JOHN PAUL II ACADEMY FOR HUMAN LIFE AND THE FAMILY COMMENTS ON THE MEETING OF THE WORLD MEDICAL ASSOCIATION, EUROPEAN REGION, ON END-OF-LIFE QUESTIONS, HOSTED BY THE PONTIFICAL ACADEMY FOR LIFE (NOVEMBER 16-17TH 2017)

I. SHORT COMMENTS ON THE PAV-HOSTED MEETING ON END-OF-LIFE QUESTIONS

1. Introduction

The John Paul II Academy for Human Life and the Family has followed with interest the recent meeting of the World Medical Association, European Region, on End-of-Life Questions, held at Vatican premises, hosted by the Pontifical Academy for Life (PAV), November 16-17th 2017. Many Catholics looked with concern on such a meeting, since several speakers defended the legalization of "euthanasia" and physician-assisted suicide. According to the words of Archbishop Paglia, who hosted the event, this meeting was intended to be held in an "academically neutral" spirit, in that it would be carried out as a "shared search for a common ground on which even differing opinions can find points of agreement about the truth of the human being" [1].

The spirit of the meeting seems to have been precisely that: a neutral presentation of differing viewpoints on end-of-life questions. In what follows, we wish to express some serious problems we see in this "neutral approach" of the PAV. In its original form as founded by St. Pope John Paul II, the PAV required its members to take an oath to always express and defend, according to their respective profession (including theoretical writings), the value of *each* human life, as well as the truth of the Gospel of Life and of the Church's teaching on Human Life.

2. Serious concerns: pro-euthanasia presentations and defenders of euthanasia in the PAV?

The presentation of "The Catholic perspective", delivered by Marie-Jo Thiel, raised serious concerns on the following grounds:

(a) Her apparent endorsement of "deep and continuous sedation" *on demand* (already legal in France), is extremely objectionable. For in the first place, "deep and continuous sedation" can be a euphemism for active euthanasia, because narcotics can provoke respiratory arrest, if the limits of maximal dosage and the need for intervals are not observed. Besides, if, as happens in most cases of

[1] See *https://www.wma.net/wp-content/uploads/2017/05/Paglia-to-WMA.pdf.*

terminal sedation, simultaneously nutrition-hydration is withdrawn, despite the fact that the latter still benefits the body for the preservation of human life, the endorsement of "deep and continuous (terminal) sedation" is an endorsement of direct euthanasia (and hence, of murder).[2]

(b) Her assertion rests solely on personal private conscience and the principle of autonomy as the main ethical references for all decision making.

We will return to both issues of concern.

3. Is a "professional consensus" of medical associations or legislators ethically binding for the individual physician or pharmacist, or is "conscientious objection" to be admitted?

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[2] This of course is not to deny the following:

- A medical doctor must be very attentive as to how much hydration he can give to the patient, without harming him. Therefore, to pump fluids into the patient without considering that it is causing fluid overload, edema of the body, pulmonary edema, or congestive heart failure would be absurd. To do so would downright hasten the death of the patient – causing a drowning-like death.
- When a physician sees the symptoms of acute renal failure in a patient who appears to be close to death (e.g., decrease urine output despite adequate hydration, and other signs, etc.), and dialysis will not be used, the physician knows he got to decrease the rate of IV fluids accordingly. As the patient gets closer to death, the rate of the IV is basically KVO (Keep Vein Open = the most minimal rate, just to keep the vein, where the IV catheter is, open). A KVO rate is virtually the equivalent of withdrawing fluids. It is evident that such an act is not passive euthanasia precisely because fluids and nutrition are no longer properly absorbed by the body and no longer benefit the person's well-being and life. All these remarks refer to the context of imminent death (= a dying process of 3-4 days, perhaps a week).
- As a person gets closer to death, he/she does not go from a healthy, alive state suddenly to a dead "state". One goes through a gradual phase of multi-organ failure, and that failure accelerates during the last week or the last 3-4 days of life. Surely there are cases in which this gradual process does not take place (e.g., a massive stroke, a massive heart attack, or the situation where the person just goes to sleep and dies). In the last days of human life the body of the dying will not assimilate anything anymore. Continue to hydrate as normal would harm the patient, drowning him/her as described above.

All of these facts and explanations confirm what we have said above: namely *that nutrition-hydration has to be given "until the body shows overt signs that nutrition-hydration no longer has any effect, and/or that it has become harmful to the patient"*.

A so-called "professional consensus" of the medical community is not a valid ethical standard and can never bind the conscience of the individual physician. In this section, we defend the right and duty of conscientious objection whenever professional ethical guidelines deviate from the truth.

Some defense, or at least no decisive critique, was voiced in the meeting hosted by PAV with respect to the positions held by Ronit Stahl and Ezekiel Emanuel (N Engl J Med 376:14 April 6, 2017). These authors firmly oppose conscientious objection, and argue that physicians, because they have embraced their profession voluntarily, are obliged to subordinate their personal moral or religious convictions to the collective convention of their profession. The same position was also defended by speakers at the PAV who claimed that, for example, termination of all treatments should be legally permitted if the "ethical standards and guidelines by professional associations, academic ethical institutions or supranational institutions are followed."

Undoubtedly, such a position is erroneous and constitutes a seriously grave ethical misdirection offered to those working in the medical profession, which today is filled with "collectively-agreed-upon" unethical tenets.

