

The Linacre Quarterly

Volume 47 | Number 2

Article 11

May 1980

Prolonging Life: The Duty and Its Limits

John R. Connery

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

Recommended Citation

Connery, John R. (1980) "Prolonging Life: The Duty and Its Limits," *The Linacre Quarterly*: Vol. 47: No. 2, Article 11.
Available at: <http://epublications.marquette.edu/lnq/vol47/iss2/11>

Prolonging Life: The Duty and Its Limits

John R. Connery, S.J.

Father Connery, a noted moral theologian, is at Loyola University in Chicago. He is a member of the Linacre Quarterly editorial advisory board.

The moral issue of prolonging life is frequently discussed today in the language of *rights*, more specifically in terms of a so-called *right-to-die*. Since death is generally looked upon as something evil, those taking the *rights* approach find themselves in the somewhat anomalous position of defending a right to what is considered undesirable. They feel that they can do this reasonably because they can show that although death may be an evil, it is not the only evil, nor even the worst evil, and hence can conceivably be desirable, at least as a lesser evil.

Since a substantial part of morality falls into the category of justice, there is no inherent reason for ruling out the use of *rights* language; it can apply just as validly to moral obligation as to legal obligation. But whatever may be said for the validity of this approach, it does not seem sufficiently basic to be satisfactory. Before one can speak in terms of any right-to-die, he has to consider the possibility of some obligation to life. If such an obligation exists, it would rule out, at least to the extent that it does, any possible *right-to-die*. Actually, it has been in terms of an obligation to preserve life that theologians have discussed the question since the early 15th century. Since in the present paper we are following this discussion, at least briefly, it is from this angle that the question will be considered. At the end of the paper, what has been said will be converted into *rights* language, to the extent that this is possible.

Theologians have generally treated the duty to prolong life in the context of violations of human life, e.g., homicide and suicide. They have always held that respect for human life as a basic good demanded that no one deliberately destroy innocent human life, either his own or that of another. On this score they condemned so-called mercy killing. Even an otherwise good motive, such as mercy, could not justify taking innocent human life. But this was not all. Respect for human life also implied a duty to preserve life. This would mean an obligation at least to take ordinary food and drink as well as other common means of preserving or prolonging life. Failure here would be tantamount to suicide, at least if it were deliberate or due to neglect.

But since the early 15th century, theologians have explicitly admitted a limit to this duty to preserve life, a limit which they thought reason itself imposed.

Before going into this question further, it might be well to distinguish it from a different, although related question — that of determining the time of death. There has been a tendency to confuse these two issues in recent discussions. A number of cases have come to public attention within the past few years where the basic question was whether the person was dead or alive. This is not the issue we are dealing with here. The assumption in the present discussion is that the person is still alive, and the issue is the obligation to keep him alive. In many cases where this question comes up, the fact that the person is still alive is quite clear. But there are cases in which this is not clear, at least initially, and in these cases confusion can arise. The problem can be illustrated by considering a practical decision to keep such a person on a respirator. The first question that would have to be answered is whether the patient is dead or alive. The criterion for determining the time of death would be operative in making this judgment. If it was judged that the patient was dead, one could turn off the respirator without further questioning. But if he was even probably alive, the person responsible would have to consider a possible obligation to prolong that life before he could turn off the respirator. The question we are dealing with here is not whether one may turn off the respirator because the person is dead, but whether one may turn it off even though he is still alive.

As already mentioned, theologians have always felt that man had some obligation to preserve or prolong life. At the same time, however, they maintained that there were limits to this obligation. It was limited, first, by the moral law itself; man could not do anything morally wrong even presuming that this would be necessary to preserve his life. They maintained further that there were limits to the obligation to preserve life even apart from those imposed by morality. In other words, even if the use of a means was morally unobjectionable, while it might be used, it was not always of obligation. Antoninus, a 15th century theologian (1389-1459), discussed the issue indirectly in terms of an obligation to obey a doctor.¹ Since the doctor had no authority over the patient, Antoninus argued that the patient had no obligation to obey him. He added, however, that it might be imprudent to disobey the doctor because of his expertise. Thus, if a sick person either knowingly or out of crass ignorance were to eat or drink something that would bring on death, he would sin seriously. The sin could be less serious if what he took were merely to aggravate the illness. Although in either case it might not be a sin of disobedience it would be a violation of the patient's obligation to preserve his life, an obligation which the patient has apart from any relationship with a doctor. Antoninus goes on to say, somewhat

cryptically, that healthy people are not bound to live *medicinaliter*, since to the healthy, all things are healthy. The implication seems to be that healthy people do not have to be scrupulous about the food or drink they take. But he adds that even a healthy person would sin if he deliberately took something harmful to his health. Briefly, what he seems to be saying is that while one has an obligation to preserve his health, he should nevertheless be reasonable about it.

