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### **Maggie, Terri, and the Problem of Life-Support**

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The film “Million Dollar Baby” caused quite a stir in certain pro-life circles. Although director and actor Clint Eastwood dealt with the tragic end of his heroine’s life with sensitivity and compassion, many people were shocked at his apparent endorsement of euthanasia. The controversy was unnecessary because the entire problematic surrounding Maggie’s death was based on a grave if common misunderstanding.

For those of you who haven’t seen the film but might like to, it would be best to stop here until you do.

Eastwood’s character, Frankie Dunn, has attended mass nearly every day for some twenty-three years. Estranged from his own daughter, he befriends then virtually “befathers” Maggie Fitzgerald (Hilary Swank), who plays the Oscar-winning role of a young woman determined to make her way in the brutal world of professional boxing. Following a gratuitous punch she receives after the bell, Maggie is paralyzed, condemned to spend the rest of her days in a bed, and slowly wasting away. For both her and Frankie, this is an unbearable situation that throws into question her very reason for being. Finally, in a gesture of heart-rending compassion, Frankie reluctantly gives in to Maggie’s repeated appeals and pulls the plug (in fact, he injects a substance—epinephrine?—into her IV line and thereby crosses the crucial line between allowing to die and actively killing). As the film ends, Frankie seems to be spending his remaining days in relative solitude and anguished soul-searching.

The very premise of the film is seriously flawed for the simple reason that throughout the last days of her life, Maggie was conscious and, theoretically, competent to make her own decisions regarding life-support. The film rehearsed the familiar scenario of a person in perpetual agony, desperately longing to die yet prevented from doing so by a medical team that insists on keeping them alive by artificial means (respirator, intubation, antibiotics). A consensus has emerged among most Christian confessions, including Roman Catholic and Orthodox, that “extraordinary means” may be foregone in cases such as Maggie’s, if the decision to refuse such measures is made by a competent, well-informed and non-depressed patient. Refusal to resort to life-support, when the burdens of those means clearly outweigh the benefits, can also be expressed in a living will and/or by granting some trusted person durable power of attorney for health-care decisions. In Maggie’s case, the burdens of her care, her level of physical and mental suffering, the material costs involved, and the “futility” of prolonging life-support could justify, to most minds, cessation of that support, in order to allow her to die. This would not qualify as “euthanasia,” since the patient would succumb to the underlying pathology. Maintaining life-support, on the other hand, would amount to “medical heroics” that place sustaining biological existence above the desires and interests of the patient.

There are those, of course, who argue that biological life has such inherent value that to remove life-support—even in a case such as Maggie’s—is immoral, since it bases the decision on “quality of life” rather than “sanctity of life” criteria. This, however, represents a very un-Christian form of “vitalism” and is not an acceptable argument. The entire Gospel message teaches us that the true end of our biological existence is precisely to pass through the crisis of death, in order to attain eternal life in the Kingdom of God. The longing for such total communion with God does not allow us to hasten our death through some form of suicide or euthanasia. But when we become the victim of an accident or illness to the extent that life is permanently and irreversibly characterized by unbearable suffering, then artificial measures to sustain that life represent a violation of life’s *sanctity*, a violation of the person, and may morally be withheld or withdrawn. In those cases where the patient has entered the terminal phase of life (engaged irreversibly in the actual process of dying), then removal of life-support may include not only a ventilator or dialysis machine, but also food and hydration.

This last measure, however—withdrawing food and liquid—can only be morally accepted in cases that are truly “terminal,” that is, where the patient has entered

the final phase of life and “the soul is struggling to leave the body.” This implies that death is imminent and that the dying process is in fact irreversible.

Such was clearly not the case with Terri Schiavo. Films taken of her during her final months of life, the recognition she showed of her family members, and the awareness she demonstrated in response to various external stimuli, made it clear that she was not, as it was held, in a “persistent vegetative state.” That expression properly describes persons whose upper hemispheres are irreversibly non-functioning and whose brain is effectively “dead” except for the brain stem (which controls breathing and heart rate) and perhaps portions of the limbic system (body temperature, blood pressure, blood levels of sugar). It seems that in her case, as in many others, the term “PVS” was redefined for political rather than medical reasons. Under these circumstances, for the courts and Terri’s guardian (her estranged husband Michael) to force removal of her feeding tube was tantamount to murder: the willful taking of a life against the best interests of the victim.

