

## **Catholic On Call handbook**

### **Chapter 8 - Euthanasia and the Advance Medical Directive**

#### **The Catholic MO/HO:**

Only some specialists can legally certify brain death and they will find it difficult to do so licitly, since brain death legislation is intended to **define** a dead person with live organs for the purpose of organ retrieval for transplantation, including even a beating heart. However, it may be licit to label a patient brain dead when he has in fact massive irrecoverable brain damage in order to forgo or discontinue disproportionate measures. Catholic MO/HOs will not find it difficult to certify normal death (cardiac death), which does not have these impediments, but care must still be exercised if organ retrieval is intended.

It is not wrong to sign a document expressing a wish not to be resuscitated or for any doctor to participate in the administration of the AMD and to abide by the terminally ill person's wishes. Indeed Catholic doctors **should** participate both in the declaration and in the administration of the AMD. It is however improper to invoke an AMD made many years before or one of doubtful validity or when principal surviving relatives disagree. Care is also necessary to avoid the pitfalls of the living will as a means to euthanasia. If there is medical doubt that the condition is terminal, the certifying *specialist* should express his reluctance and refuse to sign. MOH will then set up an independent committee to decide whether or not to allow the AMD to take effect.

Although declaring "brain death" may be a legitimate means to forgo or discontinue disproportionate measures, it is an impediment when the AMD is a step prior to obtaining organs for transplantation (see above).

Euthanasia and physician assisted suicide are currently illegal in Singapore. However MO/HOs must be on their guard against immoral or borderline situations such as refusing feeds to anencephalic children, certifying brain death or denying normal care to the dying such as restoring and maintaining dignity, treating pain, discharge, bleeding, obstruction, disfigurement, odour, suffering, depression and degradation and providing nursing, nutrition and spiritual support. A request for assistance in suicide should be regarded as a sign of unmet needs. A doctor's calling is to end suffering but never by killing the patient when he cannot cure him. The mere inability to save a patient's life need not be taken as medical or personal failure but neglecting to care for him until natural death is. A good doctor lives by the precept, "First do no harm," must care when he cannot cure and must recognise and accept human mortality, not inflict it.

#### **8.1 Basic Church teaching**

##### **8.1.1 Catechism of the Catholic Church (CCC)**

*"Those whose lives are diminished or weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible." (CCC, 2276)*

*"Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable."*

*"Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgement into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded." (CCC, 2277)*

*"Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous"*

*treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected."* (CCC, 2278)

*"Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged. (CCC, 2279)*

8.2.2 Excerpts from ***Declaration on euthanasia*** (Prepared by the Sacred Congregation for the Doctrine of the Faith. May 5, 1980) which reflects Church teaching:

*"... one is never obliged to use ... disproportionate means (judged by) the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."*

*"... a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. Thus Pius XII warns: 'It is not right to deprive the dying person of consciousness without a serious reason.'"*

*"If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage"*

*"It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter."*

*"..one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide "*

*"When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger."*

*"As for those who work in the medical profession, they ought to neglect no means of making all their skill available to the sick and dying; but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness and heartfelt charity. Such service to people is also service to Christ the Lord, who said: "As you did it to one of the least of these my brethren, you did it to me (Mt. 25:40)."*

*"(Euthanasia is) a grave violation of the law of God...a false mercy and indeed a disturbing 'perversion' of mercy. True compassion leads to sharing another's pain; it does not kill the person. (Pope John Paul II)"*

*"the death of the person properly consists in the total disintegration of that unitary and integrated whole that is the personal self. It results from the separation of the life-principle (or soul) from the corporal reality of the person. This is important because it helps to avoid the mistake of thinking that persons are only their bodies, or that the human soul is located in*

*the brain or in any other part, or even that the person is the brain.” (Pope John Paul II AUGUST 29 2000 - ZENIT.org).*

*"The right to life cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die. Nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life." (Archbishop Peter Smith of Cardiff)*

## **8.2 Background information**

### **8.2.1 Definitions**

#### 1. Death (Interpretation Act amendment 22/98 of 2 Nov 1998)

This Act defines death as either of these:

- a. cardiac death is "irreversible cessation of circulation of blood and respiration"
- b. brain death is "Total and irreversible cessation of **all** functions of the brain," when there is known irremediable structural brain damage from a known cause, there is no suspicion of hypothermia, drugs and metabolic or endocrine causes, and respiratory depression is not due to neuromuscular blocking drugs. However, death of the **whole brain** is defined under this Act by only 7 tests viz
  - (1) fixed, unreactive pupils
  - (2) no corneal reflex
  - (3) no pain reflex
  - (4) no oculo-cephalic ('dollseye') reflex
  - (5) no gag reflex
  - (6) no vestibulo-ocular reflex after 50cc of ice water in each ear
  - (7) no spontaneous respiration with pCO<sup>2</sup> over 50mm.