A successor of Antoninus, Francisco de la Vitoria (d. 1546), also discusses the obligation to eat and drink to preserve his life.² Continuing what seems to have been the thought of Antoninus, he says that one is not obliged to use foods which are the best, the most expensive or the most exquisite. Neither is one bound to live in the healthiest climate. By way of example, he says that if a doctor advises a patient to eat chicken or partridge, he can eat eggs or other common dishes.³ Such advice would not be pertinent today since the prescribed foods are in no sense considered expensive delicacies, but it does clarify the distinction for those times. In speaking of the obligation to take medicine, he comments that those who refuse to take some particular medicine are not to be condemned since one can rarely be certain that it will work.⁴ Again, he is speaking of a time when little was known about the chemical properties or effectiveness of drugs, so one would have to modify his statement today. Vitoria himself goes on to say that if one is certain that a drug will save his life, or that without it he will die, he will mortally sin by not taking it. But even an effective drug would not be obligatory if one had to continue to take it over a long period of time.

The first author to take up the question of surgery was Domingo Soto (1494-1560), a Dominican of the early 16th century.⁵ He asks whether one is bound to undergo amputation of an arm or leg to preserve or prolong life. His answer is that no one could force a patient to undergo such torture. He is speaking, of course, of surgery at a time when anesthesia was not available. Again, one would not make the same judgment today, at least not for the same reason.

Distinction Between Ordinary/Extraordinary Means

Seventeenth century theologians formulated the obligation to preserve life and its limits in terms of a distinction between *ordinary* or *common* means and *extraordinary* means.⁶ According to this distinction one would be obliged to use ordinary means to preserve life, but in general would not be obliged to use extraordinary means. The distinction was based on the burden the use of some means would place on the patient (or on others). If the burden was too heavy for the patient to carry, the means would have to be considered extraordinary, and therefore non-obligatory. The general norm for gauging

the burden was the reaction of the common man, although the sensitivities of the individual were also taken into account. Thus, theologians admitted that the fear or embarrassment of some women of an examination by a male doctor might make such an examination an extraordinary means. If a female doctor were available, an examination would generally be considered ordinary means. In assessing any particular means, it made no difference whether the burden to the patient was experienced before, during or after the treatment. The need for extensive travel, for instance, could make a treatment extraordinary even before use. In the amputation case discussed by Soto, the burden was experienced during the procedure. It could happen, however, that the burden would not be experienced until after the use of the means. In today's society, for example, a quadruple amputation might not be the painful experience it was in the 16th century, but it could certainly make life burdensome for its victim afterwards; this in itself would make it an extraordinary procedure. So if a particular means imposed a great burden on the patient either before, during or after its use, it would not be obligatory. The burden could take the form of great pain, physical or mental hardship, danger or even expense.

Some today are a little reluctant to accept great expense as an excusing reason for omitting some treatment. To them it is somewhat venal to attach more value to money than to health. There is something to be said for this attitude, but one must remember that what is sacrificed is usually not just money, but other things that money could buy — things that might be just as valuable as health. Or one might be incurring crippling debts that could make life very difficult.

It is essential to point out at this time that the distinction between ordinary and extraordinary means as used by the theologian does not mean at all the same thing it means as when used by a physician. To the physician *ordinary* means are *routine* means; whatever procedure is customary or usual in a particular case is considered ordinary. It is the relation of the means to medical practice that makes it ordinary; it has nothing to do with the burden imposed on the patient. It might well be that the two concepts would coincide, so that a treatment that was routine from the medical viewpoint would be ordinary from the moral standpoint, at least in the sense that it was easily available. But they are in no way coextensive. A procedure that might be considered ordinary or routine medically speaking could be very extraordinary from the viewpoint of the burden it places on the patient. An example of this might be the treatment for kidney failure called hemodialysis. The medical profession would consider this ordinary treatment for kidney shutdown. But if the kidneys were shut down permanently, hemodialysis could easily become very burdensome to the patient, particularly an elderly patient. In a counseling situation, one might urge a patient to put up with the burden for the benefit of prolonging

life. But one could not impose a moral duty on a patient to carry such a heavy burden. The basis of the moral distinction between ordinary and extraordinary means reinforces the reason why the option belongs to the patient rather than the doctor. Only the patient can gauge the burden he experiences. The doctor may be in the best position to judge what is "ordinary" treatment from the medical viewpoint, but he is not the best qualified to judge the burden to the patient, which is the decisive factor in the moral distinction.