This conclusion holds, even in light of the autopsy report, whose author declared that Terri was in a PVS because her brain “was profoundly atrophied.” Medical specialists from Harvard, Johns Hopkins and the Cleveland Clinic were quoted as stating that PVS is a clinical diagnosis that cannot be confirmed by autopsy. The autopsy could indeed show that she had suffered from a severe and irreversible brain injury. It could not, however, demonstrate that she died (from dehydration) without acute suffering, or that she had no awareness of the presence and affection of her family members and priest. That priest, Fr Frank Pavone, declared shortly after Terri’s death: “No details of this autopsy change the moral evaluation of what happened to Terri. Her physical injuries and disabilities never made her less of a person... Terri did not die from an atrophied brain. She died from an atrophy of compassion....” [\[1\]](#)

If Terri had left a living will or given her parents durable power of attorney, the situation would never have arisen. Living wills are often ignored; but health-care decisions can be delegated to competent proxies who can confirm that they know the patient’s desires regarding end-of-life care.

These two cases, represented by the fictional Maggie and the all-too-real figure of Terri Schiavo, should give us all pause. Pause to recognize how steep the slippery slope has become that is hurtling us toward legalized euthanasia and physician-assisted-suicide, but pause, too, regarding the importance of making

known to other people—family and friends, our doctor, the clergy, and among them, potential proxies—just what we want for ourselves in the way of life-support measures, should the situation arise.

In a case such as Maggie's, the burden-benefit calculus is morally legitimate, even necessary—so long as any decision to end life-support is made by the person involved or by others designated by the person to act in their stead. There where life can be preserved without rapid and painful deterioration, then life-support may be considered mandatory, at least from a Christian point of view (the State has no inherent right to force a person to remain on life-support when such support violates the person's autonomy and imposes unbearable suffering). As bearers of God's image, we are called to cherish and preserve our entire life, including our physical existence, as fully and faithfully as we can.

This means that we, as Christian people, may at certain times and in certain circumstances accept levels of ongoing suffering that many in our society would reject on principle. We may do so, however, as long as that suffering is not accepted or sought out for its own sake, as a kind of prideful, self-serving "martyrdom." Suffering, especially in terminal cases, can indeed be "redemptive." But suffering can also become so burdensome that the person can concentrate on nothing else. In extreme cases it can become impossible to pray or even to relate in any meaningful way to those around us. Pain and anguish can become so all-consuming that physical life itself becomes an intolerable burden. When such levels of suffering occur in clearly terminal cases, then it is not only futile but cruel and unreasonable to maintain the dying patient on life-support. An acceptable protocol would instead include appropriate pain management and measures to assure as much comfort as possible. As anyone who has accompanied the dying knows, it is far better to die in hospice than in an ICU...

Such are the crises we face at the end of life in this age of awesome yet often burdensome technology. We need to face those crises, however, and to do so in communion with others: family, medical professionals and the church community. Dying should never be a solitary, lonely experience. It should be a profoundly ecclesial act, an act transformed into a *sacrament*, by virtue of the unwavering love and compassion of those who accompany us through it. This level of compassionate caring may have redeemed to some degree Maggie's death. The lack of it on the part of the decision-makers in Terri's case, however, turned her death into a terrible and irredeemable tragedy.

[1] A misdiagnosis of PVS can have tragic consequences. See Kate Adamson's book, *Kate's Journey: Triumph over Adversity*, and the report in *The National Catholic Bioethics Quarterly* 5/2 (2005), p. 232 and note 12. Adamson was diagnosed as being in PVS, her feeding tube was removed, yet she recovered eight days later. She reported that during that time, while she was conscious yet unable to communicate, she experienced "sheer torture."