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**UNFAITHFUL MEANS: THE CHRISTIAN LIMITS OF EXTRAORDINARY
TREATMENT AT THE END OF LIFE**

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An abstract of
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Abstract

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By Sarah Kothe

The medical system has changed the way people relate to death. While medicine allows people to live longer and healthier lives, medical technology can also be used in a detrimental fashion, specifically at the end of life. Greater numbers of Americans are using technology to postpone an unavoidable and imminent death. Instead of hope and healing at the end of life, when medicine is used futilely in the final stages of life, undue suffering occurs. This paper seeks to address these concerns through a Catholic lens. Utilizing magisterial documents and the work of recent theologians, a new category of ethical terms, known as faithful and unfaithful means, will be proposed. These terms incorporate the key principles of Catholic ethics to make the case that Christians are not obligated to prolong life at all costs. On the contrary, the most faithful medical care for the dying will focus on alleviating suffering and allowing for a natural death.

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*Holy Mary Mother of God,
comfort us now and at the hour of our death.*

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There is a crisis brewing in the American healthcare system. Those in the medical field have been writing warnings for years that the way Americans relate to death is profoundly harmful.¹ Atul Gawande is one of the most recent physicians to note that Americans are increasingly relying on technology to stave off death futilely. Gawande portrays the stories of numerous patients who struggle with making decisions at the end of their lives and who ultimately decide to use every medical mean available.² In a visit to his hospital's intensive care unit, Gawande describes the patients present: a seventy-five year old with metastatic cancer on a ventilator, an eighty-year old woman whose children had requested that she receive a tracheostomy and a feeding tube, and another eighty-year old woman with congestive heart failure who was “drugged to oblivion and tubed in most natural orifices as well as a few artificial ones.”³

There is a striking juxtaposition between Gawande's description of the treatment each patient is receiving, their age, and the severity of their disease. Each of these older individuals is suffering from a terminal condition, which would contraindicate the use of aggressive measures such as ventilation, tracheostomies, and feeding tubes, yet instead of choosing to begin comfort care to relieve symptoms and extend the quality of their lives,

¹ See Jessica Zitter, *Extreme Measures: Finding a Better Path to the End of Life* (Avery, 2017). Haider Warraich, *Modern Death: How Medicine Changed the End of Life* (St. Martin's Press, 2017). Angelo Volandes, *The Conversation: A Revolutionary Plan for End-of-Life Care* (Bloomsbury, 2016). Ira Byock, *Dying Well: Peace and Possibilities at the End of Life* (New York: Riverhead Books, 1998).

² Atul Gawande, *Being Mortal: Illness, Medicine and What Matters in the End* (Picador, 2015). and Atul Gawande, “Letting Go,” *The New Yorker* 85 (2010): 36–42.

³ Gawande, *Being Mortal: Illness, Medicine and What Matters in the End*, 26.

these patients, their families, and doctors decided to pursue life-prolonging treatments up unto the very end.⁴

The patients in this ICU had various motivations for pursuing aggressive care at the end-of-life: some are afraid of death, others are convinced that biological life is of utmost value and therefore must be prolonged at all costs, a few may be motivated to continue medical treatment by their doctor's overly hopeful assessment of their condition and, finally, for some patients, the decision may be out of their hands entirely. At the end-of-life, family members frequently become surrogate decision makers for the terminally ill and for these surrogate decision makers, the desire to keep their loved one's physically present may be a deciding factor in continuing to pursue aggressive treatment, instead of comfort care.⁵

Although the reasons they pursue aggressive treatment may differ, Gawande's depiction of the patients in the ICU evokes a palpable sense of suffering. This suffering is deeper than the universally understandable suffering that accompanies those who are dying. Dying is a natural occasion for lament and sadness because this process will result

⁴ *Comfort care* refers to medical care that is not curative. This type of care is focused on relieving a patient's symptoms and increasing their quality of life, not the quantity of life. Hospices offer comfort care. Palliative care is sometimes used interchangeably with comfort care, yet palliative care is a broader medical field. While similarly focused on relieving the symptoms of chronic illness and increasing a patient's quality of life, palliative care is available to patients who are chronically, not only terminally, ill. *Aggressive care* refers to medical treatment that does not correspond to a patient's physical condition or expected outcome. This treatment may be directed toward unreasonable or unattainable medical goals. Additionally, aggressive treatment imposes great burdens on patients and families and does not usually result in a proportional health benefit. Aggressive measures at the end-of-life can take a variety of forms, but methods solely used to prolong life, including mechanical ventilation, long-term artificial fluid and nutrition, as well as cardiovascular resuscitation are frequently included under the heading of aggressive care.

⁵ Gawande, *Being Mortal: Illness, Medicine and What Matters in the End*, 170 and 186.

in an unrecoverable loss. Death creates an emptiness where there was once a vitality—a person who once shared and received love with others is now gone. Death leaves husbands without wives, mothers without children, friends without their companions, and communities without their pillars. The palpable sense of suffering depicted by Gawande, however, is again not simply this sense of loss. Instead, there is a compounded suffering experienced by the patients he describes because their lives are a perpetual stasis of dying. These patient's bodies are supported and sustained by painful and invasive procedures in the hope of prolonging life, yet this is not their prime impact. The true effect of these treatments is to sustain the physical body in a dying process, which means that all the ensuing factors that accompany dying, including pain, shortness of breath, nausea, and exhaustion, continue unabated. It is the endless prolongation of dying that causes manifest suffering at the end of life without a concordant benefit. A natural sadness at the expectant loss of a loved one is not removed by aggressive care, nor is an individual restored to a measurable sense of health by these desperate medical measures. Instead, patients continue to suffer throughout an unnecessarily prolonged dying process while their families stand nearby and believe they are doing what is best for their loved ones.

The ICU Gawande visits is not atypical. This tragic scene is repeated in medical institutions across the county. Healthcare providers are struggling to navigate end-of-life care for patients and families who want everything done. Although there has been an uptick in hospice use over the past few years, aggressive end-of-life treatment has not

concurringly diminished.⁶ Data on Medicare spending reaffirms the high use of aggressive therapies at the end of life. One study notes that twenty-five percent of the Medicare budget is used by individuals in the final months of their life.⁷ Because medical costs do increase in connection to greater illness acuity, it is reasonable to assume that the cost of medical care will be somewhat higher for individuals who are terminally ill. However, the current numbers provided by the Medicare review do not correspond to the expected increase in costs. The costs are disproportionally higher than expected, especially during the last few months of a person's life when the use of comfort care, a less costly form of therapy, would be the medically indicated treatment. Once curative treatment is foreseen to no longer offer any hope of physical improvement, physicians are likely to recommend that comfort care begin. These data reveal that Americans continue to use high rates of aggressive treatment. In addition to financial reports, there is a documented increase in the rates of hospitalization and ICU/CCU (Critical Care Unit) use in the last few months of American's lives, further indicating that there is an increased prevalence of aggressive treatment.

The use of aggressive treatment is counter to common wisdom regarding proper end-of-life care. When asked to describe ideal end-of-life care, the terminally ill state that they wish to receive "adequate pain and symptom management, avoid the inappropriate

⁶ Craig C. Earle et al., "Trends in the Aggressiveness of Cancer Care near the End of Life," *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology* 22, no. 2 (January 15, 2004): 315–21, <https://doi.org/10.1200/JCO.2004.08.136>. "Facts on Hospice and Palliative Care," National Hospice and Palliative Care Organization, accessed February 16, 2018, <https://www.nhpco.org/hospice-statistics-research-press-room/facts-hospice-and-palliative-care>.

⁷ Gerald F Riley and James D Lubitz, "Long-Term Trends in Medicare Payments in the Last Year of Life," *Health Services Research* 45, no. 2 (April 2010): 565–76, <https://doi.org/10.1111/j.1475-6773.2010.01082.x>.

prolongation of dying, achieve a sense of control, and strengthen relationships with loved ones.”⁸ Additionally, individuals also frequently express their wish to die at home with their family beside them.⁹ These insights reveal that for most Americans a “good death” is based on achieving physical and emotional peace, not the endless prolongation of physical life. And although hospice care is oriented precisely toward achieving these ends, Americans continue to pursue aggressive treatments in hospitals.¹⁰ There is a discrepancy between the “good death” that patients and families desire and the treatment they are receiving. This is a pressing problem that needs to be rectified, especially when one considers the rapidly increasing elderly population in the United States.¹¹

In 1987, the ethicist Daniel Callahan set out to address this problem in his book *Setting Limits*.¹² Worried that vast financial and medical resources were being allocated to elderly populations at the expense of younger generations, Callahan argued that it is appropriate to stop providing life-extending technology to those in their late 70s and 80s who are severely ill.¹³ For Callahan, the goal of medicine is health, not the prolongation of life. Once an individual has lived “a natural life span,” medicine should be directed

⁸ Peter A. Singer, Douglas K. Martin, and Merrijoy Kelner, “Quality End-of-Life Care: Patients’ Perspectives,” *JAMA* 281, no. 2 (January 13, 1999): 163–68, <https://doi.org/10.1001/jama.281.2.163>.

⁹ Joan M. Teno et al., “Family Perspectives on End-of-Life Care at the Last Place of Care,” *JAMA* 291, no. 1 (January 7, 2004): 88–93, <https://doi.org/10.1001/jama.291.1.88>.

¹⁰ Alexi A. Wright et al., “Associations between End-of-Life Discussions, Patient Mental Health, Medical Care near Death, and Caregiver Bereavement Adjustment,” *JAMA* 300, no. 14 (October 8, 2008): 1665–73, <https://doi.org/10.1001/jama.300.14.1665>.

¹¹ The population of those sixty-five years and older will double in the next forty years and the population of those eighty-five years and older will triple in the same time period. Institute of Medicine and Committee on Approaching Death: Addressing Key End-of-Life Issues, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, 1 edition (Washington, D.C: National Academies Press, 2015), 36.

¹² Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society with “A Response to My Critics”* (Washington, D.C: Georgetown University Press, 1995).

¹³ Callahan, 138 and 180-182..

toward “the relief of suffering, not life-extending measures.”¹⁴ Callahan’s argument was viewed with disdain by many in the religious community not only because of his insistence that allowing the elderly to die by discontinuing treatment (ie. passive euthanasia) was justified, but also because he asserted that this action was beneficial to society as a whole and should be regulated by the government. This concise overview of *Setting Limits* does not do justice to Callahan’s nuanced argument and the specificities of his suggestions. But it should be clear, from this abbreviated summary, that Callahan was attempting to address concerns regarding end-of-life care that have not been solved to this day, as attested to by the continuing concern of those in the medical community. While Callahan’s proscribed solutions may be controversial, at the very least, his work must be appreciated for seeking to address the excessive use of medical treatment at the end of life.

In this essay, I will grapple with the same issues discussed by Callahan and Gawande, but from a Christian perspective. Callahan’s approach is a distinctly secular one. Although aspects of his argument, particularly its communitarian emphasis whereby the older generations must act justly to younger generations by not exhausting limited resources, would be acceptable to Christians, his proscription for limiting care does not incorporate any theological wisdom or explore why Christians might find his solutions an affront to the sanctity of the human person. Like Callahan, I believe that limits need to be set on end of life treatment in the United States, yet I will make this argument using resources drawn from the Catholic tradition, including both magisterial teachings and

¹⁴ Callahan, 138.

scriptural texts.¹⁵ The Catholic Church has a long history of moral guidance pertaining to the end of life, yet this wisdom needs to be expanded upon to address the current overuse of aggressive treatment.

The current teachings of the Catholic Church, as well as other major Christian denominations, do not advocate for vitalism, nor do they require the terminally ill to use every medical treatment available.¹⁶ In other words, once a treatment is discerned to be overly burdensome or futile, passive euthanasia is deemed morally acceptable, yet active euthanasia, in whatever form it takes (physician-assisted or self-mediated), is deemed morally illicit. While the Church asserts that aggressive treatment is optional and not morally required, this does not preclude its continued use. My argument in this paper hinges on uplifting Church teaching regarding the end of life, while also pointing out the need for further elaboration when it comes to aggressive and futile treatment. This paper seeks to present the foundational principles of Catholic bioethics and then use these principles to craft an upper limit on medical treatment. I will argue that Christian teaching not only allows for the removal and withdrawal of life-sustaining treatment when it is no longer of benefit, but also requires it. Allowing a person to die, instead of continuing to prolong their physical existence, is many times the proper and caring

¹⁵ This project will be focused on the Catholic Church, but resources will be drawn from other Christian traditions. I believe the conclusions of the paper will hold, not only for the Catholic Church, but for other Christian denominations as well.

