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The Quinlan Case

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Directive n. 28 of the *Ethical and Religious Directives for Catholic Health Facilities* reads in part as follows: "The failure to supply ordinary means of preserving life is equivalent to euthanasia. However, neither the physician nor the patient is obliged to the use of extraordinary means." Anyone reading this directive may be puzzled at what seemed to be the reaction of both doctors and administration at St. Clare's Hospital, Denville, New Jersey, to the request of the parents of Karen Ann Quinlan to remove the respirator from their daughter and let God's will be done. The parents had come to this decision after prayer and consultation with their local pastor. Being assured that the decision was entirely consistent with the teaching of their Church, the father made the request. Unfortunately, it met with refusal.

The girl was originally admitted into another hospital on April 15, 1975, in a comatose state, but was soon (April 24) transferred to St. Clare's. She had suffered massive and irreparable brain damage, and has remained in a comatose state since that time. She has been on a respirator and has been fed through a tube, and the doctors hold out little or no hope that she can be taken off the respirator in the foreseeable future.

The case would seem to be a classic example of extraordinary means. Such artificial life-sustainers as respirators, etc., would not be classified as extraordinary means to relieve acute conditions of short duration, but moral theologians have commonly held that long-term use of these sustainers would convert them into extraordinary means. If the use of such means has to become a way of life for a patient, it becomes a real burden. This would be true even if the patient was conscious and the use of the sustainer offered real benefit. Hemodialysis, for instance, will let a person suffering from chronic kidney shutdown lead a fairly normal life if he continues it. But if it has to become a way of life for such a patient, theologians would see it as an excessively heavy burden to bear. If indeed a patient

wants to continue life even in these circumstances he has the option of doing so. But to oblige a patient to do so would in the words of Pius XII "be too burdensome for most men and would render the attainment of the higher, more important good too difficult." In the case of the Quinlan girl the burden is at least as great, and with little or no perceptible benefit.

How can one account for the negative reaction of the doctors and the hospital to the request of Mr. Quinlan? One must assume that they were acquainted with and had at least a minimal understanding of directive n. 28 quoted above. Did they consider the use of the respirator and other life sustainers in this case ordinary means? This is a possibility. They might even have judged turning off the respirator a lethal act, or at least a violation of the doctor's first norm: *non nocere*.

Obviously, there is a clear difference between turning off a respirator and injecting an air bubble into a patient's veins. The latter is a real cause of death. The respirator does no more than prevent natural causes of death from taking their effect. When it is turned off, death will result from the same causes that would have brought it about initially if the respirator had not been used. Turning off the respirator is in no sense a positive cause of death. It would be wrong, of course, not to turn on a respirator, or to turn it off, in a case where it would be judged an ordinary means. But

as an extraordinary means there is no obligation to initiate it or continue it.

Some doctors will scruple more about discontinuing extraordinary means than about not initiating them. The underlying reason for this is perhaps a greater moral sensitivity to acts of commission than to omission. This sensitivity may be justified in other contexts, but in the present case it is not. There may be a psychological problem here, but clearly there is no moral problem. If there is no obligation to initiate extraordinary means, there is no obligation to continue them. One does not assume an obligation to continue such means merely by beginning to use them. It is quite true that in the Quinlan case there may have been an initial obligation to use a respirator due to the uncertainty of the prognosis. But if the doctors had known at that time what they know now, there would have been no clear obligation even then.

Some doctors may feel that it is their duty to their profession to use all available means, as long as the patient is alive. This is in many respects a commendable attitude. If this is what the patient or relatives wish, the selflessness of the doctor will be most appreciated. But even here I suspect that the doctor himself would recognize a limit. He has other patients to take care of; he cannot be totally available to any one patient. But there are other limitations as well. Professional conscientiousness does not entitle the

doctor to override the legitimate wishes of his patient. Here the judicious words of Pius XII to the International Congress of Anaesthesiologists are pertinent: "The doctor . . . has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives his permission." The duty of the doctor to his profession does not entitle him to go counter to the wishes of his patient, unless, of course, the patient wishes him to do something morally wrong. The profession exists for the patient; not the patient for the profession. Since the patient has no obligation to use extraordinary means, he is within his rights to refuse them. And if he does, the doctor has no right to impose them on him.

Would the request have been granted if it came from the patient herself? Certainly, it is the patient who has the basic right to make the decision about using extraordinary means. But it is generally agreed that if the patient cannot make the decision, it is the responsibility of her closest relatives. They are presumably in the best position to know what the patient would want, and their decision should ordinarily be in accord with these wishes. If the wishes of the patient are not clear to the responsible relative, he should make the best decision he can in the circumstances. This might very legitimately be the decision he would make if he were

in a similar situation. In the Quinlan case from statements which the girl herself had made previously the parents had good reason to believe that she would not have wanted extraordinary treatment. And since she was not obliged to use such means, the parents were within their rights in requesting their termination. So there should have been no hesitancy about the request because it did not come from the patient herself.

There seems to be no justification or moral grounds for the refusal of the doctors or the hospital to heed the request of the Quinlan family. There may, however, be a legal problem. Everybody in the medical profession is aware today of the plague of malpractice suits afflicting it. The doctors and the hospital in this case may have been worried about their liability to such a suit if they had cooperated with the wishes of the parents in the Quinlan case. Even more serious would be liability to a criminal charge. This is a present concern even in cases where "brain death" has occurred, but so-called "vital signs" are still present due to the use of artificial life sustainers. It would obviously be more of a threat in such as the Quinlan case where "brain death" has certainly not occurred.

For several centuries moral theologians have clearly distinguished between taking a life and not using extraordinary means to prolong it. Some of these theologians were jurists as well as theologians, and so, knowledge-

able in the law. Domingo Soto, O.P. for instance, in his *De Iure at Iustitia* discusses the obligation to undergo an amputation (without anesthesia) and says: "No one is bound to prolong life with such pain; nor is he to be considered a homicide for this reason." Theologians after Soto have spelled out this obligation more in detail and formalized it in the distinction between ordinary and extraordinary means. They may differ among themselves on minor details, but on one point they are unanimous. There is a sharp distinction between homicide and failing to use extraordinary means. The underlying reason is that there is a limit to the obligation to prolong life. A strong defense could be made then against any charge of violating a homicide statute.

The danger of a malpractice suit can hardly be discounted when they are occurring with such frequency. Even though there is undoubtedly far less malpractice today than at any time in the past (the practice of medicine was largely malpractice until relatively recent times), there is an unbelievable number of malpractice suits. This tells us more about our times than it does about the practice of medicine. Interestingly enough, the threat of the law can be at least as great if the doctor tries to impose the use of extraordinary means on a patient. The present writer knows

of a case where the wife of a patient threatened the doctor with a charge of assault and battery if he forced extraordinary means on her husband.

This much should be said. If a doctor or hospital judge that they are doing the right thing, they should not be deterred by the fear of a malpractice suit. Fear of such a suit may be healthy up to a point—to the point that it prevents malpractice. But it should not become morbid; it should not prevent legitimate medical practice. If the fear of malpractice suits becomes a real phobia, the practice of medicine will suffocate.

What is most regrettable in the present case is that the parents had to have recourse to the law to exercise their rights and those of their daughter. One would have hoped that the doctors and the hospital would have been more courageous, and obviated the necessity of bringing the case into court. The court has now ruled against the parents. The decision will undoubtedly be appealed, as it probably would have been if it was in their favor. The real tragedy of the case is that neither the family nor the girl herself will get any relief. Karen will without doubt die on the respirator. The only consolation the parents can have is that through their efforts patients and their relatives in the future may be spared this ordeal.