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"Medical education in the shadow of 'stealth euthanasia'" among Catholics: Are we fighting secularism or heresy?*

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I would like to dedicate this talk to the memory of Dr. Gino Papola, past president of FIAMC, who introduced me to the Catholic Medical Association and was my mentor for forty years. When Gino died in December of 2011 at the age of ninety-one, I felt like an orphan. Dr. Papola loved to teach by discussing case histories, and as those of you who knew him will recall, he often told humorous stories to illustrate his point. One such story was about a physician who died and approached St. Peter at the Pearly Gates, wearing a white coat and a stethoscope around his neck, confident that he has led a good life and would easily enter Heaven. However, St. Peter stops him from entering and directs him to a long line of physicians who are undergoing extensive questioning by a committee of angels. Observing that other souls who are not doctors are entering the Pearly Gates without waiting in line, he asks St. Peter why doctors are being treated differently.

St. Peter answers with a quote from the Gospel of Luke (12:48): "From everyone who has been given much, much will be demanded, and from the one who has been entrusted with more, much more will be asked!" Still awaiting his turn hours later, he suddenly sees an elderly bearded man wearing a shining white coat and a stethoscope around his neck walking right past St. Peter and entering the Pearly Gates. He angrily runs over to St. Peter and demands an explanation. "Oh Him?" answers St. Peter calmly, "I do not have any control over Him. He is God the Father returning from earth where he occasionally goes in order to play doctor!"

Terri Schiavo, also known as "Theresa of the Forgotten," was martyred by a process called "stealth euthanasia," or, as our Holy Father Pope Francis refers to it, "covert euthanasia" (Abbott 2013; Bergoglio and Skorka 2013; Colegrove 2013). This form of euthanasia victimizes thousands of patients under the guise of modern so-called "end-of-life care." My experience, of course, is only in the United States, but it is done all over the world. Terri Schiavo became perhaps the best known case of death by dehydration and starvation. Consider how labels can be lethal: This non-terminally ill, brain damaged woman was classified by modern medicine as being in a "persistent vegetative state." Terri Schiavo died on March 31, 2005, at forty-one years of age, after fifteen years of being sustained by tube feeding. After tube feeding was stopped, it took thirteen days for Terri to die with

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excruciating pain and suffering, as was witnessed by Father Frank Pavone of Priests for Life, who was the only non-family member permitted to be at her bedside. Unlike most victims of this type, she was not even given morphine to alleviate the pain of dehydration because that would have been inconsistent with the erroneous claim that so called "persistent vegetative state" (PVS) patients are not conscious and cannot feel pain (Terri Schiavo Life & Hope Network).

You might ask why have I singled out Terri's case when such cases occur daily around the world, especially in elderly patients who have suffered a stroke or have advanced dementia? Her case is legally important in the United States, because when our Supreme Court failed to protect Terri's life, this form of stealth euthanasia came to be considered a private medical-treatment decision between a physician and a patient. Just as in the abortion ruling in 1973, these patients cannot be protected by the courts.

Committing stealth euthanasia by withholding food and water from patients who are not dying but merely have their ability to eat and swallow impaired, such as victims of stroke, dementia, Parkinsonism, etc., is only the tip of the iceberg. It is often claimed that a PEG (percutaneous endoscopic gastrostomy) tube does not offer any benefit because it does not cure or improve the disease process itself. These patients are inappropriately referred to hospice as if they were, in fact, dying. And of course, it becomes a self-fulfilling prophecy when they die from dehydration and malnutrition. It is claimed that the so-called evidence-based medicine shows that tube feeding does not prolong life, because only 50 percent of the patients in one study survived for more than one year. Of course, that is an oxymoronic conclusion because without the feeding tubes, 0 percent would have survived. Those who died did not die from complications caused by the feeding tube, but died from their co-morbidities. However, clinical experience and recently published studies in Israel (Glick and Jotkowitz 2013; Shapiro and Friedmann 2006) have shown stable, thriving patients at three years and beyond. Could it be that the Israelis have more respect for the sanctity of life of their elderly patients than the so-called Christian West?

