Review paper

Marian Machinek
Teology Department, University of Warmia and Mazury in Olsztyn

The issue of overzealous treatment in view of Church's Magisterium

Abstract

The essential feature of the statements made by the Magisterium of the Catholic Church, concerning ethical issues of futile therapy is the constant reference to the value of life, interpreted as a gift and mission. Recognising the autonomy of the patient to decide on the scope of therapeutic actions in view of approaching death, is limited in the situation where medical personnel are required to perform or abandon actions of a strictly suicidal character. Alleviating symptoms and the conscious shaping of the last moments of life in a manner, which satisfies human dignity, remains an essential mission for every believer, but also a challenge to health care workers.

Key words: magisterium, medical futility, the value of life, basic care, accompanying the dying, dignity, euthanasia

Adv. Pall. Med. 2008; 7: 107–114

Introduction

Referring to patients at the end of their life is an issue that has been present in the statements of the Church long before the controversy concerning euthanasia was exacerbated. Pius XII (his pontificate fell in the years 1939–1958), who left many statements and decisions concerning medical and ethical problems, had also taken a stance on some of the issues relating to spiritually accompanying the dying[1]. The initiative of John Paul II on the issue of protecting and promoting human life throughout his entire pontificate (1978–2005) is, on one hand, the result of the Pope's personal involvement in this matter; while on the other hand, it also demonstrates the growing controversies surrounding the significance, protection and promotion of human life. The establishment of the Pontifical Council for Pastoral Health Care in 1985 and the foundation of the Pontifical Academy of

[1]It is worth paying particular attention to two of Pius XII's speeches made in the 1950s and addressing doctors. The first one, concerning ethical problems of resuscitation, the Pope reflects on the boundaries of moral duty to take medical actions to sustain life. Human life, as the Pope puts it, lasts as long as the vital functions of the body, as opposed to the functioning of separate organs [Pius XII. Über moralische Probleme der Wiederbelebung. In: Herder Korrespondenz 1957;12: 228–230]. The other speech dealt with the issue of ethical boundaries for research and therapeutic methods, also in the context of terminal situations [Pius XII. Die sittlichen Grenzen der ärztlichen Forschungs- und Behandlungsmethoden. In: Herder Korrespondenz 1952–1953, 7: 71–76]. See also a short review of Pius XII statements concerning the issue: S. Kornas. Prawo do naturalnej śmierci w dokumentach Kościoła Katolickiego. Available on: http://kosciol.wiara.pl/index.php?grupa=6&cr=0&kolej=0&art=1195829041&dzi=1157649853&katg (23rd February 2008).

Address for correspondence: ks. prof. dr hab. Marian Machinek
Teology Department
Warmińsko-Mazurski University in Olsztyn
e-mail: mmachinek@msf.opoka.org.pl

Advances in Palliative Medicine 2008, 7, 107–114

Life (*Pro Vita*) in 1994, made the Church's activity on the scientific research plane concerning the issue of human life much more intense. The reflection over the statements made by the Magisterium, concerning the issue of medical futility, must start from the analysis of the question of the value of human life, which is the key to understanding the Catholic stance on the issue.

The value of human life

A common motive for all statements of the Magisterium is the confidence that human life has a unique value, from the moment of conception until natural death[2]. The fundamental statement on the value of human life is found in the *Evangelium Vitae* encyclical by John Paul II. The Pope's words that "Man is called to a fullness of life which far exceeds the dimensions of his earthly existence, because it consists in sharing the very life of God" stress "the greatness and immensity of the value of human life in its earthly dimension"[3]. Life in time is the fundament of human existence and, consequently, of the unique abilities resulting from human freedom. It is not an addition, but an integral part of human existence. However, pointing to the supernatural call of man highlights the relativity of the earthly existence[4].

The "penultimate" value of life means that it is not an absolute value. Considering life as an absolute value would inevitably lead to the obligation of prolonging life at all costs and by all means, regardless of the condition of the dying person. Furthermore, each sacrifice of life, understood as an act of moral obligation to love one's neighbour, would have to be considered as an immoral and unacceptable act. Nonetheless, life — even understood as a "penultimate" — remains a fundamental and sacred value, which must be protected and cannot be sacrificed in the name of inferior values. The Pope, in an effort to prevent ambiguous interpretations of the intention to publish the encyclical, declares in further chapters that: "The present Encyclical, the fruit of the cooperation of the Episcopate of every country of the world, is therefore meant to be a precise and vigorous reaffirmation of the value of human life and its inviolability, and at the same time a pressing appeal addressed to each and every person, in the name of God: respect, protect, love and serve life, every human life!"[5]. This unambiguous emphasis of the value of human life will have its undoubted effect on the definition of patients' autonomy in relation to making their own decision concerning their life, as well as the doctors' competence in reference to the life of the dying.

