Ethics & Medics

November 2021 Volume 46, Number 11

A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

Also in this issue: "Pandemic Visitation Restrictions at the End of Life," by Molly Antone

Child Euthanasia and the Church

Thomas Pirog

Gabriella Miller was diagnosed with brain cancer at the age of nine and died less than a year later. Her mother recalls, "We watched her suffer the terrible effects of her chemotherapy. The deep pain I feel about her final weeks of life spent on a ventilator will always be my motivating factor to push for more money for research on less toxic treatments."[1] The description of a child's suffering can easily overwhelm parents and compel them to think that euthanasia can be permissible.

Recent legislation in countries like Belgium and the Netherlands has made it legal for minors to be euthanized. These laws demonstrate a change in the relationship between the individual and death, namely, that the idea of killing another person is welcomed and preferred to suffering. No longer does God have the final say over life and death. We have usurped the role of determining the end of life on the basis of free judgement.

We do not have a right to directly bring about the death of an individual. Scripture says, "In [God's] hand is the soul of every living thing, and the life breath of all mortal flesh" (Job 12:10 *NABRE*). The opposite is also true. We are not obliged to take all steps to ward off death. Putting an end to "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."[2]

Nonetheless, the patient is owed ordinary care, and this cannot be interrupted even if death is imminent (*Catechism*, n. 2279). All ordinary means must be used to preserve a life, including necessities such as food, water, and medical care. If we discontinue basic treatment and cause the death of an individual, that can be considered murder. The end never justifies the means even if the person is severely sick, handicapped, or dying. At the very heart of this understanding is that all human life has dignity.

How does euthanasia violate dignity? To answer this, we need a clear definition. In his encyclical *Evangelium vitae,* Pope St. John Paul II writes that "euthanasia in the strict sense is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering."[3] Euthanasia occurs when a person freely intends to cause the death of another. Euthanasia goes "contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded" (*Catechism*, n. 2277).

Child Euthanasia Laws in Europe

Child euthanasia is permitted in several European countries. In 2012 Belgium became the first in the world to allow child euthanasia without any age limit. The law requires the parent's consent, that qualified medical experts determine whether the child is competent and understands the procedure, and that the child is in a "medically futile condition of constant and unbearable physical suffering that cannot be alleviated and that results from a serious, uncurable disorder caused by illness or accident that will cause death within a short period of time."[4] These laws have received much criticism, including for how they determine a child's competency and capacity for discernment.

While pro-euthanasia arguments are popular with some adults, they come into conflict with minors on the question of whether they "are capable of making autonomous choices, due to their young age and sensitivity."[5] Proponents of child euthanasia argue that "adolescent minors have often been dealing with their illness and confronting their mortality for a long time, and sometimes their whole lifetime, which enables them to approach their treatment and predicament in a measured way."[6] In their view, children are more qualified to have a say over their death than an adult who may have suddenly learned about a terminal illness and is for the first time grappling about end-of-life treatment. Proponents believe that the "maturity of the child patient with a life-limiting illness is significantly more advanced than that of counterparts."[7]

Opponents of child euthanasia do not necessarily see a link between a terminal illness and a maturation of discernment in response: "Minors are not capable of discernment because they have a different decision-making style. They tend to be more impulsive, emotional, and risk-prone which squares with what we know about human brain development."[8] Because the decision-making style of children differs from that of adults, we should be careful in setting the standard of discernment. After all, many adults make poor decisions even though they are at the age of discernment and competent in their mental abilities.

Belgian law tries to safeguard children by advancing additional criteria. To meet the conditions for child euthanasia eligibility, one must have written confirmation from a psychologist or psychiatrist that a child has "capacity of discernment," confirmation that the

child has a terminal or untreatable illness that will lead to death in a short span of time (as agreed upon by an independent doctor and psychiatrist), an agreement from a legal representative or the child's parents, a written request for the procedure by the child, and proof that psychological support has been provided.[9]

While a child may not be allowed to vote or buy alcohol or cigarettes, a child can apparently make decisions about life and death. Such a decision "is justified on grounds of a right to determine what happens in and to one's body, which underlies the 2002 Law of Patient Rights in Belgium and in other legislations."[10]

Catholic Teaching on Euthanasia

What is the Catholic response to the philosophy that we are masters of our bodies? The Church holds that we do not have absolute autonomous control over what happens "in and out of our bodies." We can act in ways to fight an illness and alleviate suffering, but we cannot take our lives because of the severity of the suffering or illness. The most obvious rebuke to euthanasia is that it violates the Fifth Commandment, "Thou shalt not kill." Humans are made in the image and likeness of God, and "God alone is the Lord of life from its beginning until its end: no one can under any circumstance claim for himself the right directly to destroy an innocent human being" (*Catechism*, n. 2258).

