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Futile Therapy versus Worthy Dying: Anthropological and Ethical Arguments

Brezplodna terapija proti dostojanstvenemu umiranju: antropološki in etični argumenti

Abstract: Nowadays, issues related to the final stages of life stand more and more at the centre of problems relating to life and health, which result, for example, from the demographic situation in highly developed societies. In the last decades of the twentieth century, an explosion of therapeutic possibilities in the field of technical medicine has caused such questions to be voiced more and more frequently: Should humans try to live as long as possible, or should they live as long as they can with dignity and then die with dignity? Despite the seemingly obvious answer, there is still considerable medical and social resistance to the policy of discontinuing futile therapy. There are probably many reasons for this situation, but one of the most important factors is that this is regarded as a form of euthanasia. This means that ineffective therapy administered to a terminally ill patient is prolonged, even when it increases their suffering and prolongs their agony. Therefore, it is reasonable to examine the relevant arguments for the right approach to treating a terminally ill person. The starting point should begin with the empirical facts about patients who are in the last stage of their life, and where there is reasonable doubt about the benefits of the treatment they are receiving. Since normative conclusions should not be directly derived from empirical data, it is necessary to collect anthropological arguments first. It is only the concept of what a human being is that is fundamental to the applied bioethics, according to which we can formulate ethical conclusions. Finally, theology will come to the fore and it can bring new perspectives on death and what is beyond death boundaries.

Key words: futile (persistent) therapy, withholding treatment, withdrawing treatment, terminal phase of disease, right to a dignified death, quality of life, suffering, dying

Povzetek: V današnjem času se vprašanja, povezana z zadnjimi stadiji življenja, vse bolj postavljajo v središče problemov na področju življenja in zdravja, ki so med drugim posledica demografskih razmer v visoko razvitih družbah. V zadnjih de-

setletjih 20. stoletja je eksplozija terapevtskih možnosti na področju tehnične medicine povzročila, da se postavljajo takšna vprašanja vse pogosteje. Ali naj si ljudje prizadevajo za čim daljše življenje ali naj čim dlje živijo dostojanstveno in nato dostojanstveno umrejo? Kljub najbrž očitnemu odgovoru na zastavljeno vprašanje še vedno obstaja opazen medicinski in družbeni odpor do ukrepov, ki predvidevajo prekinitev brezplodne terapije. K takšnemu stanju verjetno prispeva več vzrokov, eden najpomembnejših dejavnikov pa je prepričanje, da govorimo pri tem o neki obliki evtanazije. Posledica tega je, da neozdravljivo bolne ohranjamo pri življenju s podaljševanjem brezplodne terapije, tudi če takšna terapija povečuje njihovo trpljenje in podaljšuje njihovo agonijo. Na tej podlagi je smiselno preučiti relevantne argumente, da bi tako dosegli ustrezen odnos do skrbi za neozdravljivo bolne. Izhodišče bi morala biti empirična dejstva o pacientih v zadnjem stadiju življenja in vprašanje, ali pri tem obstaja utemeljen dvom glede koristnosti terapije, ki so je deležni. Ker pa normativnih sklepov ne smemo neposredno izpeljevati iz empiričnih podatkov, je treba prej zbrati antropološke argumente. Zgolj koncept o tem, kaj človeško bitje sploh je, pomeni temelj aplikativne bioetike, v skladu s katerim lahko oblikujemo etične sklepe. Pri tem navsezadnje prihaja v poštev tudi teologija, ki lahko ponudi nove poglede na smrt in na tisto, kar je onkraj smrti.

Ključne besede: neplodna (persistentna) terapija, zaustavitev zdravljenja, prekinitev zdravljenja, terminalna faza bolezni, pravica do dostojanstvene smrti, kakovost življenja, trpljenje, umiranje

1. Introduction

Careful perusal of the ongoing debate in the medical community and in the wider society clearly shows that ever more frequent problems concerning life and health are centred on issues that relate to the final phase of life. In addition to the extension of statistical human life, this phenomenon is undoubtedly also affected by the aging of the population, at least in highly developed countries. New problems in approaches to ending life began to increase with the development of technical medicine: that is, during the twentieth century, when new possibilities in the field of diagnostics and therapy opened up. Approximately until the mid-20th century, medicine tried to do everything to prolong a patient's life. From that era, the belief that everything must be done to make loved ones live as long as possible governed medical procedure. However, at least since the fifties of the last century, the question has been much more precisely articulated: Should human beings live as long as possible, or should they be allowed to live as long as they can do so with dignity? Can a society give permission for a person to end their lives with dignity and not to have their life prolonged any further?

In this context, the fundamental question arises: What does it mean to allow a human being to die with dignity? Does it mean to do everything that is techni-

cally possible to prolong their life or is it about the gradation of actions taken and – consequently – a different degree of obligations towards the patient in the end-of-life phase? Finally, is it to be the budgetary limitations set by health-care institutions in relation to a particular patient? The purely economic factor disqualifies itself because it would be tantamount to implementing euthanasia for terminally ill patients.

