

August 1985

Guidelines for Legislation of Life-Sustaining Treatment

Thomas J. O'Donnell

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

Recommended Citation

O'Donnell, Thomas J. (1985) "Guidelines for Legislation of Life-Sustaining Treatment," *The Linacre Quarterly*: Vol. 52 : No. 3 , Article 4.

Available at: <http://epublications.marquette.edu/lnq/vol52/iss3/4>

Guidelines for Legislation of Life-Sustaining Treatment

The following is reprinted with permission from The Medical-Moral Newsletter, Vol. 22, No. 4, April, 1985. whose guest editor for that issue was Rev. Thomas J. O'Donnell, S.J. The newsletter is published by Ayd Medical Communications, 1130 E. Cold Spring Lane, Baltimore, MD 21239. Subscription rate: \$20 per year.

"GUIDELINES FOR LEGISLATION OF LIFE-SUSTAINING TREATMENT." This is the title of a memorandum issued last November by the Committee for Pro-Life Activities of the United States Catholic Conference (USCC) which is the "civil authority" or implementing arm of the National Conference of Catholic Bishops of the United States (NCCB: the ecclesial organization of the Bishops of the United States). This type of public document issued by a Committee of the USCC is published only after the approval of the NCCB Administrative Board.

The document, the complete text of which is given below, is divided into two parts: a compact summary of the most basic moral principles governing the use of therapeutic procedures designed to prolong life; and, as important legislative procedures derived from these principles, a set of 10 guidelines for legislators and their constituents.

Some of the guidelines are carefully nuanced with unwritten implications and omissions; we would like to comment on three.

Guideline (a) wisely suggests that legislators avoid "phrases which seem to romanticize death, such as a 'right to die' or 'death with dignity.'" This serves as a salutary alert to those advocates of active euthanasia who would subliminally soften up the American public's resistance to the concept of merciful murder by carefully selected semantic coating.

Guideline (b) mentions the patient's right to request (emphasis added) "reasonable treatment" (what is reasonable?) This wording neatly sidesteps the complicated and multifaceted question of the patient's right to receive "reasonable" treatment, from whom, within

what context of medical triage; and for the indigent, with what degree of amortization by the paying patients.

Guideline (h), by not qualifying "hydration" and "nourishment," leaves untouched a question much disputed at the moment: whether there is a significant moral difference in some cases of terminal illness between artificially delivered and naturally ingested hydration and nourishment (see Newsletters, April 1983, May 1983, and November 1984).

With these observations, we append here the text of the guidelines.

Introduction: Moral Principles

Our Judeo-Christian heritage celebrates life as the gift of a loving God, and respects the life of each human being because each is made in the image and likeness of God. As Christians we also celebrate the fact that we are redeemed by Christ and called to share eternal life with Him. From these roots the Roman Catholic tradition has developed a distinctive approach to fostering and sustaining human life. Our tradition not only condemns direct attacks on innocent life, but also promotes a general view of life as a sacred trust over which we can claim stewardship but not absolute dominion. As conscientious stewards we see a duty to preserve life while recognizing certain limits to that duty, as was reiterated most recently in the Vatican Declaration on Euthanasia. This and other documents have set forth the following moral principles defining a "stewardship of life" ethic:

(1) The Second Vatican Council condemned crimes against life, including "euthanasia or wilful suicide" (*Gaudium et Spes* 27). Grounded as it is in respect for the dignity and fundamental rights of the human person, this teaching cannot be rejected on grounds of political pluralism or religious freedom.

(2) As human life is the basis and necessary condition for all other human goods, it has a special value and significance; both murder and suicide are violations of human life.

(3) "Euthanasia" is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated" (Declaration on Euthanasia). It is an attack on human life which no one has a right to make or request. Although individual guilt may be reduced or absent because of suffering or emotional factors which cloud the conscience, this does not change the objective wrong of the act. It should also be recognized that an apparent plea for death may really be a plea for help and love.

(4) Suffering is a fact of human life, and has special significance for the Christian as an opportunity to share in Christ's redemptive suffering. Nevertheless there is nothing wrong in trying to relieve someone's suffering as long as this does not interfere with other moral and reli-

gious duties. For example, it is permissible in the case of terminal illness to use pain-killers which carry the risk of shortening life, so long as the intent is to relieve pain effectively rather than to cause death.

(5) Everyone has the duty to care for his or her own health and to seek necessary medical care from others, but this does not mean that all possible remedies must be used in all circumstances. One is not obliged to use "extraordinary" means — that is, means which offer no reasonable hope of benefit or which involve excessive hardship. Such decisions are complex, and should be made by the patient in consultation with his or her family and physician whenever possible.