Such a position fails to recognize the demands of the Natural Law and the morality which flows therefrom, all of which are timeless and transcend any concrete historical consensus. If one were to accept the aforementioned assertions, one could no longer raise any justified objection against physicians in Nazi hospitals, psychiatric clinics in Soviet Russia, or against the guidelines approved by medical majorities under dictatorships in whatever country or historical period. On what basis would such a consensual standard permit a critique of physicians or medical majorities who carried out criminal medical acts, under the pretext that they adhered to the collective judgments of National Socialism, Soviet Communism, or to the "collectively-agreed-upon" guidelines of the medical profession in an ethically confused or corrupt medical society?

Such a position replaces the true and the good by some consensus of the changing majority opinion of a given medical association in a given country and at a given time. Under the guise of "professional guidelines," it could "justify" many objectionable actions and, ultimately, any criminal act which a given medical community has come to consider as permissible. Moreover, requiring that physicians' judgments and actions be dependent on the "guidelines adopted by a given medical community" gravely oppresses the conscience of the individual physician or healthcare professional.

Every human person has access to moral truth. Therefore, it is not acceptable to declare (i) that guidelines reached by a majority consensus are binding ethical norms for individual action, and (ii) that as such, they exclude the right and duty of critical dissent and conscientious objection to ethically wrong guidelines or patient

requests. Such a proposition should be banned from medical ethics and any civilized society.

4. Is medical science qua medical science, or the judgement of a majority of physicians and hospitals, the highest authority for medical ethical guidance?

Stahl and Emanuel also insist that it is the medical profession itself (and not some other discipline) which sets its ethical contours. Such an assertion overlooks the obvious fact that ethical questions that touch the medical and other health professions (e.g., nurses, pharmacists, etc.) can never be resolved by medical experts *qua* medical experts, but by physicians, *if and only if* they draw authentic wisdom and true knowledge from other disciplines, especially philosophy, ethics, and theology.

5. Is it legitimate to demand that, if conscientious objection is admitted, a dissenting physician must refer a patient to colleagues who perform the action he objects to (e.g. euthanasia, terminal sedation, abortion, etc.)? Certainly not!

Some speakers at the conference defended conscientious objection but advocated the view that the objector should cooperate with the medical community at large or with an ethical board of a hospital, by referring the patient to another doctor if he personally does not agree with certain procedures condoned by the medical community. Such an assertion is morally totally illegitimate, however, because it would force the objector to cooperate indirectly with evil, against his own conscience, by making referrals to the kind of medical practice that is objectively immoral.

6. Does a physician or other health professional have the right to follow his Own judgment and conscience, or does he lose his own moral autonomy and is bound by the patient's moral autonomy to carry out the patient's wishes in the name of the "principle of ethical plurality"?

At the conference hosted by the PAV, some speakers argued that, since there is no consensus on end-of-life decisions, the solution must be based on the principles of autonomy and ethical plurality[3]; others proposed, in the same vein, that "to define

[3] See *https://www.wma.net/wp-content/uploads/2017/05/Wiesing-WMA-EoL-Presentation-Vatican-Nov2017.pdf.*

the liberty of all [implies] not to impose our own moral code"[4]. Such propositions fail to see that any authentic moral law is never just "my own" or "the physician's own" moral code. To call them such can only apply to false substitutes for true morality, never to morality itself. Moreover, the new ethical imperative "Never impose your own moral code on others!" necessarily implies a moral judgment taken to express an absolute moral truth. Thus, such a conception is marred by self-contradiction. Underlying this imperative is moral relativism which, by virtue of its nature, is both false and self-contradictory.

The defense of the supremacy of the principles of autonomy and ethical plurality overlooks two fundamental facts:

(i) The autonomy of a patient does not free him from the personal responsibility to seek truth and to avoid falsehood in his ethical judgments, and to seek goodness and to avoid committing evil in his actions. Nobody has the right to invoke his autonomy to be the sole deciding factor of his course of actions, without having first properly formed his conscience in order to ground his autonomy in the knowledge of truth, which is accessible to reason, or to faith, or to both.

(ii) Given the fundamental error of ethical relativism,[5] neither an individual nor any majority of physicians may rightfully demand that a physician consider his ethical judgment as a mere subjective opinion in a pluralistic ethical universe, such that the recognition of "ethical plurality" would be the only basis for the physician's actions, or the policies of a legislative body. The physician must never be treated as a person who lacks his own relation to moral truth and who, faced with the "ethical pluralism" and prohibition to "impose one's own ethical views on patients," should bow to the patient's autonomy as the sole criterion for the medical act. The physician is not and must never be considered merely as a technician or an instrument of the patient's wishes. Rather, both the patient and the physician must look up to an ethical truth and moral standard that is not of their making nor created by the *fiat* of an autonomous decision.

Heikki Pälve's excellent presentation during the PAV-hosted conference reaffirmed the universal and perennial character of medical ethics regardless of the

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[4] *https://www.wma.net/wp-content/uploads/2017/05/Greco-WMA-EoL-Presentation-Vatican-Nov2017.pdf. December 18th 2017.*

[5] On the critique of ethical relativism, we recommend, for example, Dietrich von Hildebrand, *Ethics*, 2nd Ed. (Chicago: Franciscan Herald Press, 1978), ch. 9; John Finnis, *Natural Law and Natural Rights*, 2nd ed. (Oxford: Oxford University Press, 2011), and Josef Seifert, *Der Widersinn des Relativismus: Befreiung von seiner Diktatur* (*The Absurdity of Relativism: Liberation from Its Dictatorship*) (Mainz: Patrimonium-Verlag, 2016), ch. 5, "*Critique of Ethical Relativism*"; Martin Cajthaml, *Kritik des Relativismus* (Heidelberg: Universitätsverlag Winter, 2003).

changes of public opinion. This stands in sharp contrast to the disturbing trend of an increasingly permissive attitude in favor of euthanasia and physician-assisted suicide (known euphemistically as "assisted dying") in Western Europe. The slippery slope toward euthanasia is a sinister reality in our hospitals and society at large[6].