¹⁶ From the Protestant perspective see Paul Ramsey, *Ethics at the Edges of Life: Medical and Legal Intersections* (New Haven: Yale University Press, 1980). From a Catholic perspective see William May, *Catholic Bioethics and Gift of Human Life*, 2nd edition (Huntington, Ind: Our Sunday Visitor, 2008). and Pope John Paul II's *Evangelium Vitae*. And from an Orthodox Christian view see Vigen Guroian and Tristram Engelhardt: Vigen Guroian, *Life's Living toward Dying: A Theological and Medical-Ethical Study* (Grand Rapids, Mich: Wm. B. Eerdmans Publishing Co., 1996). H. Tristram Engelhardt Jr, *The Foundations of Christian Bioethics*, Exton, PA: M & M Scrivener Press, 2000).

response. Although I will assert that, Christians are required morally to allow death in certain situations, I will also simultaneously uphold that the prohibition on active euthanasia in the Catholic Church is still correct when one considers the sanctity of human life.

Before outlining the major steps of my argument, it is worth considering why the Catholic Church and other Christian communities have been slow to recognize and directly tackle the problem of aggressive end-of-life care. Is the Church's lack of response due to the fact that Christians are exempt from this troubling trend in medicine? Unfortunately, this hopeful question cannot be answered in the affirmative. In fact, data illustrates that Christians, in addition to other religious believers, have a greater tendency to use aggressive treatment than a secular population.¹⁷ Although the precise motivations behind this tendency in treatment have not been isolated, it is clear that, on the whole, increased religiosity corresponds with a higher use of aggressive treatment and life-prolonging technology.

With the realization that this problem decisively affects Christian communities, the Church is called to respond, yet confronting the challenge of excessive and futile end-of-life care, that results in a painful and prolonged dying, will require a new approach.

¹⁷ Tracy A. Balboni et al., "Religiousness and Spiritual Support among Advanced Cancer Patients and Associations with End-of-Life Treatment Preferences and Quality of Life," *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology* 25, no. 5 (February 10, 2007): 555–60, <https://doi.org/10.1200/JCO.2006.07.9046>. M. A. Sullivan et al., "Effects of Religiosity on Patients' Perceptions of Do-Not-Resuscitate Status," *Psychosomatics* 45, no. 2 (2004): 119–28, <https://doi.org/10.1176/appi.psy.45.2.119>. Gala True et al., "Treatment Preferences and Advance Care Planning at End of Life: The Role of Ethnicity and Spiritual Coping in Cancer Patients," *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine* 30, no. 2 (October 2005): 174–79, https://doi.org/10.1207/s15324796abm3002_10.

The traditional principles and ethical tools of Catholic bioethics, while helpful, need to be augmented to address the use of aggressive care, especially when one considers how the overuse of medical technology distorts a Christian understanding of life and death. To address the unrestrained use of medical technology at the end of human life, a modern Christian approach to these bioethical concerns will need to establish an upper moral limit to medical treatment. This paper is an attempt to articulate just such a limit. Without the development of these limits, it is no wonder that Christians, left in midst of an effusive pro-life rhetoric and a doctrinal emphasis on immorality of euthanasia, have a tendency to eschew restraints on medical treatment.

I will propose a new category of ethical terms, entitled “faithful means” and “unfaithful means.” I will build these terms on previously established bioethical principles and I will use them to determine when medical treatment at the end of life is contraindicated. “Faithful means” are treatments, procedures, practices and therapies, used when death is imminent and unavoidable, that uphold both a Christian understanding of life, as a gift from God that encompasses more than biological existence, and a theological anthropology that recognizes the unified and multi-dimensional nature of the human person. “Unfaithful means” are treatments, procedures, and therapies that do not uphold a Christian understanding of life or the person, but are instead actions rooted in a distorted and unbalanced view of these beliefs. Treatments classified as unfaithful are more in accord with the secular principle of autonomy and a materialistic understanding of the body than with a Christian standpoint. Faithful means are morally acceptable because they are based in recognition of human life’s deep

connection to God, while unfaithful treatments are morally contraindicated because they turn against this theological understanding.

When death nears, some medical treatments may prolong biological life, but from a Christian perspective this does not necessarily mean that these medical treatments are faithful means or that they serve a good end. Medical treatment that is futilely oriented toward extending physical life is a radical imposition of human autonomy that diminishes a deeper notion of human life as intimately connected to God. In a Christian milieu that recognizes human life's deep dependence on God, futile and aggressive treatment is an unfaithful mean, not only because these treatments create undue suffering at the end of life, but also because these medical acts result from an incorrect understanding of human life's relationship to God.

In applying this new category of terms, sensitivity to the suffering of the terminally ill must be ever-present. The purpose of these terms is not intended to be draconian. Although unfaithful means are morally contraindicated, compassion must be shown to families and patients who, in the midst of suffering and on the precipice of death, are struggling to make decisions. These terms and the evaluative framework they offer are proposed as a first step in addressing the detrimental overuse of aggressive measures in end-of-life care. Additionally, the terms faithful and unfaithful means should not be construed as an evaluation of an individual's personal faith and relationship to God; these terms are not intended to evaluate *people*, but various *means* or actions.

The hope is that by presenting and defining these terms, there will be a greater awareness of how the unlimited use of medical technology can turn against Christian beliefs, preventing a good death. By discouraging Christians from using unfaithful

means, the suffering exhibited by patients in a prolonged dying process, like the individuals depicted by Gawande, can be diminished. Additionally, the recognition that aggressive medical treatment does not result in an easier or more faithful death and is morally contraindicated, will open Christians to a realization that Christian faithfulness in dying does not require that everything be done, but that the believer assent to their ultimate dependence on God. With this faithful assent, life can be found even in the midst of death.

The argument will proceed in four parts. In part one, the foundational, Christian principle of the sanctity of human life will be elaborated through a close reading of John Paul II's encyclical *Evangelium Vitae*. The purpose of this definitional section of the paper is threefold: to clarify a Christian understanding of human life, to describe how the sanctity of life incorporates a conception of death that does not require an ethic of vitalism, and to note what an ethical response to the sanctity of life does require. After detailing the values that ground Catholic bioethics, section two will include a presentation of the two ethical rules (double effect and the distinction between ordinary and extraordinary care) currently used to determine the morality of an end-of-life decision. Section three will offer a critical appraisal of these tools and argue that they are insufficient to address the overuse of aggressive care. After noting this gap in ethical guidance, in section four, I will argue that there is a need for a fresh response to futile and aggressive care and propose the development of a new ethical category, in accord with the previously established principles, known as faithful and unfaithful means. Unlike the currently accepted distinction between ordinary and extraordinary care, once a treatment is found to be an unfaithful mean it would not be a morally neutral option, but morally

contraindicated. The final section of the paper will detail how the proposed ethical terms can be implemented and address potential criticisms.

I. The Foundations of Catholic Bioethics in Connection to End-of-Life Concerns

Any new approach to end-of-life ethics that hopes to be accepted by a Catholic audience, as this project does, must be rooted in the *a priori* principles of the Catholic tradition. And the foundation of Catholic bioethics rests on a belief in the sanctity of the human person. Following the tendency of Catholic magisterial documents, I consider dignity and sanctity to be synonyms; both refer to the inherent and indelible divine mark on humanity. The sanctity and dignity of the human person connotes their inseverable connection to God. For the Catholic Church, the seminal explication of this core belief is found in Pope John Paul II's 1995 encyclical *Evangelium Vitae*. In this formative encyclical letter, which has become an indispensable reference point for Catholic ethicists, Pope John Paul II utilizes natural law, biblical exegesis, and the magisterial tradition of the Catholic Church to three ends: he elaborates a Christian anthropology that is rooted in the sanctity of human persons, criticizes Western society for its "Culture of Death," and offers ethical guidance for how life can be safeguarded and promoted in a modern world that is no longer principally guided by a respect for life, but is instead, in the pope's assessment rooted in the values of relativism and radical autonomy.

Evangelium Vitae provides the key definitions and ethical resources utilized in the remainder of this project, so it is essential in this opening section to examine how Pope John Paul II's explication of the sanctity of life connects to end-of-life issues

Human life is sacred and inviolable, the pope explains in *Evangelium Vitae*, because of God's involvement in human creation, the Incarnation of Jesus Christ, and humanity's intended ends/*telos*. Recounting the creation narrative, the pope notes that life is good because it is deeply connection to God. Human beings are the pinnacle of God's creative activity and reflect the image of the maker (NRSV, Gen 1:26). The relationship between God and humanity is distinctly different from God's relationship to other created beings. Humans are the only beings created in the *imago dei* who receive the divine breath of life (Gen 2.7) and who are called to be stewards of creation. While John Paul notes that God created other animals deserving of respect and care, he emphasizes that humans have a "particular and special bond with the Creator" by virtue of the uniqueness of their creation.¹⁸ The special bond humans have with the creator is the ground upon which the concept of the sanctity of life rests. Human life is sacred because it is connected intimately to God.

The Incarnation further sacralizes the human person. In the Incarnation, God ordains human life valuable enough to empty God's self and be "born in human likeness" (Philippians 2:7). This quotation from the New Testament contains echoes of Genesis. Whereas in Genesis 1:26 humans are created in "our [God's] likeness," now Jesus takes on "human likeness." This reversal strongly reaffirms the special nature of the human person; humans are made in God's image and God takes on human form. There is no other creature on earth that experiences such closeness with divinity.

The importance of the Incarnation is further elaborated when John Paul writes that human life, washed as it is by the "blood of Christ...reveals the grandeur of the

¹⁸ John Paul II, *Evangelium Vitae* (United States Catholic Conference, 1995), 34. Numerical references to *Evangelium Vitae* refer to document's paragraph numbers.

Father's love, [and] *shows how precious man is in God's eyes and how priceless the value of his life.*"¹⁹ Human life is intertwined with the divine because the Son of God incarnates in a human body that goes through suffering and death for the salvation of humanity. The whole Christian story from creation to crucifixion and resurrection is revealed as a story that emphasizes the "almost divine dignity of every human being."²⁰ John Paul II's biblical exegesis highlights that the value of human life is upheld throughout the bible.

In addition to humanity's creation in the *imago dei* and redemption through the salvific action of Christ, human life is of value because of the ends to which human life is directed. This is a lesser-recognized aspect of John Paul's thinking in this encyclical, but it is important in a discussion of end-of-life care.²¹ John Paul writes that "The dignity of this life is linked not only to its beginning, to the fact that it comes from God, but also to its final end, to its destiny of fellowship with God in knowledge and love of him."²² While the Creation and Incarnation elevate the value of human life, so too does humanity's heavenly end. The fact that humans have a "supernatural vocation" and are intended to share in "the very life of God" reveals again "the *greatness and inestimable* value of human life."²³ The *telos* of human existence, an inchoate possibility within earthly existence, elevates the value of life. These quotes make it is clear that human life is more than simply a physical reality, life includes an otherworldly dimension because of its connection to God.

¹⁹ John Paul II. Italics original to the text.

²⁰ John Paul II, 25.

²¹ John Paul II.

²² John Paul II, 37.

²³ John Paul II, 2.

At the same time that the divine *telos* elevates the value of human life, it also relativizes physical existence. “Life on earth is not an ‘ultimate,’ but a ‘penultimate’ reality,” the pope notes.²⁴ Physical life is an inherent, but not absolute good. While humans are called to respect the value of life, due to its connection to God, physical life is not an absolute good. This understanding is apparent when one considers the example of the Christian martyrs who sacrificed their lives for higher ends such as faith and eternal life.²⁵ The fact that bodily life is a penultimate value is a particularly important insight for end-of-life ethics because it removes any tendency towards vitalism. In acknowledging that physical existence is not humanity’s ultimate aim, there is no ethical imperative to futilely prolong biological life at all-costs.

The sanctity and high value placed on life in the Christian tradition obligates believers to behave in certain ways. In response to the value of human life, Christianity advocates obedience to God and an ethic of care. Pope John Paul reiterates that, “Man’s life comes from God, it is his gift, his image and imprint, a sharing in his breath of life” and he emphasizes that the response to this gift from God is obedience because God “is the sole Lord of this life: man cannot do with it as he wills.”²⁶ Human beings are not the ultimate owners of their lives. Instead, life is a gift that is placed into human hands to be respected, cultivated, and cared for. When it comes to making decisions at the end-of-life, Christians are called to remember their relationship to life is similar to how a farmer relates to the land. A farmer is a steward of the earth cultivating the ground and

²⁴ John Paul II, 2.

²⁵ John Paul II, 47. The pope writes, “Certainly the life of the body in its earthly state is not an absolute good for the believer, especially as he may be asked to give up his life for a greater good.”