There is no need to argue that the actual state of the patient should determine the procedure. It is to be the patient's actual condition without any external pressure: that is, experience and medical knowledge should be the basic criterion in making decisions. The medical perspective should, of course, agree with the patient's autonomy, the patient's subjective expectations and his or her right to self-determination, to which we will return. The roles of the relatives of a terminally ill person and those of his or her legal representative are limited to representing his or her interests and fulfilling his or her will in case of lack of contact with the patient. This also means that neither family claims nor the fear of being stigmatized by the media can be determining factors as to the type of action taken in respect to a patient. The claims of relatives and fear of the media reaction are bad advisers in this context. We should also pay attention to the sometimes absurd narrative presented in the media that euthanasia is used in a given medical centre, as patients die there.¹ Especially in the case of hospices, such a thesis is unjust and unfair, because the essence of their action is to provide patients with the conditions necessary for a dignified death. There is no doubt that, in the context under consideration, apart from having the required knowledge, the education of the conscience of each of the actors participating in the event of a human death is also necessary. In the case of the terminally ill, it is necessary to consider the scenario realistically – this requires wisdom and courage – to avoid multiplying the suffering of a man standing at the threshold of death further.

It is not uncommon for members of the medical professions, on the one hand, and relatives of terminally ill loved ones, on the other, to ask about the criteria that, without remorse and internal anxiety that they have killed a person, will allow to accept the death of the chronically ill person, without keeping them alive at all costs. It is impossible not to notice that when we allow a sick person to die, (almost automatically) there immediately arises suspicion that the patient has been killed by euthanasia.² The confusion of two different realities – allowing the patient to die and killing the patient – causes enormous social and emotional damage. People involved in palliative care and the care of terminal patients often ask the question whether it makes any sense and whether it does any good to try

¹ A distinction should be made between »help with dying« as a medical assistance given to a dying man and »help with dying« as euthanasia (Körtner 2002, 24).

² A summary of the results of a public opinion poll in Poland regarding the abandonment of persistent therapy shows: »The term abandoning persistent therapy causes some confusion. A relatively large number of people could not name a situation where this term had any relevance to them. Some have very general associations or confuse ceasing interventional treatment with euthanasia. /... / The term »abandoning therapy« may be burdened with no less negative emotive connotations than the term »euthanasia«. (CBOS 2013)

another treatment or another form of therapy on the patient. If we add to this the claim of the relatives, the scandal-mongering of the media and the threat of criminal liability for »halting treatment«, then there is a clear and dramatic conclusion: in this context, the ethical requirement to guarantee the right to a dignified death is not likely to be taken into consideration, because it is easier and safer to proceed to the next medical intervention and not to ask about the legitimacy of further therapy.

Using the methods of a moral-theological approach (Virt 2007, 94–100), we will conduct an analysis of this issue in four steps: empiricist – anthropological – (bio)ethical – theological. The starting point will be the known empirical facts about a patient in the last phase of life, and upon whom actions are to be taken that raise reasonable doubts as to their beneficial effects for that patient. Because we cannot directly draw normative (expected) conclusions from empirical data without committing a naturalistic error, we need to introduce an intermediary anthropological step. It is only based on the human concept that underlies applied bioethics, according to which we can formulate moral conclusions. The last word will belong to theology, which »broadens the perspective« when we consider the boundary of death and what lies beyond death, and which is also a reference point for many who face moral dilemmas that arise from their faith.

2. Facts about terminal patients

For the first time in the Polish specialist literature, the subject of how to treat terminal patients appeared in the nineties of the 20th century, although it is worth emphasizing that it was already specifically mentioned in the Vatican document on euthanasia (Congregation 1980). Expressing the anxieties of the medical community, in 1995 a doctor in Cracow wrote that »the time will come (I think it has already come), when the most important and the most difficult decision in medicine will concern the problem ›when to stop treatment« (Kałuża 1995, 23). At the end of the twentieth century, a Catholic bioethicist in Poland posed the following fundamental questions: »Should a doctor always intervene to save the life of a dying person, or are there times when he should not do so? Should a doctor use all the resources available to him here and now in a particular case, or should he limit the assistance he provides, both in its qualitative and quantitative dimensions?« (Wróbel 1999, 423)

A more recent publication shows the extent of the problem signalled almost a quarter of a century ago. The author refers to an analysis of the ability to die and states that »the predisposition to die is therefore evidence of a higher stage of development; death is a gift that we should protect as the trophy of a life of long duration and the condition of survival. For now, being human still means having to die and – which is becoming more and more problematic – also being able to die« (Domańska 2017, 45). In a footnote, she also explains (recognizing the danger of being accused of pro euthanasia views): »In a world where death often

becomes a decision, I mean the right to a natural death and a conscious refusal to artificially maintain life (which is not the same as euthanasia).« (45)