Additional regulations are applicable if any organs are to be removed under the Human Organ Transplant Act 1987 (after brain death) or the Medical (Therapy, Education and Research) Act 1972 (MTA - after brain or cardiac death). These stipulate mainly the age and the medical teams involved.

These tests of the brain stem are inadequate to determine death of the whole brain. For example, neurogenic control of temperature and heart rate and hypothalamic-pituitary axis control of hormone production are not evaluated. Secretion of arginine vasopressin by the pituitary may not have ceased. Brain death so defined is not brain death. **Christopher Pallis** in his book *ABC of Brainstem Death* appears to regard death as a *process* rather than as an event (pg 4); death is thus the moment this *process* seems irreversible and judged more by a hopeless prognosis than by an actual event. **Alex Delilkan**, in his book *Dead or alive? The Medical Diagnosis of Death*, also lends support to the diagnosis of death by brainstem areflexia and attests to the universal acceptance of this definition of death in any acute care hospital providing intensive care facilities. A key symposium on the definition of death at the 5<sup>th</sup> World Congress in Intensive and Critical Care Medicine in Kyoto, Japan in 1989 made several recommendations:

1. Death is defined as irreversible cardiorespiratory function cessation and/or brain death.
2. Brain death is determined by clinical tests attesting to brain stem areflexia.
3. The corroborative test recommended for the diagnosis of brain death is demonstration of the absence of cerebral blood flow (only if a clinical brainstem reflex test cannot be done).
4. EEG evidence (isoelectric line) is not required to determine brain death.
5. The medical profession has the duty and responsibility to lay down the definition of death (for medical education and face up to any challenges in a court of law).

In addition, **Paul Byrne et al**, American Life League, 1996 believe that death is the radical incapacity of at least three basic unifying body systems - the circulatory and respiratory systems and the **entire** brain. In death there must be a consistent history, the heart must not be beating, there must be no recordable blood pressure, no tissue gas exchange and no brain function, functions or functioning. These are all untested. Circulatory control includes autonomic, endocrine and neurogenic control e.g. destruction of the heart alone does not mean destruction of circulation since an artificial heart can temporarily take its place. Respiratory control includes tissue gas exchange.

But **Pope John Paul II** more recently declared that a health worker can be morally certain of the occurrence of death if he rigorously applies the criteria that have been adopted in more recent times to determine "... *the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem)*" i.e. whole brain death not death of the cortex or brain stem.

These systems are contrasted with tissue culture (skin), which is not a human life, and DNA manipulation (like cloning transgenic animals), which has its own ethical problems. Patients in coma or in persistent vegetative state (PVS) are not dead. A parked car is not immediately functioning but it has functions and is not dead, even if its headlights are spoilt. Deficiencies in quality of life are irrelevant to death and dying since the first such quality is life itself. To state that defined brain death precedes inevitable death and thus legitimises organ retrieval is misleading and morally wrong. Death must be declared only after, not before the fact.

## 2. Advance directive

Defined as a document with written instructions made by a person before he/she reaches the terminal phase of a terminal illness or a persistent vegetative state and becomes incapable of making decisions about medical treatment when the question of administering the treatment arises. Generally falls into three categories:

- *Living will* – written document that specifies the type/s of medical treatment desired should the individual become incapacitated. May be general or specific.
- *Health care proxy* – legal document in which an individual delegates another person to make health care decisions if he/she is incapable of making his/her wishes known
- *Durable power of attorney* - allows nominated proxy to make financial transactions and applications for an individual who is medically incapacitated.

## 3. Euthanasia

Defined as any act or omission which of itself and by intention causes death with the purpose of eliminating all suffering.

