



## FAQs – Frequently Asked Questions

Following are questions often asked about end-of-life issues.

### 1. What is the difference between a hospital and a hospice?

A hospital is for patients seeking medical treatment to cure their illness or injury. A hospice is for patients who have a terminal illness, who have suspended curative efforts and who want to die in a homelike setting. Hospice care is “comfort care,” which can occur in either a hospice facility or in a patient’s home.

The hospice patient is attended by a team of caregivers including medical personnel, counselors, clergy and family members. The goal of hospice care is to ensure that the physical, spiritual and emotional needs of patients are all met so that they may live well while dying. See Hospice section

### 2. Who decides on the medical treatment of an ill patient?

If the patient is mentally competent, then he or she makes medical treatment decisions—usually in consultation with medical personnel, counselors or spiritual advisors and family members. If the patient is not mentally competent or is physically incapacitated so that communication is not possible, then the decision about treatment may be made by a surrogate, known as a *healthcare proxy*, who has been assigned by an *advance directive* known as a *durable power of attorney for health care*. In the absence of a *healthcare proxy*, medical personnel should take guidance about the patient’s wishes as expressed in a legally executed advance directive called a *living will*. And in the absence any *advance directive*, medical personnel will turn to next of kin—usually spouse first, then adult children—for healthcare decisions.

### 3. What is a *durable power of attorney for healthcare*?

A *durable power of attorney for healthcare* is a document that legally gives authority to a surrogate, or *healthcare proxy*, to make healthcare decisions for a person who is mentally incompetent or physically incapacitated. The *healthcare proxy* (surrogate) should know of any *advance directives* that have been executed or in the case where additional decisions need to be made, should know the wishes and beliefs of the person who designated him or her as a *healthcare proxy*.

### 4. What is the difference between a *living will* and an *advance directive*?

A *durable power of attorney for healthcare* and a *living will* are both *advance directives*, that is, directives regarding healthcare decision made in advance of the need to make those decisions—most often regarding decisions at the end of life. In the first case, the *advance directive* designates a *healthcare proxy* to make those healthcare decisions if necessary—and may include written instructions for certain situations. In the second case, the *advance directive* does not designate a proxy, but contains written instructions about various healthcare decisions which will likely need to be made.

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### 5. What is the difference between terminally ill and permanently unconscious?

A person diagnosed with a terminal illness is a person whose health is predicted to steadily decline until death—usually in six months or less. A terminally ill patient may or may not be mentally competent to make medical decisions. A person who is permanently unconscious is not dying, but is unable to make healthcare decisions. Another term for the state of being permanently unconscious is “persistent vegetative state.”

### 6. Does the Catholic Church require the use of all available technology to preserve life?

The Church does not promote vitalism (preserving physical life at all costs) but rather asks us to embrace the virtues of fidelity (faithfulness to those in need), compassion (suffering with those who are suffering), individual dignity, patience, humility and hope in the life hereafter.

Food and water—whether by mouth or by artificial means—are considered obligatory unless a person is imminently dying. However, the use of other technology may be optional depending on whether the means (treatments) are “ordinary” or “extraordinary.”

### 7. What is the difference between “ordinary” and “extraordinary” means?

In this context, *ordinary is obligatory*; it is *not* “usual.” And *extraordinary is optional*; it is *not* “unusual.” The “usual/unusual” distinction builds on what is customary in medical practice—which is merely *relevant* to moral judgments, not *decisive* in those judgments. Ethics is not reducible to consensus or tradition.

There are two criteria (both must be true) for a therapy/treatment to be ordinary and therefore obligatory: (1) a reasonable prospect of benefit *and* (2) *not involve* excessive expense, pain or inconvenience.

“Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience. Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain or other inconvenience, or which if used, would not offer a reasonable hope of benefit. “—G Kelly, “The Duty to Preserve Life,” *Theological Studies*, 12, December 1951, p. 550.