The above text is significant because it diagnoses the powerlessness of the human »privilege of death« in the face of the soulless »compulsion of technical medicine«, which imposes a (seemingly endless) prolongation of the dying process. The personal experience of the author of this article, who has often been confronted with the question of whether medical treatment that a terminally ill patient finds burdensome can be halted, seems to confirm the above observations. The spectrum of medical treatments that are questionable in the case of terminal patients is broad and extends from subsequent chemotherapy administered to a patient suffering grievously from multi-organ metastases, through the resuscitation of a dying patient in an intensive-care unit, to an insistence upon the additional tests (e.g. CT) needed to transport a patient with an unquestionably terminal prognosis a long distance.

A new impetus for dealing with this issue seriously at an international level was given by the widely publicized »Alfie Evans case«, as it was technically called (for a discussion, see Position 2018). Being aware of the complexity of this particular medical case, we will not analyse it here, but it is worth noting that the debate involved taking into account both the medical, bioethical and legal aspects of the problem. The main conclusion of this discussion is that we need to delve into this extremely complex issue in an integral way. It is not one that is facilitated by emotionally heated discussions that use »intellectual lock-picks« instead of arguments that confront all the different aspects of the problem.

Let us now examine what the core of the problem is in the case of terminal patients who have experienced powerlessness in exercising their right to a dignified death. First, a distinction should be made between treatment of a patient as one of the forms of medical treatment and care of a patient as part of »ordinary care«, which is referred to as palliative care. The primary therapeutic target is to provide optimal comfort to the terminal patient by minimizing their suffering and/or improving the quality of the life that is still left to them. This goal is achieved by specialized nursing care, elimination of adverse experiences – such as pain, anxiety, shortness of breath, convulsions, fever – and providing appropriate nutrition and liquid-intake, psychological assistance and spiritual support, and the company of loved ones (Registered Nurses' Association of Ontario 2011, 19–20). Ignorance of the above procedures leads to terminal patients being given medical treatment when the medical facts show that this is no longer profitable. What is more, this often inflicts additional suffering on patients instead of providing them with more basic care and nursing. All such unnecessary procedures are technically referred to as »futile therapy«.

It is worth emphasizing that, in most medical studies, »futile therapy« is the term used, while in the documents of the Catholic Church and the Polish Code of Medical Ethics (KEL) the term »persistent therapy« and »the use of extraordinary (disproportionate) measures«. It is worth agreeing on both. Although both terms

are undoubtedly correct, the concept of »futile therapy« more clearly reflects the essence of the problem: doing something that not only makes no sense, but is also a waste of time and energy, and which is ultimately harmful, because it increases suffering and prolongs agony. Where, in the light of medical knowledge, medical procedures bear all the signs of futile therapy, they should be abandoned. The cessation of futile therapy can take two forms: not taking up a therapy (withholding), i.e. not implementing further methods of treatment or not increasing the intensity of the method currently being used, or not using a particular treatment method further (withdrawing). Withholding or withdrawing supportive treatment of organs that does not benefit the patient in any way does not mean reneging on the obligation to provide him or her with medical care, which would consist of a number of the activities indicated when discussing palliative care: namely, hydration, nutrition, and the minimization of suffering. It is only the aim of the procedure that changes, which – in the absence of any benefit to the patient – does not burden organs to do unnecessary work.

It is worth reviewing the results of pan-European surveys on medical procedures at the end of people's lives, so that we might establish a better starting-point in the debate between the representatives of the original nations that formed the European Union and citizens from the countries of the former communist bloc, where the debate concerning such procedures began somewhat later. While research conducted in 17 countries of the old Union shows that the practice of restricting ineffective therapy when the patient is certain to die is widespread (Sprung et al 2003, 70–797), in the countries of the later Union the debate began only after the fall of communism and is still at the stage of formulating practical, substantively justifiable rules of conduct. The research carried out in all 35 Slovene intensive care units shows that limitation of life-sustaining treatments (in the form of: do-not-resuscitate orders and withholding treatment) was regularly used by Slovene physicians in these units. It means that medical experience in Slovenia in this area is closer to the West-European tendencies. (Grošelj et al. 2017, 2007–2012; Oražem et al. 2017, 728–736)

It is true that the Czech Republic appears among the surveyed countries, but the conclusions of the studies made as part of The Ethicus Study are generally formulated in relation to the 14 countries of the old European Union (as well as Israel and Turkey). The formulated conclusions are unequivocal and do not fully coincide with the experiences of the countries of the former socialist bloc: »The study demonstrates that end-of-life actions are routine in European ICUs. Life support was limited in 73% of study patients and 10% of ICU admissions. Both withholding and withdrawing of life support seem to be accepted by most European intensivists while shortening of the dying process, despite occurring in a few cases, remains rare.« (Oražem et al. 2017, 794) Therefore, the conducted research shows a general tendency to abandon futile therapy, while exceptions include the active shortening of a terminal patient's life, which has both ethical and legal grounds (legalized euthanasia).

