
PASTORAL APPROACHES *to* ASSISTED SUICIDE

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TABLE of CONTENTS:

I. PATIENT AUTONOMY *and* ASSISTED SUICIDE *in* CALIFORNIA LAW

II. HUMAN DIGNITY *in the* CATHOLIC MORAL TRADITION

III. ADVANCE DIRECTIVES, POLST, PALLIATIVE CARE *and* HOSPICE

IV. SACRAMENTAL MINISTRY *in the* LIGHT *of* ASSISTED SUICIDE

I. PATIENT AUTONOMY *and* ASSISTED SUICIDE *in* CALIFORNIA LAW

I.a. A SUICIDE PARTY IN OJAI

THE issue of pastoral care for those facing terminal or debilitating illness has been rendered much more complex by recent legislation that permits physician-assisted suicide in the State of California. It has always been the case that legalization of practices that were formerly forbidden both reflects changing cultural norms and is invariably accompanied by social pressure to “normalize” the now-legal practice. In the case of physician-assisted suicide this is exemplified by a “Suicide Party” (also called a “Right-to-die-Party”) held in Ojai, California, on July 24, 2016. A woman with a terminal illness invited friends to a party that culminated in her taking a lethal combination of drugs¹. It is worth noting that the victim’s sister who reported the story in a San Diego Newspaper describes herself as having been raised Catholic, and in the article she interprets Jesus’ Cry of Dereliction (Mk.15:34) as justification for the practice of suicide:

“I grew up Catholic; I went to Catholic school where we were taught Jesus’ final words on the cross, when he could no longer take the suffering: “Father, into thy hands I commend my spirit.” Tell me: How’s that not aid in dying?”

This article and the party it describes hint at the kind of pressure priests and other pastoral care-givers will increasingly face from parishoners, family members, and care-givers who become convinced that physician-assisted suicide is a legitimate, compassionate alternative to emotional and physical suffering that may accompany a terminal illness.

I.b. CALIFORNIA LAW

I.b.1. CALIFORNIA PROBATE LAW : 2000”Health Care Decisions Law” Summary:

- 1) Adults have the right to control decisions relating to their own health care, including the decision to have life-sustaining treatment withheld or withdrawn.
- 2) Medical treatment that artificially prolongs life “beyond natural limits”, thus prolonging the dying process, may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.

¹ <http://www.sandiegouniontribune.com/lifestyle/people/sdut-betsy-davis-aid-in-dying-2016aug13-story.html>

- 3) Decisions regarding withdrawing or withholding life-sustaining treatment should normally (that is, “in the absence of controversy”) be made without the assistance of the court.
- 4) A patient’s decision to withdraw or withhold life-sustaining treatment is **NOT** the same as suicide, and the health care provider who carries out the patient’s wishes is not guilty of “mercy killing, assisted suicide, or euthanasia”.
- 5) Adults may execute a Durable Power of Attorney for Health Care in which they designate an agent to make health-decisions on their behalf: this person then “has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.” The agent is to act in accordance with the patient’s wishes and best interests. In making health-care decisions for the patient the agent has priority over all other persons (including the patient’s family).
The Durable Power of Attorney for Health Care may also include the patient’s health care instructions. This document is valid in California even if it was executed in another state; and a copy of this document has the same effect as the original, which must normally be signed by the patient and be either signed by two witnesses or notarized. It remains in effect until revoked.
- 6) Unless they are related to the patient, health-care providers involved in the patient’s care may **NOT** serve as the patient’s surrogate decision-maker.
- 7) Patients are presumed to have the capacity to make health-care decisions and to appoint or disqualify surrogate decision-makers: the determination that they lack or have recovered capacity is normally made by their physician.
- 8) Patients cannot oblige health-care providers to offer treatment “contrary to generally accepted health care standards”.

I.b.2. CALIFORNIA HEALTH AND SAFETY CODE:

The “CALIFORNIA END OF LIFE OPTION ACT”

(Summary by: *The California Board of Registered Nursing* <http://www.rn.ca.gov/endoflife.shtml>)

What does the new California law do?