Another form of stealth euthanasia is commonly seen in the terminal patient, who is, in fact, dying and requires palliative treatment with narcotics and sedatives. Narcotics commonly suppress feelings of thirst and hunger, and the patient becomes dehydrated if there is no provision of intravenous or nasogastric tube supplementation of fluids. Soon the patient suffers more pain and discomfort from the dehydration itself, and instead of treating with hydration, increasing doses of morphine are given to alleviate these symptoms. In the presence of a low fluid volume, the vasodilating effects of the narcotics cause hypotension, and death is hastened. This is often justified by an erroneous application of the principle of double effect. In a well-hydrated patient, narcotics will not hasten death, and there is no reason why *both* hydration and narcotic treatment cannot be utilized at the same time. Further, double effect is justified *only* if there is no other means available to avoid the bad effect, whereas providing fluids is a readily available, ordinary medical treatment.

Another form of stealth euthanasia is common in hospice programs, where the stated principle of care is supposed to be *both* to avoid prolonging life by extraordinary means and to avoid hastening death. Death is, in fact, often hastened by the denial of ordinary treatments, which, besides withholding hydration, often also include stopping all beneficial medications such as insulin and medications which

control congestive heart failure (Mallon 2009; Panzer 2011–13).

Perhaps the most egregious form of stealth euthanasia in some hospice centers is the denial of ordinary treatment for readily reversible temporary co-morbidities, such as antibiotics for curable infections and denial of fluid replacement in reversible cases of gastroenteritis.

Now let's turn to the big question which needs to be confronted: Why is the practice of stealth euthanasia just as common in many Catholic healthcare institutions as it is among secular healthcare providers? Why is the withdrawal and withholding of ordinary medical treatments routinely approved by Catholic ethics committees and justified by many Catholic ethicists and theologians? And what can be done to reverse this trend?

Of course, there may be multiple reasons, but let us assume for the purposes if this discussion that all of these erroneous decisions are made in good faith with a sincere desire to benefit the patient. Other motivations, such as healthcare rationing, reducing costs, and attempts to reduce the burden of care for families and caretakers will not be discussed at this time.

Two case histories from my own experience in a Catholic hospital can give us some insight. A woman on the hospice service with very painful terminal pancreatic cancer was receiving an intravenous morphine drip but without any intravenous hydration. She was experiencing muscle cramps due to dehydration and electrolyte imbalance over and above the pain of the cancer itself. The morphine dose was being increased. I offered to write IV orders, which could have corrected the cramps, but was told that hospice policy did not permit intravenous hydration. It seemed to me that since she already had an intravenous line for the delivery of the morphine, that hydration and correcting electrolyte imbalance would constitute ordinary beneficial treatment, consistent with good palliative care. The charge nurse refused to carry out my order because, in her words, "it would make the patient live longer and thus prolong her suffering."

In another case, a patient with lung cancer who was not yet in a terminal stage was placed on a ventilator for a reversible bacterial pneumonia, which was improving and successful weaning was anticipated in several days. His wife demanded that his life support be immediately removed because she would rather see him die now than recover from this episode and face a painful death from his cancer in the future. The Catholic ethics committee agreed with her position and justified it by declaring that the ventilator treatment was extra-ordinary care and that the wife had a right to make the decision based on the principle of substituted judgment and the principle of autonomy. In the presence of the authority of a Catholic priest-theologian and a religious nun, my ability to convince the wife otherwise was greatly diminished, and I had to recuses myself from providing further care for this patient.

Again, I believe that the nurse from the first case, and the wife, the priest, and the nun in the second were, in fact, convinced that they were acting in the best interest of their patients.

