The Linacre Quarterly

Volume 42 | Number 2 Article 9

May 1975

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The desperately ill and dying patient occasions many moral problems: the extent and quality of medical care and support, the institutional organization of intensive care units (cf. Tagge in this issue), the meaning of extraordinary and ordinary measures of life support, the moral difference between omission (allowing to die) and commission (taking life), the provision of spiritual, psychological and familial comfort, the extension of policies and attitudes with regard to adult terminal patients to babies, and so on.

All of these — and there are many more — are *moral* aspects of our treatment of the seriously ill and the dying. We tend to think of morality in far too narrow terms, terms that restrict the notion to certain baseline external acts. Actually, the morality of conduct includes far more. It must take into account intentions, desires, dispositions, attitudes, emotions. Medical care involves persons dealing with persons — and both medical proffessional and patient, being persons, not only perform or receive certain services, but do so in a context of accompanying emotions, desires, attitudes, beliefs, intentions, biographies. The overall moral quality of healthcare cannot be separated from a consideration of such factors.

For instance, it is not impossibly difficult to state that the Christian attitude toward life and death is one that sees life as a basic good, but not an absolute one, and death as an evil but not an absolute evil. Such a balanced attitude then translates into the practical distinction between ordinary and extraordinary means to preserve life. This distinction, being highly relative to circumstantial conditions, is often difficult to describe precisely. But it becomes even more difficult in its application to this or that patient if we remember that the phrases "reasonable hope of benefit to the patient" and "no reasonable hope of benefit" must take account of the patient's attitudes, emotions, past life, value-priorities etc. The

simple little sentence so often uttered at the bedside of a dying patient "He would not want this" — this sentence leads to or accompanies the judgment that a particular means is for this patient, all things considered, extraordinary and nonobligatory — is a sentence into which is packed a rather thorough personal knowledge of the patient, his points of view, attitude to life and death, religious values, etc., with all the intuitive and spontaneous dimensions that are involved in such knowledge.

Feelings, attitudes, perceptions, beliefs, dispositions, therefore, do have an important place in the morality of our actions and omissions, and the decisions we are called upon to make. But can such personal factors and other empirical data be overstressed and be given a decisive moral relevance they do not have? I believe so, and want to use a recent discussion to lift up this point for further consideration.

The discussion concerns the relationship between infanticide and abortion. The following problem has been raised: does the moral reasoning used with regard to protecting fetal life prior to viability bear any relationship to the protection of neonatal life? Or more concretely, if one approves abortion for serious genetic defect, must he in moral consistency approve infanticide for those who have slipped through the amniocentesis screen? Worded differently, if one rejects neonatal euthanasia (active) for terribly deformed babies, must he in logical consistency reject abortion for the same disease?

Three Responses

There are three responses to this question in contemporary moral writing. The first is that of Paul Ramsey.[1] He contends that the very arguments used to justify abortion will also justify infanticide. He makes his point in urging his moral position on abortion — an intervention he rejects as immoral except in the most exceptional instances (involving, for example, the life of the mother). Thus if we refuse to commit infanticide, we ought also, Ramsey argues, to reject abortion. For the two procedures are, in their decisive moral dimensions, not that different.

The second position is associated with Joseph Fletcher.[2] He believes there are no clean and clear-cut moral differences between abortion and infanticide. However, he arrives at an entirely different practical conclusion from that of Ramsey. Fetal life is subhuman and may be aborted where prenatal diagnosis reveals deformity. The same conclusion is advocated where euthanasia of elderly patients and defective newborns is concerned. He writes:

> If we are morally obliged to put an end to a pregnancy where an amniocentesis reveals a terribly defective fetus, we are morally obliged to put an end to a patient's hopeless misery when a brain scan reveals that a patient with cancer has advanced brain metastases.
>
> Furthermore . . . it is morally evasive and disingenuous to sup-

> pose that we can condemn or disapprove positive acts of care and compassion but in spite of that approve n e g a t i v e strategies to achieve exactly the same purpose. This contradiction has equal force whether the euthanasia comes at the fetal point on life's spectrum or at some terminal point postnatally.[3]

Both of these positions (Ramsey and Joseph Fletcher), remarkably different in conclusion as they are, share a common conviction: prenatal and postnatal situations do not differ morally in any decisive ways. If one is willing to abort in certain cases, he should be willing to perform active euthanasia on babies in the same disease situation. If one is unwilling to perform active euthanasia on a newborn, he should be unwilling to abort it earlier.

