

# POPE JOHN PAUL II

## LECTURE SERIES IN BIOETHICS

### *A CHRISTIAN ETHICS OF LIMITING MEDICAL TREATMENT: GUIDANCE FOR PATIENTS, PROXY DECISION MAKERS, AND COUNSELORS*

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#### **A. Presuppositions**

Unless the context indicates otherwise, “medical treatment” will be used here in a wide sense, to include all forms of treatment and care, including ordinary nursing care, carried out under a physician’s direction to promote health or maintain life.

Life is a basic human good; much we do has no purpose but to serve it. Human life also is sacred; it is God's great gift. Faith makes clear the value of bodily life: sin leads to death; reconciliation with God leads to bodily resurrection.

People naturally cherish life. But despite this natural inclination, one can neglect health problems due to sluggishness, live unhygienically due to lack of self-control, or fail to get needed treatment due to excessive fear. Thus, there is a general, affirmative moral responsibility to overcome laziness, self-indulgence, and cowardice, and to seek needed treatment.

Those who can make decisions for themselves should not try to evade their personal responsibility. Like every other decision in life, decisions about medical treatment should take into account one’s commitments and other duties, and should be adapted to one’s unique personality, gifts, and limitations. Others cannot take all these factors into account as well as patients themselves can.

For any noncompetent person, some competent person must make decisions about many matters, including medical treatment. I call such decisions “proxy decisions.” The proxy decision maker should try to make the very decisions the patient would make, assuming the patient were morally upright and competent.

Hospital administrators, physicians, and others with technical expertise can provide helpful information to clarify options worth considering. But they are not suitable proxies for noncompetent patients. A good proxy must know the patient intimately and have the whole of

the patient's personal interests at heart. But professionals seldom know patients intimately, and at times certain interests of professionals are likely to conflict with some of a patient's legitimate personal interests. If a noncompetent patient is a member of a good, Christian family, its usual way of making decisions generally will be the best way to reach proxy decisions about treatment.

The goodness of human life and God's lordship over it have led all faithful Jews and Christians to live by an absolute moral norm: Without God's clear authorization, one may never deliberately kill a human being. It was believed that God authorized capital punishment, some killing in war, and so on. But in the matters dealt with here, there is no exception to the divine command: You shall not kill.

## **B. What will not be considered here**

Questions about limiting medical treatment often are important and difficult, and so decisions often are disputed. One function of the law is to prevent or settle disputes. So discussions about limiting treatment often concern what the law ought to be. I have dealt with this elsewhere; here I will be concerned only with what the moral truth is.

Among the presuppositions stated above is the Jewish and Christian norm which forbids deliberately killing the innocent. Many today reject this moral absolute, and say that in conflict situations, one must choose the so-called lesser evil. This view will be ignored here, for I have shown elsewhere that it is both rationally indefensible and incompatible with Catholic faith.

Nor will I consider here questions about the responsibilities of physicians, nurses, and so on. The ethics of the patient's or proxy's role is more basic; they should be the principal decision makers. Acting as servants, health-care professionals need only fulfill their trust and avoid doing anything wrong. Patients and proxies must try to discern what is right, considering everything, including personal factors only they can assess.

Sometimes a decision - e.g., whether or not to switch off a respirator - turns on whether the body is a corpse or a living person. However, I have treated the question of the definition of death elsewhere and will not treat it here. Thus, what follows assumes that there is still a living patient.

Finally, ethical reflection tries to clarify the moral truth to which decisions should conform; it does not try to judge hearts. Hence, what follows should not be read as a moral condemnation of people who have acted, presumably in good faith, according to norms which I will criticize.

## **C. What will be considered here**

Sometimes people choose to limit the medical treatment they will receive. The limitation might extend to refusal of all treatment, or stop short of that. Bad reasons for such choices to

limit will be considered in section D. People sometimes also have bad reasons, to be considered in section E, for choosing to continue or seek additional treatment.

Under certain conditions, to be considered in section F, people ought to limit medical treatment for themselves. Under other conditions, to be considered in section G, people are not obliged to limit medical treatment they will receive, but may rightly do so.

The moral norms of proxy judgments on behalf of noncompetent patients are the norms of the corresponding judgments people make on their own behalf. But applying these norms in proxy judgments involves special difficulties, to be clarified in section H.

Finally, counselors try to help both competent persons and proxies for others to make sound decisions. Besides the norms decision makers themselves should follow, counselors should shape their own activity by special norms, to be considered in section I.

### **D. Bad reasons for limiting medical treatment**

It is presupposed here that the deliberate killing of the innocent is always wrong. Deliberate suicide is a kind of deliberate killing. So it is always wrong. A choice to limit medical treatment can be a choice of a way of committing suicide. If it is, that is always a bad reason to limit treatment.

