Utilitarianism Impacting Care of Those with Disabilities and Those at Life's End

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Abstract

Society's understanding of the nature of suffering impacts the development of health-care public policy, having a significant impact on care of the elderly and those with disabilities. With scientific advances comes a societal expectation that one can have "the perfect life," not just for one's self, but also for one's offspring. Thus extinguishing the imperfect life, at its earliest or later stages through physician-assisted suicide, becomes an accepted recourse. The Catholic tradition is rich in providing meaning to those who suffer and their families, particularly those at the end-of-life or those with disabilities. The Ethical and Religious Directives for Catholic Health Care Services address the importance of advanced directives to assure that the health-care wishes of patients, no longer able to express them, are respected. However, such directives cannot anticipate all of the health-care scenarios that could arise. Thus the role of a health-care agent (surrogate), who through extensive discussions knows the will of the patient and the mind of the Church, is critical. However, increasingly public policies, especially as they pertain to the allocation of costly resources such as health care, are impacting the health-care choices available to patients, their families, and the health-care provider. Consistent with the utilitarian ethic, state sanctioned killing of those deemed to have "lost their dignity" is hailed as a "good." This essay explores the challenges for all of us who are members of a profession once entrusted with protecting the most vulnerable among us.

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Introduction

Society's understanding of the nature of suffering impacts the development of health-care public policy, having a significant impact on care of the elderly and those with disabilities. In a pluralistic society these views of suffering can be quite diverse: suffering can be seen as an unavoidable element of life, punishment for sin, something to be avoided at all costs, a retractor from human dignity, something reducible to pain and discomfort, which can be alleviated, or something with salvific meaning. The Christian understanding of suffering recognizes that suffering holds a special place in God's saving plan. Thus Christians associate their sufferings with the suffering of the crucified Christ. Juxtaposed to this understanding, Western culture promotes avoiding suffering while fostering ideologies that not only aim toward eliminating suffering, but sometimes the sufferer himself. This has led to a culture which considers those deemed less than perfect or less than fully rational human beings as lacking dignity and thus not deserving of the protections society should afford all human beings. Furthermore, utilitarian considerations lead society to evaluate human beings based on their worth to society, and even on what financial burden they are to society. *Utilitarianism*,¹ defined as the greatest happiness for the greatest number of people, prevails in the development of United States public policy. Those who are made vulnerable by such reasoning include the preborn, those with disabilities, and those at the end of life's journey. Increasingly, policy decisions factor in these variables in the allocation of costly resources, including health care. In response to such a cultural perspective, society has begun to define the role of a health-care professional as one who eliminates the suffering by eliminating the sufferer. This essay explores the challenges for all of us who are members of a profession once entrusted with protecting the most vulnerable among us.

Catholic Health Care and the Sufferer

The Catholic tradition is rich in providing meaning to those who suffer and their families, particularly those at the end of life or those with disabilities. As the largest provider of non-profit, non-governmental health care in the United States,² Catholic health care refuses to abandon those who suffer to the hopelessness that engenders the requests for assisted suicide. Assisted suicide is a refusal to love by all of those involved: "Furthermore, suicide is also often a refusal of love for self, the denial of a natural instinct to live, a flight from the duties of justice and charity owed to one's neighbor, to various communities or to the whole of society."³ Pope John Paul II instructed the Christian faithful: "Love is also the richest source of the meaning of suffering, which always remains a mystery: We are conscious of the insufficiency and inadequacy of our explanations."⁴ He continued by admonishing us not to abandon the sufferer but to model Christ in our care for the sufferer: "Christ showed his

concern consistently to those who were suffering.... He fed the hungry, consoled the afflicted, freed people from deafness, from blindness, from leprosy, from the devil.”⁵ We are to be compassionate companions to those who suffer, that is to share the Eucharist with each other, responding with Christ-like sacrificial love.⁶ As Pope Benedict instructs us, this obligation extends to the larger society:

The true measure of humanity is essentially determined in relationship to suffering and to the sufferer. This holds true both for the individual and for society: A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through “com-passion” is a cruel and inhuman society.⁷

However, Western society has developed a subjective relativistic approach to its obligations to its suffering members. No human act, in and of itself, is considered good or bad. The act is made good or bad relative to some other criterion. The criterion used in the development of public policy in the United States is what constitutes the greatest good [happiness] for the greatest number: utilitarianism. This approach can be fraught with bias and discrimination against vulnerable populations, who through stage of development, age, or disability are voiceless. Catholic health care is committed to providing care to the most vulnerable among us. The first hospital west of the Mississippi was founded in 1828 by Saint Elizabeth Seton’s Sisters of Charity in Saint Louis, to serve the un-served.⁸ This tradition continues, but the impact of public policy on such ministries continues to present significant challenges.