The conclusion regarding the correlation between the limitation of medical activities inadequate to the situation of the terminally ill patient and the religion of

the doctor is also interesting: »Catholic physicians were less willing to withhold or withdraw therapy. « (794) It would be worth following this trail to examine both the facts regarding the abandonment of futile (persistent) therapy and the ideological determinants of such decisions made by members of the medical community. The latter thread will be taken up in the last section of the study, which turns to the theological perspective.

When it comes to the mentioned tendency to give up persistent therapy, Polish data – which seems to overlap with similar data in other post-communist countries – appears to be put into question. The practice of abandoning unjustified medical action owing to the patient's condition is increasing slowly, although there is no shortage of social pressures that would justify it.³ As the research results cited by prof. Knapik (2019) show, the implementation of the guidelines on the abandonment of futile therapy (Kübler et al. 2014, 215–220) developed by a nationwide team of specialists in the field of anaesthesiology and intensive medical care has been slow and has required much educational work and training within the medical environment itself. After a five-year implementation period, the number of anaesthesiology and intensive-care wards that apply the guidelines has not exceeded 10 in any province – except for Mazowieckie, where they implement them in 22 wards out of 38 – even though there are from a dozen to forty such wards in the region. The above data shows, on the one hand, the growing awareness in the medical community of the need to regulate futile therapy and, on the other, the resistance and uncertainty in the implementation of such regulation in practice. As the procedures are well prepared, presented and justified in these guidelines, it is not a matter of a lack of tools to limit the use of futile therapy. The resistance of doctors needs to be more accurately diagnosed. It seems that the failure has resulted from not wanting to contribute to the death of patients, as well as from a lack of legal regulations; a lack of a clear definition of the concept of futile therapy; of a widespread acceptance of this type of approach; and of a discrepancy between how doctors, lawyers, the media, and different ethical traditions understand such action. Some members of the medical community also have doubts as to whether the abandonment of futile therapy contravenes the Christian principle of the sanctity of human life. It might also be the result of a centuries-long belief that the patient must be kept alive at all costs. Given this situation, it is even more worth to look at futile therapy from both an anthropological and ethical perspective, in order to develop arguments that are adequate to the gravity of the problem.

3. The anthropological step

The basic anthropological truths are so obvious that sometimes their basic message is forgotten. Firstly, man is a contingent being: namely, a mortal one whose

³ In this regard, the document issued by the Team of Experts on Bioethics of the Conference of the Polish Episcopate of Poland, »On futile (persistent) therapy for intensive care patients« (2018), which encourages efforts to reduce futile therapy is significant.

biological life will end. If we do not keep this in mind, it may seem that our duty is to do everything and as long as possible to make the dying patient »immortal«: that is, not to let that patient die. As believers, we know another dimension to life: Human beings are immortal and are called to eternal life. Here, however, we mean a limited functioning in a body in this earthly life. The preface of the *Mass for the Dead* states these truths simply and understandably: »For your faithful people, life is changed, not ended. And when this earthly dwelling turns to dust, an eternal dwelling is made ready for them in heaven« (Preface for the dead). The focus in this preface is precisely upon what occurs when the body »turns to dust« upon death.

Secondly, death is not a terrible defeat, but a normal stage during human life; to shut it out as a taboo subject is harmful to the entire society. The young medics and students who attend our classes in ethics say that »during their studies, they are only taught about the successes that the practical science of medicine brings, and that death should be seen rather as a failure«. This outlook is reinforced by the social pressure that comes from healthcare services. Might a basic problem amongst medical practitioners be that they only attend to half the truth about the human condition? We need to supplement this picture with a recognition of how finite and bounded human biological life is. Such a recognition would considerably modify current approaches to the treatment of patients in the last phase of their lives.

That human beings have the right to die with dignity derives from the fact that they are mortal. This right should not be confused with the view that one has a right to take one's own life or (as in the case of euthanasia) to have it taken away from them by someone else. Article 31 of the Code of Medical Ethics in fact states that »the right to a dignified death cannot be understood as a right to inflict death (i.e. euthanasia)«. The right to a dignified death arises from the dignity of the human person, that is, from the special status of the human being within creation.

Thirdly, every human being is an autonomous subject with the power to come to his or her own decisions. This applies equally to patients in a state of terminal illness. This power cannot be withdrawn from someone where a medical decision is involved. Patients have the right, in consultation with their doctor or the committee of doctors assigned to their case, to decide between the options that are held out to them.