## 4. Dysthanasia

Defined as the undue prolongation of life by futile therapy that ends in an undignified death.

## 5. Physician Orders for Life-Sustaining Treatment

Includes:

- **Do Not Resuscitate Order**: To withdraw life-sustaining treatment – typically cardiopulmonary resuscitation (CPR) – from a patient in a terminal condition or a permanently unconscious state. Morally permissible only if one can judge that CPR is

excessively burdensome for the patient taking into account his/her situation and physical/moral resources

- Allow Natural Death Order: to withhold assisted hydration and nutrition
- Order to Withhold Antibiotics

A patient can choose any one of the three following measures:

1. Comfort measures only – providing care to relieve pain/suffering
2. Limited additional interventions – may include intravenous fluids and antibiotics in addition to comfort care
3. Full treatment – includes CPR, breathing support and all other intensive care measures in an acute care hospital

POLST has a detrimental effect on Catholic moral teaching as it attacks the sacred value of human life by allowing individuals to hasten their own deaths on the basis of their personal intentions, exerted independently of Catholic healthcare values.

#### 6. Terminal illness

Defined as an incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery and where death would within reasonable medical judgement be imminent regardless of the application of life-sustaining treatment and the application of extraordinary life-sustaining treatment would only serve to postpone the moment of death for the patient.

#### 7. Extraordinary and ordinary means

If a medical procedure is judged to be ordinary, there is a moral obligation to use it, and if it is judged to be extraordinary, then its use is optional.

‘Ordinary’ and ‘extraordinary’ do not refer to the treatments themselves in isolation but rather only to those offered to a particular patient in his unique context. On the background of the patient’s physical, spiritual and moral resources, consider the following: the type of treatment to be used, its degree of complexity or risk, the cost of treatment, the possibilities of actually using it, the burdens it will place on the patient and others, and the positive results that can be expected. The use of a ventilator, dialysis or standard treatments for pneumonia may be judged ordinary means for one patient but extraordinary for another because of differing medical, moral and spiritual circumstances.

### 8.2.2 Physician-assisted suicide, euthanasia or mercy killing

Physician-assisted suicide, euthanasia or "mercy killing" is killing - an immoral act or omission **intended to cause death** - with patients’ consent or without, to eliminate suffering. It is an evil action intended for a good effect and must be distinguished from **allowing death when it's time** by forgoing or discontinuing treatment that is disproportionate, "futile" or an excessive burden to patient, family and community in relation to the results expected, including major operations, extended ventilation and any treatment that is experimental or has high risk or low success rates.

It is however immoral for the caregiver to deny the patient ordinary measures such as minor operations, antibiotics, nursing, (parenteral) feeding, pain control and other palliative measures when needed. It is the doctor's function to prescribe and a competent patient's right to refuse. In a process of dying, this need not be construed as assisted suicide and forced feeding is not appropriate but accelerating death **intentionally** eg with lethal drugs remains immoral. *Primum non nocere*.

Denial of nutrition is illicit if it introduces a new cause of death by starvation and dehydration, most blatant in a patient who is not immediately dying eg with PVS. There is no moral obligation for a patient to refuse analgesia and it may also not be illicit to give increasing dosages of morphine to control pain even though life may **unintentionally** be shortened (double effect); however it is wrong to bring about by means of drugs the loss of consciousness and of the use of a person's faculties.

The "right to die" or "death with dignity" may mean the right to refuse an abusive technology and die peacefully with human and Christian dignity but never the "right" to euthanasia or assisted suicide. Although death is normal and expected, whether in 50 years' time or in the next 1 hour, killing is always wrong. Conceptually, we should save life when the process is living and allow death when the process is dying. The task is to recognise and accept human mortality not to inflict it.

### **8.2.3 Palliative care**

Palliative care specialises in caring for sick and dying persons in all their needs – not solely physical pain and discomfort, but also the spiritual, emotional and social needs of the individual. It acknowledges that there is no cure for the dying person, but that holistic care and concern is essential and can bring about great healing.

A respectful and patient attitude of nursing staff towards patients and their families, provision of gathering places within the hospice for relatives and friends to provide respite and ease the stress of journeying with the sick and dying, ease of arrangements for patients to speak with their chaplain or other faith community leaders of their choosing, and a conducive physical environment (e.g. large windows to enable patients to see the sun, sky or garden) may all contribute greatly to the emotional well-being of the patient and the family.