Society and the Perfect Life

With scientific advances comes a societal expectation that one can have “the perfect life,” not just for one’s self, but also for one’s offspring. Thus children become a commodity to be engendered at will. This phenomenon, coupled with a separation of the unitive and procreative nature of marriage,⁹ has delayed parenting, with the ensuing challenges of age-reduced fertility.¹⁰ Thus there is an increased demand for assistive reproductive technology, with all that professionals of such technology promise: pre-implantation genetic diagnosis (PGD); sex selection; surrogacy; and even “designer babies,” based on such desirable characteristics as intelligence quotient. One recent survey demonstrated that 42 percent of one hundred thirty-seven pre-implantation genetic diagnosis clinics offered a gender-selection service.¹¹

By its very definition, pre-implantation genetic diagnosis necessitates *in vitro* fertilization and determines which engendered embryos (children of the very persons seeking to be parents) are allowed to live or die. Such decisions are made by arbitrary criteria, which could be as discriminatory as gender. Human dignity and personhood, with its pursuant rights, are determined by others. The absence of desirable characteristics and even loss of strength are deemed to diminish dignity. This

has implications for society's care of persons at both the beginning and end of life, particularly the care of those with disabilities. In the Netherlands, in which assisted suicide has been legal since 2002, but conventionally accepted for decades,¹² physicians have developed and implemented a protocol allowing parents to kill their own infants under certain circumstances. The Groningen Protocol allows a physician to respect such parental requests under the following conditions: there is a definitive medical diagnosis, with a certain prognosis of "hopeless and unbearable suffering"; the suffering, while having to be confirmed by a second physician, need only be anticipated (e.g., due to a disability such as spina bifida); and both parents provide consent. Then the infant is killed *in accordance with the accepted medical standards*.¹³ One is left asking, "Where is found the acceptable medical standard to deliberately kill one's own child? Is utilitarianism justifying this atrocity?"

Ending Suffering by Ending the Life of the Sufferer

If one doubts such a violation of human life as the Groningen Protocol could occur in the United States, all one needs to do is witness the growth of membership in groups such as Compassion & Choices (formerly known as the Hemlock Society). While the name euphemistically has been changed to make the morally unacceptable appear to be laudable, it is estimated that the membership contains at least fifty thousand proponents of euthanasia.¹⁴ Their "helpful" information can be seen in the yellow pages section of local telephone books.

Compassion & Choices, as the name suggests, advocates for compassion and choice in end-of-life care. One of the choices the group wishes to have legally available is the choice to end suffering by offering/receiving assistance in ending one's life. However, assisting someone to commit suicide is neither compassionate nor respectful of true informed consent (choice). Assisted suicide represents a palliative-care failure. Such assistance violates the societal role of the caregiver, and is the antithesis of choice. The message to the person who is assisted to die is that you have no other choice; we are not invested in you enough to alleviate your suffering; it is easier for us to help you die than to truly help you. Studies have shown that when pain and depression are ameliorated, the request for assisted suicide is abandoned.¹⁵

True Choice in End-of-Life Care

Patients and families need to be fully informed concerning the choices available to them to ameliorate suffering, including the anticipated benefits, burdens, side effects, and risks of any therapeutic intervention. If the benefits of a particular therapeutic intervention are outweighed by burdens, side effects, or risks, there is no moral imperative to choose that intervention, even if such a choice indirectly hastens one's death. Often such discussions to determine a patient's desires, if

they occur at all, occur in the middle of a crisis and when the patient is no longer capable of communicating wishes. The *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) address the importance of advanced directives.¹⁶ However, such directives cannot anticipate all of the health-care scenarios that could arise. Thus the role of a health-care agent (surrogate), who through extensive discussions knows the will of the patient and the mind of the Church, is critical. If the will of the patient is unknown, the health-care agent is to make decisions that are in the patient's best interest:

Each person may identify in advance a representative to make health-care decisions as his or her surrogate in the event that the person loses the capacity to make health-care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health-care decisions.¹⁷

Informed decision making by the patient and/or surrogate provides a venue in which decisions can be made concerning alternatives that truly are in the best interest of the patient.

