar sentiment, saying,

The Gospel of Life talks about it. Here’s what John Paul II says and I agree with him; “true compassion or true mercy means suffering with the person.” That's what compassion means—suffer with. It does not kill the person whose suffering we cannot not bear.” And I think that's really what happens a lot of times. The person at the bedside has such a hard time bearing it that they want to do something so they may kind of convince themselves that they’re putting the other person out of their suffering but really what they're doing is they're putting their suffering over the other person out there out of their suffering.

Because Catholic doctrine clearly denounces all forms of stealth euthanasia, Catholic hospitals and hospices are firm in their stance against any and all forms of stealth euthanasia. As written in The Linacre Quarterly, Terry Schiavo’s case is considered by some Catholics to be an example of covert, or stealth euthanasia. Schiavo’s death was caused by dehydration and starvation while she was in a persistent vegetative state. Moreover, Schiavo was not administered morphine to alleviate any pain caused by dehydration as it would be “inconsistent with the erroneous claim that so called ‘persistent vegetative state’ patients are not conscious and cannot feel pain” (Isaijw 2018:210).

Aside from stealth euthanasia by dehydration and starvation, another form of stealth euthanasia is by the administration of morphine which may depress the patient’s respiratory system. One other form of stealth euthanasia that exists is denying a patient “ordinary treatment
for readily reversible co-morbidities, such as antibiotics for curable infections and denial of fluid replacement in reversible cases of gastroenteritis” (Isaijw 2018:210).

As these many methods of stealth euthanasia show, it remains a challenge to make certain that healthcare practitioners in both Catholic and non-Catholic healthcare institutions do not intentionally or unintentionally participate in stealth euthanasia.

Conclusion

As illustrated in this chapter, “extraordinary” and “ordinary” means of intervention are useful and necessary to make decisions for when to stop life-sustaining care for patients. While technologies such as IV and ventilators can be “extraordinary” or “ordinary” depending on the circumstances of the patient, food and hydration are generally considered by the Catholic Church to be “ordinary” in any case. In the controversial Terry Schiavo case, food and hydration were deemed extraordinary by the Florida courts, and Schiavo’s feeding tube was removed, resulting in her imminent death. Rev. Yavarone disagrees with this court decision, insisting that food and hydration in the form of the feeding tube are “ordinary means” in any situation. Similarly, in Karen Ann Quinlan’s case, her family and priest argued that the respirator was “extraordinary means” and could therefore be removed. Quinlan’s case laid the foundation for the Death with Dignity movement, as her parents and lawyer emphasized Quinlan’s right to die with dignity instead of being forcibly kept alive on a respirator. Lastly, when asked how she takes care to avoid stealth euthanasia in hospice, Ms. Redding explained that Catholic healthcare institutions, including hospices, do not intend to impose Catholic beliefs on their patients, but to practice morally and ethically good care that is guided by Catholic ideology. Doctors and nurses who practice according to Catholic moral and ethical ideology, are better equipped to avoid stealth euthanasia when treating their patients. Ms. Redding stressed that hospice is not a place where
patients go to intentionally hasten their deaths, but where they receive palliation to help ease their suffering at their end of life. In the same vein, Dr. Zalot condemned the idea of “mercy killing,” arguing that true compassion taught by the Catholic Church lies in sharing in the suffering of another, and not intentionally ending another’s life because one cannot bear seeing him or her in pain.
Conclusion: So What?

Throughout this project, I have probed various facets of end of life care, and the complex issues that surround palliative sedation and analgesia in Catholicism. In Chapter 2, I compared and contrasted the view of suffering from Catholic and non-Catholic perspectives. By quoting my fieldwork interlocutors, I defined the meaning of redemptive suffering as taught by the Catholic Christian faith, and learned how redemptive suffering achieved by offering one’s suffering with Christ’s suffering helps patients come to terms with the pain that patients experience at end of life. I also quoted my interviewees on the nation’s opioid crisis as a consequence of American culture’s perception of suffering as devoid of meaning, as well as the concern for potential drug diversion in palliative care and hospice care.

In Chapter 3, I quoted my interviewees on controversial issues such as abortion, and uncovered how the Catholic view of life as a precious gift and death as an act of obedience to God justifies the Church’s position against abortion and the death penalty. Next, I unpacked the subject of legalization of physician aid-in-dying in the U.S. and its impact on Catholic medical care. I quoted my interviewees on their concerns of the effect of aid in dying on Catholic healthcare practitioners’ rights to refuse participation and patients’ concerns for stealth euthanasia. I also elucidated the “slippery slope argument” against aid-in-dying and my interlocutors’ concerns that the practice will ultimately undermine patients’ trust in their providers. Finally, I quoted my interviewees on the problems and concerns presented by increasing mergers and partnerships between Catholic and non-Catholic healthcare organizations, specifically their concerns that these mergers will gradually undermine Catholic hospitals’ ability to adhere to the ERD’s.
In Chapter 4, I defined the principle of double effect, and quoted my interviewee on how the principle of double effect is applied in the practice of opioid administration. I then explored the validity of the principle of double effect, and the potential dangers in over-using the principle in the medical field. I quoted a nurse practitioner on the practice of palliative sedation, and how the principle of double effect is used to ensure that the practice is justified. Additionally, I explored the subject of intentionality of providers behind administering opioids, and how intentionality can be determined in order to prevent abuse and ensure accountability. I learned from my interviewee that doctors and nurse practitioners hold each other accountable by rotating care for different patients. Next, I quoted my interviewees on the roles of family and healthcare proxies in caring for patients who are cognitively disabled or unable to express their wishes, and the importance of educating family and proxies to enable them to make informed decisions. Lastly, I quoted my interviewees on the careful balance between respecting patient autonomy and providing ethical care to patients.