To apply this norm, one must understand clearly when a choice to limit medical treatment is the choice of a method of committing suicide. Not every action which brings about one's death is a case of committing suicide. A suicidal action can be performed - e.g., by a severely depressed person - without a free choice. In such cases, the self-killing is not deliberate.

Moreover, one can deliberately do something which leads to one's death without deliberately killing oneself. One can freely accept death without committing suicide. Suicide is the *direct killing of oneself*. What does that mean?

Whenever one acts deliberately, one has confronted two or more options for acting, considered the pros and cons of each one, and settled the indeterminacy of the situation by making a free choice. The open options about which one deliberates are proposals, very like motions on the floor of a deliberative body. Proposals point to opportunities to achieve some good or avoid something bad, and include a plan for bringing about the desired outcome. In adopting a proposal by one's free choice, one determines oneself to live by the values it promises and to execute its plan.

A person who deliberately commits suicide considers continued life somehow bad - e.g., more painful than pleasant. The proposal to kill oneself comes to mind, with at least some idea of how one might do it. But a counter-proposal, to continue living, also comes to mind. The moral act of suicide begins with the adoption of the proposal - i.e., with the choice - to kill oneself. The carrying out of that proposal's plan is the direct killing of oneself.

Obviously, one need not formulate a suicidal proposal in terms of killing oneself. One might say to oneself something equivalent in meaning: "I could end it all." Or one might specify the deadly means to be used: "I could take all these sleeping pills at once." The plan to bring about one's death also can be by omission: "I could refuse to accept this treatment." And if it were pointed out to the person who has chosen suicide, "By refusing this treatment, you will be killing yourself," the honest reply would be: "That is exactly what I propose to do."

The carrying out of a plan of action often has important effects which one foresees during deliberation but which are no part of the proposal one adopts. The person who chooses suicide, for example, may foresee that others will be saddened, not desire that, but accept it as an unwanted side effect.

One's death itself can be a foreseen side effect of carrying out a plan not chosen for that reason. Jesus' plan was to carry on his work despite opposition. He foresaw and freely accepted death as a side effect of going up to Jerusalem. He did not directly kill himself. Similarly, a person who rejects burdensome treatment may foresee and freely accept death without adopting a suicidal proposal. Accepting death to avoid burdensome treatment may or may not be morally upright, but it is not direct killing of oneself.

Thus, not everyone who limits needed treatment, knowing that death will result, deliberately commits suicide. But one who does not seek or who terminates needed treatment in executing a plan to hasten death does deliberately commit suicide. Since such deliberate killing is always wrong, no ulterior reason for wishing to be dead can justify it. However, its wrongness can be mitigated by an ulterior reason, such as the desire not to be a burden to others.

The same outward behavior can carry out a choice to commit suicide by limiting treatment, or a nonsuicidal choice to avoid its burdens by limiting it, knowing that death will result. If the outward behavior and its results are exactly the same, why is the suicidal choice always morally evil and the nonsuicidal choice sometimes morally good? Because morality mainly concerns the heart - i.e., choices and other interior acts which accompany them. In adopting a proposal to kill oneself, one sets one's heart against the value of human life and against God, the Lord of life. In adopting a proposal to avoid the burdens of treatment by limiting it, knowing that death will result, one may or may not be upright in other respects, but one does not set one's heart against the value of life, and so need not offend God.

Probably many who commit suicide by limiting treatment think: There is nothing left for me to live for. But this reason also can motivate people who do not directly kill themselves. It is always a bad reason, because it is always false. Everyone who can make choices and communicate them to others has something to live for.

A person who can make and communicate choices can do other things. True, such a person can be virtually certain that the future holds more suffering than enjoyment. Yet this situation offers an opportunity to confront suffering courageously - to live with genuine dignity while

dying. That itself is something to do, and since doing it is not easy, it is not only upright but noble.

Christians, moreover, should recognize that suffering is part of the way of the Lord Jesus, which they are called to follow through its bitter end in this world to the joy of heaven. God has prepared a life of good deeds for each of us to live, for the praise of his glory. As long as we can make choices, we have unfinished work. We are called to be faithful servants, and a faithful servant does not quit before quitting time. Moreover, the Christian must not only receive God's gifts and thank him for them, but share them with others. By meekly accepting suffering and by manifesting confident hope, the dying Christian, strengthened by the sacraments, engages in a very important apostolate: to remind others, especially those forgetful of life's meaning, of the Gospel's basic message: Repent, the kingdom of God is at hand.