State-Sanctioned Killing: The Ultimate Utilitarian Ethic

Advocates for assisted suicide have challenged state laws prohibiting physician-assisted suicide and brought their cause as far as the United States Supreme Court. Chief Justice Rehnquist, in writing the majority opinions in 1997, stated that there not only was no constitutional right to assisted suicide, but that physician-assisted suicide is detrimental to the medical profession, society, and vulnerable populations. He identified how the role of the physician as healer would be undermined, and how the vulnerable would be exposed to abuses, such as a steady societal slide toward euthanasia. Furthermore, the state has an interest in protecting the integrity and ethics of the medical profession and the vulnerable they serve, as well as the value of human life.¹⁸ Ballot initiatives have legalized state sanctioned killing of human beings through physician-assisted suicide in two states: Oregon¹⁹ and Washington²⁰ (similar ballot initiatives have failed in California, Michigan, and Maine). The Montana Supreme Court ruled that state law does not prohibit physician-assisted suicide, but also stated the state's constitution did not guarantee a right to physician-assisted suicide.²¹ Thus the legislative debate in Montana will have to resolve the ensuing unanswered questions.

A twelve-year study of physician-assisted suicide in Oregon has provided some interesting data, contradictory of the rationales given

by advocates for assisted suicide, who claim that assisted suicide is a compassionate response to human suffering. Between 1998 and 2009, official reports from the Oregon Department of Human Services reported the expressed reasons for requesting physician-assisted suicide. The least frequently expressed reasons for requesting assisted suicide are for pain relief and the financial implications of treatment. However, fear of loss of dignity remains one of the most frequently expressed reasons for requesting physician-assisted suicide (85.2 percent). One could surmise that this translates into “I will be considered undeserving of respect and abandoned, if I continue to live.” Such fears easily can escalate within a utilitarian society. They also could be an indication of the presence of a clinical depression, particularly for those with disabling conditions who may require the care of others for their survival. Interestingly, although Oregon law requires a prescribing physician to refer a patient for a psychiatric evaluation if there is evidence of depression or another mental illness, psychiatric referral for evaluation has only occurred in 8.4 percent of the cases.²²

Terminal Sedation: A Rose by Another Name

Increasingly of concern are legislative initiatives that can mask a trend toward passive euthanasia, particular in the form of terminal sedation.²³ Such legislation includes state mandates to provide information on all legal alternatives to manage pain and provide end-of-life care. Thus a patient (on his own or through a surrogate) could elect to be sedated, even for psychic pain, and refuse assisted nutrition and hydration. Thus death occurs from dehydration or starvation. Palliative sedation is a legitimate tool to address intractable pain, when other therapeutic alternatives fail. However, unless death is imminent, assisted nutrition and hydration should be provided, consistent with directive 58 (to be addressed later).

Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health-care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.²⁴

Pope John Paul affirmed, in *Evangelium vitae*, the use of palliative care as well as the invocation of the principle of double effect in the delivery of such care.²⁵ He cited Pope Pius XII in addressing the moral liceity of using narcotics to treat intractable pain, even if the result is decreased consciousness and a shortening of life, “if no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties.”²⁶ This concept is explicated further in directive 61.

The Principle of Double Effect; Ordinary versus Extraordinary Means

Applying the principle of double effect requires strict adherence to the following criteria: the object of the act must be good or morally indifferent (administration of pain medication to treat pain); the intent of the action must be morally good (alleviate suffering), even if there is an additional unintended but foreseen consequence (depression of respiration, hastening death); the circumstances must be consistent with the object and intent—that is, the good effect only can be achieved concomitant with, but not by means of, the evil effect (the respiratory depression, which does not alleviate pain); the good effect is proportionate to the evil effect (severe pain relief for the terminally ill); and there is no less harmful alternative.