What was going on here? Was I guilty of playing God for trying to prolong the life of these two patients who both had a poor prognosis due to untreatable cancer, or were the nurse and the ethics committee guilty of stealth euthanasia? Remember that along with the Church's strong condemnation of all forms of euthanasia, put forward in the Declaration on Euthanasia in 1980 (CDF 1980), is the recognition that euthanasia decisions are often made for sincerely compassionate reasons and

with good intentions. And yet the prohibition against any form of euthanasia, regardless of good intent, is one of the strongest and uncompromisingly absolute teachings of the Church, equal to the prohibition against abortion.

Here again, is where Dr. Gino Papola has given me some insight. He presented a case history of an elderly woman who was brain damaged as a result of a stroke, who could not talk, received tube feedings, and appeared to be unconscious most of the time. Just like in the case of Terri Schiavo, there was much talk about whether the feeding tube had become "extra-ordinary" treatment and whether it could be discontinued. One day, when Gino was making rounds, this Italian woman suddenly sat up, cried out "Deo Mio," went into cardiac arrest, and died. It was a moment of revelation for Dr. Papola. It appeared to him that this was the moment that this elderly woman had "made her peace" with God. What if, Gino would say, this woman had died prior to "making her peace with God," and what effect could that have on her individual salvation? Especially what if her death was precipitated by the intentional will of her doctor, rather than the Will of God? Would not that be exactly what is meant by the expression "physician playing god?"

Well if we analyze this case through the eyes of faith—we have to ask this question: if, through the workings of Divine Providence, this woman's road to heaven required her to be in this prolonged state of diminished consciousness before her soul was ready to depart to face a favorable final judgment—would the outcome of that individual judgment have been altered by hastening her death through an act of stealth euthanasia? Would an intentional act to hasten her death have prevented unnecessary suffering, or could it actually add to her suffering? Of course, we cannot answer that question based on any scientific "evidence-based medicine," but we can look at the teachings of the Church and draw certain conclusions. But first, we must admit that there also is no scientific "evidence-based medicine" which disproves the possibility of suffering after death. Through the eyes of Revelation there exists the possibility that any attempt on our part, no matter how well intentioned, to shorten our patients' suffering by hastening their death may actually have the unintended consequence of increasing the possibility of their suffering after death.

Let me quote from Canon XXX, Session VI, of the Council of Trent, January 13, 1547: "If anyone says that after the reception of the grace of justification the guilt is so remitted and the debt of eternal punishment so blotted out to every repentant sinner, that no debt of temporal punishment remains to be discharged, either in this world or in Purgatory, before the gates of Heaven can be opened, let him be anathema" (Schouppe 1986, vi).

Most importantly, this canon applies to those who have received the "grace of justification"—those who have, in fact, been redeemed and are on their way to eternal life.

The sixteenth-century language here makes it difficult to comprehend, but here is how I interpret it, applying it to my own inevitable future. There is abundant "evidence-based medicine" that death is part of my prognosis. I also know that part of my road to redemption is the necessity to atone for my sins before I can merit eternal Salvation and the resurrection of the body. This atonement can be achieved in many ways while I am alive, and I sincerely hope that is how it happens. However, if I should die before my atonement is fully achieved, I will need to complete this atonement in

Purgatory, which, if you read Fr. Schouppe's (1986, vi) book, is a pretty scary place. So, I pray that the Lord gives me the Grace to complete whatever suffering I need on this side of the Great Divide of physical death, in the presence of people who love me and pray for me, rather than on the other side of that divide, where I may be all alone and long forgotten by others. What if God grants me that Grace, but someone else, for instance, my family or my doctor, decide, with perfectly good intentions, to alleviate my suffering by hastening my death? Will that lessen my net sum of the atonement necessary to achieve eternal salvation? God's will is unchangeable, it will simply find another way of being expressed. As a matter of fact, it may actually increase my suffering. St. Catherine of Genoa, who received revelations about purgatory and documented them in her "Treatise on Purgatory," writes the following, and I quote, "He who purifies himself of his faults in this present life satisfies with a penny a debt of a thousand ducats, and he who waits until the other life to discharge his debts, consents to pay a thousand ducats for that which he might before have paid with a penny" (Schouppe 1986, xxx).