The law authorizes a resident of California

who is **18 years of age** or older,

who has been determined to **be terminally-ill**

and **mentally-competent**, [*sic*: has “capacity”; “competence” is nowhere mentioned in act]

to make a request for a drug prescribed for the purpose of ending his or her life.

What safeguards are included in the law?

The Act includes several safeguards, which are aimed at restricting access to patients who are terminally-ill and mentally-competent:

- Two physician assessments are required. The “*attending*” and “*consulting*” physicians must each independently determine that the individual has a terminal disease with a prognosis of six months or less, and is able to provide informed consent. Elements of informed consent, including disclosure of relevant information, assessment of decisional capacity and assurance of voluntariness, are stipulated in the law.
- If either physician is aware of any “*indications of a mental disorder*,” a mental health specialist assessment must be arranged to determine that the individual “*has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.*”
- The attending physician must provide counseling about the importance of the following: “*having another present when he or she ingests the aid-in-dying drug, not ingesting the aid-in-dying drug in a public place, notifying the next-of-kin of his or her request for the aid-in-dying drug, participating in a hospice program and maintaining the aid-in-dying drug in a safe and secure location.*”
- The attending physician must offer the individual the opportunity to withdraw his or her request for the aid-in-dying drug at any time.
- The individual must make two oral requests, separated by a minimum of fifteen days, and one written request for the aid-in-dying drug.
- The written request must be observed by two adult witnesses, who attest that the patient is “*of sound mind and not under duress, fraud or undue influence.*”

- The patient must make a “*final attestation*,” forty-eight hours before he or she intends to ingest the medication.
- Only the person diagnosed with the terminal disease may request a prescription for the aid-in-dying drug (i.e., surrogate requests are not permitted).
- The individual must be able to self-administer the medication.

What are the documentation and reporting requirements?

The law explicitly stipulates a number of requirements for documentation in the patient’s medical record, largely corresponding to the safeguards above. In addition, the law creates two reporting obligations:

1. Within 30 days of writing a prescription for an aid-in-dying drug, the attending physician must submit to the California Department of Public Health (CDPH) a copy of the qualifying patient’s written request, an attending physician checklist and compliance form, and a consulting physician’s compliance form.
2. Within 30 days following the individual’s death, the attending physician must submit a follow-up form to CDPH. All forms will be posted on the CDPH and Medical Board websites.

Is participation required?

No. Participation in the law is voluntary for all parties. Individual providers -- and institutions as well -- may make personal, conscience-based decisions about whether or not to participate.

I.c. CONCERNS EXPRESSED *by the MEDICAL COMMUNITY*
 (The California Medical Association: *CMA On-Call: Online Health Library*, From the *California Physician's Legal Handbook* Document #3455: *Physician-Assisted Suicide/Physician Aid in Dying*. CMA Legal Counsel, January 2016)

[SUMMARY and HISTORY of the NEW LEGISLATION]⁽⁹⁾

IT is a crime for anyone, including a physician, to assist anyone to commit suicide, even if the person is terminally ill and competent to make medical decisions. However, under a law that will go into effect in California in 2016, death resulting from the self-administration of an aid-in-dying drug is not considered suicide, and under certain circumstances physicians can prescribe such drugs to terminally ill patients who have capacity to make medical decisions.

[...] in California assisting a suicide is a crime. Proposition 161, an initiative to legalize active euthanasia that was on the California ballot in 1992, failed. In both 2005 and 2006, the sponsors of the Oregon legislation that legalized physician aid in dying in Oregon introduced similar legislation in California. Both attempts failed. In 2015, a California Court of Appeal affirmed a lower court ruling that rejected an attempt to have the courts declare that physicians who prescribe lethal medications to terminally ill patients were essentially exempt from the California Penal Code provision that makes it a crime to assist a suicide. The court found that prescribing the lethal medication is direct participation and instrumental in accomplishing a patient's suicide and thus, is illegal under California Penal Code section 401. (*Donorovich-Odonnell v. Harris* (2015) 241 CalApp.4th 1118.)