A number of inquiries concerning what might constitute active or passive euthanasia are received by The National Catholic Bioethics Center through its twenty-four hours per day, seven days per week, free consultation service; for example, the licit use of morphine to address air hunger for a terminally ill patient; and the morally permissible alternative to discontinue dialysis for a person with terminal cancer, thus necessitating the withdrawal of assisted nutrition and hydration, since there is no method to eliminate their waste products. Historically, the use of the terminology of “extraordinary versus ordinary means” has been useful for decision-making concerning the moral obligation to initiate or continue treatment. However, as technology advances, yet remains unavailable in certain regions of the world, such terminology has become more subjective. More objective criteria can be applied by the patient or surrogate by considering what constitutes a “proportionately beneficial means” in relationship to an “excessive burden.” Relevant directives that assist patients and their family members in making such a determination include the following:

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health-care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.²⁷

Assisted Nutrition and Hydration

Increasingly, questions are raised to the National Catholic Bioethics Center concerning the moral liceity of withholding or withdrawing assisted nutrition and hydration. Much notoriety concerning this issue was generated by the case of Terri Schiavo.²⁸ Mrs. Schiavo was deemed as being in a persistent vegetative state by some physicians (though not by all), and her husband, but not her parents, wished to have her feeding tube removed. The legal drama spanned seven years. During that time, there was much scholarly debate among moral theologians and ethicists over the obligation for providing assisted nutrition and hydration to persons with such a diagnosis. The person in a persistent vegetative state is not terminally ill, but a person with a disability. In 2004, Pope John Paul II delivered an allocution on caring for those in a persistent vegetative state. While not addressing a specific case, he stated, in part, the following:

I should like particularly to underline how the administration of water and food, even when provided by artificial means, 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 in the present case consists in providing nourishment to the patient and alleviation of his suffering.²⁹

The United States Conference of Catholic Bishops sought further clarification of this matter in the form of a *dubium* it sent to the Congregation for the Doctrine of the Faith (CDF), asking two questions, to which the congregation responded (*responsum*) as follows:

First question: Is the administration of food and water (whether by natural or artificial means) to a patient in a “vegetative state” morally obligatory except when they cannot be assimilated by the patient’s body or cannot be administered to the patient without causing significant physical discomfort?

Response: Yes. 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.

Second question: When nutrition and hydration are being supplied by artificial means to a patient in a “permanent vegetative state”, may they be discontinued when competent physicians judge with moral certainty that the patient will never recover consciousness?

Response: No. A patient in a “permanent vegetative state” is a person with fundamental human dignity and must, therefore, receive ordinary and proportionate care which includes, in principle, the administration of water and food even by artificial means.³⁰

Further insight can be obtained by reading the Congregation for the Doctrine of the Faith's "Commentary" on their *responsum*, particularly the following:

When stating that the administration of food and water is morally obligatory in principle, the Congregation for the Doctrine of the Faith does not exclude the possibility that, in very remote places or in situations of extreme poverty, the artificial provision of food and water may be physically impossible, and then *ad impossibilia nemo tenetur*. However, the obligation to offer the minimal treatments that are available remains in place, as well as that of obtaining, if possible, the means necessary for an adequate support of life. 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.³¹

In response to this clarification, the U.S. Conference of Catholic Bishops modified directive 58:

In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.³²

Beneficial versus Burdensome Treatments

There often are inquiries made to the National Catholic Bioethics Center concerning the application of this directive, particularly concerning the determination of what is "excessively burdensome." What constitutes an excess burden is to be determined by the patient, or if he is incapable of communicating such a determination, the patient's surrogate, with knowledge of the patient's wishes. If such knowledge is unknown, then a decision is to be based upon the patient's best interest, using the guidance provided by directive 58. Such things as repeated infections from the tube or the feeding, through aspiration into the lungs

or site irritation can be considered. Furthermore, if restraints must be used, causing disproportionate suffering to the patient, this also could be considered an excessive burden of the assisted nutrition and hydration. However, never can it be decided to withdraw or not initiate assisted nutrition and hydration for the purpose of shortening a person's life because *life* has become too burdensome or because someone is deemed to have *lost his dignity*. Despite any utilitarian view, human dignity is never lost. Respect for such human dignity can be denied by others, but it is never lost.

