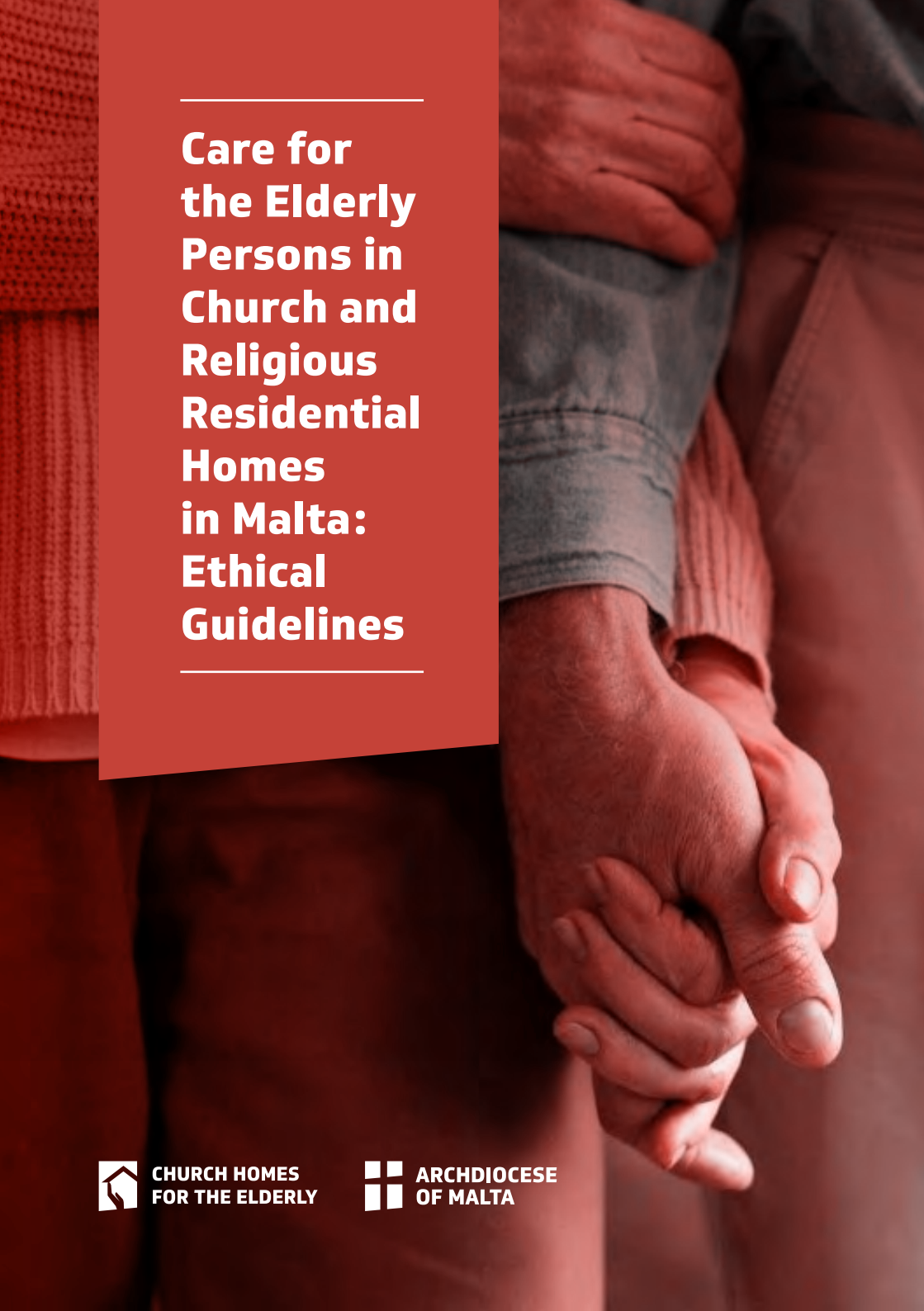
Care for the Elderly Persons in Church and Religious Residential Homes in Malta: Ethical Guidelines



CHURCH HOMES FOR THE ELDERLY

ARCHDIOCESE OF MALTA

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Care for the Elderly Persons in Church and Religious Residential Homes in Malta: Ethical Guidelines

With a foreword by

Charles Jude Scicluna

Archbishop of Malta

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Foreword

The ethical guidelines on the care for elderly persons presented in this publication are inspired by the vision and mission of pastoral ministry of the Church for senior citizens residing in Church and Religious homes in Malta.