Use of the distinction between ordinary and extraordinary means was not limited to terminal cases. Even if the use of a particular means would prolong life indefinitely (e.g., amputation, hemodialysis), if it imposed too much of a burden on the patient, it would not be considered obligatory. So the decisive factor was not benefit to the patient, but the burden involved. Theologians, however, did use another distinction in dealing with the duty to preserve life and placed a limitation on the obligation to use even ordinary means. This distinction centered around the benefit to the patient, that is, whether the means was helpful or useless. The norm was an obvious one: no one can be obliged to employ useless means. The general principle is broader than the problem of prolonging life, but these theologians were applying it only to this context. Judging from the examples they gave, one can also conclude that they were speaking of cases where people were dying. If a person were going to die in the immediate future and there was no real hope that the uses of a particular means would prolong his life except, perhaps, minimally, it would be considered useless, and therefore not obligatory, even if it were otherwise ordinary. A 17th century theologian illustrated this point by the example of one being burned at the stake.⁷ If water was easily available, but not enough to put out the fire, the victim would not be obliged to use it. Death was imminent whether he used it or not, so it would offer no real benefit; it would merely prolong the agony of dying. Another case offered by way of example was that of a person starving to death who had only one meal available. Since one meal would not make an appreciable difference in delaying death, it could not be considered obligatory means. This limitation of the obligation to use ordinary means is especially important in terminal cases, where death is imminent whether they are used or not.

Many theologians today classify means that offer no appreciable benefit in prolonging life as extraordinary, subsuming the distinction between useful/useless means under the definition of ordinary/extraordinary means. In more recent times, this has caused some confusion. My own preference is to keep them separate, and I have already hinted at the reason for this. They deal with different issues — burden and benefit — and usually apply to different types of cases. In practice, at least, the question of benefit seems limited largely to terminal cases; burden can be an issue even in cases which are not terminal.

Whether medical procedures will be classified as ordinary or extraordinary by the theologian will vary according to time and place. As already mentioned, simple amputations were considered extraordinary means because of the pain involved. Where anesthesia is available, however, surgery would not be considered extraordinary, at least by reason of the pain suffered. Similarly, such procedures as giving oxygen, IV feeding, blood transfusions, might have been considered extraordinary means 50 or a hundred years ago. Today they could hardly be considered such, except perhaps in some part of the globe where they are not easily available. Similarly, although procedures of this kind would not be classified as extraordinary on a short term basis, e.g., to pull a patient through a crisis, if they had to become a way of life, even today they would fall into this class. e.g., long term or permanent use of an artificial respirator. The burden of such use could make them intolerable.

It might be well to point out at this juncture that the traditional approach to the moral obligation to prolong life allows broader options than recent legislation in California, and some proposed legislation in other states, would permit. The California statute, for instance, legalizes the option not to use "extraordinary" means only in terminal cases.⁸ Converting this into the language we have been using, one would say that the legislation covers primarily those means which would not make any appreciable difference in prolonging life, since death is imminent whether the means are used or not. It does not cover those cases where the use of the means would prolong the life of the patient indefinitely, but would put too much of a burden on the patient to make them obligatory. It would not cover, for instance, the Quinlan case. Even if the girl had made the "living will" called for in the statute, it would have had no force in her case since it was never considered terminal. And even in a terminal case, the legislation makes no allowance for a proxy decision where the patient is comatose but has made no "living will." It would indeed be unfortunate if such legislation prejudiced rather than protected the moral right of a patient either to forego the use of extraordinary means or to discontinue them.