7. Is palliative care the alternative to assisted suicide and euthanasia, or is it a veiled form of the "culture of death"?

Ilora Finlay's presentation[7] maintained the position that palliative care should be accepted as the alternative to euthanasia and assisted suicide ("assisted dying"). We will return to this question at the end of this statement.

8. The need for intellectual clarity

The final session, the plenary panel discussion, included five panelists, of whom three (Gilli, Héman, Wiesing) are favorable to euthanasia, or at least called for "respect for autonomy" with respect to physician-assisted suicide.

Based on the presentations of the majority of speakers, obviously the meeting hosted by the PAV should give us pause and is cause for profound concern. It is troubling that, just at a time when Catholic faithful most need firm and clear directions in order to resist the prevailing secular trends, the Holy See could have hosted a meeting in which opinions, which overtly contradict Catholic teaching, were treated as worthy opinions and even placed on the same level as those which uphold the Church's teaching. In this regard, it is also troubling that the central ethical and theological truths concerning death, dying, and suffering were markedly underrepresented.

The material presented in the meeting could easily cause great confusion among health care professionals, jurists, and politicians, as well as among the clergy and lay faithful. For all these reasons, we, the members of the *John Paul II Academy for Human Life and The Family*, proceed to publish the following statement concerning some of the central ethical and theological issues involved in conscientious objection, palliative medicine, terminal sedation, euthanasia and physician-assisted suicide.

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[6] *https://www.wma.net/wp-content/uploads/2017/05/Pa%CC%88lve-WMA-EoL-Presentation-Vatican-Nov2017.pdf, December 18th 2017.*

[7] See *https://www.wma.net/wp-content/uploads/2017/05/Finlay-WMA-EoL-Presentation-Vatican-Nov2017.pdf.*

II. Detailed comments of JAHLF on conscientious objection, palliative medicine, euthanasia and physician-assisted suicide

1. Conscientious objection

Each person, as a rational and free subject, has access to "natural" truths (truths which can be attained by the use of reason [the intellect] alone), as well as the capacity to receive revealed religious truth and to accept it in faith; he ought to recognize these truths of both reason and faith and follow them in his actions, even when the political or legal authority, or the consensus of a group of physicians to which he belongs, contradicts them. This is the very foundation for the right to conscientious objection.

Our morally corrupt society allows (in most Western and Asian countries) both its women to abort their babies in the womb and its doctors to perform abortion; it also condones, in an increasing number of states, overt or covert euthanasia. No individual physician and/or politician is obliged to follow this implicit evil consensus. Both the political ruler and each individual member of a society can (and should) not only recognize a higher moral quality in the doctor who refuses to shed innocent blood – irrespective of whether the rest of the physicians have agreed that such practice is legitimate and have put collective pressure on the individual physician or other health professional who refuses to bend to the "consensus". But they should also have the fortitude to resist an evil consensus and to denounce its errors, because *it is an absolute moral obligation to reject and never to obey such a consensus.* Seeking to impose on a doctor the duty to perform abortions or euthanasia (or, alternatively, to leave the medical profession or a given hospital), or to impose on him the duty to refer a woman to an abortionist, is gravely sinful and a direct violation of his inalienable human dignity and freedom of conscience.

The same also applies to the case where a pro-life physician is claimed to be obliged to refer a patient (who requests physician-assisted suicide or euthanasia) to a colleague who would perform such acts. *Not only is the pro-life physician not obliged to refer a patient to a colleague who would perform intrinsically wrong acts, he is also absolutely morally forbidden to do so.*[8] Conscientious objection plays a fundamental role in today's efforts against the "culture-of-death". The *Pontifical Academy of Life*, as its name indicates, should have allocated ample space during the November 2017

[8] The prohibition to refer a patient to another physician or facility only applies to cases of clearly intrinsically bad acts. Certainly, the situation can arise when one no longer thinks one can continue to provide "futile" care the patient or family requests, which may lead one to suggest they need to find another facility/doctor who may be willing to provide such care. In such a case, it may be permissible to help the family find an alternate facility and facilitate transfer, assuming one doesn't think that such ongoing/future care is absolutely morally proscribed. Of course, this raises the whole contested question of what is truly futile care, but that is beyond the scope of the present document.

meeting for an unambiguous, forceful defense of conscientious objection. This, however, the PAV did not do.

2. *Philosophical critique of euthanasia*

Today, euthanasia is legally speaking an option available in many democratic countries. St. Augustine once said that when democracy is severed from truth and justice, it degenerates into a gang of bandits. Such is the case today when euthanasia is considered acceptable just because it is in accord with the reigning law and respect for autonomy. As such, euthanasia amounts to "consented murder", however. It is held that, as long as the victim consents to the act by which a third party will kill him, the act would not be immoral. Underlying such a thesis is the assertion that the human will is the source of morality, and/or the claim that nobody can suffer injustice voluntarily. Either assertion is presented as a defense of "freedom" and "autonomy". We now turn to a philosophical critique of these claims.

(i) Invoking moral autonomy to justify euthanasia, assisted suicide, or terminal sedation together with removal of nutrition and hydration, is first and foremost based on a distorted notion of respect for autonomy. According to this false notion, a person would be free to commit the crime of suicide and, the community and/or the State, being obligated to respect his autonomy, would be bound to help him in carrying out his suicide, thereby cooperating in the criminal act. One can hardly imagine a worse perversion of moral truth and natural right than the idea that a person has a right to demand that *other persons commit the crime to murder him.* Nobody has *any right whatsoever to demand from society to assist him to commit a crime against himself, or to oblige others to commit the crime of murdering him. Quite the contrary, the others and the State, in virtue of their true moral autonomy, a moral autonomy subjected to the truth, have the absolute moral duty to reject such a request.*

(ii) In end-of-life situations, the patient in question is a vulnerable person. Invoking the principle of "autonomy" to allow for the taking of his own life by another party amounts to ignoring the undue pressures to which a poor person is subjected during the weakest, saddest and scariest time of his life[9].