²⁶ John Paul II, 39.

nourishing it into fruitfulness, but the land is never fully possessed by the farmer in the same way inanimate objects are. The land has an existence and worth outside of the person who owns the deeds to the property. Similarly, God calls a Christian to care for the human body, all the while recognizing that the body is not solely their object, but a gift endowed to them. A Christian response to end-of-life decisions, based on obedience to God, is a distinctively different approach when compared to a more common, secular approach that rests on the autonomy of the individual.

In *Evangelium Vitae*, John Paul voices his concern that contemporary society disregards human life. The pope notes that the prevalence of abortion and euthanasia in the West reveals that many societies prioritize autonomy over the sanctity of human life. The autonomy the pope is critical of is defined as a “promethean attitude” that is concerned with individual freedom, pleasure and efficiency.²⁷ A society that emphasizes this form of autonomy allows individuals to choose what is most beneficial to them without concern for God or others. The pope argues that this individualistic sense of freedom leads to the strong dominating over the weak. Abortion and euthanasia are the prime examples of individual choice taking primacy over the sanctity of human life. Although John Paul acknowledges that in many of these cases people are guided by compassion for those who are suffering or even coerced into choosing abortion or euthanasia because of extenuating circumstances, none of these factors can mitigate the gravely immoral decision to take a life. A society that places individual choice over the sanctity of an individual life creates a culture where people believe “that they can control

²⁷ John Paul II, 15.

life and death.”²⁸ This is a culture that no longer recognizes that life is a divine gift that humans must steward.

It is important to be clear that John Paul is not advocating for a slavish obedience to God that does away with human agency. Christianity has always recognized that free will and rational thought are gifts from the Creator.²⁹ John Paul acknowledges that human sovereignty is ordained by God when he states that “man is ruler and lord over things but especially over himself, and in a certain sense over the life which he has received...”³⁰ The Catholic Church repeatedly reaffirms an individual’s right to determine the course of their life and make personal decisions for themselves in health matters.³¹ What is in question, when the pope critiques a secular notion of autonomy, is not whether individuals have a right to make decisions regarding their own bodies but the extent of this freedom.

Whereas autonomy, in a secular sense, is an almost unlimited freedom to make choices for oneself as long as one’s actions do not harm others persons, true freedom, in the Christian tradition, is found through willing obedience to God. In *Evangelium Vitae*, the pope clarifies that Christian autonomy rests on relationality. Freedom and the ability to act independently are a “great gift of the Creator,” but this gift is “placed at the service of the person and of his fulfillment through the gift of self and openness to others...”³² Christian freedom is only meaningful within the context of solidarity with others and in

²⁸ John Paul II.

²⁹ John Paul II. See Thomas Aquinas, *Summa Theologiae*, I-II, q.68, a.2.

³⁰ John Paul II, 52.

³¹ U. S. Catholic Church, *Catechism of the Catholic Church: Complete and Updated* (New York: USCCB Publishing, 1995), paragraph number 2278.

³² John Paul II, 19.

relationship to God. An autonomy that is completely individualistic has no place within Christian ethics.

In addition to critiquing autonomy on the grounds that it leads to a society where some individuals are able to exert power over others. The pope notes that society's understanding of autonomy contains within it an implicit anthropology. If autonomy, and therefore choice, are of ultimate import, then a person's worth is connected to their rationality and their capacity for decision-making.³³ Those who are unable to be autonomous and make decisions for themselves are not as valued as those who are able act in this way. Personhood is contingent on autonomous rationality. This logic, John Paul argues, is particularly manifest when society discards developing lives via abortion and also when the lives of those who are mentally diminished due to disease, sickness, or old age are not considered lives worth living. Belief in the sanctity of human life, resting as it does on relationality to God, does not increase or diminish based on a person's physical condition or capabilities. The sanctity of life is inviolable and can never be removed.

Secular ethical theories that connect a person's autonomy to rationality and mental capability also create a disjunction between the soul, or spiritual dimension of the human person, and the body, which is contrary to Christian teachings. The Christian tradition teaches that humans are embodied souls; soul and body are not two distinct pieces of the human person but are each an integral aspect that are united and indivisible from each other. Humans are enfleshed souls, not souls that inhabit a body. Although there has been a tendency to negate the value of the body throughout the history of

³³ John Paul II, 19.

Christianity, within the last century theologians have begun to return to a proper understanding of the body that does not create a gnostic dualism between body and soul, but acknowledges the intimate interconnectedness between the parts of the human person and the mutual dependence between soul and body.

Some modern, secular conceptions of autonomy active in ethical discourse do not give credence to the intertwining physical and spiritual elements of the human person. Instead, the secular principle of autonomy is based on a scientific-materialist understanding of the human person that solely acknowledges the physical nature of humanity. The body is not viewed as “a sign and place of relations with others, with God and with the world. It is reduced to pure materiality: it is simply a complex of organs, functions and energies to be used according to the sole criteria of pleasure and efficiency.”³⁴ Although one can sense a touch of hyperbole in this statement, the pope is fundamentally correct. Secular viewpoints do consider the body to be a purely physical reality. This is not to say that the body is not valued or highly regarded from a humanist standpoint, but ethical decisions take on a profoundly different tone when the body is considered a material object.

With a secular anthropology based on scientific-materialism and the overarching principle of autonomy as guiding principles, ethicists and the general public often make decisions regarding end-of-life care based on quality-of-life. It is often argued that if someone is in extreme suffering or mentally incapacitated, their quality of life is poor and therefore if they wished to end their life through euthanasia this would be a perfectly acceptable action. Individuals and families have the autonomy to make decisions based

³⁴ John Paul II, 23.

on quality of life because physical life is under human control. In contrast, with a belief that life is a divine gift, Christians cannot make decisions based on quality of life arguments. A medical treatment may be evaluated based on its respective benefits and burdens, but life is valued regardless of a person's physical condition. No matter what sickness, physical disability, or mental diminishment a person experiences, these conditions do not change the ontological value of life, which finds its worth not in a pristine and perfect physical condition but in its connection to God.

If end-of-life decisions are not made on the basis of quality of life, what are the principles guiding Christians as they make these difficult decisions? The encyclical *Evangelium Vitae* has become a touchstone for how to approach these issues. Guiding principles can be culled from the text. Firstly, Christians must be obedient to God. This obedience consists in the freedom to make decisions regarding one's healthcare as long as one is guided by respect for life and an awareness that Christian autonomy is not individualistic, but grounded in relationships. When making end-of-life decisions, recognizing one's obedience to God consists in respecting the sanctity of human life and realizing that while Christians are called to care for their bodies and make medical decisions regarding their health, they must always keep in mind that life is not their possession but a gift from God.

What does this look like in practice? How is obedience to God applied *in situ* when making decisions about end-of-life care? There is both a negative and positive injunction corresponding to respect for life and obedience to God. The negative injunction is stated clearly in the Mosaic law: "You shalt not murder." (Ex 20:13) A person faithful to God and God's gift of life may not take innocent life unjustly. This is a

fundamental prohibition in monotheistic religion. Most Christian ethicists and theologians, including the pope, argue that the sixth commandment is a categorical prohibition on euthanasia or physician assisted suicide because these acts are seen as the unjustified taking of innocent life. Even if a person is involved in assisting someone to die out of a sense of compassion or if someone desires euthanasia due to great suffering they experience, because Christians are commanded never kill, euthanasia is not a morally acceptable option.

It is important however to define euthanasia precisely, or this term is likely to be used inappropriately in reference to the removal or withdrawal of aggressive medical treatment. The standard definition, articulated by John Paul in his encyclical, is as follows: “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.”³⁵ An action is termed euthanasia if it directly causes death and/or if its intended aim is death. Swallowing a cocktail of drugs with the purpose of dying is consider euthanasia, yet it is not considered euthanasia for a doctor to administer drugs for the purpose of reliving pain that may result in a person’s death. The distinction between these two cases rests on the traditional rule of double effect, which states that if death is the unintended effect of necessary medical care it is still morally licit to proceed with the action. This complex rule will be detailed further in the following section of the essay.

In another important Catholic Church document from the magisterium, entitled *Iura et Bona*, the Congregation for the Doctrine of the Faith succinctly stated that

³⁵ John Paul II, 65. When the pope refers to euthanasia in the encyclical, he is referring to active euthanisa. He does not use the distinct between active and passive euthanasia. For him, the two categories are active euthanasia and natural death.

euthanasia can be determined by examining the “intention of the will” and “the methods used.”³⁶ Again the Church wanted to be clear that utilizing drugs, to minimize pain at the final stage of a disease, which could potentially lead to minimal consciousness was not euthanasia, nor unethical. Choosing to forgo or remove aggressive treatment during the final stage of a disease is not a form of active euthanasia, but a proper recognition of human mortality.³⁷

Although Christians are reminded that active euthanasia is illicit because humans do not have the ability to take life, this does not mean that human life need be prolonged at all costs. Instead, the Christian tradition recognizes that death is inevitable and that forgoing aggressive medical treatment, in the face of impending death, is an acceptable decision. Allowing death is not antithetical to a respect for life, but is recognition of the reality of death and the place of death in a wider theological narrative. While it is recognized that death was not part of God’s original plan for creation, Jesus Christ through his death and resurrection has conquered death (1 Cor 15:55). It is within these two poles that Christian thinking on death resides: on the one hand, death is not considered natural but a consequence of human sin and on the other hand, the Resurrection assures the believer that the death of the body is not the end of life. There is repulsion towards the suffering and destruction of death, yet there is also acceptance, comfort and hope when confronting this “final enemy” because the believer recognizes that God is still present at the end of an individual’s life.

³⁶ Congregation for the Doctrine of the Faith, *Iura et Bona, Declaration on Euthanasia*, 1980.

³⁷ John Paul II, *Evangelium Vitae*.

In both magisterial documents (*Evangelium Vitae* and *Iura et Bona*), there are sections of the text that speak to how a Christian should encounter death. There is recognition in these documents that the human condition encompasses death and that the process of dying is the last stage of life. Death, while it can never be willed or desired, can be accepted as a space where the believer manifests their obedience to God. In *Evangelium Vitae*, the pope writes that a Christian can experience death “as the supreme act of obedience to the Father (cf. Phil 2.8)” when they are “ready to meet death at the ‘hour’ willed and chosen by him (cf. Jn 13:1).”³⁸ This is a striking statement that goes overlooked in many Christian treatments of ethics at the end-of-life. The Christian is absolutely required to be obedient to God by never ending a life prematurely through euthanasia or other means, but Christians are also called to be obedient by accepting death when it can no longer be avoided. This is a critical point that will be highlighted again later in this thesis. Let it suffice to say here that the Christian conception of obedience encompasses both the negative injunction to not take life, but also the injunction to not futilely extend physical life for fear of death. There is a balance that must be struck between both of these extremes.

The obligation to respect the sanctity of life is more than a commandment to not take life; it also encompasses a positive responsibility to care for others, especially the weak and the sick. It is not enough to simply abstain from taking a life; the divine gift of life calls for a *caring response* from others. The responsibility to care for human life finds its roots in the identity of the human person. Made in the image of God, individuals are created to share themselves with others. Considering Christian anthropology and its focus

³⁸ John Paul II, 67.

on the relational nature of human identity, there is a focus on solidarity between people rather than on individual autonomy. Christians are called to act and make decisions with an awareness of their relationships. The pope highlights the importance of interdependence when he states “God entrusts us to one another.”³⁹ This mutual responsibility for one another is not a burden, but an opportunity to live into one’s true identity. When caring for others, the Christian believer is able to fulfill the call to imitate Christ and become his presence in the world. Modeling their life on Christ’s, Christian action is oriented toward service and self-gift, not the fulfillment of personal desires. This is not to say that service and personal desire is mutually exclusive, but if a Christian has the option of serving their neighbor or following their own desires, service to neighbor takes priority.

This call to serve others is a principle that can be applied at the end-of-life. Christians cannot turn a blind eye to the terminal or chronically ill and instead must strive to care for individuals confronting painful and long-term illnesses. With the inevitability of old age, sickness, and death comes the responsibility to care for family members and friends who are confronting these challenges. Care for these individuals must be guided primarily by the needs and concerns of the ill, not the desires of the caregivers. Necessary treatments should not be discontinued to alleviate the burden placed on caregivers, nor should unnecessary treatment be continued in an attempt to comfort family members. Caregivers must be responsive to the needs of the ill and approach treatment decisions from the dependent’s standpoint.

³⁹ John Paul II, 19.

The Church, medical institutions, and most important, the family all need to play a role in caring for the sick by first recognizing the deep and unique pain and suffering of those who are ill. Christian teaching has always made it a point to emphasize that those who are severely ill or dying deserve to have *all* their needs met. The fears and anxieties of the terminally ill must be addressed, in addition to the alleviation of their physical symptoms.