The third position is that of John Fletcher. In a recent study in the prestigious *New England Journal of Medicine*, he attempts to show that there are *morally relevant differences* between abortion and euthanasia.[4] On the basis of these differences his position is one of rejection of active euthanasia for newborns, but acceptance of abortion following prenatal diagnosis of severe deformity.

Here I wish to examine these differences to see if they go so far as to distinguish abortion and neonatal euthanasia morally. I wish to argue that Fletcher's three differences do not distinguish the two and that therefore a position advocating or justifying abortion after prenatal diagnosis of severe impairment is one that, in moral consistency, ought to advocate or justify neonatal euthanasia. And similarly, a position that rejects neonatal euthanasia (as John Fletcher does) ought, in moral consistency, to reject abortion also (as John Fletcher does not).

If this point can be argued successfully — or more accurately, if it can be shown that Fletcher's arguments are not persuasive — it may be somewhat clearer how perceptions, intentions, dispositions and other empirical and personal data, while morally relevant and terribly important in some areas, are not that decisive in others.

Fletcher's first alleged "morally relevant difference" b e t w e e n abortion and neonatal euthanasia is the separate physical existence of the infant apart from the mother. This separateness, he says, "confronts parents, physicians and legal institutions with independent moral claims for care and support." Contrarily, "before extrauterine viability the well-being of the fetus should not be considered independently f r o m the mother's condition." Fletcher sees as "extreme" the position that regards the fetus as already a human being because such a position "provides no rational grounds for the legitimate interests of parents, family and society to be expressed and guided in abortion decisions."

Here it must be insisted that separate physical existence does indeed confront parents, physi-

cians and legal institutions with independent moral claims. And the fetus' intrauterine existence does indeed mean that the treatment of the fetus cannot be considered "independently from the mother's condition." Classical theology has always granted this. Nor, I would add, can the mother's condition be approached medically in total independence of the fact that she is pregnant. That being said, however, the crucial question is this: while the claims of the separate child are independent, and the claims of the fetus occur within a dependency relationship, *are these independent and dependent claims that different?* And if they are, on what grounds? Physical dependence and separateness are but facts. To say that a moral claim is dependent is not to delineate the strength of that claim. The classical position, of course, has been that the moral claims of the fetus are very strong, indeed so strong that only life-saving interventions (e.g., ectopic pregnancies) or their equivalent are compatible with the rights of the growing fetus. Fletcher simply does not address this issue, and for that reason his first difference does not establish a morally relevant difference between abortion and euthanasia; Fletcher merely asserts such a difference.

The Second Major Difference

Fletcher's second major difference between abortion and neonatal euthanasia is "the fact that after birth the disease in the infant is more available to physicians for palliation or perhaps even cure. Confrontation with disease in an independently existing life requires physicians to respond within their obligations to heal and to relieve suffering." I fail to see how the availability of disease to treatment distinguishes abortion from euthanasia. Granted, it is difficult if not impossible to treat the fetus *in utero* in many cases. All that means is that it is difficult or impossible. How does one use that difficulty to establish a morally significant difference between two actions which are in no sense treatment of the fetus and child, but destructive acts visited upon either fetus or child?

