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**QUALITY OF LIFE
IN BIOETHIC DECISIONMAKING**

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PREFACE

«The questions, 'Is this means too hazardous or difficult to use' and 'does this measure only prolong the patient's dying,' while still useful and valid, now often become 'granted we can easily save the life, what kind of life are we saving?' This is a quality-of-life judgement. And we fear it. And certainly we should. But with increased power goes increased responsibility. Since we have the power, we must face the responsibility»¹. These words of Richard A. McCormick, uttered more than twenty years ago, still ring sharply in the ears of ethicists and doctors today. «Quality of Life» remains a hotly contested issue that stands to mold further the vision of man, for it presupposes the value of the person for the subject himself, for his family and for society. How «Quality of Life» is understood will necessarily determine the limits of the duty to conserve life, in its nascent stages, through sickness or ill health, to its twilight in old age. What is at stake is shown by the ground that «Quality of Life» covers: it touches upon the meaning and definition of personhood; it raises the issue of the meaning and value of human suffering; it inquires into the nature of intention and the limits of freedom in the moral act; it forces one to consider the nature and limits of personal autonomy; and it touches upon the ontological and anthropological understanding of man.

Being a question about man and the value of life, the central question becomes, should the «Quality of Life» of a human being be the central factor in the determination of the moral obligation to conserve or prolong its life? From other angles, the question appears: can criteria be formulated that would draw lines distinguishing those lives to be vigorously supported, from those lives which ought not be, through intentional act or omission?; can one withhold certain

life support means without necessarily harboring an intention of euthanasia? These questions are not only confined to hospitals and primary care clinics, but are encountered in civil courts and social planning, for upon its resolution relies the future of our way of life. For doctors and clinicians, jointly with families and ethics committees, wrestle with the difficult decisions to provide or not to provide life conserving means, a situation ever more common as medical technology advances. The courts find themselves arbiters of the difficult questions concerning personal autonomy in the ultimate decisions of life and death, while trying to maintain the state interest in promoting life, liberty and justice. Social planners, faced with the burgeoning demand for health care resources, grapple with «Quality of Life» questions in their attempts to justly and effectively allocate public means. Ethicists see turning points in the «Quality of Life» debate, as it lies at the heart of many profound changes in modern moral thinking, directly involving the issues of personhood, abortion and euthanasia.

One such «Quality of Life» turning point consisted in the ethico-legal resolution of abortion in most jurisdictions of the world. There is a move to similarly resolve the question of euthanasia in favor of its institutionalization or at least de-criminalization. The development of medical technology, and excesses in its application, have given rise to a certain backlash in favor of an autonomy that would allow one to escape the fate of therapeutic cruelty, if necessary, through assisted suicide or euthanasia. Thus there is a move to characterize such excesses as necessities, challenging us to discover the limits of human dignity as posited by the various ethical systems.

Another «Quality of Life» turning point, especially considered in the consequentialist ethical system, asks: does human life bring with it automatically personhood? Many ethicists prefer to begin with the questions of humanhood and personhood, as points of departure for the determination of obligations for life conservation. In this approach, to be considered a person, one would have to possess certain minimal qualities. Where human life could be present, personhood could be something yet to be attained, or something definitively lost due to the permanent lack of key qualities. Instead of universally recognizing the ontological binomial of the human being-person unity, society would proceed to quality criteria for the concession of personhood.

For those who have attained such personhood, another «Quality of Life» turning point concerns the scope of personal autonomy. Many connect the «Quality of Life» ethic with the necessary autonomy to effect decisions regarding life and death decisions, according to a unique and personal set of values. Paul Ramsey noted this trend twenty years ago which has complicated the «Quality of Life» issue, that of the increasing acceptance of the notion of patient autonomy. He wrote:

His freedom and dignity do not encompass the right to do wrong, a right to assault the value of his own life with medical assistance. Treatments are not electable because elected, desirable because desired. The translation 'a patient's right to refuse treatment,' I fear, moves too far in the direction of subjective voluntarism and automated physicians. Having gone to that state of affairs in the matter of abortion, let us not do so as we approach medical euthanasia².

Thus, Ramsey indicates the stage in which the current debate takes place: infant and adult euthanasia, with virtual and actual triage,³ while the factors of autonomy and utilitarian concerns further complicate the issue. Is such autonomy, however, in the best interests of man and his personal dignity?

Thus, discussions of «Quality of Life» themes eventually lead to discussions about the nature of man. Talk about man's life, especially his biological life, comes to clash with the notion of the patient as person, in the double unitary dimension of body and spirit. The notion of life as a gift and constitutive of the one existing subject conflicts with the notion of life as something that one *has* and can decide about in the most radical way: its voluntary continuation or termination. The question arises as to whether values, especially in terms of life and its «Quality», are to be discovered by man's intelligence, or created by it.

The ethical system of consequentialism abrogates precisely this creative role for man. Ethicists have looked to several other ethical systems to encapsulate the «Quality of Life» issue and its attendant questions for better expression and for elucidation of conclusions and

proposals. The other major systems proposed include natural law ethics, proportionalism, and Kantian deontological ethics. All these systems, taking up major anthropological assumptions, come to widely differing conclusions regarding the role of the intention in the moral assessment of acts, and the limits of man's personal freedom. Thus the current «Quality of Life» debate is presented in the light of the differing ethical systems which the authors assume in expounding their works.