Basic Duty Belongs to Person

The basic duty to preserve or prolong life belongs to the person himself. The same is true of the option to use extraordinary means. It is up to the person himself to use or forego the use of such means. This offers no problem when an individual is on his own, but if he is in a patient-doctor relationship, a conflict can arise. The doctor may want to use means that go beyond both the obligation and the wishes of the patient. Even in this relationship the decision belongs to and remains with the patient. The doctor has only those rights over the

patient which the patient gives him. If the patient, therefore, decides not to use extraordinary means, the doctor has no right to impose them on him, and if he does, he is violating the rights of the patient.⁹

Once the principle has been set down, it must be admitted that it is not always easy to determine the real wishes of the patient, especially in difficult cases. This is very clearly illustrated in a case described recently in the *Hastings Center Report*.¹⁰ The patient involved, a young man, suffered second and third degree burns over most of his body. Both eyes were blinded by corneal damage, his ears were mostly destroyed, and he suffered severe burns to his face, upper extremities, body and legs. The patient constantly and consistently resisted the very painful treatment he had to undergo, and pleaded with the doctors to let him die. But despite his repeated protests, the doctors continued to treat him for many months. Eventually, however, they gave in to his pleas and agreed that if he did not want any further treatment they would not force it on him. When that happened, the young man withdrew his resistance and agreed to go along with the treatment. One would have to conclude that in this case it would have been a mistake for the doctors to have accepted his original plea literally. The ultimate outcome seemed to indicate that all the young man wanted was a voice in his own treatment. Once this was granted, he was satisfied. He really did not want to die. The case illustrates very poignantly the difficulty of interpreting the requests of a person who is in great pain. It seems obvious that mistakes cannot be entirely eliminated in interpreting the patient's real wishes in these cases. The most one can hope for is to keep them to a minimum. What is essential for doctors is to keep in mind that the decision to use or forego extraordinary means is not their own decision. It must always be a justifiable interpretation of the real wishes of the patient.

If the patient is comatose or incompetent, it is up to a responsible relative to make the decision for him. This may be the only way a patient can exercise his right either to ask for extraordinary means or to forego them. The obligation of the proxy, then, is to make the decision the patient would make if he were able. If he has no way of knowing this, his best option is to make the decision he would make if he were in the patient's place, or the decision that reasonable people would make for themselves in that situation. Mistakes may be made, but this procedure should keep them to a minimum. What must be kept in mind is that the proxy does not have the freedom the patient himself has regarding extraordinary means. His obligation is not based on the distinction between ordinary and extraordinary means, but on the wishes of the patient. If he were to decide against extraordinary means in a situation where the patient would want them, he is doing wrong. Too often in recent times ethicists have assumed that the proxy has the same freedom the patient himself has to forego extraordinary means.

It is one thing to discuss the obligation to *use* means to preserve life of a patient; it is quite another to discuss the obligation of others to *provide* such means to a patient. Again, recent writing on this subject has oversimplified this obligation by reducing it to the distinction between providing ordinary and extraordinary means. The impression is left that the obligation to provide means, like the obligation to use means, depends on the nature of the means: if the means are ordinary, there is an obligation to provide them; if they are extraordinary, there is no obligation. The obligation to provide means is much more nuanced than that. The nature of this obligation will differ according to the relation of the person providing the means to the patient. If that person is the patient's doctor, he will have an obligation in justice to supply whatever means the patient reasonably requests. Because of their special relationship, parents will also have a special obligation to provide for the needs of their children. Others will have an obligation in charity to provide means to preserve life if the patient is in need of their help. Although these obligations are graded according to the relationship with the patient, none of them are absolute. In determining the limits of the obligation, another factor must be taken into consideration: the hardship to the donor or provider. No one, for instance, would be obliged to sacrifice his life to supply a patient's need. If someone were drowning and an attempt to save him would involve serious risk to my own life, while it might be a heroic thing to do, I would not be obliged to risk my life to save him. This would be true even of providing ordinary means. I would not be obliged to give food necessary to preserve my own life to a starving man, although food is generally classified as ordinary means. On the other hand, if a patient wishes extraordinary means, and cannot supply them otherwise, even a stranger might have an obligation to provide them if he could easily do so without serious inconvenience. And the obligation of the doctor or parent would be even more binding. So the obligation to provide means necessary to preserve life cannot be reduced to the distinction between ordinary and extraordinary means. It is determined by the wishes of the patient in need and my ability to relieve that need without serious hardship.