Throughout the centuries, the Church in Malta has played a pivotal role in the history of the elderly care and services. Today, the Church in Malta still considers social work and care for the elderly as one of its main pillars of diakonia.

Inspired by the conviction that older people have dignity and fundamental rights, the Church in Malta is committed to promote an excellent quality of care, spiritual support, compassionate accompaniment, and sound ethical guidelines in the decision-making process in order to uphold the quality standards of its residential homes for the elderly.

The values endorsed in these guidelines serve as a reminder that old people, despite their frailty and vulnerability, should not be regarded as a burden to society, as promoted by the so-called throwaway culture of today, but as the "messengers of tenderness ... and wisdom of lived experience", as Pope Francis recently remarked. Care institutions for the elderly are called to create an environment that would let them "live to the full" by respecting, unreservedly, their dignity and rights.

Promoting a holistic care for the elderly is the epitome of a sense of gratitude to God for the gift of life. Moreover, it is an acknowledgement that the quality of society and civilization in which we live depends on the sensitivity to the needs of

the elderly and the vulnerable. Our elderly people deserve the utmost respect and high-quality services and care in our residential homes for they bear the scars of the struggles of life, the wisdom gained through time, and the grace that comes from perseverance. Their lives are not to be merely prolonged, but honoured, cherished and celebrated in a caring environment that does not only add years to life, but more decidedly life to years.

This guidebook is an invaluable resource for chaplains, caregivers, families, and all those who accompany the elderly in the last stages of their life journey. It explores the complex ethical, spiritual, pastoral, and clinical challenges that arise as our loved ones approach the end of their earthly life. The insights on geriatric care enshrined in this booklet are grounded in compassion, informed by the latest developments in bioethics and healthcare professional ethics, and deeply anchored in the Christian understanding of the human person and the Christian perspective on life and death.

My hope and prayer is that everyone who reads this document will be inspired to see Christ in the elderly, and to provide the highest quality of care and support that they so rightly deserve.

May those engaged in elderly care, who are continuously navigating through thorny bioethical challenges, chart the journey of elderly healthcare with a deep sensibility and respect for a culture and civilization of life open to every human being at all stages of life.

† **Charles Jude Scicluna**
Archbishop of Malta
August, 2024

1 Ethical Values, Principles, and Norms

As part of the healing mission of Christ, institutionally based Church and religious homes in Malta have become an integral part of the nation's healthcare system. Today, this complex healthcare system confronts a range of economic, technological, social, spiritual, and moral challenges. The response of Church and religious homes and services to these challenges is guided by ethical values, principles and norms that nurture the healing ministry of the Church.

1.1 Human dignity

Christian healthcare ministry is rooted in a commitment to promote and defend the human dignity of every person. This is the foundation of its principle to respect for the sanctity of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper protection and development of life from the very start of conception to the end-of-life stages. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse. They should be treated fairly, regardless of age, gender, racial or ethnic background, disability, or other status, and be valued independently of their economic contribution.

1.2
Adequate healthcare for the poor

The biblical mandate to care for the poor and for those who suffer requires us to express this in concrete action at all levels of Christian healthcare. This mandate prompts us to work to ensure that our country's healthcare delivery system provides adequate healthcare for these persons and in Church and religious homes, particular attention should be given in this regard. In accordance with social justice, Christian healthcare should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination; the poor older persons, those with incurable diseases, those coming from racial minorities (immigrants and refugees) and persons with mental or physical disabilities, regardless of the cause or severity. These people must be treated as unique persons of incomparable worth, with the same right to life and to adequate healthcare as all other persons.