As Pope Paul VI prophetically foresaw in his encyclical *Humanae Vitae*, the apparent "autonomy" and "freedom to decide" with regard to the moral law and Church teaching – so loudly invoked by the defenders of contraception – can easily lead to slavery and a complete loss of freedom and autonomy, once society claims for itself the same kind of "autonomy" and freedom. Paul VI wrote:

[9] See Richard Stith, *Her Choice, Her Problem: How Having a Choice Diminishes Family Solidarity*, Valparaiso University Law School Legal Studies Research Paper Series (2011), Paper nr. 11-12. *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1911917##*. December 19th, 2017.

> ***17. Responsible men can become more deeply convinced of the truth of the doctrine laid down by the Church on this issue if they reflect on the consequences of methods and plans for artificial birth control. [...] Finally, careful consideration should be given to the danger of this power passing into the hands of those public authorities who care little for the precepts of the moral law. Who will blame a government which in its attempt to resolve the problems affecting an entire country resorts to the same measures as are regarded as lawful by married people in the solution of a particular family difficulty? Who will prevent public authorities from favoring those contraceptive methods which they consider more effective? Should they regard this as necessary, they may even impose their use on everyone. It could well happen, therefore, that when people, either individually or in family or social life, experience the inherent difficulties of the divine law and are determined to avoid them, they may give into the hands of public authorities the power to intervene in the most personal and intimate responsibility of husband and wife.***

Both the State and individual persons must be ruled by something higher than themselves: that is, by truth that can be known either by a direct divine revelation, or by right reason. Severed from truth, the government becomes tyrannical and the individual either a lawbreaker (criminal) or a slave. This understanding is encapsulated in the golden saying of our Savior: *The truth will set you free!* If we allow the State to declare that based on the will of an individual the State has the right to kill, then we will be forced to admit that the State has the right to kill also in other situations. Only truth, and not the individual will, is the limit to the power of the State. If we accept "euthanasia", then we would be delivering to the State absolute power over us and over our children, over our life and death, over the children of God.

Aristotle already said that to allow suicide or assisted suicide would be to allow acts against both virtue and the common good. But, since political society exists for the common good, and the common good consists in achieving a good (virtuous) life and therefore, a good death, a good legislator may not allow suicide or assisted suicide.

In Plato's *Phaedo*, Socrates offered an even more profound metaphysical and implicitly religious reason against suicide, euthanasia, and assisted suicide: namely that we must not take our own lives or that of fellowmen, because we are brought to this life by God, and have received a divine mission. We are not the lords over life and death (62a-c)[10]. This is because, not only we are creatures in total dependence on God (also lettuce heads and wild boars depend on God's creation, and yet we may

[10] The one exception to this statement is when we act as representatives of God in just punishment. In such instances, the perpetrator (the one who shed his brother's blood, as stated in the Book of Genesis) could be sentenced to death by the legitimate authority (the State). In the words of Christ, the ruler of the State receives the authority from above.

kill and eat them), but we are also creatures endowed with reason and free will, made in the image of God. As such, each individual is endowed with the dignity of the human person, a mission in life, and is related to God as to his master, such that he has no right to kill either himself or some other persons. As far as life-and-death-decisions are concerned, no man belongs in an ultimate way to himself, but belongs to God, who alone is the Lord over his life and death.

Thus, the real issue in the promotion of euthanasia is actually this: is man the measure of everything? Or, rather, is man the servant of God? As God's creature, it is not man's prerogative to impose, on his own accord, death on others or on himself, but rather he is to accept death only when it comes to him from without and when it is, ultimately, sent from God[11].

3. Palliative care

3.1. The various forms of palliative care

The topic of palliative care deserves a detailed discussion, especially since, at the November 2017 meeting, several highly problematic remarks have been made about end-of-life decisions, terminal sedation, and the interpretation of chapter 8 of *Amoris Laetitia* with respect to palliative care.

Today, there are four meanings to palliative care: the first three refer to positive and good forms of care, while the fourth corresponds to perverted forms of so-called care which, unfortunately, are becoming the prevailing practice in many palliative care centers. We would like to propose designating the good forms of care for the incurable or patients who seem to be close to death by a name other than "palliative care," especially since what is commonly being called "palliative medicine" is frequently dominated by the widespread perverted forms. There will be serious confusions if one does not introduce clear distinctions and a new terminology.

One has to recognize, however, that not only in England, but also in Germany and other countries, entire colleges of professors of palliative care medicine, medical associations on palliative care, as well as national medical have strongly rejected both assisted suicide and euthanasia.[12] The most decisive statement in this respect is that

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[11] Paradoxically, it is the same issue behind the acceptance or rejection of the death penalty. Only if the political authority is the representative of divine authority, and only if the punishment is for a just reason (and not for utilitarian reasons), could the death penalty be considered just.