Another anthropological truth is that it is not enough to believe in the success of medicine, but also to know its limitations, of which death is the most difficult to accept. Old age, illness, disability and suffering are testing areas for medicine, but also for anyone who encounters the terminal phase of human life. Experts point out that the »structural lack of mercy« in medicine is expressed in learning the truth about our own therapeutic limitations and in the soteriological attempts of medicine, which instead of curing, would like to save, thereby falsifying the human finitude and mortality (Körtner 2002, 22–23). Wherever a person is born, especially being healthy, where a patient recovers, it is easier to function. So, in

this context, it is at least worth signalling the problem of occupational burnout of people who have daily contact with loss, regularly being confronted with dying. Treating the service in a hospice, in a palliative ward as »ordinary work« will reveal inadequacy of this approach in a short time, because here one has to deal with existential questions, such as: What does death mean to me? Have I thought about the losses of relatives who have passed away through? Do I know and use the strategy of experiencing mourning properly?⁴ Human death is a strong testing area for medicine, and therefore it is very difficult to accept the death of the person I am caring for, whom I am treating, who is my loved one. This experience should also be included in the discussion on stopping futile therapy.

Another question flows from what has been said above: What happens after death? The answer to this question is important. It is essential for the patient, the medical staff, and the relatives and close friends. If a doctor has not personally confronted the »mystery of death and transience, he can offer the patient only as much as he possesses – escape« (Thielicke 1979, 72). This might be an escape into untruth, or having minimal contact with the patient, or opting for euthanasia, or else an escape into hyperactivity, or the introduction of some form of persistent or futile therapy.

In many branches of medicine (palliative medicine being an exception), mere activity on the part of the physician replaces any kind of caring and nursing. Consequently, when all the possibilities for apparent treatment end, it is not uncommon for medics simply to disappear from the scene because »nothing can be done here«. A human being who is in the fullest sense human is needed to accompany a dying person on the difficult road from life into death. This is more fundamental than simply being a doctor, a nurse, or a medical assistant. Another important requirement for a dignified death is that the patient be surrounded by their family and friends as they pass from life into death. Another reprehensible policy in such situations is the »lie of recovery«, when doctors tell patients that they are going to live, or live much longer, when they are very soon to die.⁵ The therapeutic relationship between doctor and patient develops over time; consequently, a doctor's ability to communicate and feel empathy can be just as important as medical knowledge and skill. The question of how to treat terminally ill patients is both complex and complicated. One thing is certain, however: what is most needed are doctors and medical personnel who are mature and deeply humane. Perhaps this is why putting an end to persistent therapy still faces so much opposition. In the light of the mentioned considerations, it is no wonder that questions about the existence of God, the meaning of life and what awaits us after death come to the fore when the death of a near relative or close friend, in particular, is approaching. Such closer meetings with death test our maturity as human beings and can lead us to re-think our relationship with death, and the limits that it sets on our earthly life.

⁴ It is confirmed by the statements of the hospice staff: »I dream about dead patients at night, I cannot get rid of it, I am still crying with those terminal patients to whom I have become attached.«

⁵ The problem of applying a terminal diagnosis correctly is beyond the scope of this study, but it should be emphasized that a properly formulated question is: how to give a patient a difficult diagnosis, and not: whether to tell them the truth about their terminal condition (Morciniec 2016, 161–174).

We heard years ago in a highly regarded clinic where there was no palliative ward that a terminal patient »spoils statistics«. This lesson has been well learnt and the existence of wards where people are sent to die are an accepted phenomenon. It certainly cannot be denied that, looking at the matter economically, a terminally ill patient »stays in hospital or a hospice too long«. What is more, isn't the image of a hospital spoiled if too many patients die there? Is it good, anyway, for patients to die in hospitals? And where are they supposed to die, if most deaths now occur in medical institutions? Modern developed societies, in line with the current taboo on talking about dying and death, have literally »pushed« terminally ill people into institutions especially set aside for their care and treatment (hospices, nursing homes, palliative wards), often under the firm conviction that they will receive the best care in such places. This is not surprising, since professional medical care and psychological support are undoubtedly important, and the work and housing situation of modern families makes, in many cases, the care of a dying person at home impossible. The problem of preserving an environment of familial warmth and love remains. The loneliness of a dying person can be overcome only by »being with that person« and building thereby »a culture of solidarity with the dying man« (Körtner 2002, 17–18). This dimension is an indispensable requirement for dignified dying. We should also appreciate the heroism of many employees in hospices, palliative wards and nursing homes, who show so much compassion and warmth to those under their care – unfortunately, sometimes to make up for the absence of the dying person's own relatives. It seems that one of »the most painful of existential experiences« is loneliness in the face of death. Everyone who ends that loneliness, or lightens its burden, behaves like the Samaritan in Luke's Gospel. For believers, this is no less than a test of the depth of their Christian Love.