If Fletcher accepts "availability to physicians for palliation or perhaps even cure" as establishing a morally significant difference between abortion and infanticide, it must be because he supposes that if one is unavailable *(in utero)* for palliation or cure, he may be disposed of. But that has nowhere been established in his study, and indeed is at the heart of the abortion controversy. Fletcher concludes: "For the present . . . the real situation for parents and physicians is that they must wait until birth to respond to the specificity of a disease with decisions to treat or not to treat." True, but therefore what . . . ?

Fletcher's third morally relevant difference is that "parental acceptance of the infant as a real person is much more developed at birth than in the earlier stages of

pregnancy." He then states that "we should expect loyalty to the developing life to grow, change, and moderate the ambivalence about the fetus usually present in the parents." Here several things must be noted. First, granted that acceptance is much more developed at birth, the question remains open and untouched about what even the initial acceptance ought to be, about what it ought to prescribe and proscribe with regard to fetal life.

Secondly, granted that loyalty (or better, a sense of loyalty or experienced loyalty) grows as the fetus grows, the question remains open and untouched about what even the initial stirrings of loyalty demand of us where protection of fetal life is concerned. Fletcher nowhere addresses these questions and they are essential if the differences he identifies are to add up to *moral* differences between abortion and euthanasia. If Fletcher argues that this growth and change in the sense of loyalty to nascent life establishes a morally significant difference between abortion and euthanasia, it is only because he has supposed that it is a greater or lesser sense of parental loyalty that founds the fetus' rights and claims, and generates our obligations to it.

A Manifestly Erroneous Position

This is not merely undemonstrated; it is, I believe, manifestly erroneous. It is not our sense of, experience of loyalty or acceptance that shapes our obligations. It is rather the objective reality of the fetus that ought to found our obligations and nurture our sense of loyalty. If that sense of loyalty in early pregnancy is such that it allows abortion, then we must deal earnestly with the possibility that our sense of loyalty is not what it should be, that it has been blunted by cultural forces, etc. To say otherwise is to make the fragile and vulnerable sense of acceptance and loyalty normative—which would, among other things, collapse morality into headcounting. In summary, in appealing to the sense of acceptance and loyalty, Fletcher has appealed to human perceptions. To accept these as establishing a "morally relevant difference" between abortion and euthanasia of the newborn is to accept human perceptions as normative — which is, unless something further is added, to forfeit the capacity to criticize these perceptions.

Fletcher's study concludes with this statement: "The effect of these three differences is to establish the newborn infant, even with a serious defect, as a fellow human being who deserves protection on both a legal and ethical basis . . . " Clearly, the newborn are fellow humans deserving of protection. But if Fletcher's main contention (moral difference between abortion and euthanasia) is to stand up, he should have concluded: "The effect of these three differences is to establish the fetus as *not* a fellow human being." Fletcher has not succeeded in doing this.

I have raised this question here

precisely in order to underline both the moral relevance of personal factors (perceptions, dispositions, attitudes, etc.) and the limits of this relevance. While such factors do have input and importance in the quality-of-life judgments so often hidden in the terms "ordinary" and "extraordinary" means,[5] they do not, I submit, found and constitute the very existence and personhood of the individual. Unless that is kept in mind, the lives and rights of others will be endangered.

REFERENCES

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2. Fletcher, Joseph, *The Ethics of Genetic Control* (New York: Doubleday, 1974), 121-123, 152-154, 185-187.

3. Fletcher, Joseph, "Ethics and Euthanasia," *American Journal of Nursing* 73 (1973), 670-675.

4. Fletcher, John, "Abortion, Euthanasia, and Care of Defective Newborns," *New England Journal of Medicine* 292 (1975), 75-80.

5. Cf. the perceptive remarks of Margaret Farley in *Reflection*, January 1975. She states: "If it is accurate at all to consider means more or less 'extraordinary' in relation to the capacities for fullness of life in an individual infant, then it is the case that we are basing decisions for treatment or nontreatment on 'quality of life' considerations. Such considerations seem inevitable if one stands within a tradition that values every person and every human life, but values human physical life in relation to other human values." This is precisely what the Christian and Catholic tradition does in this matter.