[12] See on this Thomas Sören Hoffmann/Marcus Knaup, Hrsg., *Was heißt in Würde sterben? Wider die Normalisierung des Tötens* (Wiesbaden: Springer VS Fachmedien, 2015), p. 297 f.; *Lehrstuhlinhaber für Palliativmedizin in Deutschland sprechen sich geschlossen gegen den ärztlich assistierten Suizid aus*; ibid., 299-303: *Stellungnahme des Deutschen Hospiz- und PalliativVerbands zur Diskussion über ein Verbot gewerblicher und organisierter Formen der Beihilfe zum Suizid sowie über die ärztliche Beihilfe zum Suizid*; This association stands for over

of the British Medical Association (BMA) which, in 2006, states that the BMA "opposes all forms of assisted dying,…insists that physician-assisted suicide should not be made legal in the UK; insists that voluntary euthanasia should not be made legal in the UK; insists that non-voluntary euthanasia should not be made legal in the UK".[13]

Described below are the four types of "palliative care":

a. *Good palliative care as pain-relief and stress-relief for all patients including the seriously ill.* In this first sense, palliative care is an integral part of medicine at all times
b. *Palliative care specifically for incurable or terminally ill patients (end of life and hospice care)*. In this second sense, palliative medicine has been part of medicine since its beginning and corresponds to one of medicine's seven ends (goals and goods medicine ought to serve): pain-relief and care of patients close to death, or of those whose health and life medicine cannot preserve or restore.[14] This good aimed at in treatment and care is distinct both from life and health, and should be served even when life and health cannot be preserved much longer (for example, in cancer patients against whose cancer no surgery or chemotherapy can help any longer, or in patients who entered already the agony of death), or when health can no longer be preserved or restored. Just as in the first sense of "palliative medicine," there is absolutely nothing anti-life nor any inevitable connection with the "culture of death" in this branch of medicine as such. On the contrary!
c. *Multidisciplinary palliative care in a Christian spirit.* This kind of medical care received the *name* "palliative care" (a term not used before) and was defined as a separate branch of medicine in the late 1950s. Established in hospices, and other sites like cancer stations, this type of palliative care for the incurably sick and those close to death goes beyond the medical dimension.[15] In its practice in hospices in the United Kingdom and elsewhere, palliative care was carried out

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1000 centers of palliative medicine in Germany. Also the ARGE „*Ethik*" der ÖGARI (anesthetists and palliative medical personnel) in Austria has formulated strong resistance to assisted suicide and euthanasia in Austria. *Ibid.*, pp. 315-319.Viena, 13.03. 2014.

[13] See the text in Thomas Sören Hoffmann/Marcus Knaup, Hrsg., *Was heißt in Würde sterben?*, cit., pp. 320-322.

[14] See Josef Seifert, *The Nature and the Seven Goods of Medicine, Aletheia. An International Yearbook of Philosophy VII 1995-2001* (2002), pp. 321-416; also published as chapter of *The Philosophical Diseases of Medicine and Their Cure. Philosophy and Ethics of Medicine,* Vol. 1: *Foundations. Philosophy and Medicine*, vol. 82 (New York: Springer, 2004); *Philosophical Diseases of Medicine and Their Cure. Philosophy and Ethics of Medicine*, vol. 1: *Foundations. Philosophy and Medicine,* vol. 82, Kluwer online e-book, 2005, ch. I.

[15] See this definition of World Health Organization (WHO): *"An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."*

in a charitable spirit, by accompanying patients who suffered immensely from depression or physical pain, and caring for them in a human and properly Christian way.[16] Also this Christian, multi-disciplinary "palliative care" has, as such, nothing to do with the "culture of death." There are also Jewish, Muslim, and other non-Christian centers that provide palliative care in a similarly holistic spirit.[17]

d. *Perversion and perverted forms of "palliative care" in contradiction to the culture of life:* "Palliative care" has often and in many places become an instrument of overt or covert euthanasia, or at least a distinct step toward euthanasia. Acting under the guise of "patient autonomy," or setting "goals of care," patients are strongly encouraged to execute advance directives which authorize withholding of medical treatment and even of nutrition and hydration. It is usually a member of the interdisciplinary "palliative care" team (IDT) who will be guiding the patient in writing his/her directive. Such advance directives (e.g. Living Wills, POLST form, etc.) then justify and give legal cover to the following types of scenarios:

(i) In the worst scenario, first the patient is removed from nutrition and hydration prematurely in spite of the fact that his body still benefits from the nutrition-hydration support. Since the patient would experience excruciating pain caused by starvation and dehydration, the expedite solution is to sedate him heavily. In other words, the patient is put to sleep. Such a perverted form of "palliative care," a kind of "humane mask" of brutal murder by passive euthanasia, can also consist in the refusal to provide nutrition-hydration via "artificial means" when the "normal way" of intake of nutrients and liquids is blocked.[18]

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[16] This kind of palliative care started in the late 1950ies, and received this name:

> *Palliative care began with a focus on the care of the dying. Dr. Cicely Saunders first articulated her ideas about modern hospice care in the late 1950s based on the careful observation of dying patients. She advocated that only an interdisciplinary team could relieve the "total pain" of a dying person in the context of his or her family, and the team concept is still at the core of palliative care.*

Taken from the large and interesting article on the history of palliative care: http://asheducationbook.hematologylibrary.org/content/2008/1/465.full.

[17] See Marcus Knaup, *Wie wollen wir sterben? Zur Frage der ärztlichen Suizidassistenz*, and Thomas Sören Hoffmann, *Das gute Sterben und der Primat des Lebens*, cit., 267-292, both in Thomas Sören Hoffmann/Marcus Knaup, Hrsg., *Was heißt in Würde sterben?*, cit.

[18] Luke Gormally's article *Terminal Sedation and the Doctrine of the Sanctity of Life*, in Torbjörn Tännsjö (ed.), *Terminal Sedation: Euthanasia in Disguise?*, Netherlands, Kluwer Academic Publishers, 2004: 81-91, treats with a version of terminal sedation which, by definition, is terminating nutrition and hydration of a patient. But terminal sedation does not necessarily have to withdraw nutrition-hydration.