Patient's autonomy in the context of the dignity of human life

In the view of the Church, each human life is both a gift and a mission. Those two categories make it impossible to treat life solely in the context of property and the right of self-determination. The Magisterium has also simultaneously underlined the conviction of the Church that God is the ultimate Lord of Life, and only He can decide about its end: "Man's life comes from God; it is His gift, His image and imprint, a sharing in His breath of life. God therefore is the sole Lord of this life: man cannot do with it as he wills"[6]. It does not imply that the patient is deprived of the competence to decide about the scope and quality of the medical treatment undertaken. It is rather a voice of objection toward the claim of absolute autonomy[7], which would be translated into a moral right to decide about (medically assisted) suicide and euthanasia. The documents of the Magisterium have, on many occasions, stressed that patients have the competence to make the decisions about the scope of the medical treatment applied to them. The declaration *Iura et Bona*, published in 1980 by the Congregation for the Doctrine of the Faith underlines, in the context of the end of life, the competence of the patient in the scope of submitting to a medical experiment: "If there are no other

[2]John Paul II frequently used this phrase as a characteristic "formula" that defined the attitude of the Catholic Church towards the issues of human life protection.
[3]John Paul II. *Evangelium Vitae* Encyclical; no. 2 (later referred to as: EV).
[4]*Ibidem.*
[5]EV, no. 5.
[6]EV, no. 39.
[7]The term "autonomy", due to its terminological ambiguity, is not used in this text in the meaning of the fundamental ability of a person to act morally, which ability is the condition for qualifying actions as morally right or morally wrong. It should rather be understood in the context of self-determination, i.e. the scope of freedom to make choices that concern fundamental values as life and health.

sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity"[8].

The instruction uses the same context to refer to the issue of the possibility to abandon this kind of experimental treatment: "It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. However, for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, and also of the advice of the doctors who are especially competent in the matter. The latter may, in particular, judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques"[9]. The presented fragment is particularly interesting for its account of the costs of applied therapy and expected results, but also for its peculiar "account of goods" in the scope of the relationship between applied measures and their inconvenience and the pain inflicted, and the simultaneous lack of hope for any recovery.

In the light of those statements, one can attempt to comment briefly on the issue, for it is worthwhile to emphasise that the problem of the scope of applying or refraining from medical actions at the end of a human life pertains not only to the conscience, rights and competences of the patients, but also to the doctors' conscience, rights and competences. It is beyond any doubt that both sides of this relation are often in conflict, but such disputes are not to be settled unilaterally, which results in empowering the patient and only the patient with the moral competence to make such decision. This would relegate the doctor to the role of a service institution, which succumbs to the will of the client. The truth is that one has to take at least two factors into consideration, both of which lead to the conclusion that it is not only the doctor who has to take into consideration the will of the patient, but the same pertains to the patient (even more to the legislator, who provides the legal framework for the doctor-patient relationship!), who is supposed to appreciate the doctor's opinions. The first factor is the **conscience** of the doctors and their moral integrity. A doctor is not a machine to administer drugs but also a person, who took an oath to save life and act in the favour of the well-being of the patient. The other factor is the **professional competence** of the doctors, which enables them to be much more than adequate about the evaluation of the situation and prognosis. By no means should it mean the reinstatement of the paternalistic approach. Documents of the Church respect both the competence and autonomy of the doctor and the patient, and point to the moral limit of each human autonomy, which is crossed whenever the decisions become lethal, be it the intention of the initiators or the direct results of actions or nonfeasance.