Obligation to Help

It should be noted at this time that the obligation to help another, whether of the doctor or the parent, or even of a stranger, goes beyond merely providing means to preserve life. A patient may have other needs, and these may continue to call for help even when the obligation to preserve life ceases. Paul Ramsey calls attention to this fact when he speaks of the obligation of "only caring" for the dying.¹¹ The only criticism I would have of his treatment is that one easily gets the impression from it that this latter obligation begins

when the obligation to preserve life ceases. Actually, the obligation to help others in need is a general obligation that extends through life. A person may have many other needs throughout his lifetime for which he himself cannot provide. The obligation of charity extends to any need the person himself cannot relieve. It continues even after the obligation to preserve life and the need for assistance in this regard has ceased. One does not simply wheel a patient, at either end of life, into a corner and leave him there because it has been decided that the obligation to preserve his or her life has ceased. As long as he is alive (and even after), the obligation of charity will continue to call for relief of whatever other needs he or she may still have.

An equally important question is whether the obligation to provide means to preserve the life of another will cease apart from the presence of serious hardship to the provider. The assumption is that ordinary means are needed or extraordinary means have been requested either by the patient or his proxy. Could a person who was easily able to provide such means legitimately refuse to do so? There are instances in which this would clearly be wrong. For example, if a man were drowning and I could easily save him, it would be wrong to refuse help because he was black. But what if he were seriously defective or handicapped? I do not think that a decision not to save the seriously defective person would necessarily involve discrimination. Thus, if one had to make a choice between saving a healthy child and a defective one, I think a legitimate choice could be made of the healthy child, unless the lifesaver was the parent (or the doctor) of the defective child. It should be remarked, however, that there seems to be considerable agreement that in general when not all can be saved, a random selection is the most just. If the decision had to do only with saving or not saving the defective child, I suspect that most people would feel very guilty about letting a defective child drown when they could easily save him. But when there is a question of letting a defective child die in a hospital, although the reality of refusing help is the same, it does not appear as stark, since death is not immediate.

As there is no evidence to show that defective people put an end to their lives more frequently than normal people, there is no reason for thinking that they consider death preferable to continued existence with their handicap.¹² If this is true, it is hard to understand how refusing help on the basis of quality-of-life estimate is generally consistent with the duty of charity; it would be dooming many handicapped people to what they would consider a lesser good. There may be a rare case where predictable quality-of-life would be so low that the life itself could not be classified as human, but this would be a rare exception and the prediction would be extremely difficult to make. Charity, moreover, would demand that the benefit of any doubt be given the defective person.

It would be impossible in this paper to go into all the nuances of

the obligation to provide help to people in dying situations. The purpose here has been chiefly to introduce the distinctions that should be made between the obligation of a person faced with a decision about prolonging life, the obligation of a proxy who has to make a decision for an incompetent, and that of a person whose help is needed to save another person's life. These are all related obligations, but they are also different. It is the judgment of the present writer that in recent writing they have been bunched together without adequate distinction. Each obligation has its own norms, and although they are related to the distinction between ordinary and extraordinary means, they cannot simply be reduced to it.

One hears rumblings today against the distinction between ordinary and extraordinary means. Robert Veatch wants to substitute the term "reasonable" in discussing the obligation to preserve life; one would not be obliged to use means if it were reasonable (to the patient, if he were competent, or to a reasonable man, if the patient were not competent) to refuse them.¹³ Since his reasonable/unreasonable distinction involves both the notion of usefulness and that of burden discussed above, he is not really departing very far from the traditional principles set down above. It is only the terminology that he would like to change. I am not sure that the change accomplishes any great clarification, but I would have no objection to it as long as one does not conclude from the fact that it would be reasonable to turn down a particular means that it would be unreasonable to use. This might be true of a useless means, but not necessarily of a means that was burdensome. If the patient wishes to accept the burden, it would be perfectly reasonable to use such means. This moral option should not be taken from him or frowned on as unreasonable.