Such a practice of a "pseudo-palliative" care, coupled with the withholding or the premature withdrawal of nutrition-hydration, is a form of euthanasia, precisely because it is the resulting starvation and dehydration that *directly cause the person's death*, and not the cancer or some other grave disease which the patient may have.

This praxis wholly contradicts ethical knowledge and the Church's teaching on the issue of nutrition and hydration, a teaching which the *John Paul II Academy for Human Life and The Family* fully supports –not only out of respect for Church authority, but also because it expresses an evident truth of natural law ethics.

At this point, it is worthwhile to reproduce the clarifications of the Congregation for the Doctrine of the Faith on the issues of nutrition and hydration, which must never be refused or withdrawn, *as long as they serve, and are necessary conditions of, human life*:

> ***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?***
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> ***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.***
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> ***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?***
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> ***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***[19].

The above reasoning regards the question of nutrition and hydration. It seems to be ethically correct to require that the same line of reasoning be applied to the question of ventilatory support in patients who are deprived of the ability of spontaneous breathing.

(ii) Besides directly killing the patient through the removal of life-sustenance necessary for survival, the perverted form of "palliative care" also

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[19] http://www.vatican.va/roman_curia/congregations/cfaith/documents /rc_con_cfaith _doc_20070801_risposte-usa_en.html.

manifests its ugliness through morally objectionable omissions, when it simply omits curative medical care and neglects to treat infections, such as pneumonia, or when it withholds/neglects the more basic aspects of medical care that include – besides the most necessary ones (hydration, nutrition, airflow) - also cleaning wounds (to avoid infections), removal of respiratory secretions and tracheostomy when needed, among others.

Neglecting basic medical care, "palliative care" turns into a kind of "euthanasia through neglect", instead of serving the life and health of patients.[20]

(iii) Frequently, perverted palliative medicine also omits adequate and urgently required medical interventions to sustain or save human life, under the pretext that these interventions are "extraordinary" and burdensome means for prolonging human life, even when they are clearly required medical intervention,

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[20] See the article on the excellent Hippocratic example of practicing medicine of Dr. Paul Byrne, a physician who has consistently and uncompromisingly resisted all the perverted forms of palliative care: http://www.clmagazine.org/article/dr-paul-byrne-from-preemies-to-end-of-life-issues-one-man-has-made-a-difference-/ See also Dr. Byrne's report on a particularly beautiful case of his resistance to this kind of false "palliative care" in his treatment of Lilliana Joy Dennis: "Lilliana is a patient, in whose treatment I had the privilege to participate. 6 years ago, when Lilliana was born and still at 4 months, no doctor would treat her. She did not get into the hands of a palliative care specialist, but was sent home to die without treatment, only palliative care. Her parents contacted me when Lilliana was 4 months. A treatment plan was developed. Here she is now:

See also the video made on her 6th birthday: https://www.youtube.com/watch?v=XcM7gjTp5dc.

such as in the case of an acute appendicitis or some other acute life-threatening condition.

Thus, as indicated in a number of studies, the current practice of palliative medicine in an overwhelming number of cases is offending against the duty of medicine to protect and preserve human life. As such, it fails to respond adequately to the dignity and preciousness of every human life.

3.2. The Dominance of Perverted Forms of "Palliative Medicine" as a Threat to the Pontifical Academy for Life

A number of close observers of the direction which palliative medicine is taking world-wide, have expressed concern that the so-called "Third Path to Euthanasia" movement[21] is becoming entrenched at the Pontifical Academy for Life. On the basis of their careful studies, it appears that the new PAV is at least running the risk of serving the euthanasia movement rather than defending human life in all its stages. The new PAV is focused on globalizing international palliative care by working with the International Association for Hospice and Palliative Care (IAHPC) headquartered in Houston and with the World Health Organization (WHO).

Therefore JAHLF finds it to be its duty to remind the PAV of the well-known fact that, as both WHO and IAHPC interpret it, *palliative medicine is frequently the vehicle chosen to institutionalize fundamental changes in healthcare that reflect a new philosophy where the value of human life is to be judged according to its quality rather than by its intrinsic sacredness.*

The announcement of a PAV-sponsored "*Palliative Care: Everywhere and by Everyone*" Workshop to be held at the end of February 2018, can be seen, not without other strong indicators, as a signal that the "Third Path leaders" who are members of the new PAV are working in the direction of reshaping the PAV to become covertly a defender of euthanasia. Dr. Kathy Foley, who is to speak during the first morning session of the workshop on "Palliative Care Improves Medicine," was in charge of the Soros-funded Project on Death in America for nine years, spending over

[21] See on this the article by Elizabeth Wickham, *Texas is About to Embark on the "Third Path" to Passive Euthanasia*. She shows how, by a shift of terminology, many centers of palliative care and hospices simply cover up the fact that they *de facto* engage in different forms of euthanasia:
http://www.lifeissues.net/writers/wic/wic_12passive%20euthanasia.html. See also the same author, *Today's 'palliative care' disrespects the natural law*: http://www.lifetree.org/newsletter/index.html.

$45 million to set the stage for societal changes to continue for decades. Dr. Foley apparently does not believe that physician assisted suicide is inherently wrong.[22]

More than half of the presenters at the upcoming workshop have ties to the World Health Organization (WHO) and are named in the WHO 2017 document published by the WHO Collaborating Center Public Health Palliative Care Programs. Reading this document helps one to understand the philosophy and practice of palliative care, as it has evolved over the last few decades on many sites, and where many leaders of palliative medicine intend to go with it.[23]

For an example of how the Center to Advance Palliative Care (CAPC) trains their medical professionals to cover up the hastening of death, see their sample policy recommendation for "Removal of Mechanical Ventilation in the Dying Patient" on pp. 31-35[24]. The orientation is ideological instead of being grounded in truth.