### **E. Bad reasons for not limiting medical treatment**

As in all else, moderation is needed in respect to medical treatment. Just as there are some inherently bad reasons for limiting treatment, there are some inherently bad reasons for seeking or continuing it.

One of these bad reasons often is expressed somewhat as follows: Since it is my body, and since I can afford it (or have insurance to cover the costs), nothing should be spared in treatment. Everything possible must be done.

This reasoning ignores the scarcity of medical facilities and services, and demands the use of unlimited resources to satisfy one person's desires. But the goods of nature and fruits of human effort used in medical treatment are gifts of God. Like all his gifts, they are to benefit all humankind, not simply the wealthy. Therefore, even if one's needs are genuine, at some point their satisfaction ought to be limited to allow some satisfaction of others' needs. But selfish reasoning simply disregards others' needs. That is unfair; it violates the Golden Rule.

In the United States and some other wealthy nations, a small fraction of the world's people want and get too much medical treatment. Their level of demand, the monopolistic structure of medical services, and other factors combine to yield exorbitant incomes for some health-care professionals and to make medical, hospital, and laboratory bills spiral out of control. Meanwhile, the needs of the very poor for treatment receive scant attention.

Another bad reason for immoderately seeking and continuing medical treatment is pride, which leads some to refuse to accept death. This refusal often reinforces greed for treatment, but sometimes stands alone as a reason for making unjustifiable demands for it. One can sympathize with those who proudly refuse to accept death, for it is horrible; no realistic and honest person sees anything good in death, considered in itself. But it is inevitable, and so fully reasonable people adjust to it. Moreover, while God did not make death, he permits Adam's children to suffer death as a deserved punishment for sin, and so faithful Christians accept

inevitable death with meekness and in a penitential spirit.

A third bad reason for immoderate demands for treatment is cowardice in the face of suffering and death. Again, one can sympathize with the anxiety of anyone afflicted with a serious injury or illness. However, this anxiety does not excuse a quest for false reassurance through excessive treatment. Moreover, faithful Christians should hope so confidently for everlasting life that they can rather easily let go of this mortal life, so that by dying in Christ they may rise to glory with him.

## **F. Reasons which require one to limit medical treatment**

There can be conditions which not only justify one in limiting medical treatment but require one to do so.

First, sometimes physicians and others propose forms of treatment which cannot be accepted without formal or unjustifiable material cooperation in moral evils. For example, certain forms of sex therapy involve masturbation, fornication, or adultery.

Second, sometimes accepting or continuing certain forms of treatment will interfere with fulfillment of other responsibilities. For example, otherwise acceptable levels of sedation might interfere with a particular patient's duty to make a last will or receive the sacrament of penance. Again, treatment, in a hospital which forbids visits by children might interfere with a dying mother's responsibility to instruct her children so that they will accept her death in the light of faith.

Third, sometimes particular patients who can profit little from beginning or continuing medical treatment encounter the clear limit of their fair share of available facilities and services. The most obvious example is a disaster situation, in which many survivors will have a good chance of recovery if they are cared for promptly. Those likely to die no matter what is done for them cannot fairly claim more than quick palliative care, if more extensive treatment for them would prevent adequate treatment for those with better chances. Fairness similarly requires indirect limits on treatment, through reasonable limits on public payments and insurance coverage.

Must one refuse pain relieving drugs if an adequate dosage will certainly block the use of reason, probably induce addiction, and possibly hasten death? Not necessarily. If patients are not prevented from fulfilling their responsibilities, they need not refuse adequate pain relief because it blocks their use of reason. Patients with a prospect of recovery normally are not offered pain-relieving drugs in dosages which might addict or kill them; if inappropriate therapy is offered, it should be rejected. Dying patients usually will not be severely harmed if they become addicted to drugs used in dosages adequate to relieve their pain; hence, they may take the drugs and need not be concerned about becoming addicted to them. And while it is wrong for dying patients to hasten death deliberately, they need not refuse drugs adequate to relieve their pain and chosen for that purpose, even if they foresee side effects which will surely

shorten life.

### **G. Factors which do not require but can justify limiting treatment**

Several factors, which do not require upright persons to refuse or discontinue medical treatment, nevertheless can be good reasons to limit it. Since these factors ground negative judgments regarding treatment, they necessarily involve its bad features and effects. These negative aspects can be grouped in six categories.

First, medical treatment can be too costly. “Cost” can mean the use of scarce resources of individuals or families, of particular treatment systems, or of societies at large. At each level, choices must be made, and at some point prior to that at which it becomes clearly unfair to others to accept or continue treatment, the cost factor can make it reasonable to limit it.