## **8.3 Issues in clinical practice**

### **8.3.1 What to do: suggested approaches to common clinical scenarios**

#### **1. Terminally ill patient asking for mercy killing**

*You are doing your inpatient ward rounds and a patient suffering from metastatic lung carcinoma requests for hastened death. How should you respond?*

- Pray to God for guidance before beginning the consult
- Be aware that such requests are not uncommon and made for various reasons (relentless physical symptoms, progressive debility, loss of sense of self/control, fear of the future, fear of being a burden to others)
- Clarify what is being asked before responding (whether the patient is simply having thoughts of ending his life, exploring the possibility of future euthanasia should his condition deteriorate, or exploring your willingness to assist in his imminent plans for suicide)
- Try to respond in a way that does not make the patient feel abandoned – be curious about what the patient is trying to communicate, avoid brushing off the issue, be honest
- Useful statements/open-ended questions:
  - “You are very distressed. Tell me what is going on.”
  - “Why are you thinking about ending your life now?”
  - “This is a really terrible/difficult situation”
  - “It’s like your world has fallen apart”
  - “You feel like you’re no longer yourself”

- Pause and stay awhile with the emotion/s expressed. If appropriate, continuing statements that may be helpful include:
  - “I wish things were not like this/were better”
  - “I don't have all the answers, but I will continue to care for you and find out how else we can help you through this”
- Optimise symptom management - ensure pain and other distressing symptoms are adequately addressed
- Ensure adequate psychological and spiritual support – initiate referral/s to palliative care team, trained counsellors/medical social workers, patient’s own faith community/healthcare chaplain

## 2. Patient’s parents/family asking for Do-Not-Resuscitate (DNR) order

*You are seeing a 15 year–old boy with Duchenne muscular dystrophy in the home care clinic and his parents ask you about a DNR order, as this had been mentioned in the ward during a recent admission for pneumonia. How should you respond?*

- Pray to God for guidance before responding
- Establish current medical condition and clinical state through directed history and physical examination – it is important to know how far advanced the disease is, the patient’s current functional state, difficulties (pain, decreased mobility etc) , care issues and prognosis. *The 15 year-old boy in this case was already wheelchair-bound and on nocturnal home ventilation during sleep for obstructive sleep apnoea.*
- Explore parental concerns – their understanding of and reason/s for asking about DNR order now
  - Establish what has been discussed with the medical team thus far
  - Seek to understand parents’ views: their understanding of child’s prognosis, desire to spare child suffering, fears of child’s death, worries that child will not be able to cope with death/dying, financial concerns that have prompted anxiety about whether the family can afford continued treatment
- Gently enquire whether disease prognosis/management/DNR order has been discussed with the patient and what his views are. If not, offer to speak to patient with or without parents present to discuss this further
- If patient is aware of proposed DNR order/prognosis, speak to him to clarify his understanding, personal wishes and views
- Optimise current medical/psychological treatment – relieve pain/discomfort and enhance quality of life as far as possible
- Refer to medical social worker for financial aid/counselling and support as required (KIV links to caregiver support groups)
- Refer to palliative care team if patient/parents agreeable – need to ensure that patient/parents do not feel abandoned or that the medical team is “giving up on them” but rather seeking the most holistic care possible
- Plan for follow-up to discuss further issues
- If both patient and parents ready at same sitting, may discuss general terms of DNR order and outline crisis management plan according to patient’s/parents’ wishes (e.g. “in the event of collapse/admission to hospital in critical condition, for maximal comfort care in high dependency unit but not for cardiopulmonary resuscitation or intubation”). Document the discussion in detail in the patient’s case notes.
- Explain to both patient and parents that they are free to request further discussion/s about the management plan with the medical team at any time should they change their minds
- Issue a memo for the parents to give to attending doctors should patient require emergent medical attention.