Ramsey Considers Distinction Outdated

Paul Ramsey would also like to bury the distinction between ordinary and extraordinary means.¹⁴ He considers the distinction not only outdated but actually harmful. His chief grievance seems to be with the use of the distinction in the case of the non-dying incompetent patient. It is his contention that the distinction brings in a quality-of-life dimension that should not be a consideration in these cases.¹⁵ Ramsey himself substitutes, at least in the case of the incompetent patient, a medical indications norm. According to this norm, if a treatment is medically indicated, it is obligatory; if it is not, it would not be obligatory. Thus, if the patient were terminal, and treatment would be useless, it would not be medically indicated and hence not obligatory. If the patient were not dying, and the treatment were not medically indicated because it would not help and might even harm the patient, it would not be obligatory. If it were medically indicated because it would help the patient, it would be obligatory. The virtue

of this position is that it puts the emphasis on the effectiveness of the means rather than on the quality of the patient's life.¹⁶

There is much to be said in favor of this approach. This is dramatically illustrated in Ramsey's own book by the examples he offers of abuse of the quality-of-life norm. But it has this drawback. The traditional distinction between ordinary and extraordinary means was meant to show that other considerations could outweigh medical indications in dealing with the duty to prolong life. More precisely, the burden of using certain means to prolong life could be such that one could not reasonably make them obligatory. It is true that in the past theologians were speaking of decisions made by competent people. But is it reasonable to make incompetent people bear burdens that competent people do not have to bear? Certainly, the decision is more difficult to make in the case of incompetents, but the difficulty does not warrant retreat to a position which seems to compromise the rights of the incompetent. Ramsey seems to be canonizing medical indications, at least in the case of incompetents. I would tend to agree with him in his concern about the dangers of quality-of-life considerations, but I do not agree that in order to avoid them we should or have to make medical decisions final.

From what has been said earlier in the paper, it should be clear that I agree with Ramsey's position that the norm for a proxy decision is not the distinction between ordinary and extraordinary means, but the wishes of the patient. In the case of infants, of course, it is impossible to know these wishes, but even in these cases one cannot simply fall back on this distinction, and forego extraordinary means. I have no hard statistics, but I think it can be said that competent people choose to use extraordinary means far more frequently than they forego them. If one cannot know the wishes of an incompetent, he may be able at least to approximate them by trying to discern what competent people would decide if they were in such circumstances. What I am trying to say is that the rights of an incompetent person should be respected as much as those of the competent. He should have the same right to bear a burden or to forego one, and it should not simply be assumed that because he is incompetent, especially if he is defective, only ordinary means are in order.

Some attention must be given to another dimension of this problem: the duty of the doctor to his profession. Does this demand that he continue to fight disease with all means available? Is he not failing in his duty if he foregoes the use of some means, even with the consent of the patient? If the doctor were fighting disease in a test-tube, or perhaps even in an experimental animal, there would be no limit to what he could do, except for the dimensions of his own resources. But the doctor who is fighting disease in a human patient must respect that person and his legitimate wishes. His professional position gives him no right to override the wishes of the patient. The

medical profession is for the good of the patient; the patient is not the tool of the profession. A doctor who would, out of his duty to his profession, impose the use of extraordinary means on the patient against his legitimate wishes would be subordinating his patient to the profession, and to that extent, abusing him.

It is quite conceivable that a conscience conflict would arise between doctor and patient regarding the use of some treatment or therapy. If the doctor cannot persuade the patient to accept the treatment which his conscience demands he give him, his only alternative is to bow out of the case. This will allow the patient to employ the services of a doctor whose conscience is not at odds with the wishes of the patient. Unfortunately, this is more easily said than done, especially if the patient is in a hospital and a proxy decision is made by close relatives. It is well known that an impasse of this kind was reached in the recent Quinlan case, which subsequently had to be taken to the courts for settlement. There may have been no alternative to a court solution in the Quinlan case, but it is certainly regrettable to have to go to the courts to settle a conscience problem. Perhaps it might have been unnecessary if the conscience problem had not been complicated by fear of a malpractice or even a criminal charge.

Decision Often Left to Doctor

Even though the option belongs to the patient, it must be admitted that patients will often leave the decision to use extraordinary means up to the doctor. Since the decision frequently involves medical judgment and the doctor knows more about medicine than the patient, the latter will often confide in his judgment. Also, even when the patient makes the decision himself, what he decides will often depend on how the doctor presents the case to him. What is the obligation of the doctor in these cases? Even here it seems clear that the interests of the patient rather than those of the profession would dictate the judgment or decision of the doctor. In the therapeutic relationship, the first duty of the doctor, even as a professional man, is to the patient and his wishes. If he gives priority to professional interests, he is really making the patient a research subject, and without the patient's explicit consent, would be abusing him to that extent.