Second, some medical treatment can be too damaging to one’s bodily self and functioning. For example, a woman who hopes to have a child might not consent to a recommended hysterectomy. Again, a cancer patient might refuse chemotherapy because of its side effects on various bodily functions.

Third, medical treatment can be too painful. Courageous patients patiently accept some pain, but reasonably draw a line.

Fourth, medical treatment can be too repugnant psychologically - e.g., too embarrassing or too annoying. Upright patients generally overcome their repugnance, but, again, there are limits. For instance, an elderly patient with many health problems might become annoyed with the routine of hospital life and prefer simpler though less adequate care elsewhere.

Fifth, medical treatment can be too restrictive on a patient’s physical liberty and preferred outward behavior. For example, someone given a year to live, with regular medical treatment and hospitalization, might prefer to take a trip, although doing so is incompatible with prescribed treatment.

Sixth, medical treatment can have too great an impact on a patient’s inner life and activity. For example, patients who prefer to be alert and clear headed might refuse treatments which interfere with mental functions.

These six categories of negative aspects of treatment do not include three categories often mentioned: too burdensome, too risky, and useless.

Burdensomeness is not an additional category alongside the six mentioned, but the genus of which they are species. Thus, cost is one sort of burdensomeness, painfulness another, and so on. Risk is some probability that a treatment will lead to some great burden. Thus, riskiness is always reducible to one or more of the six categories mentioned.

Uselessness also is omitted. Treatment is called “useless” either in a loose or in a strict sense. Treatment is called “useless” in a loose sense when its prospective benefits are considered insignificant in comparison with its great burdens. Treatment is called “useless” in a strict sense when what in other circumstances would be useful treatment becomes utterly pointless - a sheer waste of scarce resources. For example, if a patient is just as likely to die soon with or without major surgery, which meanwhile will do nothing to improve the patient's functioning or comfort, then for that patient the surgery is not truly treatment, and the materials, facilities, and services it involves are wasted. Hence, uselessness strictly so-called not only justifies but demands that efforts at treatment be terminated just insofar as they are useless. Of course, other sorts of treatment will remain appropriate.

Each of the six species of burdens includes the qualifier “too” – “too costly”, “too painful” and so on - which signify excess. Excess is a matter of proportion, and so all these reasons which justify limiting treatment raise questions of due proportion. The proportion is between negative aspects involved in or consequent on the treatment itself, and the benefits it offers the patient - prolonged life, improved health, preserved or restored functioning, lessened discomfort, and so forth. Potentially bad features always present in treatment become reasons which justify limiting it when prospective benefits are judged insufficient to make using the means worthwhile. How does one rightly make such a judgment?

In one of two ways, I think. The first - and most common where life is not at stake - is a conscientious discernment, by which all one's duties are taken into account. The second, more common in extreme situations, is by recognition that one has fulfilled the general, affirmative responsibility to seek or accept needed treatment, that no other responsibility calls one to go on with it, and that one simply has no desire to do so.

The judgment by conscientious discernment to limit medical treatment is put into proper perspective by noticing that upright persons regard virtually everything they do in life as the fulfillment of one responsibility or another. Good Christians try to do everything in the name of the Lord Jesus; through him, their whole lives become a gift of thanks to the Father. In their unique gifts and opportunities for service, good Christians find their personal vocations, and so organize their entire lives by faith in Christ, to do their part in the common enterprise of building up his body, the Church.

And so sleeping and rising, cleaning up and dressing, praying and working, eating and drinking, playing and shopping, and getting medical treatment - all fulfill affirmative responsibilities, which are parts of a unified life plan, a Christian's personal vocation. In the absence of any reason which definitely either demands or excludes doing something, conscientious discernment is needed to judge whether to do it and how far to go with it. When negative aspects of treatment reach a certain level, the judgment will be to limit it, just as when negative aspects of anything else reach a certain level, it will be limited according to the overall requirements of the patient's personal vocation.

Thus one does not seek care for every little symptom. Urgently needed treatment may be

delayed briefly while one meets other important responsibilities. Even in life threatening situations, one chooses among treatment options in view of the whole of one's responsibilities. These sometimes require that treatment be limited; they also can point to limitation without actually requiring it.

The second way of judging that one may rightly limit medical treatment is by recognizing that one has no desire to go on with it and that no norm requires one to do so. At some point, the burdens of treatment become so great and its benefits so slight that one is not interested in continuing. Of course, the general, affirmative norm that one should seek or continue needed treatment demands that laziness, self-indulgence, and cowardice not prevent one from taking good care of one's life and health. Special responsibilities also may require one to go on with treatment. For example, one might have some important task to complete, or might be impelled by mercy toward those who could benefit from research to accept an experimental treatment. But sometimes there is no such special responsibility and one is confident that laziness, self-indulgence, and cowardice are not behind one's disinclination to go on with treatment. One thus recognizes that nothing requires one to go on with it, and concludes that one may draw the line whenever one feels ready to do so.