This fundamental idea of impermissible actions is ultimately grounded in freedom and responsibility. Freedom is based in our reason and will. It is the power to "act or not to act, to do this or that, and so to perform deliberate actions on one's own responsibility. By free will one shapes one's own life. Human freedom is a force for growth and maturity in truth and goodness; it attains its perfection when directed toward God, our beatitude" (*Catechism*, n. 1731). Freedom is not doing whatever we want to do; instead, the "more one does what is good, the freer one becomes" (*Catechism*, n. 1733).

Proponents of euthanasia have a fundamentally warped idea of freedom. They are more concerned with respecting the individual's choices than with whether the action itself is moral. This does not necessarily mean that these are bad people. They may not be deliberately promoting evil, but falling into ignorance. But to willingly and knowingly do "something gravely contrary to the divine law and to the ultimate end of man is to commit a mortal sin. This destroys in us the charity without which eternal beatitude is impossible. Unrepented, it brings eternal death" (*Catechism*, n. 1874). That being said, "responsibility for an action can be diminished or nullified by ignorance, duress, fear, and other psychological or social factors" (*Catechism*, n. 1746).

We clearly see that once euthanasia was legalized, "fears that adult euthanasia would extend to minors turned out to be true."[11] The argument for a slippery slope is on display here. While we have *freedom* as human beings, freedom "characterizes properly human acts. It makes the human being responsible for acts of which he is the voluntary agent. His deliberate acts properly belong to him" (*Catechism*, n. 1745). While proponents of euthanasia say they respect an individual's choice, they are often so wrapped up in respecting everyone's individual freedoms, that they extend it to killing. Freedom means responsibilities, and these show the dignity of the human being (*Catechism*, n. 1747). Euthanasia is a clear violation of our responsibilities because it goes against the dignity of man.

We see the warning signs of a culture that embraces death in the extension of euthanasia to children. The consequences are extraordinary. Through the embrace of individual freedom and compassion, we are compelled to accept child euthanasia as commonplace. We have gradually disguised the act of killing another individual, especially someone as vulnerable as a child, making it appear as if it were nothing extraordinary at all. No longer do we allow God to have authority over life and death; instead, man has decided to take his place. We are allowing children with terminal illnesses to be killed. Perhaps this may be later extended to children suffering from depression or illnesses that can be easily cured. Every human life deserves to be respected, but once we ignore human dignity, greater evils become manifest.

The Church teaches that "as a result of original sin, human nature is weakened in its powers, subject to ignorance, suffering and the domination of death, and inclined to sin" (*Catechism*, n. 418). Suffering and death are both conditions of the fall, but man is not abandoned by God. Through Christ we have victory over sin and eternal life after death. Suffering is not a mere empty phase we go through in life; rather, "suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will."[12] This is the proper way we should regard suffering and the administration of medicine.

Thomas Pirog is a graduate student at Holy Apostles College and Seminary in Cromwell, Connecticut.

Notes

1. Andrew Kaczynski, "In Gabriella Miller's Memory, A Bill to Help Kids with Cancer," *CNN*, March 29, 2021, https://www.cnn.com/2021/03/29/opinions/pediatric-cancer-gabriella-miller-kaczynski/index.html (accessed April 25, 2021).
2. *Catechism of the Catholic Church*, 2nd ed. (Washington, DC: United States Conference of Catholic Bishops/Libereria Editrice Vaticana, 2016 update), n. 2278. All subsequent citations appear in the text.
3. John Paul II, *Evangelium vitae* (March 25, 1995), n. 65.
4. Giulia Cuman and Chris Gastmans, "Minors and Euthanasia: A Systematic Review of Argument-Based Ethics Literature," *European Journal of Pediatrics* 176 (June 2017): 838, doi: 10.1007/s00431-017-2934-8.
5. Cuman and Gastmans, "Minors and Euthanasia," 841.
6. Luc Bovens, "Child Euthanasia: Should We Just Not Talk about It?" *Journal of Medical Ethics* 41.8 (July 2015): 3, doi: 10.1136/medethics-2014-102329.
7. Anne Campbell and Liz Gormley-Fleming, "Rights of the Child: To Die?" *British Journal of Nursing* 23.6 (March–April 2014): 302, doi: 10.12968/bjon.2014.23.6.302.
8. Bovens, "Child Euthanasia," 6.
9. Campell, "Rights of the Child," 302.
10. Bovens, "Child Euthanasia," 3.
11. Csilla Deak, "Terminating a Child's Life? Religious, Moral, Cognitive, and Emotional Factors Underlying Non-Acceptance of Child Euthanasia," *Psychologica Belgica* 57.1 (April 26, 2016): 64, doi: 10.5334/pb.341.
12. Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980), III.