One sometimes hears the charge that the doctor (or the patient) who foregoes extraordinary measures is "playing God." God is the Author of life and death, and the decision to terminate life should be left to Him. In responding to this charge, one cannot of course deny that God is the author of life and death, but this does not imply that man must use all possible means to postpone death. As a matter of fact, he would seem to be more open to the accusation of usurping a divine prerogative by prolonging life than by not prolonging it. So one

cannot conclude from God's authorship of life that it would be wrong to forego extraordinary means (much less useless means). This would be wrong only if man knew his appointed time and then anticipated it. No one can claim such knowledge.

In a similar vein some will argue that since a miracle is always possible, a doctor must continue to use all means to keep a patient alive. It is hard to see how one could establish a duty on the part of a doctor to gear his practice to the possibility of a miracle. In fact, it is not even clear how he would or could do this. Presumably, God can work a miracle anytime He wants. And He is just as capable of bringing a person back from death as He is of bringing him back from a terminal illness. Keeping a person alive can hardly be a necessary condition for a miracle. So it is not clear how the possibility of a miracle provides any argument for an obligation to use extraordinary means.

In the present controversy over prolonging life, some have claimed that once extraordinary means have been initiated, there is an obligation to continue them. They have argued, for instance, that although there may have been no duty initially to put a patient on a respirator, once this has been done, there is a duty to continue its use. There is really no justification for this stand. If means are truly extraordinary, there is no more obligation to continue them than there was to initiate them. One does not create an obligation by the mere fact of initiating extraordinary means. Actually, even in a case where the means were judged ordinary when initiated, any obligation to continue them would cease if for some reason they became extraordinary. There is even less reason for obligatory continuation of means which were extraordinary from the beginning.

At least partially connected with the above problem are the misgivings of some about terminating the use of extraordinary means by acts of *commission* rather than *omission*. There are those who have no difficulty about acts of *omission* but who see in acts of *commission*, euthanasia or mercy killing. While they would not scruple about not putting a patient on a respirator, they tend to identify "pulling the plug" with direct killing. Their problem is really more psychological than moral. Not all positive acts taken by physicians involve the taking of human life; they do so only if they actually cause the patient's death. There is an important difference between injecting an air bubble in a patient's bloodstream and turning off a respirator. The air bubble really causes the person's death. If the respirator is turned off, the cause of the patient's death is the very cause that would have brought it on if the respirator had never been used. If the use of the respirator had to be considered an ordinary means of preserving life, turning it off would still be wrong, but granted that it is an extraordinary means, turning it off in no way involves either direct killing or culpable neglect.

We are in a position now to convert what we have been saying into the so-called language of *rights*. But I would have to preface what I have to say with the protest that I do not like the expression *right-to-die*. It says much more than I want to say or think should be said, and so is misleading. In other words, I think that it has legitimate meaning only within very prescribed limits. No one has a *right-to-die* in the sense that he may take his own life or authorize someone else to do the same, much less impose on him a corresponding obligation. If there were a positive *right-to-die* it would imply all this. I doubt that anyone holds a *right-to-die* in this sense. Nor does one have a *right-to-die* in the sense that he may omit the use of ordinary means to preserve life, or authorize (or even oblige) someone else to withhold such means. In other words, active euthanasia has never been acceptable, and the same is true of passive euthanasia, at least in the sense that the latter would allow the omission of ordinary means. The only right a patient has — and this is a real right — is not to use extraordinary means to prolong life, and a consequent right not to be forced to use such means. This implies a corresponding obligation on others not to force such means on him. Within these limits, and only within them, does the *right-to-die* have meaning.

In concluding this article, I should explain that the intention here was to present and explain the traditional position on the obligation to prolong life and its limits. It was felt that there was need of such a presentation because of the many misinterpretations and misunderstandings current about this position. There was no intention of presenting newer positions as such but only insofar as they implied a misunderstanding of the traditional position. The article, as a consequence, has its built-in limitations. It was not meant to be a catalog or critique of recent opinions on the duty to prolong life. These opinions may make for interesting debate, but it was not the purpose of this article to contribute to this debate. The purpose here was simply to show that the traditional position, if properly understood, is still a viable one.