In the thesis, chapter one presents the «Sanctity of Life» ethic. While «Sanctity of Life» can be found in Eastern traditions, the particular Judeo-Christian formulation has had the most universal influence in bioethics, and that tradition is traced from its biblical roots through theological developments. For the Catholic holding, the major declarations of the Popes have given more particular form to its principles for use in bioethic cases, and in particular for this work, in the issue of «Quality of Life».

Thus, after having reviewed the ethic of «Sanctity of Life», chapter two of the thesis presents many attempts to take hold of the equivocal concept of «Quality of Life»; and to clarify it for specific uses. Distinct «Quality of Life» measuring tools are presented, which are most often at the service of physicians both as descriptive aids in clinical discussion and as evaluative determinants in the development of new medical treatment. The concept of «Quality of Life» as *normative*, the major focus of this work, is presented by several authors. The entry of «Quality of Life» into sociology is likewise presented, for its use in health care rationing. The introduction of «Quality of Life» into law in the specific instances of certain end-of-life cases is explored, as well of those cases involving «wrongful life».

After clarification of the concept of «Quality of Life», chapter three follows, briefly introducing the ethical systems which are employed in the «Quality of Life» question, while subsequently focussing on issues within Judeo-Christian quarters. This extract is taken, in its majority, from this third chapter, where the question of *substantial* «Quality of Life» criteria, as employed in a proportionalist ethic, is examined in the context of the Judeo-Christian principles and anthropology mentioned in the first chapter. Such substantial «Quality of Life» criteria are seen as a challenge to the long-held theological

approach to conserving human life. Other authors, particularly seeking to remain within magisterial parameters have, in application of these same, given rise to a major controversy over the «Quality of Life» question. They propose a spiritual function criteria. Much of this debate revolves around the correct interpretation of the received principles and pronouncements, in particular with reference to unconscious patients. Other related issues concern the resolution of concurrent pathology cases, the hermeneutic of benefits and burdens in determining proportionality, and the differentiation of medicine and care, all from the Judeo-Christian perspective.

Once having covered Judeo-Christian perspectives of «Quality of Life», chapter four of the original thesis takes up the treatment of «Quality of Life» from the point of view of secular consequentialist ethics. The first points include the considerations of the requirement of minimum «Quality of Life» criteria for humanhood and personhood. Certain proposals are presented along with their attendant difficulties. The subsequent sections detail the central consequentialist approaches toward «Quality of Life», which include personalist «Quality of Life» determinations within full autonomy and a consequentialist valor calculus, as well as social utilitarian proposals for «Quality of Life» issues. A critique is then made of the consequentialist approach, while proposing arguments supporting the notions of life as an intrinsic good, limited autonomy as in consonance with that good, and the role of intention in «Quality of Life» judgements.

Conclusions are drawn on the notion of normative «Quality of Life» in bioethics. Because of the equivocal nature of the term, precisions are made as to which nuances appear to be most appropriate.

It is hoped that this thesis will serve to elucidate the extensive and complicated concept of «Quality of Life», as well as to be an aid in the Catholic exposition and resolution in favor of the «Sanctity of Life». The investigation begins with a challenge to be *verified*, that might be summed up again by Richard McCormick: «Briefly, if we must face the task of making quality-of-life judgements -and we must- then we must face the difficult task of building criteria for these judgements»⁴.





TABLE OF CONTENTS OF THE TESIS

TABLE OF ABBREVIATIONS	V
INTRODUCTION	1

CHAPTER I THE SANCTITY OF LIFE

I. THE SANCTITY OF LIFE ETHIC: GENERAL PRINCIPLES..	9
II. THE JUDEO-CHRISTIAN SANCTITY OF LIFE ETHIC ...	12
1. Roots of Judeo-Christian «Sanctity of Life»	12
a) Imago Dei and the Dignity of Man	13
b) The Original Formulation of Respect for Life	14
c) Hebrew Anthropology —the Unity of the Person	16
d) Jewish Bioethical Principles	17
2. Perennial Roman Catholic Moral Teachings	21
a) Heritage from the Jewish Tradition	21
b) Differences from the Jewish Tradition	23
c) Historical Development of «Sanctity of Life» Ethic.....	28
i) St. Thomas Aquinas.....	29
ii) Theologians —XVIth and XVIIth Centuries	32
Francis De Vitoria	33
Dominic Soto	35
John Cardinal De Lugo	36
St. Alphonsus Liguori.....	37



iii) Mid twentieth Century Theologians	37
Gerald Kelly	38
Daniel Cronin	39
3. Key Magisterial Pronouncements	40
a) The Statements of Pius XII	40
b) Posterior Magisterial Documents on Means	42
c) Recent Magisterial Anthropological Statements	47
III. WORKING DEFINITION OF HUMAN LIFE	49
IV. SUMMARY AND CONCLUSIONS	57