In other words, what we are frequently facing today is a rampant ideology of the perverse form of palliative care which includes measures to starve or suffocate helpless persons as a means to hasten their death [25]

To sum up all the aforementioned considerations and concerns of JAHLF vis-a-vis palliative medicine as being handled by the PAV, we conclude the following:

Palliative Care is a medical practice which can and should embody an integration of the medical, ethical and theological dimensions of caring for terminally ill patients. The practice in some Christian environments of the United Kingdom illustrates this. However, the remarks by Dr. Thiel at the PAV sponsored November 2017

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[22] See https://www.publications.parliament.uk/pa/Id200405/Idselect/Idasdy/86/5012008.htm

[23]https://www.uicc.org/sites/main/files/atoms/files/GomezBatiste_X_Connor_S_Eds._Building_Integrated_Palliative_Care_Programs_and_Services._2017.pdf

[24] In particular, see p. 34 in *Policies and tools for Hospitals Palliative Care Programs: A Crosswalk of National Quality Forum Preferred Practices* published by the Center to advance Palliative Care. When a family is able to make a definite decision for ventilator withdrawal, such a decision is always emotionally charged. Families will constantly second-guess themselves, especially if the death appears to linger following ventilator withdrawal. "*Support, guidance and leadership from the entire medical team is crucial, as the family will be looking to the team to assure them that they are 'doing the right thing'. Furthermore, it is common for families to have concerns that their decision constitutes euthanasia or assisted suicide; explicit support, education and explanations from the team will be needed*" (https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf)

[25] A careful review of the contents of CAPC (Center to Advance Palliative Care) Crosswalk document says that what they define as (objectively perverted) "palliative care" involves the hastening of death in many other ways as well. This stance differs profoundly from the clear "No" to voluntary and involuntary euthanasia, physician-assisted suicide, etc. issued by BMA, by the German association of Professors of palliative care, and others, cited below.

Conference, along with the positions expressed about euthanasia in some papers on "patient's autonomy", and the disturbing presence of some members of the Soros-funded PDIA (especially Dr. Kathleen Foley) in the new PAV, leads us to fear that the particular version of palliative care which the PAV is likely to promote is the one currently widespread in the USA and many other countries. It is the kind of palliative care which entails a violation of the sacredness of human life and the introduction of euthanasic practices through the refusal (or willed omission) of the required medical treatments, even of the most basic ones. It often also entails the premature discontinuation of hydration and nutrition (irrespective of the means of administration) when the patient's body still assimilates nutrient and liquids, which then becomes the direct cause of his death. This is none other than killing the patient by means of starvation.

4. "Terminal sedation"

a. *Terminal Sedation and Euthanasia (Hastening Death):* In this context, another practice often carried out in palliative care units and hospitals, is "terminal sedation", that is, in order to avoid pain (or, less nobly, in order to relieve medical staff from the more demanding needs of conscious terminally ill patients), one deprives the patients of consciousness until they die. Terminal sedation policies, even when they do not imply withholding of nutrition and liquids (as they most often do, in this case amounting to euthanasia), frequently entail the risk of hastening death (when tranquillizers and pain killers are administered in excessively high dosage).[26]
   Not only "terminal sedation" as a euphemism for euthanasia (which is always and everywhere gravely wrong), however, but administering painkillers in an *offhanded* manner, without considering the risk of hastening death, is also immoral. Nonetheless, Pope Pius XII instructed that when appropriate, pain medications may be permitted, even though they could hasten death (as an *unintended side-effect*), if they do not prevent the person from carrying out religious and moral duties
b. *Terminal Sedation is also immoral, however, even when it does not shorten life: because it is directed against the Dignity of Rational Conscious Life:*[27]

[26] See Luke Gormally, *Terminal Sedation and the Doctrine of the Sanctity of Life*, in Torbjörn Tännsjö (Ed.), *Terminal Sedation: Euthanasia in Disguise?*, Netherlands, Kluwer Academic Publishers, 2004: 81-91. See also Roberto de Mattei, *La 'sedazione profonda': forma mascherata di suicidio assistito?*, *Corrispondenzaromana.it,* 10 gennaio 2018); http://www.robertodemattei.it/2018/01/10/la-sedazione-profonda-forma-mascherata-di-suicidio-assistito/.

[27] For a detailed discussion on the dignity of conscious and rational human life (distinct from the ontological dignity which each person, conscious or not, possesses), see Josef

From a Christian spiritual perspective, the practice of terminal sedation is also wrong, even when it has nothing to do with euthanasia or would not shorten human life by any second, because, by taking consciousness away, terminal sedation deprives patients of the dignity to live in a properly human and dignified manner the last days of their earthly lives as they approach death. Imposing terminal deep sedation on human persons, with the intention for them to lapse into unconsciousness until death, in order to spare them anxiety and pain, is never permitted.

The suppression of consciousness is acceptable, however, when it is an *unintended side effect* of the treatment of agonizing pain (e.g., secondary to dyspnea, or agitated delirium) that is refractory to less radical measures. Granted that any intent to suppress any/all conscious experience of the final stages of dying is not permitted, never mind any treatment that precludes the patient from satisfying his final moral/family obligations, or preparing consciously for meeting God. Granted that permanent and irreversible terminal sedation is always wrong, granted also that we should help patients accept and deal with the suffering that may accompany dying, in a fully Christian way, temporary deep sedation may be permitted under certain conditions. As indicated in the 1980 statement of the Sacred Congregation for the Doctrine of the Faith, it would be "imprudent to impose a heroic way of acting as a general rule" or require all to undergo the final sufferings of dying to the fullest. The same text also cites Pius XII statement that pain medications may be permitted, even though they affect

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Seifert: *The right to life and the fourfold root of human dignity*. In: Pontificia Academia pro Vita, Juan de dios Vial Correa and Elio Sgreccia (Ed.), *The nature and dignity of the human person as the foundation of the right to life. The challenges of the contemporary cultural context. Proceedings of the VIII Assembly of the Pontifical Academy for Life* (Vatican City, 25-27 February, 2002), Libreria Editrice Vaticana.