Well, in order to avoid it, we must be clear as what the definition of stealth euthanasia actually is. We know that it is sometimes perfectly legitimate to withdraw or withhold medical treatment, including life support, in patients for whom these treatments have become extra-ordinary, that is, their burden outweighs their benefit, and death will occur regardless of whether the treatment is continued. The hallmark of stealth euthanasia is the withholding or withdrawing of ordinary treatment—treatment that has continued benefit and does not itself add to the patient's suffering. As our Holy Father Pope Saint John Paul II stated in 2004, nutrition and hydration—even if delivered by artificial means such as a PEG tube, nasogastric tube, or intravenously—is always ordinary treatment, and, I quote:

> always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which … consists in providing nourishment to the patient and alleviation of his suffering. (John Paul II 2004, n. 3)

We must remember, that without nutrition and hydration, death is a certain outcome for anyone, even the healthiest among us. It is not always easy to distinguish between ordinary and extra-ordinary treatments, and it is easy to fall into the trappings of making decisions based on emotion, rather than clinical reality. For instance, how often do we hear such expressions as "he has suffered enough, he is ready to die," or "grandmom has lived a good life, I'm sure that she will go right to Heaven," or, in the case of unconscious patients, statements such as "he is already gone, it is only his body that remains behind."

We hear a lot today about the need for the New Evangelization. In the context of combating euthanasia, we usually think of it as a battle against secularization. St. Luke (6:42) says, "how can you say to your neighbor, 'Friend, let me take out the speck in your eye,' when you yourself do not see the log in your own eye?" I believe that removing the log of "stealth euthanasia" from the eyes of our own Catholic brothers and sisters may be an even more difficult job than converting our secular adversaries, precisely because they are acting in good faith. For an example of this, I invite you to read over "To Peg or Not to Peg" (Isajiw 2009), which involved a truly religious, practicing Catholic family. The patient's son who opposed

placing the PEG tube is a Catholic physician. Please pay special attention to the son's objections, quoted in his own words.[1] Unexpected grace was evident in the results of our persistent efforts. Once he saw the benefits provided by the tube feedings, he not only changed his mind, but also joined the Catholic Medical Association and continues to be an active member. Furthermore, as a result of the public discussion on this subject, Deacon Peter Gummere, an ethicist who previously opposed using PEG tubes in elderly, demented patients, has completely changed his mind (Howland and Gummere 2014). When a professional ethicist changes his mind on a controversial subject, it is truly a miracle!

The fact is, however, that successes in reversing the trend towards stealth euthanasia among Catholics are few and far between, which brings us to the prayer for the beatification of Terri Schiavo.[2] I invite you to include it in your own daily prayers. If persistence in this kind of intercessory prayer results in miracles leading to the canonization of Terri as a Holy Innocent martyr, that will have a much more widespread effect of conversion than our individual efforts. Let us pray that it may be so.

Given today's secular trend towards overt euthanasia and physician assisted suicide, prayer is the first and foremost resource to stem the tide of stealth euthanasia. However, in our own practices and educational endeavors we must utilize available resources such as the clinical "decision tree" delineating the indications for assisted nutrition and hydration recently published in *The Linacre Quarterly* (Ad Hoc PEG Study Group 2012), authored by a group of fifteen Catholic practitioners, representing multiple clinical practices and specialties, including primary care, gastroenterology, neurology, ethics, theology, nursing, and nutritional sciences.

We must persist in our individual efforts, especially for the benefit of our patients. We can expect criticism and even accusations of lacking compassion. We have to be willing to make those sacrifices for the sake of the truth. St. Alphonsus Liguori, quoting St. Gregory the Great, writes: "He truly believes, who by his works, practices what he believes."

God asks us to be faithful, and he himself will decide whether we will be successful. When we inevitably face our own awesome and terrible final judgment, we will not be asked whether we achieved, but whether we tried. And perhaps, as a result, when the time comes for us to approach the Pearly Gates, Dr. Gino Papola will whisper in St. Peter's ear, and we may be given a priority pass to the head of that long, slow moving line of doctors.