CHAPTER II THE QUALITY OF LIFE

I. QUALITY OF LIFE —PRINCIPLES AND APPLICATIONS .	59
1. Elements of Bioethical «Quality of Life»	60
2. Normative Bioethical «Quality of Life»	66
a) «Quality of Life» —Definitions, Needs and Wants	66
b) W. Reich —Descriptive, Evaluative, Normative	70
c) J. Walter and T. Shannon —Normative Nuances	73
II. QUALITY OF LIFE —OTHER ETHICAL APPLICATIONS	75
1. «Quality of Life»—United States Law Decisions	75
a) «Quality of Life» in Prolonging Life Decisions	75
b) «Quality of Life» and «Wrongful Life»	83
2. «Quality of Life» in Health Care Rationing	91
III. SUMMARY AND CONCLUSIONS	94

CHAPTER III JUDEO-CHRISTIAN QUALITY OF LIFE CONTROVERSY

I. INTRODUCTION	97
II. ACTORS AND SYSTEMS	101
1. Natural Law Ethics	101
2. Kantian Ethics	106
3. Proportionalism	109
4. Consequentialism	114
III. THE CATEGORIES OF ORDINARY MEANS	117



IV. SUBSTANTIAL «QUALITY OF LIFE» CRITERIA	126
1. McCormick —Life as an Instrumental Good	127
2. May and Bleich —Life as an Intrinsic Good	132
a) May	132
b) Bleich	135
3. The Rational Standard of «Quality of Life»	136
4. Is the«Quality of Life» Approach Dualistic?	139
a) Grisez —«Quality of Life» Involves Dualism	139
b) Wildes —Life as Instrumental and Categorical	141
V. «QUALITY OF LIFE» IN APPLICATION	144
1. The Teleologic Controversy	145
a) O'Rourke —The Spiritual Function Criterion	145
b) Teleologic Approach —Effects, Support, Criticism.....	149
c) Notions —Artificial, Fatal Pathology and Dying	164
i) Artificial-Natural Means	164
ii) Is PVS a Fatal Pathology?	176
iii) Dying	180
2. Double Pathology Relativization	183
a) Representative Authors	184
b) A Critique of the Notion	188
3. Benefits and Burdens —O'Rourke, et Alii	189
a) Bole —Life in a PVS Not an Intrinsic Good	192
b) O'Rourke —Mere Bodily Life Not Proportionate	195
c) P. J. Boyle, J. Boyle —	197
d) Balsam	198
4. Medicine vs. Care. Effectiveness as Criterion	199
a) Connery —Care as Separate from Treatment	199
b) Brodeur —Treatment of the Person	204
VI. SUMMARY	206
VII. CONCLUSIONS	210

CHAPTER IV

THE SECULARIST PLANE OF «QUALITY OF LIFE»

I. INTRODUCTION	213
II. PERSONHOOD AND «QUALITY OF LIFE»	216
III. THE CONSEQUENTIALISM AND QUALITY OF LIFE... ..	249

1. The Consequentialist Good to be Maximized	250
2. Consequentialism in a Personal Perspective	256
a) Personalist Decisions about «Quality of Life»	257
b) The Principle of Autonomy and Quality of Life	260
3. Utilitarianism in a Social Perspective	267
a) The Strength of Beneficence	267
b) Other Social Utilitarian Approaches and Proposals	270
IV. CONSEQUENTIALIST QUALITY OF LIFE: CRITIQUE ..	274
1. Against Consequentialist «Quality of Life»	274
2. Consequentialism and «Wrongful Life»	283
3. Life as Intrinsic Good: Philosophical Defense	287
4. Autonomy and «Quality of Life»	296
a) Autonomy and Suffering.	296
b) The Correct Notion of Autonomy	301
5. Intention and «Quality of Life»	308
a) Killing and Allowing to Die	308
b) Finnis and May —Intention and Self Determination .	314
V. SUMMARY	322
VI. CONCLUSIONS	325
 CONCLUSIONS	 327
 BIBLIOGRAPHY	 331



TABLE OF ABBREVIATIONS

<i>AAS</i>	Acta Apostolica Sedis
<i>AJOG</i>	American Journal of Obstetrics & Gynecology
<i>AIM</i>	Annals of Internal Medicine
<i>Ann Neurol</i>	Annals of Neurology
<i>Arch IM</i>	Archives of Internal Medicine
<i>Bioethics Quert</i>	Bioethics Quarterly
<i>Br J of Nursing</i>	British Journal of Nursing
<i>Crit Care Med</i>	Critical Care Medicine
<i>FT</i>	First Things
<i>HCR</i>	Hastings Center Report
<i>HP</i>	Hospital Progress
<i>ILM</i>	Issues in Law and Medicine
<i>IJNS</i>	International Journal of Nursing Studies
<i>ICM</i>	Intensive Care Medicine
<i>J Am Ger Soc</i>	Journal of the American Geriatric Society
<i>J of Applied Phil</i>	Journal of Applied Philosophy
<i>JFC</i>	Journal of Family and Culture
<i>J of Fam Prac</i>	Journal of Family Practice
<i>J of Gen Intern Med</i>	Journal of General Internal Medicine
<i>J of Pediatrics</i>	Journal of Pediatrics
<i>J Royal Soc Med</i>	Journal of the Royal Society Medicine
<i>JAMA</i>	Journal of the American Medical Association
<i>JCE</i>	Journal of Clinical Ethics
<i>JM & P</i>	Journal of Medicine and Philosophy
<i>JME</i>	Journal of Medical Ethics
<i>L M & H C</i>	Law, Medicine and Health Care
<i>LQ</i>	Linacre Quarterly