La natura e la dignità della persona umana come fondazione del diritto alla vita: Le sfide del contesto culturale contemporaneo (Atti dell'8ª Assemblea della Pontificia Accademia per la Vita, Città del Vaticano, 25-27 Febbraio 2002), Ed. Juan de Dios Vial Correa e Elio Sgreccia (Città del Vaticano: Libreria Editrice Vaticana, 2003), pp. 194-215.

Dignidad humana: Dimensiones y fuentes en la persona humana, in: Juan Jesús Borobia, Miguel Lluch, José Ignazio Murillo, Eduardo Terrasa (Ed.), *Idea Cristiana del Hombre*. III Simposio internacional fe cristiana y cultura contemporánea (Pamplona: Eunsa, 2002); *Grandezas Y insuficiencias de la filosofía kantiana de la dignidad humana. Un análisis crítico*, in: Ignacio García de Leániz (ed.), *De nobis ipsis silemos. Homenaje a Juan Miguel* Palacios (Madrid: Encuentro, 2010, pp. 173-204); *The Philosophical Diseases of Medicine and Their Cure. Philosophy and Ethics of Medicine.* Vol. 1: *Foundations. Philosophy and Medicine*, vol. 82 (New York: Springer, 2004) – also Kluwer online e-book, 2005, ch. 1, on the seven goods medicine serves, among which the dignity of awakened consciousness ranks high, and ch. 2, on human dignity.

consciousness and could hasten death (as an *unintended side-effect*), as long as they do not prevent the person from carrying out religious and moral duties. An additional caveat is that it is not right to deprive any person, even temporarily, of consciousness without a serious reason.

The ease with which terminal sedation is frequently administered has much to do with a vision of the value of human existence being mainly dependent on a pleasurable, comfortable, and agreeable life. But this is a profoundly erroneous view of the true good for human persons. Are there not far deeper and greater values linked to life and death other than mere physical comfort?

Would it not have been blasphemous if someone would have proposed to administer terminal sedation to Jesus on the Cross, as if a pain-free death would be the greatest good, and the immense value of our redemption that required conscious and freely accepted suffering would be of no worth? This in some ways also applies to any person's dying consciously when it is accompanied by suffering. Consciously dying and living the pain and anguish of death also gives the human person a precious opportunity to reconcile himself with God (for Catholics and orthodox Christians by receiving the sacraments of confession and holy unction), to surrender his soul to God, to forgive his family members, friends, and enemies, and ask for their forgiveness. It is also a precious invitation to him to offer up his suffering and death, uniting them with the passion and death of Christ, so that his pain would not be a meaningless suffering that ought to be shortened or avoided entirely at all costs. Rather, to die a truly human death and to embrace it (spiritually speaking) can constitute a most precious supreme act of loving and glorifying God, and an act of charity for one's family and friends, which Pope John Paul II unfolded beautifully in his address to the old and suffering in the *Liebfrauenkirche* in Munich and in his magnificent document *Salvifici Doloris*.

5. Theology and the end of life

When one deals with end-of-life questions, it is necessary to keep in mind that the meaning of death holds the secret for the meaning of life. Therefore, any consideration of death in the light of human dignity must take into consideration that *the avoidance of pain can neither be the only nor the most important response to terminal illness*. The religious dimension must have a central role in the holistic care of patients with terminal illnesses. At the November 2017 meeting at PAV, Daniela Mosoiu seems to have been the only speaker to have addressed this issue adequately, insofar as it can be judged from the published parts of her presentation. May her words become a signal and guide for PAV's future work!

We can close this statement with the words of Saint John Paul II:

Illness, which in everyday experience is perceived as a frustration of the natural life force, for believers becomes an appeal to "read" the new, difficult situation in the perspective which is proper to faith. Outside of faith, moreover, how can we discover in the moment of trial the constructive contribution of pain? How can we give meaning and value to the anguish, unease, and physical and psychic ills accompanying our mortal condition? What justification can we find for the decline of old age and the final goal of death, which, in spite of all scientific and technological progress, inexorably remain? Yes, only in Christ, the Incarnate Word, Redeemer of mankind and victor over death, is it possible to find satisfactory answers to such fundamental questions. In the light of Christ'*s death and resurrection illness no longer appears as an exclusively negative event; rather, it is seen as a "visit by God", an opportunity "to release love, in order to give birth to works of love towards neighbour, in order to transform the whole of human civilization into a civilization of love"* (Apostolic Letter *Salvifici doloris*, n. 30)" (Message of John Paul II to the First World Day of the Sick, October 21st 1992)[28].

Rome, 31 of January, 2018

In the name of the entire John Paul II Academy for Human Life and the Family

Josef Seifert, President

Christine Vollmer, Vice-President

Executive Board members: Roberto de Mattei, Philippe Schepens, Thomas Ward, John-Henry Westen, Mercedes Wilson,

[28] *http://w2.vatican.va/content/john-paul-ii/en/messages/sick/documents/hf_jpii_mes_21101992_world-day-of-the-sick-1993.html* (December 19th, 2017).