### 8. When is it permissible to refuse medical treatment?

It is permissible for a person to refuse medical treatment “when death is imminent and cannot be prevented by the remedies used” ([Euthanasia, CDF, 1980](#)) or when the “means [medical treatments] are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.” ([ERD, 57](#))

### 9. Can a terminally ill patient refuse a feeding tube?

The technical term for a “feeding tube” is “artificial nutrition and hydration” in which food and water are provided by alternate means to a patient unable to eat and drink by mouth. The provision of food and water is not considered medical treatment but basic comfort care. However, the feeding of a dying patient may not be in the patient’s best interest if the patient’s death is imminent or if the patient is unable to assimilate the nutrition. Nonetheless, water should always be offered. A feeding tube may be temporary if inserted through the nose to

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the stomach for medicines, hydration, and nutrition. Long term tube feedings requires a tube being surgically placed through the abdomen into the stomach.

“There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.” ([ERD, 58](#))

### 10. What is the Church’s teaching on keeping unconscious people alive?

We owe those who are permanently unconscious basic comfort care which includes food and water.

“The sick person in a vegetative state...has the right to basic health care (nutrition, hydration, hygiene, warmth), and to prevention of the complications associated with their state...In particular, I would want to emphasize that the administration of water and food, even when it is provided by artificial means, always represents a natural means of preserving life, not a medical intervention. Its use is therefore considered...morally obligatory...

“(Pope John Paul II on [Life Sustaining Treatment and the Vegetative State, March 20, 2004](#))

### 11. Can a surrogate for a person in a “persistent vegetative state” refuse artificial nutrition and hydration for that person? Can a person sign a living will that asks that no artificial nutrition and hydration be administered if he or she falls into a permanently unconscious state?

The legal answer to both questions is yes. The moral answer may be no.

Legally, a healthcare proxy or other legally recognized and/or appointed surrogate for a person in a persistent vegetative state may withhold or withdraw artificial nutrition and hydration. Legally, a person can make such a request in a living will, although, medical judgment may prevail and overrule the request if the diagnosis of “permanent” is in question.

Morally, we owe those who are permanently unconscious basic comfort care which includes food and water—unless the provision of nutrition and/or hydration actually causes harm.

### 12. What is wrong with physician assisted suicide?

Those who advocate for the legalization of physician assisted suicide do not make a distinction between “killing” and “letting die.” They point to the law which allows a terminally ill patient to refuse treatment, including artificial nutrition and hydration and argue that because a terminally ill patient may die from refusing medical treatment and/or comfort care, the “compassionate” choice would be to make physician-prescribed lethal drugs also available to terminally ill patients. They claim that individuals should be able to control the “time and place” of their death.

We believe there *is* a distinction between “killing” and “letting die.” The Church teaches that human life is sacred because we are made in the “image and likeness” of God, and that earthly life is a precious good, although not the ultimate good, which is eternal life. This approach also fractures the relationship between patient and physician, when their role is changed to one who is to hasten dying intentionally rather than do all they can to alleviate all aspects of suffering.

“In the face of death—for many, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life...The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have

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absolute power over life. We have a duty to preserve our life and to use for the glory of God, but the duty to preserve life is not absolute...” ([ERD, Part Five, Introduction](#))

### **13. Isn't a morphine drip just another way to hasten a terminal patient's death? What is the difference between that and assisted suicide?**

A morphine (a strong opiate that offers the best, most common approach to severe pain relief) “drip” or continuous infusion (an efficient and convenient intravenous application) is often used when a terminally ill patient is experiencing progressive or intense pain. A morphine infusion (drip) is not prescribed to hasten a terminally ill patient's death, but to provide comfort to the patient. There is a method of gradually increasing strength of pain medicines as the pain changes with disease progression. Both the dosage and type of medicine can be changed to meet the individual's unique needs for relief and prevention of pain and discomfort. Beginning with mild, to moderate to strongest medications, the physician has options to maintain control over the person's pain over time.