The right to die with dignity

The principled attitude to death plays an important role in solving ethical issues. The key element in the statements of the Magisterium, referring to the end of life, is acknowledging that man is a mortal being. Death is indeed a dramatic experience, which reveals the frailty of the human condition, but it is at the same time an inherent part of life, its last act. Therefore, one should go through it with dignity. Just as man needs assistance and care at the beginning of his life, so his departure from this life requires care and concern. Although dying is a personal act, it is not a strictly private matter but a situation in which the dying person has the right to expect kindliness and professional medical assistance; in the broader context — legal regulations which favour dying with dignity. One can, without any hesitation, formulate a moral "the right to die peacefully with human and Christian dignity"[10].

Pointing to dignity serves as a rectification. Such a point of view means that, on the one hand, the right to a conscious procurement of one's own death is dismissed and, on the other hand, it points that it is inappropriate to avoid it, for the price of overzealous treatment.

It is also important, in view of the definition of overzealous treatment presented in this publication,

[8]The Congregation for the Doctrine of the Faith. Declaration on euthanasia *Iura et Bona*; no. 4 (later referred to as: *IeB*).
[9]Ibidem.
[10]*IeB* no. 4.

being the result of a consensus of the working group. This definition makes use of the idea of dignity, referring to those medical actions that violate it as futile. It is particularly appropriate, when taking into consideration the fact of how far the use of invasive therapeutic methods can prolong the agony of the dying and intensify the accompanying symptoms. It may, however, become theologically problematic when the dignity of the patient is confined to their free decision, without any reference to fundamental ethical principles. One of such fundamental principles is undoubtedly the obligation to respect the non-reducible value of human life.

As highlighted in the Charter for Health Care Workers published in 1995, by the Pontifical Council for Health Pastoral Care: "*the terminally ill patient* is one who needs human and Christian accompaniment, and it is here that doctors and nurses are called on to make their expert and unrenounceable contribution"[11]. This document specifies that it is about assistance which will allow the dying to perceive and accept themselves as living persons. The document quotes the statement of John Paul II, made in 1990: "Referring to the terminally-ill patients is very often a test of righteousness and love, nobility of the spirit, responsibility and skills of health care workers, starting from the doctors"[12]. The purpose of medicine is not only to restore health and treat the disease, but also to accompany the patients in the last stage of their lives, when there is no longer hope for any recovery.

Morally permisibility of refusing overzealous treatment

The moral right to refuse overzealous treatment is rooted in the acknowledgement of the human condition, which is inherently connected with mortality. "Death is an inevitable fact of human life: it cannot be uselessly delayed, fleeing from it by every means"[13]. The death of a man cannot be treated as a failure in the effort of healing, particularly in the medical context, but as a way to express the limits of the human condition: man is and shall remain a mortal being. According to the statements of the Magisterium, therapeutic futility is defined as "the use of methods which are particularly exhausting and painful for the patient, condemning them, in fact, to an artificially prolonged agony"[14]. It's worth paying attention to the fact that the above statement suggests confining the definition of therapeutic futility to the stage of death throes, and that the main criteria is the level of inconvenience the patient suffers from, because of the applied measures.

As it has already been quoted from, after the declaration *Iura et Bona*, published by the Congregation for the Doctrine of the Faith, commonly used measures are to be considered sufficient. The danger of there being additional negative results or too great an inconvenience related to a specific, or even already applied method of treatment, may legitimate its rejection. The declaration clearly states that rejecting such means is not equal to a suicidal act: "it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community. When inevitable death is imminent, in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. 'In such circumstances, the doctor has no reason to reproach himself with failing to help the person in danger'"[15].

It is also worthwhile to refer to the statement included in the Catechism of the Catholic Church, where important aspects of "over-zealous" therapeutic treatment are referred[16]. Such aspects include not only high costs, but also high level of risk, the extraordinary character of measures and the disproportion (lack of proportion), in terms of expected therapeutic results. All those factors are to be taken into account in total, *i.e.* none of them can be

[11]Pontifical Council for Health Pastoral Care. Charter for Health Care Workers; No. 115 (later referred to as: CfHCW).
[12]CfHCW; no. 116–118.
[13]CfHCW; no. 119.
[14]CfHCW; no. 119.
[15]*IeB*; no. 4.
[16]See the Catechism of the Catholic Church (later referred to as: CCC) no. 2278: "Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate. It is the refusal of *over-zealous* treatment. Here one does not will oneself to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected".

used as a superior interpretation principle for other factors. The intention of the person who decides to abandon overzealous treatment is also important: this intention is not to end life, but refraining from preventing impending death. It should also be the motivation of the doctor's actions: not to neither prolong nor shorten the patient's life. It is the broadly understood well-being of the patient, not the lifespan, which dictates the actions to be taken and those that are to be abandoned. The guideline on the competence to make the decision to abandon overzealous treatment included in the text of the Catechism "reasonable will and legitimate interests (of the patient) must always be respected" means, that the patient's right to make decisions concerning their life is respected, but such decisions are linked with objective ethical criteria. It is, therefore, not about respecting the will of the patient, whatever it may be.