4. The (bio)ethical dimension of the debate on abandoning futile therapy

The good of the patient is the highest value – this principle of medical ethics has been in force since antiquity, and it should be followed by doctors and indeed by all medical staff. The problem remains, however, of what the patient's good might be, both from the perspective of the patient and from the point of view of those who either treat or care for that patient. A conflict could also arise between the patient's right to self-determination and the duty of medical personnel to care for that patient appropriately, as well as the human right to life. To be able to read what the good of the patient is, means seeing them in the light of the contingency of their being and determining the action to be taken in this light. Our own Catholic evaluation results »from a specific anthropology, i.e. the vision of the human being, his or her nature and dignity, his or her origin and destiny, which is the basis for solving many of the ethical problems discussed« (Ratzinger 1987, 24).

The basic premise for a correct understanding of human nature can be found in the encyclical *Veritatis splendor* of Saint John Paul II (VS 50):

»The origin and the foundation of the duty of absolute respect for human life are to be found in the dignity proper to the person and not simply in the natural inclination to preserve one's own physical life. Human life, even though it is a fundamental good of man, thus acquires a moral significance in reference to the good of the person, who must always be affirmed for his own sake. /... / Indeed, natural inclinations take on moral relevance only insofar as they refer to the human person and his authentic fulfilment, a fulfilment which for that matter can take place always and only in human nature.«

If we draw ethical conclusions from this text, we can affirm that not only physical (biological) life is a sacrosanct value, but it must be seen in a fully personal context. The biological life of a human being is a fundamental good for that human being, but it needs to be read in the context of the dignity of the human person and to be reconciled with that dignity. Therefore, prolonging the biological life of a human being, if it damages his or her dignity and well-being, cannot be considered morally good.

Normative conclusions constitute the pillars of a universal bioethics. We have largely laid them out above. They are as follows: the dignity of the human person; the »sanctity« (the inviolability) of human life; social justice and love; the awareness that pain and suffering are evil.

As part of an analysis of the problem area with which we are concerned, these core principles are especially important, for they indicate what can be seen as morally unacceptable actions (taking human life or increasing pain and suffering, for example), while at the same time affirming the dignity of the human person. Thus, the principle of acting with dignity applies not only to patients, but also to relatives and friends and members of the medical community. If the above principles are given equal weight, a conflict might appear between the principle of the inviolability of life and minimizing the pain and suffering of terminally ill patients. The putting aside of any of these core principles strikes at the patient's personal dignity and should be avoided. It is the patient's dignity as a human being that should be the measure of proper conduct. In dealing with pain and suffering, we must consider the subjective perception of the patient, who can give a different worth on these principles than members of the medical staff, for example, by not placing the religious significance of suffering last.

The concept of human dignity is often used as a kind of an intellectual lock-pick when it is not clear how to justify specific rights, but in this case the proper understanding of this »special status of a person« makes it easy to explain imperatives arising from human nature. Human dignity is, by definition, associated with certain rights and obligations (Cheshire 2002, 10) which in the face of death take the form of a moral challenge. If, as a doctor, nurse, or family member of a sick person, I stand by the patient's side at the end of his or her life, then my personal dignity implies the obligation to take care of this person properly, to treat him or her subjectively, and it also includes permission for the terminally ill person to

end life with dignity. And just as throughout the whole life, the dignity of the human person demands the protection of human life from conception to natural death, so in the terminal phase of life this special status, the same dignity requires consent for the man to die, i.e. to complete their contingent, lethal nature. Therefore, the same human dignity requires treating the patient with respect and care as a subject of rights and finds its different expression in the affirmation of life or acceptance of human finiteness.

The rights to self-determination and self-responsibility are components of a person's dignity, therefore an ill person (also terminally) should be guaranteed the opportunity to decide on their fate in the last stage of life. Since this is not an absolute right, it is limited by other rights, especially by the inalienable right to life, which means that the decision to end life (euthanasia) remains an abuse of autonomy. The justification for this thesis is found, among others, in the Declaration on euthanasia, which recalled the teaching of Thomas Aquinas. The person deciding to end his or her life – and modern euthanasia usually takes the form of assisted suicide – violates the commandment of love in all its extent. Such action denies God's power over life, insults the dignity of the human being, is a crime against life and strikes at interpersonal relationships. (DE 1980, II) The conclusion of the right to self-determination is twofold: if the patient is conscious, he or she remains the first to decide whether to continue or discontinue therapy – of course, after medical consultation; if the patient is unconscious, there are several instruments that support the decision, such as (otherwise ethically controversial) the last will, testimony of a person authorized by the patient, and only after all options have been explored – is the decision of the medical team. Such a decision is to be an expression of the protection of human dignity and concern for the good of the patient, when their ability to self-determination is limited. Staying with the subject to whom the debate on abandoning futile therapy, i.e. about a terminally ill man apply, we should also take into account the patient's biography, i.e. their life experiences, injuries, losses, because it can significantly modify decisions regarding further therapeutic steps (Körtner 2002, 25).

