

The paper goes on to say that at the time of diagnosis a full range of treatment options should be discussed with the patient. Where there is the potential for cure in the event of a life-threatening event, one should proceed with resuscitation. In the case where the disease is controllable but not curable the decision to proceed with resuscitation requires prudential judgment of burden and benefit.

As the disease progresses the decision to resuscitate needs careful re-negotiation. At the point where the treatment has failed, the goals of treatment are now different; the hopes for cure are replaced by hopes for maximum quality of life. This needs to be recorded in the notes. Normally, in the event of a life-threatening episode there would be no move to institute resuscitation.

The last stage which involves symptom control and relief of distress is of course a situation in which one would not normally, institute resuscitation. However, here again judgment may need to be exercised; for example, if an important loved one were travelling to see the person, life-prolonging measures might be warranted.

There is no substitute for a benevolent, ethical health care practitioner who will be called on to make just such difficult judgments.

## 6. Advance directives and enduring power of attorney

The legal solution to the diminishment of powers of judgment and thus autonomy is the right to say before these powers are lost what one's desires would be in the event

of a life-threatening event. This may be done either by appointing somebody to speak on the patient's behalf at the time when decisions need to be taken, called an **Enduring Power of Attorney** or by writing one's preferences down, called an **Advance Directive**.

Laws which govern these two instruments vary between States. Whatever they are called, essentially these are the two types of document which come into play only when a person's life is threatened and the person is incompetent to make decisions.

## CONCLUSION

Human life is not just a physiological state but an existential reality. The experience of suffering, diminishment and death are not welcome but accepted as limits of humanity. In Catholic health and aged care institutions the hallmark of our acceptance of this is our steadfast commitment to caring for even the most hopeless of cases to the end.

## End Notes

<sup>1</sup> Gillon, R. Euthanasia, Journal of Medical Ethics, 1988, 14, 115.

<sup>1</sup> Haines, I., Zalberg, J. & Buchanan, J.D. Not-for-resuscitation orders in cancer patients – principles of decision-making. The Medical Journal of Australia, 1995, 153, 225-9.



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# End-of-Life Issues

## 1. The purpose of health care

The purpose of health care is to cure the sick and care for the frail and dying. It is good to be well and to live in a community of healthy people. Health is a social good.

A further important understanding is that Jesus' ministry was focussed on health in the holistic sense. He cured the sick, healed the lame, gave sight to the blind, restored hearing, gave speech to the dumb and raised the dead to life. As long as there are sick in our midst, there will be a need for Jesus' followers to continue His ministry.

Life is fundamental for our personal activities. There is an obligation to protect life, but not at all costs. We honour, for instance, those (like Jesus) who lay down their lives for others. This principle will affect in practice the methods we use to heal and care for the sick and frail. The resurrection of the body is a basic truth for Christians.

While health care has cure as its desired end, the group of women at the foot of the cross signal to us that even when we are beyond cure we are never beyond the need for care. The women show us that even when all appearance of hope is gone, we should never abandon the person for whom we undertake care. The women at the foot of the cross are a model for us to emulate.

Progress in health care means many things to many people; one thing is certain: decisions are now more complex than ever before. In an age when death can be held at bay indefinitely by artificial means, we are

# End-Of-Life Issues

faced with the question: what should life mean for us, under what circumstances are we free to decide enough is enough, and what constitutes reasonable means to extend life?

## 2. Whose decision?

The doctrine of informed consent has become the central commitment of professional codes of conduct. The underlying value which it seeks to serve is that of respect for the dignity of the person. Sane adults ought to have some autonomy about what is done for them, how they would like to be treated, and what their life's commitments mean in terms of what they see as reasonable.

Sadly, decision-making capacity is sometimes impaired and the person is not able to indicate what their preference for treatment would be. There are several categories to be considered: children, whose decision making capacity is in the process of forming; those who have never developed decision making capacity and those who been autonomous adults and now are temporarily or permanently denied this faculty. In short, for all these people a surrogate decision maker needs to be available.

Generally, the surrogate will be a relative or close friend; sometimes it will need to be a statutory official. How they make decisions is of vital importance for the individual patient. There are two ways in which decisions may be made.

The first is the **substituted judgment standard** and this is said to be subjective in interpretation as, for example, when the person making the decision says: 'I think that X would want this

done in the circumstance.' It is different from saying: 'If I were X I would want this done.' The former implies intimate knowledge of the other uninhibited by emotions surrounding the present events.

The second, well known to health care professionals, is the **best interests standard**, which has the advantage of being more objective, in that all members of the health care team can evaluate the situation and come to some agreement about the facts of the case. It involves using a sort of calculus to work out the burdens and benefits of a treatment.

## 3. Benefit/burden ratio

The benefit/burden ratio depends on an accurate diagnosis and prognosis, which of course, is not always possible. Then the range of possible treatment options, including doing nothing at all about the condition, together with the outcomes need to be spelt out to those making the decision. It is not ethical to provide a futile treatment.

The costs and benefits are not simply matters of medical efficacy or futility but must take into account things like social, financial, as well as health burdens and benefits. Further, the patient's own sense of what is fitting and right should be taken into account. As the *'Declaration on Euthanasia'* (1980) implies;

*...it will be possible to make a correct judgment as to the means by studying 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. (p14)*

## 4. Withholding and withdrawing treatment

The Catholic tradition makes a clear distinction between 'killing' and 'allowing to die'. The former is never licit and the second is always subjected to intense scrutiny. Gillon<sup>1</sup> holds that the distinction is real, so that while all acts of killing the innocent are wrong, so also are some acts of 'letting die', where one intends the death of the person whether by an act of omission or commission.

The consistent teaching of the Church over centuries is that the patient may refuse even life-saving treatment which s/he considers too burdensome. Indeed, the Vatican *'Declaration on Euthanasia'* (1980) states:

*'...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.'* (p15)

Furthermore, the burdens considered may be physical, financial and/or social in nature.

## 5. Decisions about CPR and NFR orders

In 1995 a group of doctors working at a Catholic hospital in Melbourne, published what some have come to regard as the clearest guide to making these difficult decisions.<sup>1</sup>

Basically, they said that not-for-resuscitation decisions should be tailored to the stage of illness. The context of this guide makes it particularly applicable to cancer patients, even though it can be applied more widely.