Regardless of the precision of those statements, they are not complete as to what "extraordinary" really means. In more recent statements of the Magisterium, the differentiation between ordinary and extraordinary means is substituted with the difference proportional and disproportional measures, as we can find in the statement of the Pontifical Council "Cor Unum" from 1981: "Earthly life is a fundamental but not absolute value. Hence, the limits of the obligation to keep a person alive must be specified. The distinction between 'proportionate' means and "disproportionate" means reflects the above truth and lights its use in specific cases. The use of synonymous expressions, particularly the term "proportionate care" expresses this problem in a manner which seems most satisfying"[17].

Abandoning overzealous treatment and euthanasia

Many statements of the Magisterium underline that the consent to abandon overzealous treatment is not synonymous to accepting any euthanasia actions. It refers to direct euthanasia, which, as defined in the Catechism of the Catholic Church: "Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable. Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator"[18].

The difference between the actions aimed at abandoning overzealous treatment and actions connected with euthanasia is, on one hand, the intention of the doer (the intention to shorten life) and, on the other, the selection of measures, intensity or time and scope of intervention, so their result is the death of patient. It is also of merit to stress that according to the definition above, not only action, but also conscious refraining from intervention may become an act of euthanasia.

The issue of "patient's disposition"

There is a fundamental reservation towards the term "Patient's testament" (*Patiententestament*), pointing to the fact that a testament, according to common belief, comes into force after the person that made it has died, while in the context of abandoning overzealous treatment, it is the decision concerning the last stage of the patient's life. However, the term "living will" seems to be even more inadequate. The concept of "Patient's disposition" (*Patientenverfügung*) seems to be much more appropriate that other expressions. The Magisterium does not specify the question of the decency of such a disposition, although, as it has already been mentioned, it does recognise that, on many occasions, the right of the patient to express their will concerning the continuation or abandonment of medical activities (as already presented).

Episcopacies and Christian medical circles in some countries, have proposed their own versions of such dispositions, based on the fundamental principles of Christian morality. It particularly concerns those countries that have empowered such dispositions within a proper legal framework. It is worth taking a brief look at the solution adopted in Germany[19] and the United States[20]. In both cases, the test of the patient's testament has been supported with explanations and clarifications.

[17]Quote (partially) after: CfHCW; no. 121, endnote 240.
[18]CCC; no. 2277.
[19]Christliche Patientenverfügung mit Vorsorgevollmacht und Betreuungsverfügung, Handreichung und Formular der Deutschen Bischofskonferenz und des Rates der Evangelischen Kirche in Deutschland in Verbindung mit den weiteren Mitglieds- und Gastkirchen der Arbeitsgemeinschaft Christlichen Kirche in Deutschland, Bonn 2003.
[20]See http://www.ncbcenter.org/ (10th September 2008).

The German version, published in 2003, as a joint effort of the German Episcopal Conference, Council of the Evangelical Church in Germany and the Working Council of Churches in Germany, underlines the differentiation between "assisted dying" (*Sterbehilfe*), which means alleviating symptoms, and the "presence and accompanying the dying" (*Sterbebegleitung*). At the same time, the document disassociates from such understanding of the term *Sterbehilfe*, which would point to causing the patient's death. If the demand of "death with dignity" is made, together with the demand to decide about one's lifespan and moment of death, then this term is not interpreted as "assisting in dying" (*Hilfe beim Sterben*), but as "assistance towards dying" (*Hilfe zum Sterben*), which is equal to active euthanasia. The German proposition includes a declaration of rejecting the actions aimed at life prolongation (*lebensverlängerte Maßnahmen*), provided that such actions, according to knowledge and conscience, bear no chance of success and only prolong the agony. The document highlights the necessity to continue basic medical care and formulates a request to enable the relative to accompany the signatory.