There is a need to think of unique ways to address the suffering of those dying in contemporary society and find ways to provide the highest possible care. This frequently includes the use of palliative and/or hospice care. These medical specialties cannot be considered a sign of defeat or a disregard; instead palliative/hospice care should be viewed as a beneficial form of medicine that directly correlates to the needs of the chronically and seriously ill.⁴⁰ Whatever medical treatment is provided to the sick and dying it should not eclipse the profound duty to care for the soul and spiritual life of those who are ill. Medical treatment should be provided, yet in tandem with spiritual and psychological care. Caring for only the body without redress to a person's soul is insufficient care from a Christian perspective.

II. Ethical Mechanisms for End-of-Life Decision-making: Double-Effect and Ordinary and Extraordinary Means

While the above discussion includes some mention of how Catholic principles are applied to end-of-life concerns, there are further ethical tools to help determine whether

⁴⁰ John Paul II, 92.

treatment at the end of life is obligatory or optional. Ethicists use two primary rules to determine whether an end-of-life decision is morally acceptable and in accord with the sanctity of human life: the rule of double effect and the standard of ordinary and extraordinary means. These concepts are an aide in applying theory and theology to real-life situations and in this sense they can be considered ethical mechanisms—data is collected and inputted within the framework of double effect and extraordinary/ordinary means and the output of the process is a determination of whether the action is permissible (in the case of the principle of double effect) or whether the action is an “ordinary mean” and required or “extraordinary mean” and optional. Both the principle of double effect and the terms ordinary/extraordinary means are widely used and accepted in secular and Catholic bioethics; however, there is still controversy over the usefulness of these mechanisms and dispute over their application. Defining these concepts and their history will reveal both their usefulness for biomedical decision-making, but also their limitations.⁴¹

Joseph Mangan, in his historical essay on the principle of double effect, notes that this principle was first articulated by Thomas Aquinas. Aquinas developed the principle in response to the question of whether it is morally acceptable for a human to kill someone in self-defense. This act of killing is an action with two effects: one person has saved himself or herself from harm but another individual is dead. Aquinas argues that an action that produces two effects (both good and evil) can be either morally licit or illicit, based on whether certain conditions are met. Mangan clarifies that there are four

⁴¹ For a critique of the principle of double effect see Timothy E. Quill, Rebecca Dresser, and Dan W. Brock, “The Rule of Double Effect - A Critique of Its Role in End-of-Life Decision Making,” *The New England Journal of Medicine* 337, no. 24 (December 11, 1997): 1768–71.

conditions that must be met for an action that produces good and evil effects to be considered licit: (1) the action cannot be inherently evil; (2) the intention of the action must be good; (3) the good effect cannot be caused by the bad effect; (4) there must be a proportional reason for allowing the evil effect.⁴² In abstract the distinctions between these conditions are a bit difficult to decipher, but in practice these conditions are helpful in determining whether end-of-life decisions are moral.

Palliative sedation, also sometimes referred to as terminal sedation, is a typical example used to elucidate double effect. Patients with terminal illnesses who are in extreme pain may be given a high dose of pain-relieving medicine that can result in the loss of consciousness and even death. When evaluated with the principle of double effect, palliative sedation is a morally acceptable action even if it results in death because it meets all four conditions outlined above: (1) providing sedative drugs to patients is not an inherently immoral act; (2) palliative sedation is intended to relieve pain (i.e., the good effect is the intention behind the act); (3) the relief of the patient's suffering is not caused by their death but by the drugs themselves; (4) the relief of excruciating pain in the face of imminent death is a valid justification for prescribing drugs that have the potential to speed death. In comparison to palliative sedation, the rule of double effect proves that euthanasia or physician-assisted suicide is not morally acceptable. Although there is often a good intention behind euthanasia (e.g. the alleviation of pain and suffering) and in this regard the act passes the required second condition, euthanasia is still a morally unacceptable action because it is viewed as inherently immoral from a Catholic

⁴² Joseph T. Mangan, "An Historical Analysis of the Principle of Double Effect," *Theological Studies* 10, no. 1 (February 1, 1949): 41–61, <https://doi.org/10.1177/004056394901000102>.

perspective. Therefore, the first condition of the principle of double effect is not met in the case of euthanasia.

Double effect is a nuanced rule that is a useful, but not necessarily easy, tool to apply in medical decision-making. Mangan remarks that double effect is “not an inflexible rule or mathematical formula but rather an efficient guide to prudent moral judgment.”⁴³ His insight is well grounded. Because double effect relies on an honest assessment of the intentions behind one’s actions there is room for ambiguity. However, this does not negate the rule’s value, but instead reaffirms the need to be careful and forthright when making difficult medical decisions. Daniel Sulmasy, in an article which challenges critics of double effect, argues that to use this rule properly, physicians and other involved parties must be “careful to specify the effects one is aiming at” and that although human intentions are sometimes difficult to judge, clinicians usually have a sufficiently clear sense of how various medical treatments will impact a patient. In Sulmasy’s estimation, the criticisms levied against this rule are not strong enough to prevent its use because double effect allows those “who are morally opposed to euthanasia and assisted suicide to provide adequate pain relief without violating traditional medical morality or their conscience.”⁴⁴ The rule of double effect is an evaluative tool that is centered on helping decision makers provide patients the care they need.

Double effect is not the only rule that guides end-of-life decision-making. The distinction between ordinary and extraordinary means is another important concept.

⁴³ Mangan, 43.

⁴⁴ Daniel P. Sulmasy and Edmund D. Pellegrino, “The Rule of Double Effect: Clearing Up the Double Talk,” *Archives of Internal Medicine* 159, no. 6 (March 22, 1999): 545–50, <https://doi.org/10.1001/archinte.159.6.545>.

While double effect evaluates the morality of introducing a treatment, the distinction between extraordinary and ordinary means is used to evaluate the permissibility of refusing or withdrawing treatment.⁴⁵ The terms “ordinary” and extraordinary” have a long history of use in ethical discourse. First used in the 16th century, the terms were formulated during a time when medical care was often a brutal and painful process; there was no anesthesia and surgical procedures could lead to excruciating pain and even disfigurement.⁴⁶ In 1582, Dominici Soto argued that a religious superior could oblige those vowed in obedience to them to use medical treatments that would preserve their lives without “too much difficulty,” but superiors could not obligate their subjects to undergo excruciatingly painful treatments to save their life.⁴⁷ The differentiation between required and “ordinary” medical treatment that does not impose an excessive burden and “extraordinary” treatment that imposes a significant physical, financial, or psychological burden continued to be developed throughout the 18th and 19th centuries.

In more recent history, the Catholic ethicist Gerald Kelly, concerned with the advances in medical technology, provided a comprehensive definition for ordinary and extraordinary means that is still in use. It is worth quoting Kelly’s clear and specific language for each term:

Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconveniences.

⁴⁵ Sulmasy and Pellegrino.

⁴⁶ James J. McCartney, “The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology before the Karen Quinlan Case,” *The Linacre Quarterly* 47, no. 3 (August 1980): 215–24.

⁴⁷ McCartney, 216.

Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer reasonable hope of benefit.⁴⁸

After defining these terms, Kelly goes on to state that individuals are obligated to use ordinary means to preserve their life, but they are not morally required to use extraordinary means. There are a couple points of Kelly's definition that deserve to be explored.

The first aspect that needs further attention is not mentioned explicitly in the above definitions, but it is clear when these terms are used in practice that they pertain to individual situations; ordinary and extraordinary means are only understood within an *individual* context—what is an ordinary mean for one person in their given situation, could be an extraordinary mean for another individual. For example, if a young child falls and breaks their hip and surgery is needed, this would be considered an ordinary mean. In this case, surgery offers a reasonable hope of improvement and this treatment can be obtained without excessive expense or other inconvenience. The benefits of the treatments (helping a young child walk again) greatly outweigh the risk and pain of the surgery. Yet imagine an elderly, terminally ill individual breaks their hip, surgery to repair this damage would now be considered an extraordinary mean. The elderly individual, who is close to the end of their life, would have a much greater struggle undergoing and recovering from the surgery. So although repairing their hip may not be entirely futile, it is true that their hipbone would be fixed, this procedure is still considered extraordinary based on the criterion of burdensomeness. The surgery would include “excessive pain and inconvenience” and potentially could further weaken this

⁴⁸ Gerald Kelly, “The Duty to Preserve Life,” *Theological Studies* 12, no. 4 (December 1, 1951): 550–56, <https://doi.org/10.1177/004056395101200405>.

individual. This example illustrates that these terms must be applied to individual circumstances. The entirety of a person's experience must be taken into consideration when evaluating whether a treatment is an ordinary or extraordinary mean.

The above example also provides a means to elaborate on the two distinct qualities used to describe extraordinary means: excessive burden and futility.⁴⁹ A treatment may be considered extraordinary on the basis of either (or both) of these criteria. Excessive burden refers primarily to the impact the treatment will have on the individual. The side-effects, risk, pain, and recovery time associated with a treatment are all aspects encompassed by this criterion. A treatment can also be considered excessively burdensome based on expense or a lack of availability. So although the criterion is primarily an evaluation of a treatment's impact on the patient, a treatment could be considered extraordinary based on wider familial and community concerns. If an experimental treatment will bankrupt one's family, although it may extend one's life, an individual would not be obligated to pursue this treatment because it is extraordinary based on the financial burden it imposes. Futility is the second marker of extraordinary care. If a treatment offers no hope of a cure or a substantial health benefit, then this medical option could be considered extraordinary.

When a treatment is considered extraordinary by virtue of its burdensomeness or futility, no one is obligated to use this means to preserve their life, yet people can choose to pursue extraordinary care if they desire it. There is no injunction against using extraordinary means. The distinction between the terms is intended to allow people to ethically withdraw or refuse extraordinary treatment.

⁴⁹ May, *Catholic Bioethics and Gift of Human Life*, 283-284.

As an important aside, there is no ethical distinction between refusing or withdrawing medical care. Once a treatment has been determined to be extraordinary, whether it is being refused or removed makes no moral difference. Upholding the moral equivalency of withdrawing and refusing treatment corresponds to the changing nature of medicine and disease. It is quite understandable that a treatment that was once considered ordinary could become extraordinary. Another example can help to illustrate this point. An unconscious patient with head trauma arrives at the emergency room. They are immediately intubated and placed on a ventilator in the hopes that they will regain consciousness and the ability to breathe on their own. After six months of monitoring, doctors inform the family that tests have confirmed that their loved one is in an irreversible coma. When the patient initially came into the emergency room the ventilator would have been considered an ordinary means, yet after the doctor's advice the family can now decide to remove the ventilator because it has become an extraordinary mean—this treatment no longer offers any hope of benefit. Patients and families are not compelled to continue using a treatment that at one point was ordinary and has now become extraordinary. Additionally, families should not be concerned that if they start life-sustaining care, that it must be indefinitely continued, even if it becomes futile or excessively burdensome. The distinction between ordinary and extraordinary means can change based on different circumstances; it can also change based on one individual's changing prognosis.

Another aspect of the distinction between ordinary and extraordinary means that should be uplifted is that a variety of factors may decide whether a treatment is ordinary or extraordinary. This is apparent in the examples already presented. A treatment's

availability, cost, and long term side-effects as well as an individual's chance for improvement or recovery and even strong feelings of fear or disgust can be sufficient reasons for determining that a treatment is extraordinary. There is no one standard or quality that can determine whether care is ordinary or extraordinary. William May clarifies that this does not mean that the distinction between ordinary and extraordinary means is entirely arbitrary and subjective. He notes that the factors used to determine if a treatment is extraordinary are all "objectively discernible features in the treatment itself, its side effects, and its negative consequences that impose undue burdens on the patient and/or others."⁵⁰ Even though a diversity of reasons can be used to define a treatment, these different reasons must be connected to treatment.

May's point counters the criticism that the distinction between extraordinary and ordinary means is entirely subjective. The patient's insights and emotions regarding their medical care will impact whether a treatment is ordinary or extraordinary for them, but the subject's view of their care needs to be grounded in a realistic assessment of their condition. For example, an otherwise healthy individual who is diagnosed with diabetes cannot morally refuse to take insulin injections because they have a fear of needles. While this person may exhibit a profound fear and disgust of the treatment, which in their mind makes it extraordinary, this fear is not directly related to the treatment itself. This individual would be scared to receive any injection—it is not the insulin shot that is their primary concern. This example may seem a bit trivial, but hopefully the intention behind its presentation is clear: the distinction between ordinary and extraordinary, while incorporating some subjective measures, does not mean that the rule is not objective. A

⁵⁰ May, *Catholic Bioethics and Gift of Human Life*, 283. Italicized in the original.

detailed, honest, and sensitive assessment of the treatment and its consequences will be grounded in facts in addition to personal feelings and desires.