In the case of terminal patients, the question arises at some point during the disease progression whether the therapy should be given up, abandoned, so as not to intensify suffering and to let the patient end life with dignity. In order to be able to properly classify given medical means or therapeutic activities, it is worth identifying the latter as proportionate and disproportionate.⁶ Proportionate means are those effective methods of treatment and medical treatments that can be used in a given place and time by most people without causing undue inconvenience, while disproportionate means are exclusive (elite) measures and measures which are burdensome to use for the patient, and above all those that are not adequate to the patient's condition, i.e. are not able to help or may even

⁶ This terminology was introduced in the document of the Congregation for The Doctrine of The Faith, Declaration on Euthanasia («lura et bona») of 1980. It divides measures into ordinary and extraordinary. It seems that talking about the proportionality of measures to the patient's condition and situation is more understandable.

worsen their condition. They might otherwise help, but they become a source of (intensification of) great suffering or great discomfort. Speaking of being burdensome to the patient, one should also consider the subjective, and not only objective measure of burden.⁷

It is good that challenging the paternalistic model of medicine has led to placing the patient in the centre of the decision-making and therapeutic process along with their perception and subjective feelings and a view of reality, which in the face of the terminal phase of the disease are decisive. In the case of the latter, it can be seen that a big change in thinking is needed to accept the human right to die with dignity, without applying futile treatments that deny the patient's dignity.

5. The theological perspective on persistent therapy

The fundamental theological postulate in this area is the need to restore the inextricable connection between life and death first, and then the inextricable one between death and dying. This is a serious challenge in the face of the taboo on talking about death and dying that permeates the contemporary Western world. In practice, we need to develop a moral theology of human dying, which – based on a truly Christian anthropology – begins with core theological truths about death and dying and draws moral conclusions founded upon these truths (Zuccaro 2004, 8). The source for such a theology would primarily be the books of Holy Scripture, which, although they contain nothing that might explicitly help us with modern-day bioethical issues, nevertheless provide the basis of a proper understanding of human dignity and a way to come to terms with human dying and death. The biblical-theological tradition does not separate life from death, and it thus provides an excellent resource for implementing the principle of »restoring death to life«, and thus of transforming the dying life of the terminally ill person. Ancient wisdom says: *natura sanat – medicus curat – Deus salvat*. It is directing us to the proper place from which to assess all therapeutic methods and procedures. When the ultimate point of reference (God) is left out of the equation, either the enormous possibilities that the science of medicine offers are deified or God's lordship over all manifestations of life is put into question, and the result is that life is taken away from people through means such as, for instance, euthanasia.

Through the dying and death of Jesus Christ, we can overcome the »hopelessness of death«. We do this by reading it as a fulfilment rather than a deprivation of life: that is, as the last step on the way to the Father's house; as a door that

⁷ A meaningful example is the firm opposition of a very old woman who refused to accept being taken to the ICU, even though her objective condition required it. Her opposition resulted from an earlier traumatic experience: she was left naked on the bed in such a ward, without privacy or clothes to cover her body. As she put it, she couldn't stand such »shame« again. The reason for the soulless actions of the employees of this department of a hospital is very sad indeed – the woman is elderly, and her body is not erotically appealing, so there is no need to cover her up. Here, we are dealing not only with a brutal lack of sensitivity but a failure to respect the right that every person has (whether old or young) to have their private sphere of intimacy preserved.

opens onto resurrection and immortality; and as a final liberation from the slavery of sin. The key to a proper understanding of why a policy of therapy at all costs needs to be abandoned is to relate questions concerning the end of human life to God, who is simply eternally abiding Love. The essence of a theological vision of the human person is that death is not an end but a new beginning (according to a theology of the New Creation). It is not a truism therefore to say that dying people are alive, since they not only live until they die, but never stop living as a result of the death and resurrection of Christ. In Christ, the dignity of the human person acquires a new meaning, as it is no longer simply an ethical axiom but a state of intimate fellowship with God. If we speak about »dignified dying and dignified death« from the theological perspective of the teachings of the Catholic Church (The Pontifical 2017, no. 149), then both a Christological perspective (Christ accompanies the dying person and »saves that person from eternal death«) and an eschatological one come to the fore. Through the perspective of the later, we break with a morbid clinging to a vanishing life with the help of an awareness of the eternity that lies open to us. This eternity is not one of endless emptiness but of eternal union with a loving Father. It is not an entry into a foreign place but a return to our rightful homeland through the guidance of the Holy Spirit (Hauschild 2002, 148–151).

It is no wonder, then, that the general approach of the medical community to continued methods of treatment only increases suffering or stalls death. Even if we do not return to the statements of the Church Fathers and the theologians of past centuries, it is enough to turn to the statements that have been made in contemporary Church teaching, with the Declaration on Euthanasia (Congregation 1980) being a good place to start. Regarding the prevention of persistent therapy, the encyclical *Evangelium vitae* (no. 65) repeatedly relates dying and death to the fundamental principles of faith and the fulfilment of human life in the passage (i.e. »Passover«) through the gates of death into eternal life.