As for the American version, from 1997, prepared by the National Catholic Bioethics Center in cooperation with the Unites States Conference of Catholic Bishops, it strongly underlines the spiritual aspect of dying, emphasising the will of the patient, so as to avoid any actions towards them, which are in conflict with the moral teaching of the Church, and to enable them to contact a priest. The document that expresses the will of the patients has been herewith referred to as Advance Medical Directive, which is a conscious disassociation from the term "living will", used in pro-euthanasia circles. The document not only highlights the patient's right to self-determination, but also, what's more important, the care for those who will be made to take the decisions concerning the patients. Therapy may only be abandoned when there is no substantiated hope for any therapeutic advantages, when therapy causes unnecessary inconveniences, or imposes excessive expenses on the family and community. The document underlines the necessity to assume the will of the signatory to provide them with food and drinks. It does not specify detailed procedures, but rather defines the goals that should motivate those who decide about the scope of any measures applied. According to the document, specific decisions are to be made by doctors and relatives, as the signatory is unable to predict all aspects of their future situation. Both versions are supplemented with a plenipotentiary power which specifies the person authorised to decide in the name of the signatory, should they be unable to do so themselves. Legal systems in both countries anticipate such substitute decision to be taken.

On the basis of the analysis of both proposals, it is possible to formulate the conditions such a document should satisfy, in order to be in conformity with the principles of Christian morality. The advanced disposition of the patient, expressed in such a manner, cannot question the value of life itself and contain judgments referring to the purpose of prolonging one's existence in a hypothetical situation of loss of consciousness. It is therefore not about defining the moment in which life in not worthwhile to be continued (according to the present ideas of the signatory), but a declaration of reconciliation with inevitable death and the will of not prolonging agony. The Christian disposition of the patient is based on the **right to die with dignity**, when death is impending, and not on the **right to an autonomous decision on the moment of death**. This difference should be already visible in the verbal plane. In the view of Christian morality, the most important principle of medical action is not the rigorous respecting of the patient's decision, but the obligation to care for his health and life. The Christian disposition will therefore not go beyond the fundamental ethical principle of medical actions: *Salus aegroti suprema lex*.

Basic medical care

The statements of the Magisterium highlight that basic medical care cannot ever be abandoned, even in the event of abandoning overzealous treatment. Basic medical care includes not only increased human support (accompanying, psychological and spiritual care), but also nursing the body, satisfying physiological needs — food and drinks — and also alleviating pain and other symptoms, such as fear, dyspnoea or nausea.

The question of alleviating pain

Documents of the Church dedicate a lot of attention to the issue of pain alleviation and the use of painkillers. According to the already mentioned declaration *Iura et Bona*, alleviation of pain by pharmacological means may be a requirement of "human and Christian prudence", even when their side effects cause the disturbance of consciousness. As for those who are not in a state to express them-

selves, one can reasonably presume that they wish to take these painkillers[21]. However, the document says that the dying cannot be deprived of consciousness without a just cause. Unjustified administering of medicines, which suppress consciousness, may be caused not by the wish to alleviate the suffering, but by a desire (unrealised) of the environment (medical personnel) to break the relationship with the dying and sparing themselves from the distress connected with nursing such patients[22]. The Charter of Health Care Workers adds another crucial aspect. Patients must be provided with "the possibility that the dying person has fulfilled or could still fulfil his moral, family and religious obligations"[23].

As for the possibility of hastening death caused by the use of painkillers, such actions may be considered acceptable, provided that death "is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine"[24].

The question of artificial nutrition and hydration

One of the issues, which leads to a lively debate, is the question about the decency to abandon artificial nutrition and hydration. This problem was addressed by the Congregation for the Doctrine of the Faith in 2007. The Chairman of the United States Conference of Catholic Bishops issued a special note, which answered the questions submitted to the Congregation. The answers were probably established as a result of a discussion that originated after Theresa Marie Schiavo was disconnected from artificial nutrition and died in 2005.

The 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?", received an affirmative response from the Congregation, which stressed that feeding and providing liquids (artificially too) is to be generally considered ordinary and proportionate, thus a binding method of sustaining life. At the same time, the official answer emphasises that such actions "are 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"[25].