The key takeaway from the above discussion is that treatments need to be evaluated in context before they can be labeled “ordinary” or “extraordinary.” There is no standardized list that details which treatments are ordinary versus which treatments are extraordinary. The flexibility of this rule is the precise reason why it is used so widely. Individuals, with the help of healthcare professionals, ethicists, and pastors, weigh the benefits and burdens of each treatment and then determine whether, in their condition, the treatment is an ordinary mean and required, or an extraordinary mean and therefore optional.

While the distinction between ordinary and extraordinary means is accepted and applied by ethicists, there is ongoing debate about whether certain medical care is *always considered ordinary and obligatory*. This concern makes intuitive sense; there are some needs (e.g. water, food, human touch, warmth and shelter) so fundamental to the human person that they can never be considered extraordinary. The earliest papal allocutions on ordinary and extraordinary means never include an express statement noting that certain care is obligatory, yet Pope John Paul II offered explicit guidance on this point.⁵¹ In multiple documents, John Paul stresses that natural means of preserving life are ordinary

⁵¹ Pope Pius XII, “Discurso Sobre Las Implicaciones Morales y Religiosas de La Analgesia” (24 February 1957), *Acta Apostolicae Sedis* 49 (1957) 129-147. Speaking to a group of anesthesiologists, Pope Pius XII makes a distinction between ordinary measures to preserve life, which are required, and “heroic” measures, which are not incumbent upon anyone, but he does not elaborate on any specific treatments that would be considered ordinary.

means.⁵² For John Paul II, natural means refer to fundamental life-sustaining goods, such as water, food, comfort, cleanliness. Difficulties arise with this new terminology, which links “natural” needs to ordinary means, when the pope asserts that even the artificial administration of fluid and nutrition is natural, ordinary and morally obligatory. If the artificial administration of fluid and nutrition is an ordinary mean, as Pope John Paul asserts that it is, this places a limit around extraordinary means that was not present previously. At this point, let us avoid getting bogged down in the internecine debates between Catholic ethicists on this issue but remember that before Pope John Paul’s statement, *any and all* medical treatments could be withdrawn or removed if the burdens exceeded the benefits. With the pope’s injunction, it would seem that certain treatments are always considered ordinary.

Determining whether a treatment is extraordinary or ordinary is a moral judgment, not a medical one, yet the distinction between these two terms closely corresponds to terms used in the medical field. Physicians do not label treatments as ordinary or extraordinary, but they do label care aggressive or futile. These terms, aggressive and futile, are typically used synonymously, but it is helpful to try and provide a discrete definition for each. In medicine, aggressive care is treatment that actively pursues a medical cure, even though a cure and a return to full health may be a distant possibility based on the physical condition of the patient. Futile care, a more ambiguous and controversial term, is care that cannot achieve any improvement in health.⁵³ Futile care is

⁵² John Paul II, Address to the Participants in the International Congress on Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas, (20 March 2004), section 4.

⁵³ Lawrence J. Schneiderman, “Defining Medical Futility and Improving Medical Care,” *Journal of Bioethical Inquiry* 8, no. 2 (June 2011): 123–31,

the stronger of the two terms and it denotes a treatment that will have no beneficial outcome for a patient. Aggressive care, on the other hand, is employed in a variety of critical care situations. Aggressive care that no longer offers any benefit to the patient becomes futile care.

Ethicists hesitate to equate extraordinary care with medical determinations of aggressive or futile care because they are concerned that doing so will create a detrimental blending between the medical field and decisions of conscience.⁵⁴ This viewpoint argues that doctors are trained to propose treatments that are in accord with medical goals, yet patients do not solely choose medical procedures to further ends established by healthcare providers. A doctor may consider the continued ventilation of an 80-year-old patient futile care, yet their family may believe that this treatment is serving its intended purpose: the prolongation of the patient's biological life. Here we see that the distinction between extraordinary and ordinary care, while based on medical input, also includes a variety of other non-medical factors, including cost, values, and religious beliefs. With this understanding, it is argued that decisions about ordinary/extraordinary care are best left to patients and their families.

While it is important to acknowledge that medical advice *alone* is not determinative of the morality of end-of-life decisions, medical input should not be undervalued; it is a vitally important aspect of ethical decision-making. Drawing too great a line between the medical and ethical evaluations of end-of-life treatments can lead to harmful and inappropriate medical care where a patient's health is subordinated to

<https://doi.org/10.1007/s11673-011-9293-3>. Deborah L Kasman, "When Is Medical Treatment Futile?," *Journal of General Internal Medicine* 19, no. 10 (October 2004): 1053–56, <https://doi.org/10.1111/j.1525-1497.2004.40134.x>.

⁵⁴ Engelhardt, *The Foundations of Christian Bioethics*.

other values. When a doctor determines that a treatment is aggressive or futile from a medical perspective, in most cases, this would suggest that the treatment is extraordinary from a moral perspective. The correlation between medical and moral assessments may not occur in every situation, but for the most part, when dealing with end-of-life decisions, when a treatment is futile or aggressive from a medical standpoint, it can be considered an extraordinary mean that is not morally obligatory.

By acknowledging that moral discourse at the end-of-life is closely intertwined with medical judgment, it becomes clear that the concerns of the medical community, particularly their worry about the overuse of aggressive and futile treatment, become concerns for Christian ethicists. If futile and aggressive care is being over utilized, this would suggest that more patients are deciding to accept treatment that is extraordinary and morally optional. Can the rule of double effect and the distinction between ordinary/extraordinary means serve to correct this imbalance in care and help limit the overuse of aggressive measures?

III. The Limitations of Ordinary and Extraordinary Means

As these two rules are currently formulated, the answer to this question is no. The rule of double effect evaluates actions prior to their implementation; this rule is not helpful in guiding patients to withdraw or remove medical treatment. And while the distinction between means of care allows patients to refuse extraordinary forms of treatment, the distinctions cannot be used to help limit aggressive or futile care. Extraordinary treatment can be refused *or accepted*. Once a treatment is categorized as

extraordinary, it is completely up to an individual to determine whether they want to pursue this treatment or not.

If one considers the historical development of this ethical rule, it is not surprising that there is no injunction or advisement against the use of extraordinary means. Remember that the ability to distinguish between the means of care was formulated in the 15th century, during a time when medical procedures were often cruel, unusual and accomplished without anesthesia. Religious superiors developed the distinction between ordinary and extraordinary means in a time when people were more likely to refuse extraordinary treatment than to accept it.⁵⁵ Leaders of monastic and clerical communities needed guidance on when they should require those entrusted to their care to use medical treatment. There was no concern that extraordinary means would be used inappropriately. At this time, the use of extraordinary means was considered a heroic activity, an option that, it was thought, only a few individuals could stomach. This emphasis on the “heroic” quality of extraordinary means is present up to the writings of Pope Pius XII in 1957.⁵⁶

With the advent of new medical technologies, extraordinary means no longer come with the excessive burden and heroic quality they once did. Now, many individuals choose to pursue this care. Thankfully, anesthesia and analgesics prevent patients from suffering unbearable amounts of pain during and after procedures. What was once an unbearable burden or an unimaginable possibility has become routine and commonplace. Aggressive measures, such as intubation, mechanical ventilation, and resuscitation, are frequently used. The ease of access to these treatments has increased dramatically in the

⁵⁵ McCartney, “The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology before the Karen Quinlan Case.”

⁵⁶ Pope Pius XII, “Discurso Sobre Las Implicaciones Morales y Religiosas de La Analgesia” (24 February 1957), *Acta Apostolicae Sedis* 49 (1957) 129-147.

past fifty years. Previously, there was a sense that most people would not desire treatments that were labeled extraordinary; yet now, with modern medicine, this is not the case necessarily. Receiving aggressive or extraordinary treatment may not be an easy experience, but there is easier access to and implementation of these treatments.

The increased utilization of extraordinary means coupled with an implicit assumption within Catholic teaching that extraordinary care, while optional, is a morally neutral activity poses problems. Because there is no further evaluative framework to determine whether extraordinary care is in itself ethical or to discourage its use, there is a critical gap in ethical guidance. This gap needs to be rectified in our current context.

Before proscribing a new approach to extraordinary care, it is worth exploring why this issue has been overlooked. It is not surprising that the Church, theologians, and ethicists have never set out guidelines to limit extraordinary care. The priority in Catholic bioethics has been the protection of human life. The use of abortion and euthanasia was, and still is, seen as a great evil that the Church must combat in word and deed. This defensive stance is witnessed extensively in John Paul II's writings. Within his encyclical *Evangelium Vitae*, John Paul II coins the phrase, "Culture of Death," to describe modern culture and its devaluation of life.⁵⁷ For the pope, Western society is a place where the powerful are in a war with the weak and lives that "require greater acceptance, love and care" are seen as a burden and cast aside.⁵⁸ This is a society with a "conspiracy against life."⁵⁹ The Church offers an alternative to the Culture of Death. In a world where there

⁵⁷ John Paul II, *Evangelium Vitae*, 12.

⁵⁸ John Paul II.

⁵⁹ John Paul II.

is active disregard for human life, the pope calls Christians to return to the message of Christ and uphold the sanctity of every human life.

This presentation of the pope's assessment of modernity is not intended to arouse the assent or dissent of the reader. Instead, this material is relayed to highlight that the Church's focus on protecting life and the rhetoric surrounding pro-life discourse has a tendency to distract from other end-of-life issues. The Church has been focused on the problem of euthanasia, yet the overuse of aggressive and futile care at the end-of-life goes unaddressed.

In a Christian climate that uses labels such as the "Culture of Death" and warns individuals to protect human life, it seems natural that Christians would have a tendency to favor treatments that extend life at all costs. Although ethicists and theologians assert that Christianity is not vitalistic, but allows for the discontinuation and removal of ineffective medical care, patients and their families may have difficulty squaring a natural allowance of death with pro-life rhetoric against euthanasia. When faced with an extraordinary treatment option, families may be more likely to choose this treatment to protect life, rather than allowing for natural death.

In some cases, choosing extraordinary care may be a morally good or neutral act, yet when the decision to prolong life either creates a "bad death" filled with needless suffering or is contrary to Christian principles then the decision to use extraordinary care is not warranted. Church teaching on the inviolability of human life and its strong stance against euthanasia is not at fault for the increased use of aggressive care at the end of life, but there does need to be a recognition that the moral questions surrounding death and dying are wider than traditional pro-life concerns.

IV. Faithful and Unfaithful Means: A New Approach to Aggressive End-of-Life Treatment

When a strong pro-life rhetoric is coupled with the distinction between ordinary/extraordinary means that were developed in entirely different medical circumstance, there is no way to limit the use of unbeneficial end-of-life treatments. And this is the crux of the problem—the traditional methods for dealing with end-of-life decisions are insufficient to the challenges society is confronting. In a society where extraordinary and aggressive means are often employed in inappropriate and harmful ways at the end of people’s lives, what resources and guidance can Catholic ethics offer to address this challenge? The remainder of this paper will propose a new construct to determine when extraordinary care is appropriate and when it is morally contraindicated. Although Catholic ethicists have been hesitant to set moral limits on the use of extraordinary care, leaving it up to individual discretion, it will be argued that if these means are harmful and in contradiction to foundational theo-ethical principles than they should not be allowed.

The approach to this problem offered by this paper is not revolutionary, but will build on the previously elaborated principles guiding Catholic bioethics. The objective is to build an ethical category *in addition* to the already present category of ordinary and extraordinary means; this new category of *faithful and unfaithful means* will not circumvent or eliminate the need for the prior distinction. Once a treatment has been classified as extraordinary, then it would be re-evaluated to determine whether it is

faithful or unfaithful. Unfaithful means are medically aggressive and morally extraordinary treatments that are counter to Christian principles, in intention or application. If a treatment is extraordinary and unfaithful its use is morally contraindicated.

The terms “faithful means” and “unfaithful means” have not been used by bioethicists in regards to end-of-life treatment. However, a few bioethicists have used other terms to establish a category of ethically inappropriate medical care. Reasonable and unreasonable means are one such set of terms. These terms helpfully set limits on treatment at the end-of-life, but the way ethicists determine when a treatment is unreasonable has not been elaborated in detail and therefore is not helpful. An examination of the way reasonable/unreasonable means is utilized will help to flesh out the unique approach presented in this paper.

