Position Paper of the Abrahamic Monotheistic Religions on Matters Concerning the End of Life

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About the Authorship

This declaration was produced by the Pontifical Academy for Life and was signed by Christian, Muslim, and Jewish scholars and leaders on 28 October 2019. It was commissioned by Pope Francis at the suggestion of Rabbi Avraham Steinberg, who is a paediatric neurologist and co-chair of the Israeli National Council on Bioethics and whom the Pope had appointed as a member of the Pontifical Academy for Life in 2017.

Summary

The medical treatment of dying patients presents particular challenges, which are made more problematic by contemporary cultural mores and moral assumptions informed by secular and humanistic values. Dilemmas that arise are not merely in the medical or scientific dimensions of human dying, but also the moral, religious, social, and legal.

Correspondingly, medical professionals not only make decisions purely on medico-scientific grounds but also informed by their personal values, which creates challenges to families and healthcare providers navigating social norms.

This Paper expresses the position of the three Abrahamic monotheistic religions regarding principles and practices relevant to end-of-life care, for the benefit of patients, families, health-care providers, and policy makers who are adherents of one of these religions, and to promote reciprocity of understanding between different traditions on issues relevant to end-of-life care.

Included are discussions suffering, the use of medical technology, the importance of community support and spiritual care, an affirmation of palliative care as a medical specialism and a consistent, unequivocal and common rejection of euthanasia and assisted suicide (EAS).

Position Paper of the Abrahamic Monotheistic Religions on Matters Concerning the End of Life

Preamble

The moral, religious, social and legal aspects of the treatment of the dying patient are among the most difficult and widely discussed topics in modern medicine. They have generated intense intellectual and emotional arguments and a very large body of various publications throughout all cultures and societies.

The issues concerning end-of-life decisions present difficult dilemmas, which are not new, but they have intensified greatly in recent years due to several factors and developments:

- The enormous scientific-technological advances enable significant prolongation of life in ways and situations never previously possible. However, often prolonged survival is accompanied by pain and suffering due to various organic, mental and emotional dysfunctions.
- The fundamental change in the patient-physician relationship from a paternalistic approach to an autonomous one.
- The fact that most people in developed countries nowadays die in hospitals or nursing homes, which are frequently strange and unfamiliar surroundings for them. Many patients are attached to machines, surrounded by busy people unknown to them. This situation contrasts with that in the past when people usually died at home, surrounded by their loved ones in their customary and recognised environment.
- The greater involvement of various professionals in the treatment of the dying patient, as well as the involvement of the media, the judicial system and the public at large. These often reflect different cultural backgrounds, outlooks, and varying and even conflicting opinions as to what should or should not be done for the dying patient.
- Cultural changes, particularly in Western societies.
- The growing scarcity of resources due to expensive diagnostic and therapeutic options.

The dilemmas concerning the care and treatment of the dying patient are not primarily medical or scientific ones, but rather social, ethical, religious, legal and cultural dilemmas. While physicians make decisions based on the facts, most of the decisions concerning the dying patient are not of a medical-scientific nature. Rather, they are based on personal values and ethics. Hence, caring for the dying patient by families and health-care providers within societal norms is a challenging task.

The principles and practices of the Abrahamic monotheistic religions, and particularly their understanding of the proper balance between conflicting values, are not always in accord with the current secular humanistic values and practices.

The aims of this position paper are:

- To present the position of the Abrahamic monotheistic religions regarding the values and the practices relevant to the dying patient, for the benefit of patients, families, health-care providers and policy makers who are adherents of one of these religions.
- To enhance the capacity of healthcare professionals to better understand, respect, guide, help, and comfort the religious patient and the family at life's end. Respecting the

religious or cultural values of the patient is not only a religious concern but is an ethical requirement for staff at hospitals and other facilities where there are patients of diverse faiths.

- To promote a reciprocal understanding and synergies of different approaches between the monotheistic religious traditions and secular ethics concerning beliefs, values, and practices relevant to the dying patient.

Definition

A dying patient is defined as a person suffering from a fatal, incurable and irreversible disease, at a stage when death will in all probability occur within the space of a few months as a result of the disease or its directly related complications, despite the best diagnostic and therapeutic efforts.

Suffering and Dying

While we applaud medical science for advances to prevent and cure disease, we recognise that every life will ultimately experience death.

Care for the dying is both part of our stewardship of the Divine gift of life when a cure is no longer possible, as well as our human and ethical responsibility toward the dying (and often) suffering patient. Holistic and respectful care of the person must recognise the uniquely human, spiritual and religious dimension of dying as a fundamental objective. This approach to death requires compassion, empathy and professionalism on the part of every person involved in the care of the dying patient, especially from care workers responsible for the psycho-sociological and emotional welfare of the patient.

The Use of Medical Technology at the End of Life

Human interventions by medical treatments and technologies are only justified in terms of the help that they can provide. Therefore, their use requires responsible judgment about when life-sustaining and life-prolonging treatments truly support the goals of human life, and when they have reached their limits. When death is imminent despite the means used, it is justified to make the decision to withhold certain forms of medical treatments that would only prolong a precarious life of suffering. Nonetheless, even when persistence in seeking to stave off death seems unreasonably burdensome, we must do whatever is possible to offer comfort, effective pain and symptoms relief, companionship, emotional and spiritual care and support to the patient and his/her family in preparation for death.