It must be noticed that even in the wording of the question, the range of obligation for the use of artificial nutrition and hydration was limited and excluded the situations when food cannot be assimilated, and administered food/liquids cause severe physical discomfort (psychical discomfort or the patient's aversion is not mentioned here). Therefore, the fundamental context of the question is not, as it may seem, the situation of direct closeness of death, because patients in a permanently vegetative state are not dying, but they only not in a prognosticate state for recovery. This issue seems to be addressed by the second question submitted to the Congregation and concerning the issue of whether nutrition and hydration supplied by artificial means may be discontinued when competent physicians judge with moral certainty that the patient will never recover consciousness. The Congregation gave a strong negative answer.

The afore-mentioned settlements were supported by a commentary of the Congregation, which summarised all statements on the issue made by the Holy See to date. One of the references was made to the speech of John Paul II given in 2004, in which the Pope addressed the condition of patients in a vegetative state. According to John Paul II, they are not a "vegetable" or an "animal", but a form of human life, although not individual. Such patients are still human beings, persons with all the rights they are entitled to: "The sick person, in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.), and to the prevention of complications related to their confinement to bed. They also have the right to the appropriate rehabilitative care and to be monitored for clinical signs of eventual recovery. 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 pre-

[21] *IeB*; No. 3.
[22] CfHCW; No. 124.
[23] *Ibidem*.
[24] *IeB*; No. 3.
[25] Congregation for the Doctrine of the Faith. Responses to certain questions concerning artificial nutrition and hydration. Available on: http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html (23rd February 2008).

serving 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 their suffering"[26].

The end of the commentary has been supplemented with yet another crucial passage, concerning the situation of health care in poor countries: "By saying that delivering food and water is generally a moral obligation, the Congregation for the Doctrine of the Faith does not dismiss the possibility that in some isolated or very poor regions, nutrition and hydration by artificial means may be physically impossible, thus *ad impossibilia nemo tenetur* [no-one can be obliged to impossible things — note by Ma]; there is still the obligation to provide the minimum possible care and provide, as much as possible, for the necessary means to sustain life properly. One cannot exclude the possibility, that the patient, due to existing complications may be unable to assimilate food and liquids, which would make their administering utterly useless. Furthermore, one cannot dismiss the possibility that in some rare cases, artificial feeding and hydrating may cause too much distress to the patient, or result in extremely severe physical suffering relating to, for instance, the complications resulting from the use of medical equipment. Such extraordinary cases do not, however, contravene the general ethical principle, according to which administering water and food, even by artificial means, is always an ordinary means to sustain life, not a therapeutic measure. They are therefore to be treated as ordinary and proportionate, even when the *vegetative state* is prolonged"[27].

The afore-mentioned statement by the Magisterium may, as it seems, be applied analogically to other supporting actions, *e.g.* facilitating and supporting breathing. Prevention of dyspnoea and restoring patency of the respiratory tract belong to the range of basic medical care. Unless the supporting of breathing (also with a respirator) functions are according to its expectations and does not induce excessive discomfort, it must be considered as morally binding. Here, we must again turn our attention to the definition of overzealous treatment proposed herewith, which emphasises the obligation to provide nutrition and hydration as long as it is for the well-being of the patient. Similarly, as in the reference to the patient's dignity, a more specific definition of the well-being of the patient will require taking into account not only their own decision, but also the essential ethical value, binding both to the doctor and the patient, being the value of life.

In conclusion, we may say that the essential feature of the statements made by the Magisterium of the Catholic Church, concerning ethical issues of overzealous treatment is the constant reference to the value of life, interpreted as a gift and mission. Recognising the autonomy of the patient to decide on the scope of therapeutic actions in view of approaching death, is limited in the situation where medical personnel are required to perform or abandon actions of a strictly suicidal character. Alleviating symptoms and the conscious shaping of the last moments of life in a manner, which satisfies human dignity, remains an essential mission for every believer, but also a challenge to health care workers.

[26]John Paul II. "A sick person is not deprived of their dignity". Address of John Paul II to the participants in the International Congress of Catholic Doctors (20th March 2004). Available on: http://www.opoka.org.pl/biblioteka/W/WP/jan_pawel_ii/przemowienia/chory_godnosc_20032004.html (23rd February 2008).
[27]Congregation for the Doctrine of the Faith. Responses to certain questions concerning artificial nutrition and hydration in: Commentary. Available on: http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070629_commento-responsa_en.html (23rd February 2008).