- NEJM* The New England Journal of Medicine
Phil Stud Philosophical Studies
PCPA Proceedings of the Catholic Philosophical Association
Theor Med Theoretical Medicine
TS Theological Studies
AAN The American Academy of Neurology
AMA American Medical Association
CPR Cardio Pulmonary Resuscitation
EEG Electroencephalogram
PVS Persistent Vegetative State
ARTIFICIAL MEANS G. KELLY, «The Duty of Using Artificial Means of Preserving Life», *TS* 11 (1950) 203-220.
BIOMEDICAL ETHICS *Biomedical Ethics (2nd ed)*, T. A. MAPPE, J. S. ZEMBATY, eds., McGraw-Hill, New York, 1986.
BRC *Bioethics Readings and Cases*, H. T. ENGELHARDT JR, B. A. BRODY, eds., Prentice Hall, Englewood Cliffs, New Jersey, 1987.
BSD *Birth Suffering and Death: Catholic Perspectives at the Edges of Life*, (volume 41 in the Philosophy and Medicine Series), K. WILDES, F. ABEL, J. HARVEY eds., Kluwer Academic Publishers, Dordrecht, 1992.
CC-RAM *The Critical Calling: Reflections on Moral Dilemmas Since Vatican Council II*, R. A. MCCORMICK, Georgetown University Press, Washington, D. C., 1989.
CCC Catechism of the Catholic Church
CDF-ABOR Sacred congregation for the doctrine of the faith, *Declaration on Procured Abortion*, *AAS* 66 (1974), 730-747.
CDF-EUTH Sacred congregation for the doctrine of the faith, *Iura et bona, Declaration on Euthanasia*, *AAS* 72 (1980), 542-552.
CONSERVING *Conserving Human Life*, RUSSELL E. SMITH, ed., The Pope John Center, Braintree, Massachusetts, 1989.
DDE *Death Dying and Euthanasia*, D. J. HORAN, D.



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- EUTH-CARMI* *Medicolegal Library 2: Euthanasia*, A. CARMI, ed.,
Springer-Verlag, New York, 1984.
- EV* JOHN PAUL II, Encyclical Letter:
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Polyglot, Vatican City, 1995.
- GS* Vatican Council II, Dogmatic
Constitution on the Church in the Modern
World *Gaudium et Spes*, (December 17,
1965), AAS 58 (1966).
- I & H* *Infanticide and the Handicapped Newborn*, D.
J. HORAN, M. DELAHOYDE, eds., Brigham
Young University Press, Provo, Utah, 1982.
- LIFE & DEATH* *Life and Death with Liberty and Justice*, G.
GRISEZ, J. M. BOYLE JR., University of Notre
Dame Press, Notre Dame, 1979.
- PIUS-MEANS* PIUS XII, *Adstantibus multis honorabilibus Viris
ac praeclaris Medicis et Studiosis, quorum plerique
Nosocomiis praesunt vel in magnis Lyceis docent, qui
Romam convenerant invitatu et arcessitu Instituti
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I. PROPORTIONALITY AND QUALITY OF LIFE

The question of «Quality of Life» is asked against the background of a «Sanctity of Life» ethic. Thus, the teaching of the Magisterium is presented to provide a basis for understanding the ethical changes proposed by those supporting a «Quality of Life» ethic. This doctrine is presented in terms of negative duties, (thou shalt not kill) and positive obligations to conserve one's life. This latter category has been most recently formulated in terms of proportionate and disproportionate means. This section presents the teaching, as well as objections and proposals.

1. The Proportionality of Ordinary Means

The most clear sources for the teaching on the obligation to conserve one's life are found in the discourses of Pius XII, and in the magisterial teachings under John Paul II. These more important statements are presented.

a) Magisterial Teaching on Proportionate Means

Pope Pius elaborated the right and obligation that one has in taking the necessary treatment in order to preserve one's life. One fulfills this duty before God, before one's community in social and even strict justice, and before one's family. However, he limited such a duty:

But normally one is held to use only ordinary means — according to circumstances of persons, places, times, and culture— that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life

and health, as long as he does not fail in a more serious duty⁵.

Within the Catholic heritage, the terminology ordinary, extraordinary, proportionate, disproportionate have been used to elucidate the obligation to conserve life. «Means» refer to the positive obligation that enjoins one to conserve human life. The obligation has been seen to bind, except in the case of moral impossibility. In pronouncing on this question, Pius XII (Allocution of November 24, 1957) clarified that this duty is relativized by what constitutes a excessive burden in a particular culture, place, time, etc., thus allowing for the coexistence in time of one means as ordinary *and* extraordinary depending on the place, and equally dichotomous but in different epoches. Also to be considered are the pertinent moral and physical resources of the particular patient and his family. This approach allows for an on-going development of means from extraordinary to ordinary—a concession to medical technology's positive effect on the lessening of the burdens of treatments and remedies.