1.3
Fundamental rights

Christian healthcare ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions guarantee the protection for the fundamental rights of all individuals and enable all to fulfil their common purpose and reach their common goals. Older persons should be able to enjoy human rights and fundamental freedoms when residing in a care facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

1.4
Just distribution of scarce healthcare resources

Christian healthcare ministry exercises responsible stewardship of available healthcare resources. A just healthcare system will be concerned both with promoting equity of care—to assure that the right of each person to basic healthcare is respected—and with promoting the good health of all in the community. The responsible stewardship of healthcare resources can be accomplished best through dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons. Older persons should have access to healthcare to help them maintain or regain the optimum level of physical, mental, and emotional well-being and to prevent or delay the onset of illness. Discrimination on the basis of age or utility to society is unethical, even in the more subtle forms.

1.5
Institutional care

Older persons should be able to utilise and access appropriate levels of institutional care providing protection, rehabilitation, and social and mental stimulation in a humane and secure environment. The needs and interests of institutions should never prevail over the needs and holistic care of the residents.

1.6 Spiritual needs and pastoral care

Since Church and religious homes are communities of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment, but it also embraces the physical, psychological, social, and spiritual dimensions of the human person. The multidisciplinary expertise offered through Christian healthcare is combined with other forms of care to promote health and relieve human suffering. For this reason, Christian healthcare extends to the spiritual needs of the person that are often appreciated more deeply during times of illness. Therefore, pastoral care is an integral part of Christian healthcare. Irrespective of the belief of the individual, it encompasses the full range of spiritual services, including: a listening presence; help in dealing with powerlessness, pain, and alienation; and using the spiritual beliefs of the person to go through difficult moments with spiritual support. For non-Catholics, the spiritual guide of choice of the person concerned may be contacted.

1.7 Conscientious objection

Within a pluralistic society, Christian healthcare services will encounter requests for medical procedures contrary to the moral teachings and ethos of the Church.

Christian healthcare does not offend the rights of individual conscience by refusing to provide or permit medical procedures in the Church and religious homes that are judged morally wrong by the teaching authority of the Church. Healthcare workers should be guaranteed freedom of conscience and religion to object to participating in such above-mentioned procedures. The home administration should offer full support to their healthcare workers who make these conscientious objections.

2 Basic Principles

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our life and, hence, do not have absolute power over it. We have a duty to preserve our life and to use it for the glory of God and the service of others. Human life is a fundamental but not an absolute value. Physician assisted suicide and euthanasia are never morally accepted options.

2.1 Use of technology

The task of multidisciplinary (including medical) care is to provide holistic care even when it cannot provide a cure. Physicians and healthcare professionals must evaluate the proper use of the technology at their disposal ensuring that the resident is always the main focus of care. Reflection on the inherent dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to sustain life. This technology is judged in light of the Christian meaning of life, suffering, and death. In this way, two extremes are to be avoided: medical pessimism on the one hand and medical utopianism on the other. The complete mistrust in technology is just as harmful as the absolute reliance and dependence on technology. The aim should always be to use technology appropriately and rationally for the best interest of the resident.

2.2 Nutrition and hydration

From a Christian perspective, the basic need of nutrition and hydration is a fundamental right. The acts of withholding and withdrawing of nutrition and hydration are guided by the ethical distinction of the Church between ordinary (proportionate) and extraordinary (disproportionate) treatment.

2.3 Morally legitimate choices

Persons in the end stage of life should be provided with whatever information is necessary to help them understand their condition and should have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided with the spiritual support required at this stage in their life.

2.4 Preservation of life

A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that, in the judgment of the resident, offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expenses on the family or the community. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the judgement of the resident, do not offer a reasonable hope of benefit or entail an excessive burden or impose excessive expenses on the family or the community.