The medical team and society at large should respect an authentically independent wish of a dying patient to prolong or preserve his/her life even for an additional short period of time by clinically appropriated medical measures. This includes the continuation of respiratory support, artificial nutrition and hydration, chemotherapy or radiotherapy, antibiotics, pressors and the like. This wish can be expressed either by the patient him/herself, in "real time"; or, if not competent at the time, by advance medical directive, by a surrogate, or by testimony of close family members. This approach represents both the respect for life as well as the respect for independence, which should not only be respected when it is in agreement with the healthcare provider. Clergy are often consulted by the family to aid in this decision. In cases of religiously practicing/devout patients or where the immediate next-of-kin are religiously observant/devout, a

relevant member of the clergy should be consulted.

The Rejection of Euthanasia and Physician-Assisted Suicide

Matters pertaining to the duration and meaning of human life should not be in the domain of health care providers whose responsibility is to provide the best possible cure for disease and maximal care of the sick.

We oppose any form of euthanasia – that is the direct, deliberate and intentional act of taking life – as well as physician assisted suicide – that is the direct, deliberate and intentional support of committing suicide – because they fundamentally contradict the inalienable value of human life, and therefore are inherently and consequentially morally and religiously wrong, and should be forbidden without exceptions.

The Nurturing Community

We emphasise the importance of community support in the decision-making process faced by the dying patient and his/her family. The duty to care for the sick, demands of us also to reform the structures and institutions by which health and religious care are delivered. We, as a society, must assure that patients' desire not to be a financial burden does not tempt them to choose death rather than receiving the care and support that could enable them to live their remaining lifetime in comfort and tranquility. For religiously observant/devout patients and families there are several possible forms of communal support facilitating thoughtful and prayerful consideration by the parties involved, with medical, religious, and other appropriate counsel. This is a religious duty of the faith community to all its members, according to each one's responsibilities.

Spiritual Care

The greatest contribution to humanising the dying process that health care workers and religious persons can offer is the provision of a faith-and-hope-filled presence. Spiritual and religious assistance is a fundamental right of the patient and a duty of the faith community. It is also acknowledged as an important contribution by palliative care experts. Because of the necessary interaction between the physical, psychological and spiritual dimensions of the person, together with the duty of honouring personal beliefs and faith, all health care providers are duty-bound to create the conditions by which religious assistance is assured to anyone who asks for it, either explicitly or implicitly.

The Promotion of Palliative Care

Any dying patient should receive the best possible comprehensive palliative care – physical, emotional, social, religious and spiritual. The relatively new field in medicine of palliative care has made great advances and is capable of providing comprehensive and efficient support to dying patients and their families. Hence, we encourage palliative care for the patient and for her/his family at the end of life. Palliative care aims at achieving the best quality of life for patients suffering from an incurable and progressive illness, even when their illness cannot be cured, thus expressing the noble human devotion of taking care of one another, especially of those who suffer. Palliative care services, provided by an organised and highly structured system for

delivering care, are critical for realising the most ancient mission of medicine: "to care even when there is no cure". We encourage professionals and students to specialise in this field of medicine.

Conclusion

Based on the arguments and justifications articulated in this position paper, the three Abrahamic monotheistic religions share common goals and are in complete agreement in their approach to end-of-life situations. Accordingly, we affirm that:

➢ Euthanasia and physician-assisted suicide are inherently and consequentially morally and religiously wrong and should be forbidden with no exceptions. Any pressure upon dying patients to end their lives by active and deliberate actions is categorically rejected.

➢ No health care provider should be coerced or pressured to either directly or indirectly assist in the deliberate and intentional death of a patient through assisted suicide or any form of euthanasia, especially when it is against the religious beliefs of the provider. It has been well accepted throughout the generations that conscientious objection to acts that conflict with a person's ethical values should be respected. This also remains valid even if such acts have been accepted by the local legal system, or by certain groups of citizens. Moral objections regarding issues of life and death certainly fall into the category of conscientious objection that should be universally respected.

➢ We encourage and support validated and professional palliative care everywhere and for everyone. Even when efforts to continue staving off death seems unreasonably burdensome, we are morally and religiously duty-bound to provide comfort, effective pain and symptoms relief, companionship, care and spiritual assistance to the dying patient and to her/his family.

➢ We commend laws and policies that protect the rights and the dignity of the dying patient, in order to avoid euthanasia and promote palliative care.

➢ We, as a society, must assure that patients' desire not to be a burden does not inspire them the feeling of being useless and the subsequent unawareness of the value and dignity of their life, which deserves care and support until its natural end.

➢ All health care providers should be duty-bound to create the conditions by which religious assistance is assured to anyone who asks for it, either explicitly or implicitly.

➢ We are committed to use our knowledge and research to shape policies that promote socio-emotional, physical and spiritual care and wellbeing, by providing the utmost information and care to those facing grave illness and death.

➢ We are committed to engage our communities on the issues of bioethics related to the dying patient, as well as to acquaint them with techniques of compassionate companionship for those who are suffering and dying.

➢ We are committed to raising public awareness about palliative care through education and providing resources concerning treatments for the suffering and the dying.

➢ We are committed to providing succour to the family and to the loved ones of dying patients.

➢ We call upon all policy-makers and health-care providers to familiarise themselves with this wide-ranging Abrahamic monotheistic perspective and teaching in order to provide the best care to dying patients and to their families who adhere to the religious norms and guidance of their respective religious traditions.

➢ We are committed to involving the other religions and all people of goodwill.

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