Ethicists have defined unreasonable means in a variety of manners. Some ethicists favor exchanging the terms “ordinary” and “extraordinary” with the terms “reasonable” and “unreasonable.” In these cases, unreasonable means would have the same ethical import as extraordinary means—treatments with either classification would be morally optional, but not inappropriate. David Kelly approaches the term unreasonable means from a different angle. He argues that some medical treatments, in addition to being extraordinary, may be “unreasonable, even silly or stupid.”⁶⁰ Kelly considers placing feeding tubes in the irreversibly comatose one of these “unreasonable” instances.⁶¹ Kelly’s use of this term is not particularly helpful however because he does not offer a

⁶⁰ David F. Kelly, *Medical Care at the End of Life: A Catholic Perspective*, 1st edition (Washington, DC: Georgetown University Press, 2006), 10.

⁶¹ Kelly.

robust definition of unreasonable means, nor does he provide insight into how treatments would be evaluated and determined to be unreasonable.

Building on Kelly's work, Daniel Daly, in an article for *Christian Bioethics*, proposes that unreasonable means "are present when the burdens to the patient and community far outpace the benefits to the patient and when the use of such means directly or indirectly limits another patient's access to ordinary means."⁶² Daly's approach to unreasonable means is grounded in social ethics and, aside from the Christian tone, is similar to the approach taken by Daniel Callahan in *Setting Limits*. The call to support the common good, as elaborated in Catholic social teaching, he argues, needs to be considered when determining the morality of medical decisions. With this in mind, Kelly notes that the Catholic tradition "does not support the unlimited use of medical treatments at the end of life."⁶³ Individuals and medical institutions should "preferentially opt for other people's basic medical needs before one's own superextraordinary medical needs."⁶⁴ Daly's perspective on unreasonable means isolates a gap in ethical guidance that this paper also seeks to address. He notes that there is an incongruity between the moral tradition of the Church and its application in healthcare settings. Although the "Catholic tradition argues for moral limits on the use of material things and goods," this insight does not apply to medical treatment where there has been no discussion of the ethical need for limits.

⁶² Daniel J. Daly, "Unreasonable Means: Proposing A New Category for Catholic End-of-Life Ethics," *Christian Bioethics: Non-Ecumenical Studies in Medical Morality* 19, no. 1 (April 1, 2013): 40–59, <https://doi.org/10.1093/cb/cbt006>.

⁶³ Daly, 53.

⁶⁴ Daly.

While Daly's grasp of this anomaly in Church teaching is insightful and his recognition of the need for a new ethical category is in line with the objectives of this project, Daly's definition of unreasonable means lacks distinction and practical applicability. For Daly, unreasonable means are treatments where the "burdens to the patient and community far outpace the benefits to the patient."⁶⁵ This definition only offers a slight difference in emphasis when compared to Gerald Kelly's formulation of extraordinary means. In Kelly's definition, extraordinary means are all medicines, treatments, etc. that impose an excessive burden on patients or their families and/or do not offer reasonable hope of benefit. Daly's definition of unreasonable means simply emphasizes the burden of these treatments and their effect on a wider community.

Instead of proposing a new and distinct ethical category of unreasonable means, Daly's argument is seen more accurately as uplifting the communitarian dimension of extraordinary means. Daly argues that the use of unreasonable means in the global north are unethical because they draw resources away from underdeveloped countries and oppressed peoples in the global south. His analysis leaves unanswered questions regarding the applicability of his proposals: If cost is the primary marker for unreasonable means, does that mean that other expensive treatments or medicines should be refused on the basis of the common good? How do reduced health care expenditures in the global north transfer into greater economic resources for the global south?

Daly's connection between unreasonable means and the common good is a laudable contribution to the discussion of extraordinary means, but his approach does not fully contribute to the reduction of aggressive means because Daly fails to address the

⁶⁵ Daly, 40.

ideological roots of aggressive care. The definition of unfaithful means proposed in this paper is an attempt at tackling this concern. Instead of focusing on comparing the benefits and burdens of a treatment, which is already evaluated through the distinction between ordinary and extraordinary, unfaithful means are evaluated in connection with the principles of Catholic bioethics. Once again, the definition of an extraordinary and unfaithful mean is any medical intervention that violates, by intention or by means, the theo-ethical principles connected to the sanctity of life. The violation of these principles occurs in two primary ways: an enacting of radical human autonomy and/or of a materialist anthropology that is not grounded in care for oneself or one's neighbor.

Before elaborating in further detail how extraordinary means can morph into unfaithful means that stand in opposition to theo-ethical principles, it is important to pause at this junction and restate the following, fundamental points of Christian ethics in regard to the sanctity of human life:

- (1) The sanctity of human life is rooted in humanity's close relationship to God. Humans are created in the *imago Dei*, redeemed by Christ, and destined for unity with God.
- (2) The human person, a unity of body and soul, has an inherent and omnipresent sanctity that can never be reduced or diminished.
- (3) In response to the sanctity of life, Christians are called to respect and care for life.

In upholding these three points, a Christians approach to end-of-life decisions stands in contrast to a secular approach. By recognizing that human life is a gift from God, not an object to be possessed and manipulated at will, Christian decision-making is

oriented around the virtue of obedience to God. In a country where individualism and personal freedom are of the utmost value, the word obedience has a tendency to be vilified. Yet obedience to God does not connote blind faith and unquestioning acceptance of biblical proscriptions. Instead, obedience is an ethical orientation that recognizes humanity's dependence on God and others. This orientation can be contrasted to forms of autonomy where an individual is seen in isolation from God and their neighbors and personal freedom of choice is the utmost value.

In addition to limiting unbridled autonomy, Catholic teaching on the sanctity of human life offers an implicit anthropology that is distinct from a secular materialist perspective on the human person. Christian thought teaches that the human person is a unity of body and soul. These elements are integral and united aspects in a human person. Humans are enfleshed souls, not souls that possess a body. To place a priority on the soul at the expense of the body is a form of Gnosticism. And to too tightly clasp onto the body, ignoring the soul or spiritual dimension of the person, is a form of idolatry. Christians do not advocate a flight from the body, nor an undue attachment to physical existence. The preservation of both bodily and spiritual life is incumbent upon believers; yet, if one element is to be subordinated to another, the soul may be prioritized over the body. It is in this sense that earthly life is seen as a penultimate value.

Catholic end-of-life ethics proceeds then with the sanctity of life as a grounding principle, an elevated anthropology and an orientation toward obedience. Typically, keeping these theological and ethical priorities in mind has meant prohibiting euthanasia (i.e. the direct and willful taking of a human life to relieve suffering), allowing for natural death, and encouraging the compassionate care of the sick and dying. This is a very broad

assessment of the recent tradition in bioethics, yet it highlights that these principles have not been analyzed in connection with the need to limit aggressive care. There is an unstated assumption that while extraordinary or aggressive care may not be morally required, it is certainly not an immoral act. Yet, the following presentation will examine how extraordinary means of medical care can in fact be morally dubious. I hope to show how aggressive and extraordinary means can become unfaithful means that should be dissuaded if they turn against essential norms. Recognition of the category of unfaithful means and the detrimental impact of these forms of medical care is an important step in broadening ethical discourse at the end of life.

Before describing the two modes of unfaithful means in further detail, it is worth clarifying the method with which this ethical rule will proceed. Unfaithful means, like the rule of double effect, rely primarily on an analysis of an agent's intention. In end-of-life situations, the agent is the individual who makes medical decisions. This agent could be the patient themselves or the patient's health care surrogate. The severity of terminal illness often renders patients incapacitated and unable to make decisions. In these circumstances, the health care surrogate would make decisions in accord with the patient's previously stated wishes. If the patient's intentions cannot be expressed, then the intentions of the health care surrogate would be evaluated. The category of unfaithful means will apply to any extraordinary treatment whose intention or application is contrary to Christian norms.

At first glance, one may question whether there are in fact unreasonable medical means that counter the principles of Christian bioethics. How can continuing medical care, in whatever form it takes, be considered unreasonable? If medicine and health are

both goods, how can aggressive care at the end of someone's life be morally contraindicated? People may recognize that some treatment is unwarranted from a medical standpoint, but is it possible to be unwarranted from a moral standpoint? These questions percolate in the background of any discourse that seeks to limit the use of medical treatments. There is a wariness to discussions that seek to limit treatment because the immediate thought is that limiting medical therapies is antithetical to recognizing the sanctity of human life and yet, it is precisely the argument of this paper to show that *not* limiting treatment can itself be antithetical to the principles inculcated in Catholic bioethics.

Although the unfaithful use of aggressive care does not directly violate the sanctity of human life by taking innocent life, like the practice of euthanasia, these means of treatment can undercut and violate the theological and anthropological claims deduced from an understanding of the sanctity of life. So while unfaithful means of care may be seen to uphold the sanctity of life, they are in fact destroying this principle's attendant assertions. There are two primary ways an extraordinary mean can become an unfaithful mean. If there is an exertion of unbridled autonomy or an attachment to a materialist understanding of the human person during the use of extraordinary treatment than these means would be classified as unfaithful. In these cases, the use of aggressive treatment is more ideologically aligned with a secular, rather than a Christian, perspective on end-of-life ethics.

The use of unfaithful means of treatment are a unique manifestation of the "Culture of Death" that Pope John Paul II criticizes because these acts, many times unintentionally so, divorce human life from God. However, not every extraordinary

means of treatment can be classified as unfaithful. After detailing the first two manifestations of these means, attention will be paid to means of treatment that uphold Christian principles and are oriented toward an ethic of care. In outlining instances of unfaithful means, the goal is not to encourage a careless removal or withdrawal of treatment from people who are suffering, but to emphasize that limiting medical therapies at the end of life may be the ideal way to offer compassion to the sick and dying while following Christian teaching. The unlimited use of medical technology alone does not guarantee that these primary goals have been met.

In the first case, if extraordinary means are an expression of absolute autonomy these means are unfaithful. Absolute autonomy is an orientation contrary to an obedient stance that recognizes God's connection to life. Absolute autonomy is a Promethean attitude that asserts that humanity, not God, is the ultimate arbiter of life and death. Instead of approaching life with reverence, respect and an awareness that life is in God's hands, an individual who uses autonomy as their working principle seeks to control life to an unreasonable extent and, in essence, is asserting that life is their possession, not a gift from God. This type of autonomy is exhibited in a desire for euthanasia, but it also manifests in the alternative request, heard by many doctors, to "Do everything possible!" A patient or family member who requests that aggressive and futile care be continued when death is imminent is in danger of uniquely manifesting a form of autonomy that does not recognize God's presence during the final moments of life.

Numerous biblical passages articulate God's authority over life and death. Although death is a consequence of sin and not God's creation (cf. Wis 1:12-14 and Rom 6:23), there is a unified insistence throughout the bible that God is involved in

determining when life begins and ends. The psalmist lyrically notes that although human life is “like a breath” and our “days are like a passing shadow,” God still cares for mortal people (Psalm 144:4). Both the psalmist and Job emphasize that God has numbered human days (Job 14:5 and Psalm 139:16). The repeated use of this turn of phrase serves to emphasize that humans have limited control over the length of their lives. This is not to say that proper care of the body should be ignored in an apathetic resignation to our fate, but is instead a call to remember that humans do not have unlimited control over the beginnings and ends of life.

In response to this biblical vision of life, humans are called to practice humility in the face of death’s imminence. Acts of a Promethean nature that futilely attempt to stave off death cannot be considered in accord with the sanctity of life; these acts are more protective of an individual’s desires than the sanctity of life. It is beyond understandable that people fear the physical extinction of life, yet a desire to postpone death, when it is inevitable and imminent, is not a mark of respect for life, but an inappropriate exertion of human control over the dying process. Dying is an aspect of life and when death approaches, a death that is not willed or sought, it should be protected from unnecessary and futile manipulation.

It is inevitable that some Christians will take umbrage with this statement. For many, death is an evil that is meant to be avoided at all costs and never willingly accepted. In his article “The Indignity of ‘Death with Dignity,’” Paul Ramsey forcefully defends a view of death that is partially in line with this sentiment.⁶⁶ Ramsey argues against any ideology that “beautifies” or “naturalizes” death; death should “not be

⁶⁶ Paul Ramsey, “The Indignity of ‘Death with Dignity,’” *The Hastings Center Studies* 2 (1974): 47–62, <https://doi.org/10.2307/3527482>.

accepted as a natural part of life,” but recognized for what it is: an encounter, a brutal and “ignoble” encounter, with the end.⁶⁷ For Ramsey, contemporary discourse that seeks to dignify death is an untruth that correspondingly reduces the dignity of man. He writes that “the more acceptable in itself death is, the less the worth or uniqueness ascribed to the dying life.”⁶⁸ This statement captures the troubling tone of Ramsey’s piece. For Ramsey there are two opposing visions of death: death as an enemy and death as a natural and accepted part of life. He draws a hardline between these two views and does not acknowledge that there could be an overlap between them. This hard dualism creates practical concerns for end-of-life care. As a Christian, if the only acceptable way to view death, as Ramsey suggests, were as an enemy, then there would seem to be an ensuing ethical imperative to use every available means of treatment. While Ramsey may not have been advocating for this conclusion, his unbalanced argument can be taken to support such a stance.