3 Guardianship and Advance Care Planning

3.1 Advance care planning

Church and religious homes will make information available to the residents in question about their rights to have an active role in the formulation of an advance care plan in conjunction with their healthcare professionals. The institution, however, will not honour an advance care plan that is contrary to Christian teaching. If the advance care plan conflicts with Christian ethics, an explanation should be provided as to why the care plan cannot be honoured. Residents who do not adhere to Christian belief and practice have to respect the Christian ethos of the institution.

3.2 Guardianship

Each person may identify, in advance, a representative (guardian) to make healthcare decisions as his or her surrogate in the event that the person loses the capacity to make healthcare decisions. Decisions by the designated surrogate should be faithful to Christian ethical principles and to the wishes and values of the person. If these wishes are unknown, end-of-life decisions should be taken in the best interests of the person. Ideally all residents should have an appointed legal guardian on admission to the home. In the event that a guardian has not been legally appointed, those who are in a position to know the wishes of the resident best—usually family members and loved ones—should participate in the treatment decisions on behalf of the person who has lost the capacity to make healthcare decisions.

3.3 Consent

The free and informed consent of the person or the person's guardian is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained. Free and informed consent requires that the person or the person's guardian receives all reasonable information about the proposed treatment and its benefits, risks, side effects, consequences, and any reasonable and morally legitimate alternatives, including no treatment at all.

3.4 The conscience of the resident

Each person or the person's guardian should have access to medical and moral information and counselling so as to be able to form his or her conscience. The free and informed healthcare decision of the person or the person's guardian is to be followed so long as it does not contradict Christian values.

3.5 Preservation of health

While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit himself or herself to a healthcare procedure that the person has judged, with a free and informed conscience, as not providing a reasonable hope of benefit without imposing excessive risks and burdens.

3.6 Resident well-being and benefit

The well-being of the whole person must be considered when deciding about any therapeutic intervention or use of medical technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the resident.

3.7 Ethical issues

An ethics committee on an inter-diocesan level should be available to provide ethical advice and facilitate clinical decisions.

4 Palliative Care

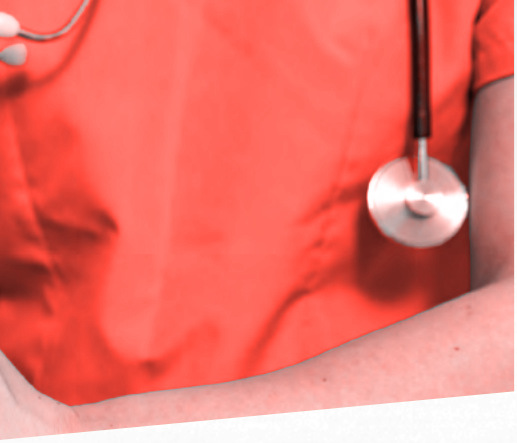
Palliative care is an interdisciplinary medical caregiving holistic approach aimed at optimizing quality of life and mitigating suffering among people with serious, complex, and often terminal illnesses. It is an approach that improves the quality of life of residents and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and comprehensive assessment and treatment of pain and other issues, including physical, psychosocial, and spiritual problems. The principles of palliative care should be applied as early as possible to any chronic and ultimately, fatal illness. This person-centred model prioritizes relief of suffering and tailors care to improve the quality of life of terminally ill residents.

Palliative care is appropriate for individuals with serious illnesses across the age spectrum and can be provided as the main goal of care or in tandem with curative treatment. It is provided by an interdisciplinary team which can include physicians, nurses, occupational and physical therapists, dieticians, psychologists, social workers, and chaplains. Although an important part of end-of-life care, palliative care is not limited to individuals near the end-of-life, but it can be helpful for persons suffering pain or discomfort secondary to chronic illnesses.