There is a distinct difference between the action of prescribing pain medication for a terminally ill patient and prescribing a lethal drug for a terminally ill patient. In the first case, the intent of the prescriber is to relieve pain and the drug of choice would be an opiate such as morphine. In the second case the intent of the prescriber is to purposefully hasten death and the choice of drug would be a barbiturate. While it is true that the terminally ill patient's life may be somewhat shortened as a result of the ingestion of an opiate—that is not the intent of the prescriber. Catholic moral theology recognizes and accepts this situation—calling it the “rule of double effect.” (See discussion below.) Often the person who has struggled with pain for some time may be finally able to “let go” and die peacefully once they are no longer suffering. This can happen simultaneously but is rarely a direct result of the medication. The health care providers must assess and monitor and adjust the medication to achieve the proper dose and comfort balance.

“It is worth recalling here a statement of Pius XII that is still valid. A group of physicians had asked: ‘Is the removal of pain and consciousness by means of narcotics...permitted by religion and morality to both doctor and patient even at the approach of death and if one foresees that the use of narcotics will shorten life?’ The pope answered: ‘Yes—provided that no other means exist and if, in the given circumstances, the action does not prevent the carrying out of other moral and religious duties...death is by no means intended or sought, although the risk of it is being incurred for a good reason; the only intention is to diminish pain effectively by use of the painkillers available to medical science.’” [Euthanasia, CDF, 1980](#)

### **14. What is the rule of “double effect”?**

The rule of double effect, found in Catholic moral theology, has a long history of use by bioethicists and philosophers as a means to resolve a particular type of ethical conflict in clinical cases. Basically the rule comes into play when a proposed action (such as administering morphine to a terminally ill patient in pain) has two known outcomes. One outcome is intended and desired (relief of pain). The other outcome is neither desired nor intended (hastening death), although it may be foreseen.

### **15. Is it wrong to offer increasingly high doses of morphine to a terminally ill patient in severe pain? Won't the patient become addicted?**

No, it is not wrong—even knowing that the medicine may actually, although not intentionally shorten the life of a terminally ill person (See discussion of “double effect.”) A well informed physician is not worried about “addiction” but about providing adequate pain relief. Addiction is only a problem for those who are receiving curative care and who anticipate resuming ordinary life, or who have no underlying cause for pain and are taking

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strong pain medicine for the emotional high or escape from the euphoria. When a physical cause for pain exists it is utilized by the body and may need to be increased over time as the body adapts to it and changes occur in condition.

One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying [ERD, Part Five, and Introduction](#)

Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering. [ERD, No. 61](#) When a person is more comfortable they have the energy and ability to focus on family, relationships, living as well as possible for whatever time they have. Relief of pain can improve the time and duration of life and provide a window of meaningful celebration of one's life. Family can then use the time to share stories, have gatherings, create lasting loving memories, using the time well with good pain relief. Family's benefit from pain relief just as patient does. When one suffers, the other does too.

### **16. What if a patient's doctor won't prescribe adequate pain medicine?**

Unfortunately some physicians are not properly informed about pain relief medications or have an unreasonable fear of "addicting" their patients. Usually such physicians do not customarily treat the dying, but rather have a mind set of "curing" a patient.

A terminally ill patient (or those advocating for him or her) would be wise to seek out a physician who is well informed about pain management. One of the advantages of hospice care is that the medical personnel are well informed and well trained in the application of adequate and appropriate pain medication. In California physicians are required to receive continuing education on pain management which provides them with proper assessment, use and options available for various types of pain. Adequate pain relief is a right of every person and should be expected with good hospice or end of life care as well as during earlier treatment phase, as needed.

### **17. What are the obligations and the rights of parents of a profoundly disabled newborn?**

Parents of these newborns need to be properly informed as to the seriousness of their baby's condition, provided with the range of treatment options and intensity of care that is available to provide for the optimal support of life. Parents should be made aware of the availability of hospice care to support them if the baby has an incurable condition that may prove fatal, or even the possibility of being life threatening. Parents should be informed about all possible resources available, locally- people, organizations, nationally, specialists in the condition, counseling of emotional and spiritual, genetic if indicated. The parents and baby should be treated with dignity and respect no matter how long the life or how impaired the baby is.; have the option of going home with their baby if time is short and have support for the siblings, other relatives if they are grieving, having difficulty accepting the condition.