The recognition that one has done all that one should to cherish life and health comes most easily when one is certain that one will die soon whether or not one limits treatment. One can be certain of this either because one accepts a confirmed diagnosis that one is suffering from some fatal disease or because one's general condition is so clearly and steadily declining that there is no room for doubt that death is imminent.

But even without being certain that they will die soon in any case, upright people sometimes seem to recognize that they have fulfilled their responsibility to take care of themselves. For example, patients on hemodialysis, who are not doing well and who have no special duty requiring them to go on, sometimes decide to quit treatment. It seems to me that in some cases such a decision is justified, although in others the patient's poor condition is due to lack of self-discipline and the patient's decision to withdraw from the program is due to impatience and faintheartedness.

Whether or not patients are certain they will die soon, their lack of interest in further treatment will be the product of their reflection on both the burdens and the benefits of going on. Potential benefits are not primarily quantitative - simply prolonging life - but qualitative. Patients want restored or preserved functioning, with an opportunity to experience and do things they consider worthwhile. In this sense, quality-of-life considerations are an unavoidable element in any reason which justifies without requiring limitation of treatment.

Those who reject moral absolutes hold that in conflict situations one should commensurate prospective benefits and harms, and choose the option which offers the better proportion of the two. One line of argument against this proportionalism is that the commensuration it requires is impossible. Proportionalists are likely to claim that just such commensuration is admitted in the preceding analysis. However, this claim will be mistaken. The judgment that

one is justified in limiting treatment does not override any moral absolute. Rather, this judgment becomes possible only when all relevant moral norms leave open the question of whether or not to limit treatment.

The judgment of conscientious discernment is not a moral judgment reached by commensuration of benefits and harms, considered from a premoral point of view. Rather, patients discern what is suitable for themselves, all things considered; good Christians first consider the total responsibilities of their personal vocation. Thus, the moral standards which shape their commitments and character are operative in their discernment, which leads to a moral judgment only in the sense that it selects what is right for the individual from a set of options all of which are right in themselves.

Similarly, a decision to limit treatment which follows on the recognition that no norm requires that it be continued and that one has no desire to continue with it is a personal choice between morally open alternatives. Prospective benefits and harms are commensurated on the scales of the patient's feelings. When these feelings belong to a virtuous character, whose core is a set of upright commitments faithfully fulfilled, they translate true moral norms into a language which can speak for the individual as a whole, including the bodily self and the subconscious mind. Hence, patients who have fulfilled their responsibilities in respect to treatment are entitled to follow their feelings in choosing from morally open alternatives the option which is right for themselves.

## **H. The application of the same norms in making proxy decisions**

Sections D-G have clarified the moral norms for limiting medical treatment, assuming they will be applied by patients making judgments for themselves. In itself, the non-competence of patients to make decisions is irrelevant to what treatment they should get. Moreover, proxies decide rightly by deciding on behalf of others as those others would decide if they were both morally upright and able to decide for themselves. Hence, there are no special substantive moral norms to guide proxy judgments.

It is usually easy to make proxy decisions for previously competent patients rendered temporarily noncompetent by some injury or illness. However, anyone making proxy decisions has been competent and expects to be so for some time. Thus, it is hard for proxies to put themselves in the place of the newborn, the irreversibly comatose, and others who have never been competent or will not be so again. Hence, special consideration must be given to some of the problems of proxy decisions to limit treatment for such persons.

In Section D, I explained the concept of *direct killing of oneself*. If one adopts a proposal to kill oneself and carries out the plan embodied in that proposal, one directly kills oneself. The ulterior reason for adopting the proposal may be good, and the carrying out of its plan can be by limiting treatment. But as long as the proposal is to bring about or hasten death, the act will be suicide. A similar analysis holds true of proposals to bring about or hasten someone else's death. If a proxy chooses to limit treatment so that a patient will die, the withholding of

treatment which results in the patient's death is the means of committing murder.