## 3. Withdrawal of care in paediatric intensive-care unit (ICU)

*You are the paediatric ICU consultant providing medical care to a 5 year-old boy in a coma and on artificial ventilation following a subdural/subarachnoid haemorrhage sustained in a road traffic accident two weeks ago. Despite timely resuscitation, emergent brain surgery and maximal supportive care, he has not regained consciousness. He has been reviewed by neurology/neurosurgery and has been declared brain-dead. His parents request an update on their child's condition and want to know his prognosis. How should you respond?*

- Pray to God for guidance before responding
- Acknowledge that this is a very difficult situation for the parents/family as well as the medical team, with many important issues to consider. Plan a date, time and appropriate venue (e.g. meeting room) to hold a family conference with the parents, any relatives they may want present and members of the ICU team (yourself, your registrar and medical officer, the nurse-in-charge and the medical social worker).
- Hold a separate discussion with your medical team prior to the family conference to ensure all members understand the patient's clinical condition and management plan
- Provide a general summary of the case, from the time the road traffic accident occurred, the child's presentation in the emergency department and subsequent clinical course in the ICU
  - Include details of the resuscitation and management to assure parents that everything possible was done for the child
  - Gently explain the severity of the child's injuries, illustrating with imaging scans where helpful/necessary. Bear in mind the possibility of post-traumatic stress symptoms if the parents were also in the vehicle /injured during the accident
  - Use simple language and avoid complex medical terms. Check understanding
  - Allow parents to ask questions/clarify matters where desired
- Outline child's current condition and explain the concept of brain death to his parents (*"Despite emergency surgery to relieve the pressure in [name of child]'s brain, supporting his breathing via the machine [ventilator], all the medications we have given him to support his blood pressure and maintain normal blood sugar levels etc and round-the-clock monitoring, he has unfortunately not regained consciousness. The part of his brain vital for controlling the heartbeat and breathing [brainstem] is no longer functioning. When I examined [name of child] this morning, I checked again and unfortunately still found no response. His breathing and heartbeat are currently being supported by the machine and the medications we are giving him, but without these, and perhaps even despite these, his breathing and heartbeat will eventually stop as well."*). Reassure parents that child is not conscious and not in pain/suffering.
- Pause and elicit parents' reactions to the information. Allow emotional expression and space for questions.
- Offer appropriate psychological, spiritual and financial support as required (medical social worker, healthcare chaplain or spiritual leader from patient's/parents' own faith community)
- If appropriate at this sitting, gently broach withdrawal of care (*" [name of child] has died. We are only keeping his heart beating and his lungs breathing with the breathing tube, the machine and medications. When we remove the breathing tube and stop the medications, he will stop breathing and his heart will eventually stop beating. But we will not do this until you are ready."*)
- If appropriate, proceed to discuss a date/time for extubation. Enquire if the parents would like other family members to be present and what arrangements they may need to make beforehand.
- If appropriate, you may then proceed to broach the topic of organ donation (*" Sometimes parents, in extremely difficult situations such as this, even while trying to*



*come to terms with their own grief, want to make sure that something good comes out of all this suffering, or want to help other parents whose children are also critically ill. Something that they might consider in this situation is organ donation. Is this something that you might be willing to consider?").*

- Reassure parents that this decision will not make any difference to their child's medical care and that any surgical procedures will only take place **after** death has been certified
- Avoid pressuring the parents to consent to organ donation at this sitting if they are uncertain. Allow them time to consider the issue and make a mutual decision.
- Offer to arrange a further meeting with the organ donation coordinator at your institution should parents have further questions/desire further discussion
- Document the discussion in detail in the patient's case notes and outline the subsequent management plan based on the decisions made jointly by the parents and medical team
- Debrief your medical team following the family conference. Allow expression of emotional reactions and questions as required. Check for staff uncertainties or disagreements about the proposed management plan and address these as required.

### 8.3.2 What to say: Questions and answers on end-of-life issues

*Q. Who makes decisions about treatment or refusal of treatment?*

A. The moral obligation to use ordinary or proportionate means to preserve life falls normally to the patient. Even if the patient refuses such treatment, as long as she is competent, such a refusal is generally acknowledged by law. The fact that the state or the law may accept a competent patient's refusal of ordinary means of preserving life does not mean that the decision is objectively right. **The Church maintains that we have a moral obligation to accept ordinary means to preserve our life.** Determining what is ordinary for a particular person in a particular circumstance is the crucial task.