Endnotes

1 Isajiw (2009, 214):

> PEG is invasive, not easily reversible, often painful/uncomfortable, and can be hugely depressing to sensitive, cultured patients, such as Mom, as it can be smelly, unsightly, leaky, and cause skin irritation, not to mention the patient's concern that it might fall out or get stuck or whatever; and many have interrupted sleep w/ "startle" due to subconscious fear of lying on tube … is futility of care and may increase suffering w/o hope/benefit of reversal of the underlying condition, namely ordinary aging (no reversible/treatable disease has been diagnosed here). A PEG tube is potentially harmful in terms of procedural morbidity and patient dignity.

2 Prayer for the Beatification of Terry Schiavo:

> Prayer for the cause of Theresa of the Forgotten:

"Merciful Lord,
you filled the heart of
Terri Schindler Schiavo
with a spirit of profound sacrifice
for love of neighbor.
She became a holocaust
offered to your Heart
for the end of the culture of death.
Through her excruciating agony and death
we plead for a change of heart in all
who have compromised or failed
the cause of life.
In life Terri would say,
'Where there is life, there is hope.'
Bring hope to my cause that seems hopeless.
May I have unbounded trust in Jesus,
Most Merciful (here mention your petition).
My sins render me unworthy of your mercy,
but be mindful of Terri's sacrifice of love.
I offer this prayer to your glory,
and confident of your help." Amen

References

Abbott, Matt C. 2013. The tragic reality of "covert euthanasia." *Renew America*, May 9, 2013. http://www.renewamerica.com/columns/abbott/130509.

Ad Hoc PEG Study Group. 2012. When to recommend a PEG tube: A decision tree for clinicians from a Catholic perspective. *Linacre Quarterly* 79: 25–40.

Bergoglio, Jorge Mario, and Abraham Skorka. 2013. *On heaven and earth*. Trans. Alejandro Bermudez, and Howard Goodman. New York: Image Books.

Colegrove, Lauren. 2013. Elderly face danger of "covert euthenasua," pope says in book. *Catholic News Service*, May 6, 2013. http://www.catholicnews.com/data/stories/cns/1302007.htm.

Congregation for the Doctrine of the Faith (CDF). 1980. Declaration on euthanasia. http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

Glick, S.M., and A.B. Jotkowitz. 2013. Feeding dementia patients via percutaneous endoscopic gastrostomy. *Annal of Long-Term Care: Clinical Care and Aging* 21: 32–34.

Howland, John S., and Peter J. Gummere. 2014. Challenging common practice in advanced dementia care: A fresh look at assisted nutrition and hydration. *National Catholic Bioethics Quarterly* 14: 53–63.

Isajiw, George. 2009. To PEG or not to PEG: A case of a hospice referral for vitamin B12 deficiency. *Linacre Quarterly* 76: 212–27.

John Paul II, Pope. 2004. Address to the participants in the International Congress on "Life-sustaining treatments and vegetative state: Scientific advances and ethical dilemmas." March 20, 2004. http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html.

Mallon, John. 2009. Palliative care: The new stealth euthanasia. *Celebrate Life*, November–December. http://www.clmagazine.org/article/index/id/OTAwOQ/.

Panzer, Ron. 2011–2013. *Stealth euthanasia: Health care tyranny in America*. Rockford, MI: Hospice Patients Alliance, Inc. http://www.hospicepatients.org/this-thing-called-hospice.html.

Schouppe, F.X. 1986. *Purgatory explained by the lives and legends of the saints* (translated from the French). Charlotte, NC: TAN Books.

Shapiro, Dvorah S., and Reuven Friedmann. 2006. To feed or not to feed the terminal demented patient—Is there any question? *Israel Medical Association Journal* 8: 507–08.

Terri Schiavo Life & Hope Network. Terri's story. http://www.lifeandhope.com/terri-s-story/.

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