However, in 2015, after the *Donorovich-Odonnell* decision, the Governor signed into law the End of Life Option Act, which effectively creates an exemption to the penal code by declaring that it is not suicide to self-administer an aid-in-dying drug pursuant to the End of Life Option Act and providing immunity to physicians and other health care providers who participate in the End of Life Option Act.

⁽⁹⁾After stalling in the California Assembly Health Committee, Senate Bill 128 was effectively reintroduced as A.BX2-15 through a special session of the legislature. CIA’s concerns were addressed in the legislation, which was passed and signed by the Governor in 2015. A.BX2-15 creates *The End Of Life Option Act* in California. For more information, see CIA ON-CALL document #3459, “The California End of Life Option Act.”

[CONCERNS]

AMONG CMA’s specific concerns about active euthanasia and physician aid in dying were the following, as outlined in the 1988 white paper and further articulated during the Proposition 161 campaign and the 2006 effort to legalize physician-assisted suicide:

- Legalizing physician “aid-in-dying” would introduce disturbing POTENTIALS for ABUSE. The “right” to a lethal injection could become an expectation of appropriate behavior, and then a duty, pressed forward by other

demands on scarce resources and by the perceived burden imposed on others. Further down this “slippery slope,” an expectation might arise for other “unfit” members of society (e.g., certain disabled individuals) voluntarily to end their expensive suffering as well. By passing the ethical threshold of having physicians endorse the concept of PAS, physicians would have no defense against an extension of the right to patients other than those terminally ill.

- Suicide is rarely a rational decision; most often it is a psychologically abnormal event associated with DEPRESSION or other disorders. This has been found to be as true among terminal patients as among others. Suicidal behavior suggests a condition deserving medical treatment, not lethal medication. Of those people who commit suicide—terminally ill or not, more than ninety-five (95%) percent of those had a major psychiatric illness at the time of death; 1994 “When Death is Sought Assisted Suicide and Euthanasia in the Medical Context,” *New York State’s Task Force on Life and the Law*. [For a copy of this report, go to http://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/index.htm]
- PAIN suffered by the vast majority of terminal patients CAN BE CONTROLLED, and other needs, including emotional counseling and support, can be provided for through hospice care. Legalizing euthanasia could undermine efforts to further improve pain control and to promote hospice care, since an expectation could arise that terminal patients should simply dispatch themselves rather than consume valuable resources by “prolonging the inevitable.”
- There is always an element of UNCERTAINTY in MEDICAL DIAGNOSIS and PROGNOSIS. Errors are bound to occur, as hospices and cancer research centers have learned through experience. The course of a terminal illness is not always predictable. Someone given six months to live may actually live several more years with a reasonable quality of life.
- Legalizing assisted suicide might GLAMORIZE the PRACTICE and establish its acceptability, thus inviting imitative suicides. Studies have shown that publicized suicides raise the overall suicide rate, especially among teens.
- Physician-assisted suicide and physician-administered lethal injections contravene the fundamental ethic of the medical profession: “Do no harm.” Proponents seek the moral authority of the medical profession to legitimize an attempt to overturn ancient prohibitions against taking the life of another. Placing physicians in the DUAL ROLE of HEALER/ KILLER would undermine trust in the physician-patient relationship, since patients may fear that physicians will steer them toward a lethal injection rather than pursuing what may be a more difficult course of treatment to relieve suffering. Further, CIA fears that out of deference to physicians, patients may feel pressured to accept physician-assisted suicide as an option, particularly if the patient feels obligated to relieve their loved ones of the burden of caring for them.
- CONSENT: It is inherently difficult for a physician to determine capacity or voluntariness. Physicians often state that they are ill equipped to know if patients are being abused or if the patient is requesting or not requesting treatment because of some internal or external pressure. How will physicians be able to determine this in this context, especially when under both the Oregon and proposed California law, there is no obligation for the patient to involve his or her family? Some argue that PAS forces physicians to make a highly subjective decision that the patient’s life is no longer worth living.