The patient would be considered **competent** to make medical decisions for himself if, alone or with the help of others, he can actually understand the diagnosis and prognosis, can weigh the benefits and burdens of accepting proposed treatments or rejecting them, and can make a decision freely.

Despite meeting criteria for competence, patient may exercise his rational opinion to allow a family member/friend to make medical decisions for him if he has confidence that the latter can understand the medical information better than he can. The family member or friend is then termed a "**proxy**" with **durable power of attorney**.

Health care professionals need to be aware that there may be cases where family or culture actually usurps the decision-making process from a competent person; under the duress brought about by serious illness, the patient may feel coerced by strong family views and yet not give voice to this experience of being manipulated.

*Q. May a patient have recourse to pain relief even though it hastens death?*

A. One may take positive steps to lessen a dying person's pain even though a drug used may hasten his death. In such a difficult situation it is essential that one does not directly intend the death of the patient but rather directly intends the relief of pain (principle of double effect, see Chapter 1). With current advances in palliative/hospice care, use of morphine and other pain control interventions is done with great care and rarely results in shortened life due to respiratory depression; more troubling dilemmas may be encountered in the setting of an intensive-care unit in view of the often greater medical complexity of the patients' conditions.

*Q. May a person refuse pain relief, and if so, why?*

A. Patients may choose to endure pain for many reasons – fear that pain medications will shorten their lives or cause addiction, desire to be as alert as possible to spend more time with their loved ones rather than being drowsy/sedated by opioid analgesics, or a belief that the acceptance of pain is part of their religious duty.

Accepting pain for any reason is the patient’s choice. However, it should be gently explained to her that God does not expect people to suffer, and that pain may get out of control and affect a person’s ability to concentrate on family members or other desired activities. If the severity of pain begins to disturb others (e.g. nearby patients hearing moans/screams, family members agitated by seeing their loved one in pain), then the patient has no right to refuse pain control for any pious or personal reason.

*Q. Should we always tell persons that they are dying?*

A. In today’s medical climate, patients’ rights to know the truth about their condition and prognosis, even if they are dying, is given far greater emphasis compared to the paternalistic medical attitude of old. The patient requires proper information in order to make informed decisions about the type of treatment he should have or forgo, and may need to attend to personal, financial, spiritual and familial matters before death.

Denying a person the truth is misplaced compassion, but difficult situations do arise, and this is when the manner of telling the truth to the patient can make a difference. The words used, the amount of information given at a particular time, the availability of the doctor or other healthcare workers to answer questions, and the support of the family when the news is given can make the difference between truth-telling that respects the rights of the patient to know and truth-telling that simply leaves a person in despair and confusion. Patients often have a sense that they are in the dying process even when others may not wish to talk about this reality with them. Secrecy then becomes a barrier that inhibits real communication about the most important aspects of life and death. If the patient expressly states that he does not want to know his diagnosis, treatment options or prognosis, and simply says, “Tell my spouse” upon being asked by the treating physician, then the doctor may proceed to deal with the spouse as the authorised substitute decision-maker while remaining open to the possibility of the patient later changing his mind and desiring to be more involved in making decisions for himself.

*Q. Is withholding or withdrawing life support a form of euthanasia?*

A. While it is always morally wrong to directly kill an innocent person, it can sometimes be morally right to allow a person to die. There may be a time in our lives when we have to face the fact that our death is inevitable and that additional medical treatment will place an **excessive burden** on us and our caretakers, with **little benefit**. To refuse such treatment is not a form of suicide; rather, it is a decision to allow the dying process to take its natural course. When is the medical treatment of a respirator too burdensome to bear and able to be withdrawn? When is the natural care of nutrition and hydration failing to do what it ought to do? A person may not be dying but still wish to refuse certain medical treatments or forms of care because the burden is deemed too great for him and the benefits too little. Such a judgement, however, should not be made without careful consideration, medical and spiritual consultation, and a well-formed conscience.