With the steady advance of medical technology and the attendant questions on its use, the magisterial document *Declaration on Euthanasia*, summarized much of the Catholic teaching on the «Sanctity of Life», while forbidding euthanasia. The *Declaration on Euthanasia* clarifies the definition of euthanasia for purposes of ethical treatment. It states: «By euthanasia is understood an action or omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference are to be found in the intention of the will and in the methods used»⁶. The document goes on to clearly denounce all acts that kill innocent human beings. This definition makes it clear that omissions that introduce a cause of death, as a directly intended effect, or as the only effect where a moral impossibility is not encountered, are to be counted as euthanasia. In developed analysis, the document, in the section on due proportion in the use of remedies, states the conditions under which omissions are not to be construed as euthanasia. It cites and develops the teaching confirmed by Pius XII:

In the past, moralists replied that one is never obliged to use «extraordinary» means. This reply, which as a principle still holds goods, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of «proportionate» and «disproportionate» means. In any case, it will be possible to make a correct judgement as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibility of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

In order to facilitate the application of these general principles, the following clarifications can be added:

—If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity.

—It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter. The latter may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques.

—It is also permissible to make do with the normal means that medicine can offer. Therefore one can not impose on anyone the obligation to have recourse to a technique which is already in use but carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human

condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

—When death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such cases the doctor has no reason to reproach himself with failing to help the person in danger⁷.

In this lengthy citation, the Magisterium provides a coherent approach using the proportionality of means for deciding the extent of the obligation to conserve human life. While the patient's condition, both before and as projected after prospective treatment, is an important element in this decisionmaking, the primary focus is on the means to be applied, and not directly upon the «Quality of Life» as normative. Means that are proportionate offer hope of success and freedom from excessive burdens in keeping with the benefits sought, (and the side effects to be tolerated).

b) Proportionality —Objections and Proposals

This focus upon means and their proportionality, allows for advancement in medical technology to bring many means, once considered excessively burdensome in certain aspects (cost, pain, risk, etc) to be considered proportionate. Callahan, however, asks for a more critical assessment of the «progress» that medical advance provides.⁸ While claiming not to be anti-technologic, he opposes the process by which a means could become ordinary based solely on the burdensomeness of the application. He averts to the fact that while some technological advances ameliorate suffering due to old age and sickness, others may in effect prolong suffering. Thus appealing that «no one should have to die a worse death as a result of medical technology than would have been the case prior to that technology», he goes on to state:

If technology threatens to leave us worse off, and we nonetheless feel obliged to use it, we have indeed become its slaves.... Doctors should feel as great an anxiety that a patient will die a poor death from technological excess as the present anxiety that the patient will die because there is too little technology⁹.

He then asks if new technology should be invented for the sole purpose of keeping people alive with a poor «Quality of Life», especially, for example, those with in a PVS: «If one believes that it is a good to be kept alive in a PVS state, does this not imply that further research should be carried out to make such a thing more possible — to keep those in that state alive longer and longer, even to a full lifetime?»¹⁰ The challenge is clear: should the process by which a means becomes ordinary be left untouched, or should it be governed by «Quality of Life» principles which seek the quality of life preserved?

Catholic teaching introduces a relativizing standard, that directs toward the determination of the burdens of moral impossibility on a case by case basis, with the decisions to be taken in conscience. A difficulty with the «Quality of Life» standard, (or perhaps equally stated here, the «Quality of Death» standard) lies in fixing the operational criteria. Also, how is the better death to be determined? This suggests in practical terms, a rejection of the means approach as such, and the nature of this thinking leads necessarily to replacing the burden of *means* by the burden of *life* in the determination of what constitutes proportionate means. Thus, establishing the value of the lives of the permanently unconscious, that is human life that does not exhibit any rational or affective signs, becomes necessary.

Lynn and Childress rightly point out that, in medical practice, some of the criteria implicit in the means debate are foreign, that is, not morally relevant in the determination of proportionality.¹¹ But they conclude that «medical nutrition and hydration do not appear to be distinguishable, in any morally relevant way, from other life-sustaining medical treatments that may on occasion be withheld or withdrawn»¹². This shift in common outlook toward the evaluation of the proportionality certain effective means for life itself will be dealt with in a separate section.

However, even the seemingly simple task of appraising reasons for withholding or withdrawing, —the usefulness of a given means (or its futility), is fraught with difficulty. Several authors emphasize that each aspect of this deliberation comes conditioned by one's previous stance on the value of life. Youngner states: «Physicians are in the best position to know the empirical facts about the many aspects of futility. I would argue, however, that all, except for physiological futility and an absolute inability to postpone death, also involve value judgements»¹³.

In the midst of this controversy over the validity of the means approach, Ramsey made a valiant effort to avoid the slipperiness of the «Quality of Life» terminology and approach, and to found the whole approach on an objective basis. For this he sought a foundation in the physiological understanding of futility:

I suggest that the morally significant meaning of ordinary and extraordinary medical means can be reduced almost without remainder to two components. I further urge that the older language be abandoned, and that instead we should speak of (1) a comparison of treatments that are 'medically indicated' and expected to be helpful, and those that are *not* medically indicated. In the case of the dying, that in all cases, or in many cases, a judgement that further curative treatment is *no longer* indicated. Instead of the traditional language, still current among physicians, we should speak about (2) a patient's right to refuse treatment¹⁴.

Still Ramsey expressed misgivings about making such a change, admitting that an advantage of the older terminology was that it directed the attention of the concerned parties toward the objective features of the patient's condition and the curative means, (even those previously be expressed in advance directives), rather than towards value judgements about the «Quality of Life». One of the pioneers in eschewing patient autonomy,¹⁵ he warned against the unbounded use of such a concept that would attempt to empower subjective decisions with the creation of right and wrong, something the prior means approach could avoid. Ramsey intended that such considerations be

applicable only to *dying* patients. Here the difficulty arises in practice as determining who qualifies for this label. Furthermore, despite the well intentioned effort, it is not clear how this proposal would escape the critique of Youngner that points to inevitable «Quality of Life» elements.