II. HUMAN DIGNITY *in the* CATHOLIC MORAL TRADITION

1. The Moral Vision.

“The Catholic Church proclaims that human life is sacred and that the dignity of the human person is the foundation of a moral vision of society. Our belief in the sanctity of human life and the inherent dignity of the human person is the foundation of all the principles of our moral teaching. In our society, human life is under attack from ... assisted suicide.” (*The United States Catholic Catechism for Adults*, 2006, nos. 422-423)

- A. The human person is the foundation of a moral vision of society (*imago Dei* – made in God’s image and likeness [Genesis 1:26]). St. Thomas Aquinas (*ST I-II: 26*): “...*homo ... est ... in Deum et ad Deum* {the human person is in God (origin) and toward God [destiny]}.
- B. Human dignity (inherent worth, value, status, ground of respect, irreplaceable) = a divine gift, our highest common denominator. We are born with human dignity.
- C. Respect (earned by our actions/conduct): esteem, admiration, deference, admiration.

- D. Human dignity: foundational, intrinsic, ontological. We are created in God's (a) image and (b) likeness – our actions may not always be like God, but we never forfeit our image, e.g., St. John Paul II and Capital Punishment (*Evangelium Vitae*, 1995, no. 56).
- E. Accrued dignity: abilities, capacities, relatability which develop over a lifetime, e.g., care of oneself, recognizing one's children, being able to communicate.
CASE STUDY: THERESA (Terri) Marie Schiavo: diagnosed in an irreversible persistent vegetative state (PVS); cardiac arrest on February 25, 1990, suffered massive brain damage due to a lack of oxygen to her brain; she died on March 31, 2005. (Fifteen years)
- F. Personal dignity, e.g., self-care, independence, enjoying a meal, exercise, hobby.

2. Assisted Suicide – a Challenge to Human Dignity.

- A. Vocabulary:
 - (1) Euthanasia: the act or practice of killing or permitting the death of a sick person for reasons of “mercy.” Euthanasia can be (a) direct or (b) indirect.
 - (2) Assisted Suicide: suicide committed by someone with the assistance of another person, e.g., a husband facilitating the death of his wife as he watches her deteriorate into Alzheimer's disease.
 - (3) Physician-Assisted Suicide (PAS): suicide by a “patient” facilitated by a “willing” physician who knows of the patient's intent and prescribes the appropriate medication(s) or information.
 - (4) Physician-Assisted Suicide (PAS), Medicalized-Suicide, Assistance-in-Dying, Physician-Assisted-Dying, End-of-Life-Option (June 9, 2016-2026 in California).
- B. Legal: Washington State, Oregon, California, Vermont, Montana (disputably), Washington, D.C. (February 2017).
- C. Statistics:
 - (1) May 2017 Gallup Survey “Values and Beliefs:” 7 of 10 adults polled in the U.S. affirmed that doctors should be allowed to end a terminally-ill patient's life if the patient requests it. This is the highest level of approval in a decade.
 - (2) From Washington State and Oregon - Major reasons for “seeking” PAS:
 - 1. Losing autonomy (91.5%)
 - 2. Less able to engage in activities making life enjoyable (88.7%)
 - 3. Losing control of bodily functions (50.1%)
 - 4. Being a burden on family, friends, caretakers (24.7%)
 - 5. Concern about adequate pain control (24.7%)

CASE STUDY: Mable is a very alert and independent 87 year old woman. She lives alone and is very involved in her community. Her grown children live at a distance. She is brought to the hospital due to some type of bowel obstruction. The physicians are unable to find the cause of this blockage. Her children gather to discuss what the next step(s) might be, e.g., return home (Mable's option), go to a rehabilitating center and then hopefully return home, enter a skilled-nursing facility. As the children debate these options, Mable dies in the hospital. She had been told that her children were not favorable of her return home due to her continued and escalating pain, advanced age, inability to be close to her, and financial worries about home-care.