Agency ethics committees³³ are useful advisory bodies to assist patients and families to resolve quandaries concerning what constitutes morally licit alternatives, including care of persons with disabilities and end-of-life care. Ethics committees provide ethical consultation on particular ethical situations, offer educational opportunities related to bio-ethical decision making, and provide review of, and recommendations concerning, health-care policies. Ethics committees are to respect the diocesan bishop's pastoral responsibility, and be familiar with Catholic medical ethics and the *Ethical and Religious Directives for Catholic Health Care Services* (dir. 37). It could be preferable that the chair of the ethics committee be the agency's director of pastoral care. The director of pastoral care should be appointed in consultation with the diocesan bishop (dir. 21). All clergy appointments must be made with the explicit approval of the diocesan bishop in collaboration with agency administration (dir. 21). There may be times in which the wishes of the patient or the patient's surrogate are in conflict with the *Directives*. Thus life-affirming policies should be publicized and made available to patients and families. If the conflict cannot be resolved, the agency's general policy for the safe transfer of care, when an agency cannot accommodate the needs or wishes of the patient, should be invoked.

Conclusions and Future Perspectives

The recently enacted federal Patient Protection and Affordable Care Act (2010) continues to generate grave concerns pertaining not only to the unborn, but also to persons with disabilities and the elderly. The Patient Protection and Affordable Care Act, despite President Barack Obama's executive order and claims to the contrary, will pay for programs providing abortion on demand, and provides inadequate conscience protections for health-care providers. Health-care professionals who are advocates for the youngest to the oldest of human beings with disabilities easily could find themselves coerced into violating their conscience when it is telling them to protect the very lives they hope to serve. As the largest provider of non-profit, non-governmental health care in the United States, Catholic health care is particularly vulnerable to mandates within such public policy. Furthermore, while the Patient Protection and Affordable Care Act explicitly protects health-care providers from coercion to participate in assisted suicide, however, the act

will allow providers to high-need Medicare beneficiaries (the elderly and those with disabilities) to share in savings if they reduce the cost of health care services. This constitutes an incentive not to treat these vulnerable populations. Thus the elderly and persons with disabilities have legitimate concerns that other persons will be determining their quality of life in the allocation of health-care resources.

Utilitarianism prevails in the development of United States public policy. This philosophy is defined as the greatest happiness for the greatest number. Thus those in the majority will be beneficiaries of public policy over those in the minority. That minority includes persons with disabilities, and other voiceless populations, such as the unborn and those with dementia. The need is greater than ever to protect such human beings. Furthermore, there is a real need for individuals to prepare for the possibility of a disability or a condition of aging that makes one voiceless. Resources are available through diocesan offices and state Catholic conferences to assist in such advanced health-care planning. The key is to not only express one's wishes through an advanced directive. More importantly, it is prudent to designate a health-care agent (surrogate), with whom one has had thorough conversations concerning one's wishes, respectful of natural law, as explicated by Catholic teaching. No one should be made to consider himself a burden or to be deemed lacking in dignity. Advocates to assure that human dignity is respected can be identified and secured. More importantly, we may be called upon to be such an advocate. We are to respond *cum passio*, as compassionate companions, *cum pane*, to those who are approaching life's end or have a disability, that is, to share the Eucharist with each other.

Notes

¹ See John Stuart Mill, *Utilitarianism* (London: Longmans, Green Reader and Dyer, 1871).

² See the Catholic Health Association of the United States, *Catholic Health Care in the United States* (January 2010), 1.

³ Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980), I, n. 3, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

⁴ Pope John Paul II, apostolic letter *Salvifici doloris, On the Christian Meaning of Human Suffering* (1984), n. 13, http://www.vatican.va/holy_father/john_paul_ii/apost_letters/documents/hf_jp-ii_apl_11021984_salvifici-doloris_en.html.

⁵ *Ibid.*, n. 16.

⁶ Compassion (*cum passio*: with suffering); companion (*cum pane*: with bread).

⁷ Pope Benedict XVI, encyclical letter *Spe salvi, In Hope We Are Saved* (2007), n. 38, http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20071130_spe-salvi_en.html.

⁸ Grace L. Deloughery, *History and Trends of Professional Nursing*, 8th ed. (St. Louis: Mosby, 1977), 68.