McCormick offers a newer version on determining the obligatoriness of treatments that are considered ordinary or proportionate in most situations. He prefaces this by also noting, correctly, a certain ambiguity in the term *dying*. For those with an illness that would prove fatal without treatment, he proposes a twofold determining criterion: «(1) a return to relatively normal health: (2) ultimate independence from the technology. It is these two features that constitute the notion of ‘reasonable hope of benefit’»¹⁶. Thus, for a dialysis patient requiring on-going treatment, or for one with a pacemaker with an external power source, McCormick speaks of a grey area involving optional treatment. Equally to be deduced from this is that for a person that can be maintained, but not returned to anything approaching normal health, we also begin to view the treatment as inappropriate. Thus the «Quality of Life» to be preserved determines whether we view the patient as dying or not, as well as the moral obligation of the treatment. If the life is of poor quality, the means can be extraordinary, and we can judge it appropriate to withdraw or withhold the means and allow the «dying» process to run its course. McCormick charges that to decide independently of this criterion is to fall back on vitalism.¹⁷ It is not clear, however, that the means approach, in its assessments of burdens inherent in the treatments themselves, does not offer a safeguard against unnecessary, useless or excessive treatment. Again, much turns on how one views the value of life of lesser quality.

Quay intuits in McCormick an attempt to return a moral dimension to moral acts, yet questions the method: «But is it desirable to achieve this goal by turning the definition of the physiological deterioration, already at work, that dying is, into a value judgement about the utility of means?»¹⁸

c) Nuances —Artificial-Natural Means

The distinction between artificial - natural frequently arises in considering the obligatoriness of means. The question is posed: does this distinction have moral content, that is, is it a factor in itself in determining whether a means is proportionate? Discussion of this distinction dates at least from the writings of Vitoria. A number of authors opine on the content of such a distinction; presented here are Kelly, Cronin, and McCormick.

Kelly, writing in the early 1950s, introduced, for modern bioethics debate, the question itself of the natural - artificial distinction by examining the fittingness of certain means. He distinguished artificial means as remedies, and not obligatory unless offering a reasonable hope of checking or curing a disease, that is, *spes salutis*. Kelly sees remedies as supplanting natural functions:

[A]nd on this basis, [to arrive at a prudent, human evaluation of the factors involved], all artificial means of sustaining life seem to be remedies. All of them are used because of some diseased or defective condition. I suggest, therefore, that any principle which is applicable to remedies as such is applicable to the use of any artificial means of preserving life¹⁹.

He continues to make it clear that the overriding principle in the determination of the obligatoriness of the means rests not with the determination *natural* or *artificial*, but with the evaluation of ordinary or extraordinary. It is not clear if Kelly wanted to distinguish nutrition and hydration administered artificially from «ordinary care» which he considered obligatory.

Cronin, writing a few years after Kelly, took up certain historical aspects of the duties of conserving life, and within this context, singled out Vitoria for the beginnings of the natural - artificial distinction. While in Vitoria's time technological advances in medicine were only in their nascent stages, drugs and special diets were not unknown, and thus formed part of his inquiry, and he concluded: «There is no such similarity between a drug and food. For food is *per se* a means ordained for the life of the animal and is natural, not so however for

a drug.... Medicine *per se* is ordained by nature for health»²⁰. Cronin interpreted Vitoria as seeing food as basically and fundamentally necessary for the physical sustenance of the organism from its very beginning, required by all, and part of the order of nature. Because of this, man has a right to cultivate and procure food. Drugs are not needed in this same way, but are intended by nature *per se* for the conservation of life, by way of exception, when man is sick or in pain and unable to sustain himself with the ordinary means that nature provides. Were man never to fall ill, he would not need these remedies²¹.

Thus Cronin resumed:

To summarize Vitoria's teaching in this matter, we may say that natural means of conserving life are *per se* intended by nature as the means whereby man is to conserve his life and ordinarily these are strictly obligatory. Furthermore, artificial means of conserving life are *per se* intended by nature as a means whereby man can supplement the natural means of conserving life when these natural means are lacking or insufficient etc. Ordinarily, these artificial means are obligatory too if they can be obtained and used conveniently and with some certitude of benefit²².

As Cronin noted, Vitoria introduced several considerations: that there is a difference between a natural means and an artificial means, but for the purpose of determining the obligations of their use, they fall under the same scrutiny as natural means; and while the distinction can be made, the artificial means are still seen as «intended by nature» for man's use; that artificial means can be considered as a supplement.

While Cronin looks and studies the differences between natural and artificial means in themselves, McCormick, however, focuses on its administration and the attendant complication in order to maintain a distinction between means applied in an 'ordinary' fashion, and medical treatment ('artificial' feeding, such as nasogastric and gastrostomy tubes, or hyperalimentation)²³. He first raises a question:

Does the simple fact that artificial feeding 'gives what all men need to live' imply that how it is given makes no

difference in its description? Most of us would not know how to go about providing nutrition and hydration by nasogastric tube and I.V. lines. These procedures require skilled medical training. Does that constitute them strictly medical procedures? This is an important issue because normal feeding has profound symbolic importance in human relationships and societal structure. It is one thing to starve the hungry. We should be appalled at the idea. It is quite another to withhold or withdraw a medical procedure. That we do routinely and justifiably²⁴.