### **8.3.3 Useful contact numbers**

1. Assisi Hospice

820 Thomson Road S(574623)

6347 6446

assisi@assisihospice.org.sg

2. Dover Park Hospice      10 Jalan Tan Tock Seng S(308436)  
(Behind National Skin Centre)  
6500 7272  
**[info@doverpark.org.sg](mailto:info@doverpark.org.sg)**
  
  3. HCA Hospice Care      12 Jalan Tan Tock Seng S(308437)  
(home care services)      6251 2561  
**[info@hcahospicecare.org.sg](mailto:info@hcahospicecare.org.sg)**  
<https://www.hca.org.sg/hospice/>
  
  4. Star PALS                      [starpals@hcahospicecare.org.sg](mailto:starpals@hcahospicecare.org.sg)  
<http://www.starpals.sg/>
- Paediatric palliative care service (under auspices of HCA)

## **8.4 Legal issues**

### **8.4.1 Advance Medical Directive (AMD) of 1 Jul 1997**

The AMD is a legal, written, voluntary opt-in declaration, a "living will", that anyone above 21 years can make with 2 witnesses (one of whom must be a doctor) to refuse disproportionate measures in the event of *future* terminal illness. The law is expressly opposed to euthanasia, requiring the continuation of palliative care eg nutrition, airway and pain control. The person can revoke the AMD orally or in writing at any time. To be invoked the medical attendant and 2 independent specialists have to certify terminal illness and only then, and not before, can the AMD Registry at MOH be contacted to determine if the patient has lodged an AMD.

As presently interpreted, the AMD is not euthanasia or assisted suicide and is intended to foster an appropriate approach towards dying persons. Death is normal and to refuse disproportionate treatment and allow death to take its course may be licit when a person is in the process of dying as opposed to being threatened with premature death.

Reservations however have been expressed which are mainly administrative rather than moral, because of the inherent vagueness of the law's definitions, the changed circumstances years, even decades, later, the anti-life times we live in and the promotion of abortion by radical feminists and of the living will by the euthanasia lobby. Advance directives tell us what people felt under the medical, social and personal conditions of the past. Some words need special clarification, eg "imminent" means "within hours"; "terminal illness" means incurable, irreversible illness in which death is expected soon (reasonably within 6 months) with or without life-sustaining treatment; "death" does not mean "brain death", persistent or irreversible coma or Persistent Vegetative State.

### **8.4.2 Penal Code of Singapore**

#### **Punishment for murder**

**302.**(1) Whoever commits murder within the meaning of section 300(a) shall be punished with death.

(2) Whoever commits murder within the meaning of section 300(b), (c) or (d) shall be punished with death or imprisonment for life and shall, if he is not punished with death, also be liable to caning.

*[Act 32 of 2012 wef 01/01/2013]*

### **Abetment of suicide of child or insane person**

**305.** If any person under 18 years of age, any insane person, any delirious person, any idiot, or any person in a state of intoxication, commits suicide, whoever abets the commission of such suicide shall be punished with death or imprisonment for life, or with imprisonment for a term not exceeding 10 years, and shall also be liable to fine.

*[Indian PC 1860, s. 305]*

### **Abetment of suicide**

**306.** If any person commits suicide, whoever abets the commission of such suicide shall be punished with imprisonment for a term which may extend to 10 years, and shall also be liable to fine.

*[Indian PC 1860, s. 306]*

### **8.4.3 Landmark cases**

#### *1. Karen Ann Quinlan*

- Case illustrating right-to-die controversy in the United States of America (USA) in 1975-6
- 21 year-old who consumed diazepam, dextropropoxyphene and alcohol at a party
- Collapsed at home following return and stopped breathing twice for 15 minutes or more
- Lapsed into persistent vegetative state despite attempted resuscitation and being brought to hospital
- Kept alive on a ventilator for several months without improvement
- Parents requested hospital to discontinue active care and allow her to die, but treating physicians refused
- New Jersey Supreme Court eventually ruled in parents' favour
- Quinlan removed from mechanical ventilation in 1976 but resumed spontaneous breathing subsequently
- Nasogastric feeding and hydration continued
- Survived till her death from pneumonia in 1985
- The New Jersey Supreme Court decision on the groundbreaking and precedent-setting case quotes extensively from an address given by Pope Pius XII to medical professionals on the matter of preservation of life:

"The request of plaintiff for authority to terminate a medical procedure characterized as "an extraordinary means of treatment" would not involve euthanasia. This upon the reasoning expressed by Pope Pius XII in his address to anesthesiologists on November 24, 1957, when he dealt with the question: 'Does the anesthesiologist have the right, or is he bound, in all cases of deep unconsciousness, even in those that are completely hopeless in the opinion of the competent doctor, to use modern artificial respiration apparatus, even against the will of the family?'