A fuller account of Christian teaching provides a more nuanced understanding of death that does not support the ethical conclusions drawn from Ramsey’s argument. There is recognition in scripture that death is a consequence of sin. Death was not part of God’s original intention for humanity; the disintegration of the body is an aspect of fallen creation (Rom 5:16-21). In this sense, death is an evil that is to be fought against. However, this is not the complete story. Christ’s Resurrection relativizes the evil of death. Through the Resurrection, death has lost its sting and no longer has an inexorable hold on humanity (1 Cor 15:55). In the face of death, Christians have faith that God is still present and hope that the end of physical existence is not the final end of life.

⁶⁷ Ramsey.

⁶⁸ Ramsey.

Christian theology recognizes the enmity of death, but holds this recognition in tandem with a belief that Christ has conquered death.

With this theology in mind, Ramsey is correct to assert that Christianity views death as an enemy to be challenged. Christian theology does not sugarcoat death. There is a clear recognition that individuals, families, and communities suffer when loved ones die. This idea is in contrast to a perspective, articulated by Elisabeth Kubler-Ross, that views death as the natural and fitting finish to life's journey.⁶⁹ Christianity does not assert that death is a good, but there is recognition that death is not the *greatest evil* confronting humankind. Sin is the greater enemy. The "Canticle of the Sun," a famous poem penned by Francis of Assisi, makes this point clear. In one section of the poem, Francis calls out to "Sister Bodily Death (*sora nostra Morte corporale*) who no living man can escape." In this poem, death is not an enemy, but a part of creation. God is praised through "Sister Bodily Death" and Francis asserts that those who die without sin have nothing to fear from death. Sin is the enemy in Francis's poem, not death, whom is a familial or, at least, a benign presence. This poem is only one example from the Christian tradition where death is not seen as the greatest enemy.

Although Christians are to "rage against the dying of the light" and preserve their lives and the lives of others, death is an enemy that cannot be mastered by humanity in this world.⁷⁰ It was Christ who overmastered death via the Resurrection. Contrary to what Ramsey asserts, with recognition of Christ's salvific act, death can be an accepted aspect of life for Christians and this acceptance of death does not diminish human dignity. In fact, if death is only recognized as an enemy to be confronted and staved off endlessly,

⁶⁹ Elisabeth Kubler-Ross, *Death: The Final Stage of Growth* (New York: Scribner, 1997).

⁷⁰ Dylan Thomas, "Do Not Go Gentle into That Good Night," 1953.

human dignity can be diminished in a different way. When death is the ultimate enemy, other goods are harmfully subordinated. This danger is visible in the use of aggressive treatment at the end of people's lives in the United States. Instead of recognizing that death is an inevitable and acceptable end, people use every means available to ward off the final hour. In these desperate acts to defeat death, one's relationship to God and others, as well as the right care of the human body, are subordinated to a material end that is unattainable. This is the precise problem that the ethical category of unfaithful means serves to address. In striving to overcome death, Christians cannot damage or forfeit other values. The category of unfaithful means helps to distinguish whether our fight against death is a valid act in keeping with the sanctity of human life, or an act of Promethean exertion that does not recognize God's purview over life and death.

In addition to undermining an acceptance of death and encouraging drastic attempts to prolong life, Ramsey fails to recognize the ways technology can be inappropriately used during end-of-life care. Instead of offering care and healing, the tendency to use medical technology for unreasonable ends is another manifestation of the autonomy the ethical category of unfaithful means attempts to mitigate. Published in the late 1970s, Ramsey's essay on the "Indignity of 'Death with Dignity,'" is dated in this regard. Although he briefly mentions that doctors "may sometimes use disproportionate means to avoid final surrender," there is no further discussion of unnecessary and harmful medical treatment for the dying.⁷¹ During the time Ramsey wrote this essay, futile and aggressive treatment was not on the steep incline it is today. Instead, Ramsey was more concerned with the acceptability of legal euthanasia in the public square. We now live in a

⁷¹ Ramsey, "The Indignity of 'Death with Dignity.'"

different medical climate where the use of “disproportionate means to avoid final surrender” is more and more common.

The greater availability of technology makes it easier for patients and families to use futile therapies to prevent death. This can become a manifestation of absolute autonomy and a form of unfaithful means. Medical therapies that are simply used to prevent an imminent and inevitable death are not acceptable because they reveal an unwillingness to accept human “creatureliness.” Christian teaching asserts that humans are not absolutely independent beings capable of controlling every aspect of their reality. Instead, humans are finite and vulnerable beings who rely on God for their existence. Creatureliness stands in contrast to an idea of individual autonomy where humans are the final arbitrators and masters of their lives. By acknowledging that we are limited creatures, subject to God’s ultimate authority, Christians can recognize their reliance on God when medical treatments fail to offer a curative potential. This approach exhibits obedience and submission to God in the final stage of human life, not a forceful imposition of human autonomy. The recognition of our finitude is connected to obedience to God when Pope John Paul II calls for Christians to “experience one’s death as the supreme act of obedience to the Father” and be “ready to meet death at the ‘hour’ willed and chosen by him...when one’s earthly pilgrimage is completed.”⁷²

The above discussion hopefully makes it clear that one determinant of unfaithful means is an attitude of Promethean autonomy that does not recognize humanity’s finite nature and dependence on God. This mentality is frequently witnessed in an overuse of medical technology. If an extraordinary treatment is undertaken from a desire to uphold

⁷² John Paul II, *Evangelium Vitae*, 67.

individual autonomy by staving of an imminent death, then it can be considered an unfaithful mean.

Unfaithful means can manifest in a second form. In addition to an exertion of Promethean autonomy, if an extraordinary mean is initiated or sustained with a materialistic conception of the human person that subordinates the soul to the body, then this would be considered an unfaithful form of treatment because this medical care does not uphold a Christian anthropology. An attitude of unbridled autonomy, that seeks to technologically manipulate and prolong life indefinitely, was critiqued because this mentality does not recognize the creatureliness of humanity and God's ultimate control over life and death. Alternatively, unfaithful means can also be present if individuals are too connected to their physical embodiment. If Christians are solely concerned with the continuation of their bodily life, at the expense of the spiritual dimension of the human person, and if this is their motivating factor for the use of aggressive treatment, then this treatment would be considered an unfaithful mean.

Christian hope in eternal life after bodily death disrupts the need to futilely prolong biological life. For Christians, bodily life is a penultimate value. Medical decisions at the end-of-life need to keep this truth in mind. As the Orthodox bioethicist, Tristram Engelhardt notes, "Health, health care, and long life are put into perspective by Christianity's transcendent goals."⁷³ A dying body, weakened to the point that vital functions can no longer be sustained naturally, supported by the continuous workings of medical technology, is an affront to a Christian anthropology that recognizes that human

⁷³ H. Tristram Engelhardt and Ana Smith Iltis, "End-of-Life: The Traditional Christian View," *The Lancet* 366, no. 9490 (September 17, 2005): 1045–49, [https://doi.org/10.1016/S0140-6736\(05\)67383-7](https://doi.org/10.1016/S0140-6736(05)67383-7).

life has a divine telos. Vitalistic tendencies are not only unrequired by Christianity, they are repudiated by an anthropology that recognizes the eternal dimensions of the human person. Christians are called to care for the body responsibly, but also recognize their mortality, allowing for bodily life to expire when the end is near.

Many theologians and ethicists, including Allen Verhey and George Khushf, have addressed undue attachment to bodily life with the vocabulary of idolatry, the excessive attachment to something other than God.⁷⁴ For these two ethicists, American society has a tendency to replace Christian priorities with an idolatry of health. When health becomes the *summum bonum*, science and medicine are viewed as the ultimate salvific forces, and Christianity's insistence that sin, not disease, is the true impediment to human flourishing becomes minimized.⁷⁵ This tendency is witnessed in the use of unfaithful means of treatment at the end of life. When the physical health and healing of the body are the priorities of a dying patient and/or their family, there can be a tendency to brush aside the need for a spiritual preparation for death. The desire to prolong physical life is a natural impulse and reaction to death, yet for Christians a desire to prolong life by medical treatment cannot get in the way of the need to prepare one's soul for death.

Basil of Caesarea, the Cappadocian Church Father, recognized this truth over 1,500 years ago, in his *Long Rule* for monastics, when he advises against any medical act which "requires an undue amount of thought or trouble or involves a large expenditure of

⁷⁴ George Khushf, "Illness, the Problem of Evil, and the Analogical Structure of Healing: On the Difference Christianity Makes in Bioethics," *Christian Bioethics: Non-Ecumenical Studies in Medical Morality* 1, no. 1 (March 1, 1995): 102–20, <https://doi.org/10.1093/cb/1.1.102>. Allen Verhey, *The Christian Art of Dying: Learning from Jesus* (Grand Rapids, Mich: Eerdmans, 2011).

⁷⁵ Khushf, "Illness, the Problem of Evil, and the Analogical Structure of Healing."

effort and causes our life to revolve, as it were, around solicitude of the flesh.”⁷⁶ For Basil, healthcare, like other temporal goods, is subordinated to spiritual ends. Present day Orthodox Christians take Basil’s injunction seriously and assert that the quest for physical healing at the end of life cannot become an “all-consuming” impediment to spiritual preparation.⁷⁷ A Christian believer, who forgoes or postpones repentance before death because they refuse to acknowledge the severity of their illness and the fragility of the body, is putting their soul at risk, in favor of pursuing fleeting and temporal goods. It is this type of action that the category of faithful/unfaithful means tries to prevent.

The magisterial tradition of the Catholic Church contains a similar injunction against ignoring the human person’s spiritual dimension in the pursuit of the prolongation of biological life. In his 1957 “Address to an International Congress of Anesthesiologists,” Pope Pius XII confirmed the distinction between ordinary and extraordinary means, noting that extraordinary means could not be morally obligatory because these treatments may be so burdensome as to make a “higher, more important good too difficult.”⁷⁸ Pope Pius identifies the “higher good” to which he refers in the following sentence of the address: “Life, health, all temporal activities, are in fact subordinated to spiritual ends...one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he [sic.] does not fail in some more serious duty.”⁷⁹ In this statement, the pope, like Basil of Caesarea, reminds Christians

⁷⁶ Basil of Caesarea, *Ascetical Works*, trans. Monica Wagner (Washington, D.C: The Catholic University of America Press, 1999).

⁷⁷ Engelhardt and Iltis, “End-of-Life.”

⁷⁸ Pope Pius XII, “Address to an International Congress of Anesthesiologists,” *The National Catholic Bioethics Quarterly*, May 1, 2002, <https://doi.org/10.5840/ncbq20022257>.

⁷⁹ Pius XII.

that medical treatment and the pursuit of health and healing cannot impinge on religious responsibilities. This reasoning is in line with the proposed category of faithful and unfaithful means. If the medical treatment employed at the end of an individual's life, is focused on bodily life at the expense of a person's spiritual health then this treatment is morally inappropriate because it is unfaithful to a Christian understanding of the person.

Although the underlying rationale for utilizing unfaithful means may be different (i.e., there may be a Promethean attitude of autonomy or there may be an undue attachment to bodily life), these means are typically exhibited by the excessive prolongation of human life through medical technology. At this point, it may be helpful to present an example of how faithful/unfaithful means would be determined in context. The following example is a slightly adapted account of a real medical case. This case was brought to my attention in conversation with a palliative care doctor.⁸⁰ The doctor presented the patient's case without divulging any distinguishing personal information; the patient was referred to by a pseudonym. A bioethical analysis will follow the factual presentation of the case.

Mr. Edwards, a fifty-nine-year-old man with Stage IV pancreatic cancer, was admitted to the hospital with respiratory distress and mental state changes. He had a feeding tube placed ten days after his admittance due to his inability to swallow. A few days later, he had difficulty breathing and was intubated and placed on mechanical ventilation. One month after his admission, Mr. Edwards was still in the hospital, intubated and unresponsive to verbal or tactile stimulation. His kidney function had deteriorated and his body was swollen with fluid. Doctors were unable to administer

⁸⁰ Jean Murphy M.D., in discussion with the author, October 24, 2016.

analgesics because of his low blood pressure. And nurses reported that Mr. Edwards would grimace when his body was touched or moved. These same nurses noted that they had emotional difficulties caring for Mr. Edwards because they felt that medical treatment was adding to his suffering. Multiple medical specialists, including palliative care, nephrology, critical care, and oncology, visited the patient and determined that he was in a terminal condition. His wife, the surrogate decision maker, wanted *all medical treatment* to continue. She strongly asserted that treatment would help her husband and that she could not abide with discontinuing anything because she believed life was of deepest value. Mr. Edwards remained in the terminal state described for approximately a month until he had a cardiac arrest and was unable to be resuscitated. His wife had not even allowed a DNR (Do-Not-Resuscitate) order to be placed on record, so doctors attempted to revive Mr. Edwards even when his body had expired.