5 Medical Assessment at an End-of-Life Stage

Before it is decided that a person has reached an end-of-life stage a medical assessment must be carried out by a competent professional/s. This is important to be able to exclude possible reversible factors such as hypothermia, infections, and other potentially reversible conditions. Even so, an end-of-life situation is a dynamic situation which can go either way and it is not the first time that a resident in an end-of-life situation reverses to a better health status. This means that an end-of-life diagnosis needs review from time to time according to the situation of the resident.

It is also important that individuals in Church and religious homes who are in an end-of-life situation would also have a 'not for resuscitation' (DNAR) status which would have been decided on by the professional (doctor) taking care of them and which would have been discussed with the relatives. This would prevent residents in end-of-life situations, who for some reason or another need hospitalization, from undergoing heroic resuscitation efforts which will likely result in a traumatic and undignified death with an anyway very bleak chance of survival.



5.1
Individualized care

The main aim of the end-of-life care is to keep the resident as comfortable as possible. Care must be holistic and individualized, and in the best interests of the resident. When there is no perceived benefit from sending a resident to hospital, the resident should be cared for in the home providing that the institution can offer a perceived benefit. Unnecessary transfer of residents to hospital at the end-of-life without the need for reasonable medical intervention is highly unethical due to the discomfort of the transfer, over-investigation and possible death in unfamiliar surroundings without the full support of staff who know them and often with restricted family members.

5.2
Facilities and set-up

To be able to care for a resident at the end-of-life, the Church and religious homes need to have the necessary facilities and a set-up to do so. These include:

i.
Every resident should have a named doctor who will be prepared to visit them in the home. The home should also have a regular visiting doctor/s who provides services in the home.

ii.
Staff should have training in end-of-life care that includes the practical, psychological, ethical, and spiritual aspects.

iii.
Appropriate information sessions regarding this stage in life should be organized for the residents and relatives/loved ones.

iv.
There should be the equipment available for this type of care. This includes electrically operated beds, air mattresses and the option for insertion of a subcutaneous infusion line in case the person is not able to take any fluid orally at all.

v.
The residents should also have access to multidisciplinary care and the home should be able to contact allied health professionals such as speech therapists, physiotherapists and occupational therapists.

5.3 Life-sustaining procedures

The free and informed judgment made by a competent adult resident/guardian concerning the use or withdrawal/withholding of life-sustaining procedures should always be respected and normally complied with unless it is contrary to Christian ethics.

5.4 Advance care plan

Residents should be empowered to have an Advance Care Plan that respects their dignity and rights.

5.5 Euthanasia

Euthanasia is an action or omission that, of itself or by intention, causes death in order to alleviate suffering. Healthcare institutions with a Christian ethos should never condone or participate in euthanasia or assisted suicide in any way. Dying residents who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

5.6 Preparation for death

Residents should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the life of the person so long as the intent is not to hasten death. Residents should have the free access to be accompanied by their chaplain/spiritual leader of choice.

5.7 Determination of death

The determination of death should be made by the physician or competent medical professional in accordance with responsible and commonly accepted scientific criteria.

5.8 Organ donation

Christian healthcare institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

6 Regulations: Policies and Procedures

Church and religious homes must adopt regulations as policy and procedure, adhere to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the regulations for administration, medical and nursing staff, and other personnel. Church and religious homes should be marked by an ethos of mutual respect among caregivers that disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need.

6.1 Religious mission

Employees of a Church and religious home must respect and uphold the religious ethos of the institution and adhere to the regulations. They should maintain professional standards and promote the institution's commitment to the respect of human dignity and the common good.

6.2 The dignity of the resident

The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Church and religious homes.

6.3 Privacy and confidentiality

Healthcare providers are to respect the privacy and confidentiality of each person regarding information related to the diagnosis, treatment, and care of the individual.

6.4 Abuse and violence

Healthcare professionals should be educated to recognize the symptoms of abuse and violence and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.

6.5 Employee rights

A Church and religious home must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.

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