In the most recent statements of the Church concerning persistent therapy, we find a strong connection between human rights and human dignity. Although arguments for the dignity of the human person are often based upon different sources than those found in secular documents (for example, the proposition that the human person is made in the image of God), the obligations in regard to human rights are the same.

The New Charter for Health Care Workers states that »contemporary medicine has at its disposal methods which artificially delay death, but without real benefit to the patient« (The Pontifical 2017, no. 149). The dignity of a person implies »the right to die in the most peaceful way possible on the basis of that person's human and Christian dignity«. The distinction between the two »types« of dignity refers precisely to the theological sources mentioned above and translates into promoting appropriate attitudes towards the dying. Humility towards the Creator and Giver of Life is also expressed in recognising the finite character of human life, and thus respecting the inviolable dignity of the terminally ill person, without degrading them by inflicting futile medical treatments upon them. For example, anen-

cephalic children should be provided with »ordinary medical care«, i.e. palliative care, which can do so much to relieve the suffering of a patient, without having them go through futile therapy.

This charter clearly reflects a change in the ethical paradigm for the terminally ill. Respect for the dignity of a human person involves not so much adding days to his or her life (maximizing life expectancy) but maintaining a quality of life that is dignified. Consequently, when the only thing left that one can do is to prolong life, that is, extending the duration of the patient's suffering, it is morally responsible to give the gravely ill person the right to die with dignity, (as far as possible) in peace and without pain: in other words, humanly.

The Statement of the Team of Experts on Bioethics of the Polish Episcopal Conference (Statement 2018) supports this position. The document also formulates univocal moral conclusions:

»Contemporary bioethics, the one that is also in line with the teachings of the Catholic Church, regards the prolonged maintenance of organ functions that does not benefit the patient – that is, futile therapy – as a medical malpractice. It is only permitted in cases where the patient explicitly requests further life-preserving action. In some situations, this is not only a mistaken professional policy but is also blameworthy, since it unnecessarily prolongs the patient's suffering. If a case of futile therapy is identified, it should be immediately replaced with full palliative care, i.e. ordinary and proportionate measures.« (7)

The document, however, adds: »A withdrawal of persistent therapy does not mean leaving the patient without basic forms of care (e.g. preventing bedsores, administering analgesics and anti-inflammatory medicines), as well as maintaining life-processes (nutrition, hydration, ventilation, if necessary, artificially). If this were not done, then such deprivations would become the direct cause of death and would thus constitute passive euthanasia.« (9)

Regarding the last statement, it is worth mentioning the controversial issue of feeding and providing liquid to a patient in a vegetative state. The Congregation for the Doctrine of the Faith, in response to a request from the United States Conference of Catholic Bishops (2005), confirmed the obligation of providing nutrition and hydration,⁸ whether by natural or artificial means, even if the patient does not regain consciousness, and remains »in a vegetative state«. The abandonment of such intervention would also constitute passive euthanasia: »The administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented.« (Congregation 2007b) However, the authors of the document

⁸ For more on the issue of the nutrition and hydration of patients in intensive care: Schockenhoff 2009, 392–403.

place a note in the commentary that directly refers to the issues under discussion: »Nor is the possibility excluded that, due to emerging complications, a patient may be unable to assimilate food and liquids, so that their provision becomes altogether useless. Finally, the possibility is not absolutely excluded that, in some rare cases, artificial nourishment and hydration may be excessively burdensome for the patient or may cause significant physical discomfort, for example resulting from complications in the use of the means employed.« (2007a) Hence, it turns out that, in certain cases, the maintenance of »normal activities« might also be disproportionate, because they are not keeping with the patient's condition. In such cases, there is no obligation to maintain them, provided the patient's condition does not change.

We should welcome the efforts of medical and other communities to formulate appropriate guidelines and set out clear procedures to avoid the spiral of futile therapy. Such action is not easy to carry out, because a change of attitude is also necessary. The previous generation of physicians had tried to cure the sick at all costs, with far more limited technical possibilities at their disposal. The younger generation, having a much greater range of technical and pharmaceutical alternatives available to them, is now taught (thankfully) in assessing the treatment that should be administered to a patient, that suffering should not be intensified or prolonged, since such action diminishes the dignity of the patient, which is the basis of all morally acceptable action in this sphere. The ethical face of modern medicine is revealed in how the possibilities it has opened are either applied or not applied in particular cases: that is, whether the alternative chosen is more humane one or not. This newer approach also involves a reconsideration of how terminally ill patients should be treated. In this domain, palliative care might be a better option than therapy.

Abbreviations:

- CBOS** – Centrum Badania Opinii Społecznej.
DE – Congregation for The Doctrine of The Faith 1980 [Declaration on Eutansia].
VS – John Paul II 1993 [Encyclical Veritatis Splendor].

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