REFERENCES

1. Antoninus, *Summa Theologica*, Tom. 3, l. 7, c. 2 (Graz: 1959).
2. Vitoria, Francisco de la, *Reflectiones Theologicae*, IX, De temperantia, n. 12 (Lyons: 1557).
3. Vitoria, Francisco de la, *Comentarios a la Secunda Secundae de S. Thoma*, q. 147, a. 1 (Salamanca: 1952).
4. Vitoria, *Reflectiones, op. cit.*, De temperantia, n. 1.
5. Soto, Domingo, *De Iustitia et Iure*, Lib. 5, q. 2, a. 1 (Venice: 1568).
6. De Lugo, Ioannes, *Disputationes Scholasticae*, VI, *De Iustitia et Iure*, Disp. 10, nn. 29-30 (Paris: 1869). In an address given to an International Congress of Anesthesiologists in Rome, Pius XI applied these norms to the question of resuscitation. See *The Pope Speaks* (1958), pp. 393-398.
7. *Ibid.*
8. AB 3060. For a discussion of this act see Paul Ramsey, *Ethics at the Edges*

of Life (New Haven: Yale University Press, 1978), pp. 318-332.

9. This is not to say that the doctor has no part in these decisions. He is the one who supplies the medical judgment, i.e., whether a means will be effective, what are the effects of a treatment, etc. It is only after the patient has this information that he will be able to make an informed decision. Thus, for instance, he has to know what burdens may be attached to a particular treatment before he can decide whether he wants to undergo them. But the decision is his prerogative.

10. *Hastings Center Report*, vol. 5, no. 5 (June, 1975), pp. 9-10. See also vol. 5, no. 6 (Dec., 1975), pp. 9-12.

11. Ramsey, Paul, *The Patient as Person* (New Haven: Yale University Press, 1970), pp. 113-164.

12. We are not dealing here with an after-life. There is, of course, no comparison between this life and the after-life. The comparison here is rather between continuing life with this particular burden and not continuing it. Handicapped people, at least if they are young, seem no more prone to elect discontinuing life than normal people.

13. Veatch, Robert, *Death, Dying, and the Biological Revolution* (New Haven: Yale University Press, 1976), pp. 77-115. The following chapter is also pertinent. Veatch defines what he would consider an unreasonable refusal of treatment on page 112. Other questions might be raised about Veatch's views, but our concern here is limited to the meaning of his general norm.

14. Ramsey, *Ethics at the Edges of Life*, *op. cit.*, pp. 145 ff.

15. The quality-of-life dimension is introduced in means that would make life subsequent to their use very difficult, e.g., a quadruple amputation. This would make the use of the means extraordinary, and therefore, not obligatory. Richard A. McCormick, S.J., has recently suggested ("To Save or Let Die," *America*, July 13, 1974, pp. 6-10) that in some cases the quality-of-life can be so low that all obligation to sustain it ceases, even the obligation to use ordinary means. He was dealing with infants so defective that there existed neither a physical nor moral possibility of ever developing human relationships. He was referring to an initial absence of human potential. Whether he would apply the same norm to those who once had such a potential (and realized it), but lost it irretrievably, is not clear. What is clear is that McCormick has shifted the emphasis from the nature of the means to the quality of life itself. To this extent he departs from the tradition. Failure to employ ordinary means that were useful to prolong life would have been classified in the tradition as suicide. But since the patients he was speaking of were incompetent he was not dealing with the obligation of the patient himself but that of a proxy, or of one who was providing the means. As pointed out, these cannot simply be reduced to the norm for the patient himself.

16. Ramsey criticizes McCormick's acceptance of quality-of-life norms, especially in decisions made by others. He himself is willing to admit cases where efforts to help will not reach the patient because he is permanently comatose or totally distracted by pain. These cases seem quite similar to those McCormick was discussing. Ramsey argues that his position is superior to that of McCormick because it does not depend on any quality-of-life judgment. Care is omitted not because of a judgment that the kind of life open to the individual is not worth prolonging, but because care will be of no use. Thus far, I think there may be something to be said for the validity of his position. But he goes further and allows even active measures to shorten the lives of these individuals. To justify this he would have to admit that where one cannot help it is all right to harm. I question whether this is a sound principle. Incapacity to receive help may relieve another person of any obligation to provide it, but it is unclear, at least to me, how incapacity to receive help affects or removes the obligation not to harm. Harm, as is obvious, is still possible in such cases, and the capacity to receive harm is quite different from the capacity to receive care.