⁹ Pope Paul VI, encyclical letter *Humanae vitae* (July 25, 1968), II, n. 12, http://www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae_en.html.

¹⁰ Carl Wood, Ilan Calderon, and Amanda Crombie, "Age and Fertility: Results of Assisted Reproductive Technology in Women over 40 Years," *Journal of Assisted Reproduction and Genetics* 9 (1992): 482.

¹¹ Survey by Genetics and Public Policy Center at Johns Hopkins University (2006), cited in Gautam Naik, "A Baby Please. Blond, Freckles—Hold the Colic," *Wall Street Journal*, February 12, 2009, <http://online.wsj.com/article/SB123439771603075099.html>.

¹² H. Buiting et al., "Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands: Descriptive Study," *BMC Medical Ethics* 10 (October 2009): 18.

¹³ E. Verhagen and P.J. Sauer, "The Groningen Protocol—Euthanasia in Severely Ill Newborns," *New England Journal of Medicine* 352 (2005): 959–962.

¹⁴ Compassion & Choices: Choice & Care at the End of Life, <http://www.compassionandchoices.org/learn/faq>.

¹⁵ New York Task Force on Life and the Law, "When Death Is Sought—Assisted Suicide and Euthanasia in the Medical Context" (1994), <http://www.health.state.ny.us/nysdoh/consumer/patient/preface.htm>.

¹⁶ Dioceses and state Catholic conferences often develop advanced directive and health-care agent designation documents, particular to their respective states, e.g., Bishops of Maryland, *Comfort and Consolation: Care of the Sick and Dying* (June 2007), <http://www.mdcathcon.org/endoflife>.

¹⁷ U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, D.C.: USCCB, 2009), dir. 25.

¹⁸ *Washington v. Glucksberg* 521 U.S. 702 (1997), and *Vacco v. Quill* 521 U.S. 793 (1997).

¹⁹ Measure 16 of 1994 established Oregon's Death with Dignity Act, which unsuccessfully was challenged through another ballot initiative, Measure 51.

²⁰ Initiative 1000 passed in November, 2008.

²¹ *Robert Baxter et al. v. State of Montana and Steve Bullock*, in the Supreme Court of the State of Montana, MT 449 (2009).

²² Oregon Department of Human Services, "Table I: Characteristics and End-of-Life Care of 460 DWDA Patients Who Died After Ingesting a Lethal Dose of Medication, by Year, Oregon, 1998–2009," *Death with Dignity Annual Reports*, <http://www.oregon.gov/DHS/ph/pas/docs/yr12-tbl-1.pdf>.

²³ Such legislation has been enacted in California and Vermont.

²⁴ U.S. Conference of Catholic Bishops, *Ethical and Religious Directives*, dir. 60.

²⁵ Pope John Paul II, *Evangelium vitae* (1995), n. 65, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

²⁶ Pope Pius XII, address to an international group of physicians, February 24, 1957, III: AAS 49 (1957), 147; cf. Congregation for the Doctrine of the Faith, Declaration on Euthanasia *Iura et bona*, III: AAS 72 (1980), 547–548.

²⁷ U.S. Conference of Catholic Bishops, *Ethical and Religious Directives*, dirs. 32, 56, 57.

²⁸ George W. Greer, Circuit Judge, “In re: The Guardianship of Theresa Marie Schiavo, Incapacitated. Michael Schiavo, Petitioner, vs. Robert Schindler and Mary Schindler, Respondents,” File No. 90-2908-GD-003, Fla. 6th Judicial Circuit, March 9, 2005.

²⁹ Pope John Paul II, address to the participants in the international congress on ‘Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,’ March 20, 2004, 4, http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html.

³⁰ Congregation for the Doctrine of the Faith, “Responses to Certain Questions Concerning Artificial Nutrition and Hydration, Response to Dubium from the US Conference of Catholic Bishops” (2007), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html.

³¹ Congregation for the Doctrine of the Faith, “Commentary” on the reponses in note 30 above, 4, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html.

³² U.S. Conference of Catholic Bishops, *Ethical and Religious Directives*, dir. 58. The quotation is from the Congregation for the Doctrine of the Faith’s “Commentary” on “Responses to Certain Questions,” 4.

³³ This includes not just institutional ethics committees and boards, but also the ethics committees of other health-care entities, such as home-care agencies.