Pandemic Visitation Restrictions at the End of Life

Molly Antone

The process of dying today looks dramatically different than it did a century ago. As technology has advanced, questions regarding treatment options have become a major focus for patients, families, and health care providers. As these questions come into medical practice, "the tasks of preparing for death and caring well for those who are dying can be neglected, and opportunities for spiritual growth or completion of important relationships can be missed."[1] Identifying when treatment is no longer beneficial or has become excessively burdensome is increasingly complex and requires discernment.

Moreover, the Catholic tradition has always held that treatment options "should be considered in light of factors relative to the person and her or his total circumstances (e.g., physical, spiritual, financial, familial, social, and so on). Only then can one get a true sense of the benefits and burden of treatment and decide whether it is proportionate and hence morally obligatory, or disproportionate and hence morally optional."[2] Decisions and assessments about morally obligatory options for care must be done on a case-by-case basis.

Pope St. John Paul II's discussion of pain management and lucidity in *Evangelium vitae* provides a basic guide for patient care at the end of life: "In modern medicine, increased attention is being given to what are called 'methods of palliative care,' which seek to make suffering more bearable in the final stages of illness and to ensure that the patient is supported and accompanied in his or her ordeal. … As they approach death people ought to be able to satisfy their moral and family duties, and above all they ought to be able to prepare in a fully conscious way for their definitive meeting with God."[3]

As health care has progressed and technological advances improved, palliative care has become more widely available, provoking new conversations about treatment options at the end of life. The World Health Organization and the Pontifical Academy for Life share the same foundational conception of palliative care: "Providing relief from pain and other symptoms, integrating the psychological and spiritual aspect of patient care, enhancing quality of life, utilizing a team approach, and addressing both patient and family needs."[4] The challenge today is remembering that the essential function of palliative care does not come to an end during a pandemic.

Challenges of Conscience Formation

While the desire of health care institutions to mitigate risk is certainly understandable, it is not their job to replace family members and friends in deliberative moral decision-making. The family must be free to decide, based on their own risk assessment made from a well-formed conscience, the ultimate good of the patient, the family, and the community.

The *Catechism of the Catholic Church* describes conscience as "a judgment of reason whereby the human person recognizes the moral quality of a concrete act that he is going to perform, is in the process of performing, or has already completed. In all he says and does, man is obliged to follow faithfully what he knows to be just and right."[5] Hospitals must give patients and family members time to communicate in order to assess the situation and appropriately form their consciences.

Bishop Thomas Paprocki of the Diocese of Springfield, Illinois, notes how extreme safety measures can interfere with everyday life: "If we have a moral obligation to use every possible means, even extraordinary means, to preserve life, then we should not even get into our cars, since there is a risk that we could be killed. … [But] there is no moral imperative to stop driving, because we recognize that it would be an extraordinary burden on everyday life if people could not get to where they need to be. … Instead we take safety precautions to minimize the risk."[6] This same reasoning applies to health care institutions that forbid or severely restrict patient contact with families. While risk-reducing strategies must be implemented during a pandemic, ultimately "only ordinary means that are not unduly burdensome are morally required to preserve life, both on the part of an individual as well as society as a whole."[7]

In discussing options for care, the unfortunate reality is that families are often not informed early enough about the severity of a patient's overall condition and therefore "are not given sufficient time to reconcile this reality before they are asked to forgo life-sustaining treatments" on behalf of a loved one. Additionally, far too often, families are given only certain "pieces of information about the patient's condition or progress," while at other times, "conflicting information is presented by the various caregivers."[8] These problems existed in health care before the pandemic when hospitals had open visitation policies. During the pandemic, this information has proven even more difficult to obtain.

For patients with COVID-19, assessments may be limited to fewer care providers. As a result, there may be fewer points of contact for communication.[9] Furthermore, patients and families have often been forced to make decisions by video conference or by telephone. For some, these impersonal conversations may be the last they have with a loved one before a major medical decision such as the implementation of mechanical ventilation. Restrictions on visitation and communication clearly create a very inadequate scenario for proper, well-understood, and sound decision-making.

For patients who do not have COVID but face end-of-life decisions, communication has changed as well. Their family members find visits limited or restricted altogether. While certain states have made allowances, guidelines often fail to address the time it may take to reach an appropriately informed decision regarding the end of life. The process requires conversation, direct visualization of a patient's condition, and adequate medical information. Limitations placed on visitation leaves families heavily reliant on health care providers to relay information concisely and transparently, something that did not always happen before COVID restrictions.

The National Catholic Bioethics Center

6399 Drexel Road, Philadelphia, PA 19151–2511 www.ncbcenter.org

Ethics & Medics
Volume 46, Number 11
November 2021

The views expressed here are those of the individual authors and may advance positions that have not yet been doctrinally settled. Ethics & Medics makes every effort to publish articles that are consonant with the magisterial teachings of the Catholic Church.