This is a terribly sad case that repeats itself all across the county, as attested to by the recent spate of books authored by physicians who have had similar experiences regarding dying patients.⁸¹ The suffering experienced by Mr. Edwards as his dying body was forcefully kept from death via medical technology is a situation that continues in hospitals. As Catholic bioethics is currently formulated, there is no ethical imperative to stop the futile care Mr. Edwards is receiving. This gap is what the proposed category of faithful/unfaithful means attempts to remedy.

While Catholic bioethicists are unlikely to assert that Mr. Edward's treatment is morally inappropriate, they would, however, classify his treatment as extraordinary because it is apparent that the medical therapies he was receiving were excessively

⁸¹ Zitter, *Extreme Measures*. Also see other sources cited in the essay's first footnote.

burdensome and futile. If Mrs. Edwards had desired to refuse further treatment and withdraw the feeding tube and ventilator from her husband's body this would have been morally permissible in Catholic bioethics. However, Mrs. Edwards did not want to discontinue any medical care. Instead she steadfastly sought further treatment for her husband, although it was extraordinarily burdensome and futile. Is Mrs. Edwards decision morally acceptable? Without the framework of faithful/unfaithful means, her decision is, troublingly, completely acceptable.

When evaluated within the framework of faithful/unfaithful means, a different conclusion is drawn. Mrs. Edwards decision is no longer a morally neutral choice, but a morally dubious one. Mrs. Edwards' decision seems to be an expression both of radical autonomy, in that she refused to recognize her husband's ultimate dependence on God and instead placed her faith in medical technology, and of a misplaced attachment to bodily life. Seen in this light, the continued treatment of Mr. Edwards was a form of unfaithful means because this treatment turned against theological assumptions and caused unnecessary suffering.

It is important to note that these ethical conclusions are inferred from Mrs. Edwards' behavior detailed in commentary provided to me by her husband's doctor. When classifying extraordinary treatments as faithful/unfaithful, a pastor or ethicist would need to take deliberate time to speak with Mrs. Edwards and determine her motivation for pursuing this treatment. Every person has a different experience at the end of life and faithful/unfaithful means cannot be determined in abstract from an individual's medical status and the internal intentions behind their decision to continue using aggressive care. Just as ordinary and extraordinary means are determined situationally, so

too would faithful and unfaithful means. There is no standard list of what would be considered an unfaithful means of treatment during the final stage of life. Yet, if the sole purpose of a treatment is to prolong bodily life or if treatment becomes a means of exerting unbridled human control over life and death, then this treatment is unfaithful and must be discontinued. In many cases, allowing death is the most faithful means of care.

Underlying this discussion of “faithful means” and “unfaithful means” is the importance of properly loving the dying. Christ’s injunction to love one’s neighbor as one’s self extends into the final moments of life on earth. The use of aggressive care treatment is often times an expression of misguided love. Family members, like Mrs. Edwards, cannot imagine “giving up” on their loved one and discontinuing treatment. For many surrogate decision-makers, love is shown through continued treatment.

Withholding and withdrawing treatment and allowing someone to die is seen as an anathema to the love and duty due to one’s family members. This is a mentality that the category of unfaithful/faithful means attempts to shift. To love the dying, which means to will their good, does not simply square with the continued use of aggressive medical treatment. In fact, as Mr. Edwards’ case emphasized, this treatment can be unloving because it causes a prolongation of suffering and does not respect the spiritual ends to which a person is destined.

Faithful means of medical treatment at the end-of-life are not usually directed toward curative ends, instead they are directed toward the alleviation of suffering in its many forms. To love those who are dying does not mean to mount a reckless offensive against death, using every piece of technology to stave off an invincible enemy; to love those who are dying primarily means to accompany them through the valley of the

shadow of death, to comfort their bodies with medicine, to care for their physical needs, and to comfort their souls with one's presence. These faithful means then are not a passive resignation to death, nor apathetic to the needs of the dying. Using faithful means does not mean ignoring the needs of a dying individual. This is the antithesis of a faithful mean of care. Instead, faithful means of treatment at the end of life are in tune with the needs of dying individuals and are a deep expression of love.

Following this discussion of faithful and unfaithful means, there is a need to address two potential criticisms of this approach. One easier criticism to address deals with method, while the other, more incisive critique, deals with the potential for this terminology to promote euthanasia. The first criticism centers on asking whether the criteria for determining whether a treatment is faithful or unfaithful is too subjective. If unfaithful means are determined by evaluating the intention of the actor, either the patient or their surrogate decision-maker, how can these terms be verified? Can ethicists truly determine an individual's intention for continuing treatment and then proceed to deem it morally acceptable or not?

To respond to this question it is necessary to refer back to the rule of double-effect. This ethical rule is also criticized on the grounds of subjectivity because the intentions of the actor are vital to determining whether an action with two effects is morally licit. Although a person's intentions can never be verified fully, ethical discourse still allows for them to be considered when determining the permissibility of certain acts. This lends credibility to the assessment offered via the terminology of faithful and unfaithful. To determine whether a treatment qualifies as unfaithful or faithful, the intentions of the actor will have to be examined; this examination, like the examination

asked for in the rule of double-effect, if done conscientiously and with honesty, can provide needed insight. The determination of faithful and unfaithful means is not a robotically precise method, yet this is an advantage in the end because this set of terms is able to be used sensitively in a variety of circumstances. It is a cooperative method, dependent upon the insights of ethicists, doctors, patients and their families, to determine whether a treatment is in line with Christian teaching on life and death.

Any discussion of withdrawing and withholding treatment from the dying will incite questions about euthanasia. If faithful means include limiting curative treatment and focusing on the alleviation of pain, why do they not also include active euthanasia and physician-assisted suicide? In line with other Catholic and Christian teaching on this topic, the proposed category of faithful/unfaithful means is not intended to offer support to active euthanasia. Although some dispute that there is no difference between allowing death (i.e. passive euthanasia) and willing death (i.e. active euthanasia), the Catholic tradition continues to uphold that there is a clear demarcation between these two actions. Building off of this premise, faithful and unfaithful means are intended to uphold the distinction between allowing death and active euthanasia. Actively willing one's own death or assisting someone to commit euthanasia would be considered an unfaithful mean.

By supporting the limitation of futile and aggressive treatment, it can also be argued that this new ethical category will further limit the desire for euthanasia. Data consistently reveals the key priorities of the terminally ill and their families when it comes to end-of-life care. Individuals are concerned preeminently with minimizing their symptoms, having as much control over their life as possible, and limiting the use of

aggressive and futile life prolonging measures.⁸² While some people may desire euthanasia at the end of their life, data suggests that a majority do not desire to shorten their dying, instead they want the assurance that this final stage of life will not be excruciatingly painful or prolonged. The use of the category of faithful and unfaithful means can help to further elaborate what a faithful Christian death looks like, offering a positive contrast to vitalism and euthanasia.⁸³ Once Christians can be assured that dying faithfully does not require the excessive and harmful use of medical technology, they may be more comfortable accepting death and less likely to actively seek euthanasia to prevent future suffering. A robust Christian approach to the end of life must include the setting of limits on unfaithful means of treatment or Christians may be tempted to an excessive vitalism or euthanasia.

Summary Remarks

The Catholic Church has a long tradition of moral teaching regarding the end of life. These teachings, which were elaborated in the first section of this essay, are rooted in

⁸² Singer, Martin, and Kelner, “Quality End-of-Life Care.” Daren K. Heyland et al., “What Matters Most in End-of-Life Care: Perceptions of Seriously Ill Patients and Their Family Members,” *Canadian Medical Association Journal* 174, no. 5 (February 28, 2006): 627–33, <https://doi.org/10.1503/cmaj.050626>. Institute of Medicine, *Approaching Death: Improving Care at the End of Life*, 2001, <https://doi.org/10.17226/5801>.

⁸³ Other ethicists have also come to this conclusion. Daniel Callahan writes that “both the modernizing and pro-life positions are likely to abet a movement toward euthanasia...” He notes that while the pro-life movement may “seek to protect the elderly,” it may simultaneously be doing a “grave disservice” to those at the end of their lives if the pro-life position does not accept limitations on aggressive treatment. If the elderly and the terminally ill are never encouraged to limit medical treatment, then their bodies may be “invaded” with medical technology for “no good” and their “suffering may increase.” Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society with “A Response to My Critics”* (Washington, D.C: Georgetown University Press, 1995), 196, 218-219.

the sanctity of the human person. Because humans are created in the *imago Dei*, there is an obligation to respect, protect, and care for life from beginning to end. The dying person, still an image of God, is afforded the best care possible. Yet this care does not necessarily entail the use of every medical mean available. As part two of this essay highlighted, the Catholic Church, through the rules of double-effect and the distinction between ordinary and extraordinary means, allows for individuals to withdraw or remove medical treatment that is futile or excessively burdensome.

While the moral tradition of the Church offers humane and commonsensical advice regarding end-of-life treatment, as it is currently formulated, it is unable to limit aggressive and futile treatment. Rapid advances in medical treatment and greater accessibility of these treatments have led a higher number of individuals to seek extraordinary medical treatment that prolongs life at the cost of great suffering. In the midst of this problem, Catholic ethics needs to augment its approach to end-of-life decisions. To address this problem, the new terms of faithful and unfaithful means were proposed. If a treatment is declared to be counter to Christian teaching, whether by expressing a form of Promethean autonomy or by an excessive attachment to the human body, then it can be labeled unfaithful. Unlike the current labels of ordinary and extraordinary means, once a treatment is declared to be unfaithful it is morally contraindicated, not morally neutral. This terminology limits the use of unrestrained medical treatment that is antithetical to a Christian understanding of the person and asserts that at the end of a Christian's life, the most faithful means of care may often include allowing for death. With the category of faithful and unfaithful means it is clear

that a faithful dying often includes an acceptance of death and an ensuing use of comfort care.

Death and dying are not pleasant topics, even for religious believers who assert that the demise of the earthly body leads to eternal life. There is an understandable tendency in Christianity to leap over death and look straight to the Resurrection. This natural inclination to overlook, gloss over, or ignore the reality of death, however, is not commensurate with the painful reality in which we exist—death and dying are inextricably intertwined with life. The silence and animosity surrounding death, when coupled with an increasing reliance on medical technology, leads to a harmful relationship to this facet of life, whereby bodily life, in a fragile and ailing state, is sustained to avoid death.

Christian leaders and theologians have begun to speak out about this aversive attitude and medicalized approach to dying. In a recent address, Pope Francis reaffirmed the need for “greater wisdom...today...because of the temptation to insist on treatments that have powerful effects on the body, yet at times do not serve the...good of the person.”⁸⁴ The pope makes it plain that for Christians there is no technological imperative at the end of life, but rather an imperative to accompany those who are sick and suffering and to never abandon them.⁸⁵ In addition to magisterial statements, other theologians have authored texts on how a Christian can personally and virtuously prepare for the end

⁸⁴ Pope Francis, “Message of the Holy Father to the President of the Pontifical Academy for Life on the Occasion of the European Regional Meeting of the ‘World Medical Association’ on ‘End of Life’ Issues,” (16-17 November 2017),” accessed January 13, 2018, <https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2017/11/16/17116d.html>.

⁸⁵ Francis.

of life.⁸⁶ I have attempted to add to this discussion by developing the terms faithful and unfaithful means. The hope is that these terms provide more robust guidance than is currently available to help Christians decide on morally appropriate treatment at the end of life.

This essay is only one part of a wider pastoral and theological project that needs to occur throughout the Church. It will take the entire Church community—pastors, ethicists, theologians, laywomen, and laymen—to foster a Christian approach to dying in a modern context. This approach will simultaneously uphold the inviolability of human life, while also recognizing that prolonging physical existence, in the face of an imminent death, is not a faithful response to dying. Christians are called to witness to their faith throughout their lives. By responding to those dying with compassion and care and by accepting death with a belief in God’s power over this darkness, Christians can be a light to the world even in their final moments.

⁸⁶ See Christopher P. Vogt, *Patience, Compassion, Hope, and the Christian Art of Dying Well* (Lanham, Md: Rowman & Littlefield Publishers, 2004). Verhey, *The Christian Art of Dying*. Matthew Levering, *Dying and the Virtues* (Grand Rapids, Michigan: Eerdmans, 2018).

O death, where is thy sting? O grave, where is thy victory?
1 Corinthians 15: 55

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