This shows the complication of modern bioethics in that procedures which were once experimental, highly risky, and perhaps rather inefficacious, are now common, developed, and easier to provide. The point McCormick makes is that commonness or ubiquity of a means does not make it in itself «ordinary» and thus obligatory. These characteristics are not sufficient in themselves; while these means may be common in a hospital, they exceed the skill of the untrained, and bring with them risks. McCormick concludes that the qualification 'artificial' can bring with it that of «treatment». This would lead to consider nutrition and hydration, for example, as a medical means subject to medical autonomy. This would also discount the claim made by others, that certain means always belong to «ordinary care», a care which ought not to be interrupted except in the case medical futility, since it is assumed proportionate from other aspects.²⁵

2. Normative Quality of Life

Some authors have undertaken the task of formulating a definition of normative «Quality of Life» for bioethic discourse. While such definitions have their limitations, they do bring out the basic differences between a «Quality of Life» ethic and a «Sanctity of Life» ethic, and the underlying ethical theories used to support them. This extract examines the «Quality of Life» debate within Judeo-Christian circles, where the prevalent ethical theories are Natural Law ethics, Jewish Hallakah law, and Proportionalism.

a) Reich —Descriptive, Evaluative, Normative

Reich proposed summary definitions of «Sanctity of Life» and «Quality of Life» ethics for the bioethic field, showing their underlying assumptions as revealing options for moral theories that are often found in sharp conflict:

A quality of Life ethic can be defined as one that (1) depends on an ethical theory of consequentialism; (2) assigns relative and unequal value to human lives on the basis of the possible consequences of variable qualities; and (3) espouses the norm that the conservation and protection of human life are not required or do not carry an overriding obligation, unless the directly experienced qualities or the qualities expected to be experienced actually invest that life with sufficient value.

In contrast, a sanctity-of-life ethic (1) typically depends on a deontological theory of ethics (though other moral theories can be used to support its norms); (2) assigns equal value to human lives regardless of their condition, usually on the basis of inherent values; (3) frequently presupposes the general moral orientation favoring a strong moral belief that human life should be treasured and respected; and (4) espouses the presumptive norm that human life ought to be sustained and protected and that life ought not to be taken without a very serious justification²⁶.

A «Sanctity-of-Life» ethic must respond to the challenges posed by new medical technology, principally if the proportionate means analysis can adequately address the difficult cases such as suffering deformed newborns and fetuses in terms of that same suffering, the suffering of the family, and the costs to society. A «Quality of Life» ethic, which claims to resolve these questions neatly, must defend itself against the charge that such clarity of action is not purchased at a price that erodes the very human values it attempts to safeguard.

As mentioned, «Quality of Life» is an equivocal term, leading to many ambiguities. The usage for describing a patient's condition will not necessarily provide directly an ethical treatment option; likewise,

identifying «Qualities of Life» that are appealing to most men, does not serve to illuminate the present physiological condition of this patient, nor indicate to us his or her particular preferences. In order to shed light on usage, Reich, in an entry in the *Encyclopedia of Bioethics*, makes a threefold distinction for «Quality of Life»: namely, descriptive, evaluative and normative²⁷.

He distinguishes «Quality of Life» as a descriptive statement when one «makes an observation about the presence or nature of a quality, characteristic, or property When used to describe a patient's present or future condition, the term 'quality of life' is morally neutral»²⁸. Clearly, in order to make rational, ethical medical decisions, one must take into account the condition of the patient. This does not necessarily imply a normative relation between that condition and the treatment decision. Disagreement thus often arises over terminology, with one party claiming that «Quality of Life» assessments must not be made, (taken in a normative sense), while another misconstrues this to mean that one must somehow make sensible medical decisions without evaluation of the medical condition of the patient («Quality of Life» taken in a descriptive sense).

Reich continues with another distinction, the *evaluative* «Quality of Life»:

An evaluative statement about quality of life indicates that some value or worth is attached to the characteristics of a given individual or to a kind of human life. This means that a quality of life is good or desirable or valuable. When a quality is valued in this way, the life may be appreciated, desired, or judged worth living as something sacred, beautiful or beneficial, but this does not necessarily imply that actions terminating or supporting life are right or wrong. Some call this a nonmoral value judgement. For example, one may value a physically mobile life; but the question remains unanswered as to what actions are permissible in reference to a life that is less than normally mobile.²⁹

Much has been written on evaluative «Quality of Life», including such diverse points of view ranging from the positive valuation of

human suffering to the exaltation of a life that precludes any such suffering. Medicine has made great use of the evaluative «Quality of Life» concept, seeking advances in medicines and techniques to better the overall «Quality of Life» of persons. An example is a test designed for the efficacy of three anti-hypertensive drug therapies. A number of quality of life dimensions were chosen, thought to be affected by the drug treatment from their significant side effects: general well-being, sleep dysfunction, sexual problems, work performance, social activity participation, physical stress, and cognitive function. Despite the quite comparable effectiveness of the three drugs tested, comparable differences in the health-related quality of life were detected, giving a basis for differentiation of the treatment options.³⁰