In Chapter 5, I defined “ordinary” and “extraordinary” means of intervention, and the benefits vs. burdens discussion in medicine. I explained how these terms apply specifically to end of life care, when patients and their families have to make difficult decisions to either end or continue life-sustaining care. I used specific case studies, including the Terry Schiavo and Karen Ann Quinlan cases, to illustrate how these cases set legal precedents for defining “extraordinary” and “ordinary” means of care and asserted the importance of respecting the dignity of the patient by allowing him or her to die. Finally, I addressed the question of how doctors and nurses avoid “stealth” or “passive euthanasia” in Catholic hospices. One interviewee explained that the goal of hospice is never to hasten the death of the patient, and that doctors and nurses in a Catholic hospice can follow Catholic morals as a compass for morally good care. Finally, my interviewees
explain the misguided concept of “mercy killing” that goes against the Catholic definition of true compassion, in which one shares in the suffering of another.

The first question I sought to answer in this thesis is: How do Catholic and non-Catholic hospitals and hospices navigate the principle of double effect in the context of America’s opioid epidemic? In my interview with Catholic Missions Coordinator Bobi Martinez, I learned that hospice and home care can potentially serve as a platform for drug diversion. In these cases, it is up to the hospice provider to monitor patients and their drug use to prevent such abuses. Similarly, in a non-Catholic hospital, palliative care practitioners are mindful of the opioid crisis in practice by re-directing patients who have a history of abusing drugs to another department that specializes in addiction medicine. Furthermore, as Mr. Johnson described, palliative care doctors and NP’s do their best to reduce drug doses as much as possible, keeping in mind that many of their drugs are addictive. In my interview with Ms. Redding, I learned how the double effect applies specifically to opioids, and how doctors and NS’s in their hospice titrate the dosage of morphine to manage a patient’s symptoms. In this way, providers are able to avoid hastening the death of the patient by suppressing the patient’s respiratory system.

The second question I posed at the beginning of this thesis is: How do Catholic and non-Catholic healthcare facilities avoid “stealth euthanasia,” and adapt to the shift towards acceptance of physician aid-in-dying? As explored in chapter five, “stealth euthanasia” or any form of “mercy killing” goes against Catholic moral teachings. As Dr. Zalot explained, true compassion lies in sharing the burden of suffering rather than ending the person’s life as a way of ending suffering. Although my interviewees did not offer definitive answers to how to avoid “stealth euthanasia,” Ms. Redding emphasized the use of Catholic theology as a basis for moral and ethical care for patients. In her example of a patient in chapter five, she explains that doctors...
and NP’s in Catholic hospices must weigh the benefits in proportion to the burdens of treatment, which will allow them to make appropriate choices for the plan of care according to the principle of double effect.

The third question I aimed to answer is: How does the approach of Catholic hospices and hospitals in pain management differ from that of non-Catholic hospitals and hospices? In my interviews with Catholic administrative staff, doctors, and nurse practitioners, many of them stressed that Catholic hospitals and hospices who are diocese-approved and adhere to the Ethical and Religious Directives are cautious to avoid practices that hasten the death of their patients. Because of this guarantee and the reputation of Catholic healthcare facilities, many patients including both Catholics and non-Catholics seek care in Catholic hospices. Bobi Martinez claimed that some non-Catholic hospitals and hospices “do clockwork,” or intentionally hasten the death of their patients with palliative drugs to make a greater profit. Both Mr. Johnson and Dr. Williams firmly denied these allegations, asserting that non-Catholic hospitals do not prescribe to hasten the deaths of their patients. While Mr. Johnson noted that he observed that Catholic-affiliated hospitals are more conservative in using opioids, Dr. Williams, claimed that some Catholic hospitals have reputations for being more aggressive in their use of opioids. In conclusion, Catholic healthcare facilities cannot be definitively shown to be less or more aggressive in opioid use compared to non-Catholic healthcare facilities.

The final question I hoped to answer in my thesis is: How will faith-based medicine maintain its autonomy as more Catholic hospitals are merging with non-Catholic healthcare organizations? Although this trend does raise concerns for Catholic bioethicists and healthcare workers, Dr. Zalot recommends that Catholic healthcare facilities make thorough merger agreements that protect them from performing treatments or procedures that violate the ERD’s.
Additionally, bishops who approve of mergers may consult with the NCBC on merger agreements before signing off on the mergers to ensure that Catholic bioethics are not violated in the agreements.

**So What?**

When I first began writing this thesis, I knew it would be an ambitious undertaking and I wasn’t sure if I would be able to answer all of the questions I set out to address. Originally, I was only interested in understanding how palliative sedation and analgesia are practiced in Catholic healthcare institutions, but with each interview, I found myself drawn to new and different ideas that hadn’t crossed my mind when I first decided to embark on this project. In writing this thesis, I gained a newfound appreciation for Catholic conceptions of human life and the suffering that accompanies it, and how these beliefs are reflected in the Catholic approach to compassionately care for patients at end of life. Although Catholic theology appears to be dogmatic and orthodox to its opponents, its advocates see it as a compass for moral and ethical care that can benefit people of all faiths and backgrounds. Furthermore, although Catholic and non-Catholic healthcare facilities may have their disputes over specific modes of care, practitioners in both parties are ultimately seeking the best outcomes for their patients.

It is my hope that this thesis fosters an understanding of Catholic ideology behind Catholic healthcare, as well as the nuances of palliative sedation and analgesia in end-of-life care. Instead of resorting to preconceived notions of what it means to be a “Catholic” or “non-Catholic” hospital or hospice, we should consider the intentionality at the core of each hospital’s or hospice’s mission of care. In this way, we can learn that compassion for those at their end of life is not limited by our religious faith, political stance, race, or ethnicity, but an innate human quality that we all share.
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