Importance of Spiritual Life

The introduction to part 5 of the *Ethical and Religious Directives for Catholic Health Care Services* (*ERD*s) discusses care for the seriously ill and dying: "The Catholic health care ministry faces the reality of death with the confidence of faith. 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 spiritual dimension of care must be prioritized. As each patient is unique, his or her spiritual needs will be unique as well. For some patients, discussions regarding death may be met with peace, for others with anxiety and fear.

The *ERD*s go on to state that "the task of medicine is to care even when it cannot cure."[10] The spiritual life is crucial to moral decision-making that must be incorporated into care when medicine can no longer cure. The provision of Catholic spiritual and sacramental support at the end of life distinguishes our faith from that of other denominations. Frequently in the Catholic hospital setting, one hears patients, families, and health care workers expressing the need to call a priest as someone nears the end of earthly life.

In the early days of coronavirus, so-called nonessential health care workers, including those providing spiritual care, could not access personal protective equipment to attend to patients with COVID or non-COVID-related infections. Spiritual care was conducted by telephone call or tele-visits, creating significant challenges. Sacraments such as Anointing of the Sick and Reconciliation require the presence of the priest and cannot be done at a distance. *Catechism* n. 1269 states that as a member of the faith, Catholics have a right to receive the sacraments. This right should never be restricted, even during a pandemic. For those in danger of death, the right to receive the sacraments is not conditional, but absolute.

A policy of extreme restrictions on visitations "poses clearly foreseeable risks to those who are sick, their family, the staff, and society." One important risk is the "grave harm to the nature of persons through the marginalization of the intrinsic familial aspect of their being."[11] In particular, the institution of Catholic health care has a strong moral obligation to support and uphold the dignity of the person, including the familial aspect of the human being, especially in this challenging era of the coronavirus.

Molly Antone is a registered nurse working in palliative care at Franciscan Health in Crown Point, Indiana.

Notes

1. Marilyn J. Field and Christine K. Cassel, eds., "A Profile of Death and Dying in America," in *Approaching Death: Improving Care at the End of Life* (Washington, DC: National Academies Press, 1997), 34.
2. Michael R. Panicola et al., *Health Care Ethics: Theological Foundations, Contemporary Issues, and Controversial Cases*, 2nd ed. (Winona, MN: Anselm Academic, 2011), 288.
3. John Paul II, *Evangelium vitae* (March 25, 1995), n. 65.
4. National Catholic Bioethics Center, "A Catholic Guide to Palliative Care and Hospice" (Philadelphia: NCBC, 2020), 2, referencing World Health Organization, "World Health Organization Definition of Palliative Care," n.d., https://palliative.stanford.edu/overview-of-palliative-care/overview-of-palliative-care/world-health-organization-definition-of-palliative-care/; and Carlos Centeno et al., *White Book for Global Palliative Care Advocacy* (Vatican City: Pontifical Academy for Life Press, 2019), 11, 102.
5. *Catechism of the Catholic Church*, 2nd ed. (Washington, DC: US Conference of Catholic Bishops / Libreria Editrice Vaticana, 2016 update), n. 1778.
6. Thomas Paprocki, "Social Shutdowns as an Extraordinary Means of Saving People's Lives," *Ethics & Medics* 25.9 (September 2020): 2, doi: 10.5840/em20204592.
7. Paprocki, "Social Shutdowns," 2. See also US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018), dirs. 56–57.
8. Panicola et al., *Health Care Ethics*, 336
9. US Centers for Disease Control and Prevention, "Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages," updated December 29, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html.
10. USCCB, *Ethical and Religious Directives*, part 5, intro.
11. Annemarie Hosie et al., "Why Family Is Critical to Care for the Sick," *Ethics & Medics* 45.8 (August 2020): 1, doi: 10.5840/em20204583.

Ethics & Medics is a publication of The National Catholic Bioethics Center. Regular annual subscription rates for twelve issues include both the print version by mail and online access at www.ncbcenter.org/em: United States, $28; foreign $38; institutional $55. Individual copies are available for $3 each. To subscribe, please write to The National Catholic Bioethics Center, PO Box 596, Wynnewood, PA 19096, e-mail orders@ncbcenter.org, or phone (215) 877–2660. Publisher: Joseph Meaney, PhD. Editor: Edward J. Furton, MA, PhD. Contents © 2021 The National Catholic Bioethics Center. ISSN 1071–3778 (print), ISSN 1938–1638 (online). To submit an essay or request submission guidelines, please e-mail submissions@ncbcenter.org. For permission to reuse material from Ethics & Medics, contact the Copyright Clearance Center, Inc. (CCC), 222 Rosewood Drive, Danvers, MA 01923, phone (978) 750–8400, website www.copyright.com. CCC is a not-for-profit organization that provides licenses and registration for a variety of uses.