**"Death With Dignity" and Comfort Care**

The death of Karen Ann Quinlan of New Jersey in June of this year brought the attention of the entire country to her astounding record of having lived over nine years in "comfort care". Ever since she fell into a coma in April, 1975, at the age of 21, this young woman survived under comfort care. For less than one year of that period, she was kept breathing with the aid of a mechanical respirator. In a landmark decision, the Supreme Court of the State of Jersey decided, on March 31, 1976, that the respirator could be removed — a decision based on the premise that an individual's right to privacy "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances" even if that decision might lead to the death of the individual. Contrary to medical expectations, Karen Ann continued to breathe on her own for over nine years. Providing comfort is, of course, a basic requirement on all levels of medical care. The phrase "general nursing care" or "comfort care", however, generally is reserved for patients who are clearly in the terminal phase of an irreversible illness. Since often nothing can be done medically to prolong the lives of such patients, attention is focused on tender nursing care with a view to eliminating pain and to assuring comfort and dignity to the highest degree possible. Since many patients in hospitals and nursing homes share the experience which Karen Ann Quinlan endured (but for shorter periods), the situation presents a grand opportunity to every Catholic health facility to demonstrate that the final phase of the healing mission of the Church is above all spiritual — to prove in tender, caring ways that catering to the "higher spiritual welfare" of every terminal patient is the distinguishing feature of a Catholic health facility — a "specialty of the house."

The Spiritual Implications Of Comfort Care

For patients who are in a terminal phase of an irreversible illness, the "Martha" routines of on-the-dot pulse-taking, blood-pressure readings, lab analyses, etc., can be tempered or even omitted in favor of "Mary" manifestations of hushed anticipation of the moment of truth and the hour of liberation. Freedom from tubes, testing and monitoring might even advance to the stage where the patient could be taken home to die amid familiar things and among loved ones as the "hospice movement" might propose. Whether at home or in the hospital, however, the treasures of the Catholic faith (Mass, if possible, sacraments, crucifix, rosary, bible quotes, praying together, etc.) should be used, as appropriate, by the chaplain and pastoral-care team as well as all hospital workers and volunteers so as to promote an atmosphere of Faith, Hope and Love.

These last days are "Come, Lord Jesus" days (Revelation, 22:20) for God’s faithful people, and medical technology should not be allowed to obfuscate the dignity and sacred significance of the occasion. When Governor Richard Lamm of Colorado was quoted as having said that people who are terminally ill have a duty to die, he had a right to object that his words had been taken

(continued on page 2)

**IN THIS ISSUE**

"Death With Dignity" and Comfort Care"

Assisting The Infertile Couple

Part Two
out of context. What he wanted to stress is that “medical science is replacing God in deciding when we die.” He added: “I am merely saying people have a right to die without medical science intervening” (as quoted in Time, April 9, 1984, p. 68). The fact is that 80% of Americans die in hospitals or nursing homes, generally in the course of receiving some sort of medical treatment. The truth is that Catholic teaching does not favor the expensive but futile attempt to prolong life by the marvels of medical technology once the call to eternal rest is clear and final (i.e., in last phases of irreversible illness): “When death is imminent and cannot be prevented by the remedies used, it is licit in conscience to renounce treatments that can only yield a precarious and painful prolongation of life” (cf. Declaration on Euthanasia, May 5, 1980, in The Pope Speaks, 1980, p. 295).

When death is imminent, then, and there is no available treatment which might prevent death, there is no obligation for a competent patient to keep utilizing futile life-prolonging treatments. The patient may insist in good conscience, for example, that the renal dialysis treatments be discontinued, or that the mechanical respirator be disconnected, and/or that a “do-not-resuscitate” rule be strictly enforced. If the patient is incompetent, similar orders to discontinue life-prolonging treatments may be given by the patient’s proxy if the patient definitely had made known his or her will in the matter while still competent. The exercise of such prerogatives should present no difficulty with civil law.

Withdrawal of Comfort Care Measures

The phrase “comfort measures” refers to nursing care and other efforts designed to make the patient comfortable. It includes pain relief, hygiene, medication, as well as hydration and nutrition as dictated by the patient’s condition. Most writers agree that if the dying patient in a terminal, irreversible illness is competent, such needs can be regulated by patient-physician communication. In fact, if the patient can get along without the facilities provided by acute care, he or she could be transferred to a nursing facility or to the family home to live out the final days in a more comforting and caring setting.

The Quinlan Family’s Legacy to the Human Family

Throughout their ordeal of the past 10 years, the family of Karen Quinlan has lived out of 1900 years of Catholic wisdom in dealing with the gift of human life. In their legal battle to have respiratory devices withdrawn, they chose not to do everything technologically possible to prolong her life. Yet they have exercised as a moral option their right to reverence their daughter as a bodily person by maintaining artificial food and fluids. While many would argue forcefully that they had no moral obligation to do even that, their free choice to do it speaks volumes to a world where human life is increasingly a throwaway item.

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Assisting The Infertile Couple

Part Two: Common Causes of Infertility and Licit Therapy

This is the second of three articles dealing with problems of male infertility. Part I appeared in the August, 1985, issue of Ethics & Medics and dealt with medical-moral problems associated with various techniques developed to collect semen for male infertility testing.

Parts II and III of this series will deal not with testing, but with therapy for male infertility problems. While it is appropriate to follow the topic of diagnosing male infertility with a discussion of some of the morally licit treatment available, space does not allow a full treatment. For a more in-depth treatment of the