In recent years, many have acknowledged making proxy decisions to limit medical treatment for handicapped infants to ensure their quick death. Morally speaking, the carrying out of such a choice is the direct killing of an innocent person - i.e., murder. A famous case decided by the Indiana Supreme Court exemplifies one class of such murderous proxy decisions to limit medical treatment. An infant afflicted with Down's Syndrome was denied surgery it needed to survive, not because of the burdensomeness of the treatment in comparison with its probable benefit, but simply because the parents did not want a baby with that handicap. In many places, infants who are in no imminent danger of death but are suffering from open spina bifida with a prognosis of severe deformity are selected for so-called nontreatment. "Nontreatment" sometimes means that surgery is omitted, although it might be helpful and is not contraindicated. Of course, if the child nevertheless survives, its handicap is increased. So some are more radical in their "nontreatment." They withhold feeding, the most basic life-support care, to make sure that the child will die. That clearly is murder.

Does it follow that it is always wrong for proxies to decide that noncompetent patients should not be fed? No. There are times when the ordinary nursing care a good mother gives her child excludes offering the child food. For example, if death is imminent regardless of the care given, and if eating seems only to increase the child's suffering, a good mother would omit feeding but try otherwise to make her child comfortable.

***Editor's Note: Professor Grisez delivered this lecture in 1985. Subsequent development in his assessment of the provision of nutrition and hydration to persons who are permanently unconscious produced an important revision of the opinion he expressed in the following paragraphs, which he published in Issues in Law & Medicine in the fall of 1989 entitled "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?" Professor Grisez's subsequent article is available at <http://www.twotlj.org/OW-ShouldNutHyd.pdf>.***

If a patient is not in imminent danger of death but is in an irreversible coma, as the late Miss Karen Quinlan was, life-support care more sophisticated than ordinary nursing care is very costly. It seems to me that such costly care exceeds a permanently comatose person's fair share of available facilities and services. Thus, I believe that when Miss Quinlan was removed from intensive care, she ought not to have been placed in a special care facility, but should instead have been sent home or cared for in the hospital with only the sorts of equipment and services available in an ordinary household. These do not include feeding by tube, and Miss Quinlan could not be fed otherwise. Thus, if I am right, she should not have been fed. Not feeding patients in irreversible coma would cause their early death, and it would be wrong to omit feeding them to hasten their death. But a proxy could decide against care in a special nursing facility out of fairness to others, and accept the patient's death as a side effect.

Does it follow that no one is entitled to a lifetime of care, including feeding by tube, at the level Miss Quinlan received? No, because the same principle of fairness by which the cost of

that level of care is excessive for people in irreversible coma will require as much or more care for many other patients. This can be seen by applying the Golden Rule, which expresses what fairness demands, to various cases. We all know that each of us might sometime be in irreversible coma, might sometime need public funding of long-term treatment for some other condition, and must always pay taxes. I think we can honestly say that we are willing to limit treatment of ourselves and those we love, if ever in irreversible coma, to ordinary nursing care, without feeding by tube. By setting this limit, we will keep publicly funded special care facilities free for other patients, and avoid increasing taxes to provide additional facilities of this sort. But if we or someone we loved were conscious and able to do some good things and have some good experiences, we would want a lifetime of care at or even above the level Miss Quinlan received, including feeding by tube, if necessary and we would want public funds to be available for what was needed. Hence, we cannot fairly limit others' care if they are in this condition. Nor can we reject the taxation required to provide facilities for such people.

As explained in section G, those convinced they will die soon with or without certain types of treatment often recognize that they have no obligation to prolong their lives as they die. The prospect of the imminent death of noncompetent persons should have a similar impact on proxy decisions about their treatment and care. But here there may be a temptation to stretch the meaning of "imminent death" or "terminally ill."

Everyone whose pathological condition is incurable and whose cause of death can be predicted with confidence is dying, yet death may not be imminent. For example, at present everyone suffering from AIDS is dying, but some survive for many months. If death is not imminent, mortal illness is not at its end, and so the patient should not be called "terminally ill." Thus, not everyone who is dying is terminally ill. Patients are terminally ill only when their condition deteriorates steadily, so that it is certain that there will not be even a very brief remission. Because surprising remissions sometimes occur, no one can be sure beyond reasonable doubt that death is imminent - that the patient can be safely considered terminally ill - until death is expected within a few hours or, at most, a few days.

If a patient is permanently noncompetent, terminally ill, and unconscious, an upright proxy may decide to forgo all but the ordinary nursing care of a family without special equipment or training could supply in their own home. If such a patient is sometimes conscious, in addition to ordinary nursing care, the proxy should require good palliative care to make the patient comfortable. Thus, in making decisions for such patients, one has no obligation - indeed, it is likely to be morally wrong - to require treatment to resuscitate them, maintain their breathing with respirators, give them blood transfusions, give them food and water intravenously or by tube, fight their infections with antibiotics, and so on, except insofar as such forms of treatment and care may be necessary to ease suffering.