Although these principles have grown out of a specific religious tradition, they appeal to a common respect for the dignity of the human person rather than to any specific denominational stance. We offer them without hesitation to the consideration of men and women of good will, and commend them to the attention of legislators and other policy-makers. We see them as especially appropriate to a society which, whatever its moral and political pluralism, was founded on the belief that all human beings are created equal as bearers of the inalienable right to life.

Legislative Guidelines

Today the application of these principles to the legislative debate regarding treatment of the terminally ill is both difficult and necessary. The medical treatment of terminally ill patients, including the withdrawal of extraordinary means, has always been subject to legal constraints. Since 1975, however, an increasing number of court decisions and legislative enactments have been constructive, but others have not. Technological changes in medicine occur so rapidly that it is difficult to keep pace with them. These changes have had a drastic effect on the physician/patient relationship, and make much more difficult the decision process by which a patient determines treatment with the counsel and support of physician and family.

As problems and confusions surrounding the treatment of terminally ill patients continue to multiply, new legislation dealing with this subject is being enacted in some states and proposed in many others. Yet the law relating to the treatment of terminally ill patients still differs from state to state, and does not always adequately reflect the moral principles which we endorse. The Church therefore feels an obligation to provide its guidance through participation in the current debate.

In light of these considerations, we suggest the following as ways of respecting the moral principles listed above as well as related concerns of the Church, whenever there is a debate on whether existing or

proposed legislation adequately addresses this subject. Such legislation should:

(a) Presuppose the fundamental right to life of every human being, including the disabled, the elderly and the terminally ill. In general, phrases which seem to romanticize death, such as "right to die" or "death with dignity," should be avoided.

(b) Recognize that the right to refuse medical treatment is not an independent right, but is a corollary to the patient's right and moral responsibility to request reasonable treatment. The law should demonstrate no preference for protecting *only* the right to refuse treatment, particularly when *life-sustaining* treatment is under consideration.

(c) Place the patient's right to determine medical care within the context of other factors which limit the exercise of that right — e.g., the state's interest in protecting innocent third parties, preventing homicide and suicide, and maintaining good medical standards in the health care profession. Policy statements which define the right to refuse treatment in terms of the patient's constitutional rights (e.g., a "right of privacy") tend to inhibit the careful balancing of all the interests that should be considered in such cases.

(d) Promote communication among patient, family and physician. Current "living will" laws tend to have the opposite effect — that of excluding family members and other loved ones from the decision-making process. As a general rule, documents and legal proceedings are no substitute for a physician's personal consultation with the patient and/or family at the time a decision must be made on a particular course of treatment.

(e) Avoid granting unlimited power to a document or proxy decision-maker to make health-care decisions on a patient's behalf. The right to make such decisions on one's own behalf is itself not absolute, and in any event cannot be fully exercised when a patient has had no opportunity to assess the burdens and benefits of treatment in a specific situation. Laws which allow a decision to be made on behalf of a mentally incompetent patient must include safeguards, to insure that the decision adequately represents the patient's wishes or best interests and is in accord with responsible medical practice.

(f) Clarify the rights and responsibilities of physicians without granting blanket immunity from all legal liability. No physicians should be protected from liability for acting homicidally or negligently. Nor should new legal penalties be imposed on a physician for failing to obey a patient's or proxy's wishes when such obedience would violate the physician's ethical convictions or professional standards.

(g) Reaffirm public policies against homicide and assisted suicide. Medical treatment legislation may clarify procedures for discontinu-

ing treatment which only secures a precarious and burdensome prolongation of life for the terminally ill patient, but should not condone or authorize any deliberate act or omission designed to cause a patient's death.

(h) Recognize the presumption that certain basic measures such as nursing care, hydration, nourishment, and the like must be maintained out of respect for the human dignity of every patient.

(i) Protect the interests of innocent parties who are not competent to make treatment decisions on their own behalf. Life-sustaining treatment should not be discriminatorily withheld or withdrawn from mentally incompetent or retarded patients.

(j) Provide that life-sustaining treatment should not be withdrawn from a pregnant woman if continued treatment may benefit her unborn child.

These guidelines are not intended to provide an exhaustive description of good legislation, or to endorse the viewpoint that every state requires new legislation on treatment of the terminally ill. They outline a general approach which, we believe, will help clarify rights and responsibilities with regard to such treatment without sacrificing a firm commitment to the sacredness of human life.