His answer made the following points:

1. 'In ordinary cases the doctor has the right to act in this manner, but is not bound to do so unless this is the only way of fulfilling another certain moral duty.
2. The doctor, however, has no right independent of the patient. He can act only if the patient explicitly or implicitly, directly or indirectly gives him the permission.
3. The treatment as described in the question constitutes extraordinary means of preserving life and so there is no obligation to use them nor to give the doctor permission to use them.
4. The rights and the duties of the family depend on the presumed will of the unconscious patient if he or she is of legal age, and the family, too, is bound to use only ordinary means.

5. This case is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life, and we must apply in this case the principle of double effect.' " [from the text of the New Jersey Supreme Court decision, "On the Matter of Quinlan" (1976)]

- **May be morally right to allow discontinuation of extraordinary means (ventilator), but provision of natural care (nutrition/hydration) is morally obligated and was given in this case**

2. *Nancy Cruzan v. Director, Missouri Dept of Health*

- Case illustrating right-to-die controversy in the USA in 1989-90
- Young woman lost control of her car, was thrown from the vehicle and landed face-down in a water-filled ditch on Jan 11, 1989
- Found by paramedics with no vital signs and resuscitated
- Diagnosed to be in PVS after 3 weeks in coma
- Family wanted patient removed from life support/cessation of artificial nutrition, State of Missouri disagreed
- State's policy initially upheld in court as there was no "clear and convincing evidence" of what Nancy Cruzan would have wanted for herself, while acknowledging legal standard that competent persons are able to exercise the right to refuse medical treatment under the Due Process Clause and its implied right to privacy
- After the case was decided the **family** went back and found more proof that Nancy Cruzan would have wanted her life support terminated and eventually won a court order to have her feeding tube removed
- Cruzan died 11 days later on December 26, 1990
- **Erroneous because nutrition and hydration are ordinary means of care whether administered through invasive means or not and there is a moral obligation to accept ordinary treatments**

3. *Airedale N.H. Trust v. Bland*

- Regarding the **lawfulness of withdrawal of artificial feeding in patient in persistent vegetative state (PVS)**
- Patient was 17 year-old Anthony Bland, who sustained catastrophic injuries in the Hillsborough football ground disaster on 15 April 1989
- Suffered crushed and punctured lungs and resultant hypoxic ischaemic injury to the higher centres of the brain leading to PVS
- No preceding advance medical directive or expressed views from the patient about his desires should he find himself in such a condition
- Patient's family, medical consultant in charge and independent physicians were unanimous in the diagnosis and prognosis – that there was no hope for improvement in his condition or recovery
- Sought legal declarations in 1992 to lawfully discontinue all life-sustaining treatment including the termination of ventilation, nutrition and hydration by artificial means and all medical care save that enabling the patient to end his life and die peacefully with the greatest dignity and the least of suffering, pain and distress
- Declaration granted, appeal from official solicitor dismissed stating that "the object of medical treatment and care was to benefit the patient, but since a large body of informed and responsible medical opinion was of the view that existence in PVS was not a benefit to the patient, the principle of the sanctity of life, which was not absolute, was not violated by ceasing to give medical treatment and care involving invasive manipulation of the patient's body, to

which he had not consented and which had conferred no benefit upon him...for over three years....the omission to perform what had previously been a duty would no longer be unlawful”

- **Erroneous because sanctity of life is absolute, and nutrition and hydration are ordinary means of care whether administered through invasive means or not**

### **8.3 References**

1. Evangelium Vitae
2. Congregation for Declaration of the Faith
3. Websites
  - a. <http://www.fiamc.org/bioethics/guide-to-end-of-life/>
  - b. <http://www.fiamc.org/bioethics/euthanasia/>
  - c. <http://www.fiamc.org/bioethics/brain-death/>
4. *ABC of brainstem death* (Christopher Pallis)
5. *Dead or alive? The Medical Diagnosis of Death* (Alex Delilkan)
6. *Life, Death and Catholic Medical Choices – 50 Questions from the Pews* (Kevin O’Neil, CSSR & Peter Black, STD)