Many people feel intuitively that while it is right not to initiate such forms of treatment and care for terminally ill patients, it is wrong to discontinue them if doing so will lead directly to the patient's death. But, as explained above, the morality of omissions and performances which cause death chiefly hinges on what proposal they carry out and why it is adopted. Thus, if the

proposal is to hasten death, either by not initiating or by terminating some sort of treatment or care, the omission or act will be direct killing. But if the proposal is to avoid burdens, and the foreseen patient's death is only accepted as an inevitable side effect, then discontinuing whatever is burdensome is not direct killing, no matter how directly it leads to death. Therefore, any current treatment is justifiably discontinued if its initiation would not now be morally required.

Still, there is a basis in experience for greater reluctance to discontinue life-saving treatment than to omit its initiation. For, at least in the past, decisions not to initiate some potentially life-saving treatment, probably were based on medical contraindications or other burdens, and any act whose foreseeable result was immediate death was an act of violence, outside the context of medical treatment, which carried out a proposal to cause death. But these generalizations based on the sounder morality and simpler technology of earlier days no longer hold true today, when withholding treatment is often advocated as a method of euthanasia and when complex medical technology often becomes excessively burdensome, not least due to its costs, even as it becomes the necessary condition for the survival of terminally ill patients who, with the technology of earlier times, would long since have died.

If a patient is permanently noncompetent and dying, but conscious and not terminally ill, the upright proxy often will require treatment needed to prolong life. Most competent, dying persons who are conscious and not terminally ill want life-prolonging treatment, and patients' inability to express their wants should not make any difference. A grave injustice is done dying, noncompetent patients whose treatment is limited simply on the basis that they are dying and noncompetent. For example, if insulin is withheld without a medical contraindication from a noncompetent, dying diabetic, it is clear that this limitation of treatment carries out a proposal to hasten death, since care of this sort neither has itself nor causes any burdens.

Nevertheless, an upright proxy will decide for limitation, if convinced that a conscious and nonterminal patient, if competent, would be justified in limiting treatment, and probably would choose to limit it. Deliberation leading to such a decision, while it must rule out the patient's noncompetence considered in itself, rightly takes into account the difference the patient's non-competence will make to the burdens and benefits of treatment. For example, a proxy will not require something which cannot succeed without a patient's cooperation when the noncompetent patient's limitations preclude that cooperation. Similarly, if a retarded patient's inability to understand the point of treatment will make it particularly repugnant, that repugnance should be taken into account.

Just as competent patients who are not dying can be justified in limiting medical treatment, so proxies at times may rightly limit it for permanently noncompetent patients who are not dying. Since permanently noncompetent patients do not have serious responsibilities to fulfill, the reasons rooted in such responsibilities for either requiring or limiting treatment will be irrelevant. But the general, affirmative responsibility to provide needed treatment remains in force. Therefore, withholding from noncompetent patients who are not dying the treatment they need to stay alive cannot be justified unless burdensomeness of one or more kinds is great

indeed.

Generally, it is not so great. For example, where the prognosis is good, the burden of surgery to remove cancerous growths is almost never so great that competent people consider refusing such treatment for themselves or those they love. Hence, in cases with a good prognosis, such surgery should be chosen for permanently noncompetent patients, including the severely retarded, the incurably psychotic, and the senile. On the other hand, just as some competent patients on hemodialysis may justifiably withdraw from the program and accept death, so at times a justifiable proxy decision might be made to withdraw from hemodialysis a permanently noncompetent person, whose general condition is poor and whose great repugnance to the treatment is evident.

## **I. Special norms for the work of counselors**

Counselors often must help patients and proxies make decisions about medical treatment. This important work has its own moral norms. Counselors such as priests, who are approached because they hold office in a community, are expected to advise in accord with the community's values and beliefs. If they cannot do so in good conscience, they should either stop counseling or resign their office and offer their services without the community's authorization and support.

Those who counsel about limiting medical treatment should really understand relevant norms and know how to apply them. It is not sufficient to memorize a few rules and follow them blindly, without careful fact gathering and accurate analysis. For example, it is true that extraordinary means need not be used, and that doubtful laws do not bind. But the abuse of such rules by ill-educated counselors easily leads to unnecessary bodily deaths and spiritual disasters.

The expression "extraordinary means" signifies those means which are too burdensome in a situation where the reason for wishing to limit care is not a bad one. Means called "extraordinary" in some other sense - e.g., means not usually demanded by the ordinary standard of good medical practice or means which are seldom used - can be obligatory in a particular case. Moreover, no one ever rightly limits treatment in carrying out a proposal to kill or to hasten death. And so, no means excluded with that end in view is morally extraordinary. Therefore, counselors who tell parents of unwanted defective children that they need not consent to life saving treatment which they would authorize for a wanted child, on the ground that the treatment is in some sense extraordinary, gravely err in applying the rule that extraordinary means need not be used.