3. The Catholic Tradition and Treatment for Persons Facing Terminal Illness:

- A. Medical treatment: e.g., breathing machines, dialysis, cardiopulmonary resuscitation (CPR), surgical interventions, feeding tubes, radiation/chemotherapy.
- B. Care for a Person, e.g., comfort care, palliative care (a team approach which cares for a patient and his/her family, provides relief from pain, affirms life, integrates psychological, emotional and spiritual aspects of one's life, works with a patient's physician, aims to improve mood, comfort, stress and the overall quality of life).
- C. Treatment (allows for ordinary/extraordinary analysis) and Care (always obligatory).
- D. Relief from pain: consult *Ethical and Religious Directives for Catholic Health Care Services*, USCCB, 2009 (Fifth ed.): “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.” (no. 61)

CASE STUDY: Frank’s father is 85 and has been hospitalized for nearly a month due to a malignant brain tumor. To help alleviate his pain, his physician has prescribed a certain dosage of morphine. Each time Frank visits his father, he always appears to be in pain and tells Frank that he wants to die. Frank is in terrible anguish over his father’s condition and pain and desires to fulfill his father’s wish. Frank asks the doctor to increase his father’s morphine to the highest level possible. What should the physician do?

E. Ordinary and Extraordinary Means of Treatment:

- (1) Following St. Thomas Aquinas, 16th Century Catholic moralists affirmed (a) the existence of a positive moral duty to preserve one’s health and life by using medical treatments that offer a reasonable hope of benefit (*spes salutis*) and (b) do not involve a physical or moral impossibility for the person, using the classic norm that “no one is obligated to the impossible” (*nemo ad impossibilia tenetur*). If one of these conditions is not fulfilled, a treatment is considered extraordinary and not morally obligatory, even though it might be morally elective for some individual(s).
- (2) Francisco de Vitoria (1483-1546): Regarding a sick person, “if the decline of the spirit is so great and the alteration of appetite is much, so much that the infirm is able to take nourishment only with great trouble, then it can be considered an impossibility and one is excused from sin...” He also wrote that “even in those cases in which recourse to medicine could serve to prolong life for a short while, a person could be exempt from the moral duty to use it ... for example ... excessive expense... The person is not obligated to give all his patrimony to preserve life...”
- (3) Dominic de Soto (1494-1570): “...no one is obligated to suffer enormous pain (*ingens dolor*) to preserve one’s life.” (This was in a pre-anesthesia era.)
- (4) The moralists of the time, e.g., Domingo Banez (1528-1604) thus designated the causes for moral impossibility:
 - +ultimate effort (*sumus labor*)
 - +certain torment (*quidam cruciatus*)
 - +enormous pain (*sumptus extraordinarius*)
 - +valuable means (*media exquisita*)
 - +severe horror (*vehemens horror*)
- (5) Cardinal Juan de Lugo, S.J. (1583-1666): physical life is a fundamental and primary good, but not an absolute good; only eternal beatitude can be considered an absolute good. This teaching represents an early rejection of what later became known as “vitalism.”
- (6) These teachings later became incorporated into the ordinary teaching of the magisterium, e.g., Pope Pius XII, *Address to Anesthesiologists*, 1957, Congregation for the Doctrine of the Faith, *On Euthanasia*, 1981, Pontifical Council *Cor Unum*, “Ethical Questions Relative to the Gravely Ill and Dying,” 1981, John Paul II, *Evangelium Vitae*, 1995, no. 65, 1994, *Catechism of the Catholic Church*, no. 2278.
- (7) The BENEFITS – BURDENS scale: e.g., a simple intervention which in itself is effective may not be required for a particular patient: from a medical point of view a simple and effective means for reducing potassium in blood exists (medically ordinary) but these measures would be burdensome (morally disproportionate) for a patient in a terminal stage due to cancer.

III. ADVANCE DIRECTIVES, POLST, PALLIATIVE CARE *and* HOSPICE

III.a. ADVANCE DIRECTIVES

AT present there are no Roman magisterial declarations on the right of Catholics to create advance directives, a document providing instructions on what is to be done when patients cannot express their own wishes. However the *Catechism of the Catholic Church* has reaffirmed Pius XII's declarations concerning the necessity of free, informed consent when medical procedures are experimental; and the U.S. Conference of Catholic Bishops have provided clear guidelines concerning advance directives in their Ethical and Religious Directives.

ETHICAL and RELIGIOUS DIRECTIVES for CATHOLIC HEALTH CARE SERVICES
fourth edition PART THREE: *The Professional-Patient Relationship*

23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.
24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.
25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.
26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.
27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.
28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

CLINICAL CASE:

A 75 year old Benedictine monk serving as a parochial vicar in a parish in the Archdiocese of Los Angeles was in a severe automobile accident and was hospitalized in the intensive care unit of a county hospital. He was placed on a ventilator with IV lines, urinary and nasogastric tubes, and extensive electronic monitoring. He was not able to speak or otherwise communicate his wishes. His injuries were so severe that it was clear he could not survive, and that advanced medical technology was serving only to increase his pain and prolong the process of dying. The physicians in charge of his care were not willing to remove any life-sustaining treatment without authorization from a family member or legally-designated proxy. The patient had been born in China and had no living relatives. When his monastic superior requested that life support be withdrawn the superior was informed by the physicians that he had no authority to make such a request on the patient's behalf. The patient lingered for more than a week in obvious pain on full life support.

III.b. LIVING WILL

The least helpful form of advance directive is a so-called living will, in which an individual tries to describe in some detail what they would like to have done for them when and if they are in a condition where they can no longer express their wishes. The very serious problem with such documents is the fact that no one - not even health-care professionals - can anticipate all the possible circumstances and contingencies that may arise. Most preferences are contingent and associated with uncertain probabilities such as:

"If there is no possibility of my ever returning to consciousness . . ." or

"If there is no possibility that further treatment will result in a cure or in improvement in my condition . . ."

But such contingencies, even if accompanied by percentage survival-rates, are often impossible to reconcile with patients' wishes expressed in a living will. Far better and more helpful to physicians is a document that designates a proxy decision-maker, such as a Durable Power of Attorney for Health Care

III.c. DURABLE POWER of ATTORNEY *for* HEALTH CARE

IN this or any similar document in which one designates a proxy decision-maker the goal is to designate someone whose decision-making processes one trusts. The person designating the proxy should share with that person their

wishes and values, and choose someone able to act on those values when the time comes. It is much easier for health-care professionals to work with a living proxy than with an inscrutable statement of wishes or intentions.

III.d. P.O.L.S.T.

THE difficulties attendant upon admission to a hospital where one is not known have given rise in many states to the “Physician's Orders for Life-Sustaining Treatment” form. This is most commonly filled out when an individual does not wish to have the full range of life-sustaining modalities employed, such as chest-compressions and intubation. The form must be signed by a physician who is responsible for the patient and who agrees that the listed measures should not be used. Such forms are usually respected by emergency-response personnel: however, admitting physicians generally have the right to re-examine the patient to insure that what has been ordered on the form is in accord with their best medical judgment and the standards of care of the community.

III.e. PALLIATIVE CARE *and* HOSPICE

From *The Catechism of the Catholic Church*:

2279 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.

From an Address by Pope John Paul II On the Occasion of the International Conference of the Pontifical Council for Pastoral Health Care Friday, November 12, 2004

4. True compassion, on the contrary, encourages every reasonable effort for the patient’s recovery. At the same time, it helps draw the line when it is clear that no further treatment will serve this purpose.

The refusal of *aggressive treatment* is neither a rejection of the patient nor of his or her life. Indeed, the object of the decision on whether to begin or to continue a treatment has nothing to do with the value of the patient’s life, but rather with whether such medical intervention is beneficial for the patient.

The possible decision either not to start or to halt a treatment will be deemed ethically correct if the treatment is ineffective or obviously disproportionate to the aims of sustaining life or recovering health. Consequently, the decision to forego aggressive treatment is an expression of the respect that is due to the patient at every moment.