The maxim "Doubtful laws don't bind" is relevant to moral judgment only in a legalistic framework which is, at best, inadequate. Even within a legalistic framework, the maxim was applicable only after one had done one's best to discover the moral truth. It always was taken for granted that those who enjoy the gift of faith should accept its moral implications as certain and try to live in accord with them. Thus, dissent from very firm and constant moral teachings

of the Church never could render these teachings doubtful. And so, counselors abuse legalism if they encourage people to choose arbitrarily between traditional Christian teachings and dissenting theological opinions, by suggesting that the latter make the former doubtful and invoking the maxim that doubtful laws don't bind.

Sometimes people ask moral advisors for help in choosing between two morally acceptable options. In such cases, nondirective counseling techniques are appropriate to help clients clarify their own thoughts and feelings, and so discern which option is right for them. As death approaches and daily choices must be made between morally acceptable options of continuing and limiting treatment, the counselor's moral support often facilitates discernment and inspires the confidence necessary to forestall groundless guilt feelings for making upright but hard choices.

Sometimes counselors are convinced that an option under consideration is morally unacceptable. In many cases, they can uncover appealing aspects of a morally acceptable alternative, or even bring to light a good option which has been entirely overlooked. But whether or not counselors can positively promote upright choices, they must clarify the truth about morally unacceptable alternatives. In doing so, they in no way impose obligations on those they advise. For the counselor's role is neither to make decisions for others nor to give them orders, but to clarify the moral truth. This truth is part of reality, and no matter what the counselor says, it is likely to impose itself on the client's conscience. Thus, counselors who try to relieve those they advise of real moral responsibilities are likely both to succeed in encouraging them to make immoral choices and to fail in preventing the grave guilt of those choices.

Finally, counselors who share the light of Christian faith with their clients should make the most of the occasions when they are asked for help in reaching decisions about limiting medical treatment. Generally, such help is sought when life is at stake, and that is a moment of special grace, for it offers a unique opportunity to communicate the gospel effectively. This will be done if the counselor firmly believes that the sufferings of the present are unworthy to be compared with the glory for which we hope, clearly communicates this conviction, and unmistakably lives and works according to it. The counselor's living of the gospel makes it credible, when suffering and death at one and the same time test faith and cry out for the light and peace only firm faith can give. Thus, a Christian counselor who lives the gospel truly is another Jesus, who bears others' crosses with them, and so fulfills Jesus' law - the law of the Cross, the law of love.

## **Author's Selected Bibliography**

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treatment of many of the questions treated in this lecture.

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\_\_\_\_\_ and Joseph M. Boyle, Jr. *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate* (Notre Dame and London: University of Notre Dame Press, 1979.) Treats euthanasia and related questions, including those covered in this lecture, but with a focus on jurisprudential problems. Chapter 3 (59-85) deals with the definition of death; chapter 9 (259-97) deals with justice and care for the noncompetent, including infants afflicted with birth defects; chapters 11-12 (336-441) deploy the same ethical theory used in the lecture and apply it to all the relevant issues, but proceed by a strictly philosophical method.

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the members of the working party. Much of the ground covered in the lecture is treated, but with a focus on euthanasia, jurisprudential issues, and points of view other than that of the patient or proxy making decisions.

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Oden, Thomas C. *Should Treatment Be Terminated? Moral Guidelines for Christian Families and Pastors* (New York: Harper and Row, 1976). A thoughtful, genuinely Christian treatment by a Protestant theologian, experienced in pastoral counseling. Although I do not agree with everything in this book, I consider it worth careful study for its many insights, and because it is a remarkable witness from outside classical Catholic moral theology to the unity of the Christian tradition.

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Sacred Congregation for the Doctrine of the Faith. "Declaration on Euthanasia," in *Vatican Collection, Vol. 2: Vatican Council II: More Postconciliar Documents*, ed. Austin Flannery, O.P. (Northport, N.Y.: Costello Publishing Co., 1982), 510 -17. The most recent, authoritative summary of received Catholic teaching on matters treated in the lecture. The lecture is meant to conform to this teaching, and to supply theological clarifications and specifications of many details. Unfortunately, this Declaration was rather weak inasmuch as it did not straightforwardly confront radical theological dissent from the relevant norms it accurately summarized, and so it has been ineffectual in shaping a sounder Catholic response to the anti-life movement and present confusion about limiting care.