IV. SACRAMENTAL MINISTRY *in the* LIGHT of ASSISTED SUICIDE

GENERAL PRINCIPLES:

1. Since suicide, objectively speaking, is a gravely immoral act, it follows that “to concur with the intention of another person to commit suicide and to help in carrying it out through so-called ‘assisted suicide,’ means to cooperate in, and at times to be the actual perpetrator of an injustice which can never be excused.” (John Paul II, *Evangelium Vitae*, 1995, nos. 65-66)
2. Catholic priests should be disposed to celebrate the sacraments generously as long as the person asking for the sacrament is properly disposed and asks for it. If the person is not properly disposed, rather than denying it, it seems better to delay it.
3. Repentance necessarily includes the intention to change one’s life, often referred to as a “firm purpose of amendment.”
4. For a sin to be mortal, three things must be present: (a) the matter must be grave, (b) the person must be aware of this gravity, and (c) the person must freely choose it. Freedom can be impaired by, e.g., depression, drugs, pressure from others. Subjective culpability might be lightened or not present.
5. Anointing of the Sick should not be celebrated if a person obstinately persists in manifest serious sin. (Canon 1007)
6. Catholic funerals are offered for all sinners. At the same time, the funeral celebrations should be real signs of faith. If a priest/pastor believes clearly that a funeral would cause scandal, e.g., due to the notoriety of a particular situation, the bishop should be consulted and then a decision made.
7. If a decision is made not to celebrate a Catholic funeral, it is not to punish the person but to recognize that his/her decision is contrary to Catholic teaching.

8. Family circumstances must also be considered, e.g., looking to the Church for assistance and comfort. In such a situation, if there is no scandal, the funeral should be celebrated.
9. A priest/pastor should also consider the appropriateness of a liturgy of the Word at the funeral home or gravesite; and also consider a memorial Mass. This calls for good pastoral judgment. "Pastors must know that, for the sake of truth, they are obliged to exercise careful discernment of situations." (John Paul II, *Familiaris Consortio*, 1981, no. 84)
10. Three scenarios: (a) a person thinking about PAS, (b) a person who has attained the necessary medications, and (c) a person who has decided to self-administer the medications. In each case, the priest can be present to this person and try to help the person articulate why they are considering PAS. These situations are also good times for moving a person beyond PAS by explaining carefully the Church's teaching on life and bringing the person to a re-consideration regarding PAS. Always assume a hope for conversion and a turning away from PAS.
11. A priest should never be present when a patient self-administers PAS.
12. We "should never despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives." (*Catechism of the Catholic Church*, no. 2283)

WHOLE PERSON CARE INITIATIVE

1. Aspirational Statement: "As Church and Catholic health care leaders in California, we believe that physician-assisted suicide, while legal, is not yet an entrenched cultural or clinical reality. Recognizing this, we are committed to developing together, and in collaboration with other leaders in the palliative care field, a medical and pastoral approach to care through the end of life that provides a dignified, compassionate, and loving alternative to physician-assisted suicide for seriously ill people and their families. Our intent is to create a Church and Catholic health care collaborative model that serves our California parishioners and patients well. And that can be replicated by Church and Catholic health care leaders in other states."
2. The Whole Person Initiative is a collaborative project of the California Catholic Conference (CCC) and the Alliance of Catholic Health Care, guided by a Leadership Council comprising representatives from the two organizations, including Bishops, Catholic health care executives, and thought leaders.

The Initiative is aimed at creating an environment in our parishes, communities and health care systems in which all persons are loved, wanted, and worthy and will be prepared and supported in health and serious illness through the end of life.

The Whole Person Initiative has a twofold purpose:

+Strengthen and improve the availability of Whole Person Care and palliative care services in Catholic health care systems and their hospitals, and

+Develop and implement Whole Person Care programs in dioceses and parishes.

(The Initiative will be rolled out on May 23-24, 2017)

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