Finally, Reich presents his description of a statement of «Quality of Life» that is morally normative, one that «entails a moral judgement on valued qualities of life, which involve saying that certain norms indicate which attitudes toward or ways of treating human bodily life are morally good or bad, right or wrong. Quality of life has its real significance for bioethics, then, only when it is used in a morally normative judgement that states whether one ought to support and protect life on the basis of a perception of human qualities».³¹

b) Walter, Shannon —Nuances in Normative

Walter and Shannon provide a threefold division of normative «Quality of Life» for bioethic discourse.³² In this approach, three categories are made of patients with impaired «Quality of Life». The first involves those with a congenital or acquired condition of diminished «Quality of Life». Such a patient would be functional, the illness, non life threatening and manageable. The normative content requires proportionate means, and this situation is not rightly judged to be one where heavy ethical analysis needs to be invoked. No ethical or medical basis to withdraw or deny life support is indicated. The second group involves those with a diminished «Quality of Life» caused by a life threatening illness, or terminal condition. Here again the proportionate disproportionate means analysis is applied, and the question is thus rightly posed: should life support be begun or continued? The third group involves a combination of the preceding two: a diminished quality of life from a preexisting

condition, complicated by a different, life threatening, or terminal, illness. Here the proposal is that the normative analysis of the second group is modified in that the poor «Quality of Life», which would render some treatments otherwise considered obligatory, as optional, based on the ability of the patient to continue to seek the spiritual purpose of life. The principle of proportionate benefit still applies, but it may be concluded that continued life in this poor «Quality of Life» state may or may not be a benefit, and one may allow the underlying fatal pathology to run its course in given situations.

c) «Quality of Life» Definitions,—Needs,Wants

In a survey of definitions as they have appeared in the literature, Johanna de Haes and Ferdinand van Knippenburg offer six versions of «Quality of Life»:

- a) Ability of patients to manage their lives as they evaluate it;
- b) the degree of need satisfaction within the physical, psychological, social activity, material and structural area;
- c) a function of the patient's natural endowment, and the efforts made on his behalf by his family and by society;
- d) the global evaluation of the good or satisfactorily character of people's life;
- e) the totality of those goods, services, situations and states of affairs which are delineated as constituting the basic nature of human life and which are articulated as being needed and wanted; and
- f) the output of two aggregate factors: physical and spiritual³³.

What is clear is that «Quality of Life» must include all areas of life and experience. Häyry presents two approaches for quality of life definition: a *needs* basis and a *wants* basis. The former is the subject of many measurement tools that see «Quality of Life» in the satisfaction of certain basic needs as mentioned previously, such as health, (or lack of disease), mobility, good physical performance, adequate nutrition and shelter, etc. The latter views «Quality of Life» as being able to be improved by the fulfillment of the wants or personal goals of the individual³⁴. One such wants theory defines:

A good quality of life can be said to be present when the hopes of an individual are matched and fulfilled by

experience. The opposite is also true: a poor quality of life occurs when the hopes do not meet with experience. Quality of life changes with time, and under normal circumstances can vary considerably. The priorities and goals of an individual must be realistic and would therefore be expected to change with time and be modified by age and experience. To improve the quality of life therefore, it is necessary to try to narrow the gap between hopes and aspirations, and what really happens. A 'good' quality of life is therefore usually expressed in terms of satisfaction, contentment, happiness and fulfillment, and the ability to cope³⁵.

The wants approach sees «Quality of Life» and its improvement then in this gap between the sought after, and the present possession. This clearly contrasts from the needs approach, which analyzes «Quality of Life» from the angle of the basic needs that all men require.

There are some important assumptions explicit in the wants approach. It is multi-dimensional with regard to the individual's life. His or her aims and goals must be realistic. Furthermore, such an approach, if taken strictly, is irreconcilable with the needs approach, and similarly renders all «Quality of Life» measurement scales useless. Thus Calman voices the most important assumption: «It is *not* possible to make value judgements about other people's 'quality of life'. It is their own perception which matters».³⁶ Sartorius gives a similar version of wants approach which includes these assumptions: «quality of life can be defined as the individual's perception of their position in life, in relation to their goals, and to the value-system which they have accepted and incorporated into their decision making».³⁷ Once joined to unlimited patient autonomy, this wants approach comes close to personalist «Quality of Life», in which a consequentialist ethical theory is used.

In the needs approach, «Quality of Life» approach leads to the development of «Quality of Life» scales, (which differentiate the differentiate functional, physiological, and social needs of patients), an emphasis on medical paternalism, and proxy judgements. In a Catholic context, we have Richard A. McCormick's attempt to introduce substantive «Quality of Life» into the bioethical discourse. For

applications, we encounter the double pathology question, and the spiritual criterion of O'Rourke.

II. SUBSTANTIAL «QUALITY OF LIFE» CRITERIA

Thus, one of the pioneering advocates in Catholic circles of introducing the «Quality of Life» ethic is Richard A. McCormick. He presents his view on the particular good that life is, as well as a criterion for discriminating when such life no longer serves the person. As well he suggests how this criterion could be converted into concrete operational terms for use in actual cases. A number of authors take exception to this approach. William May and David Bleich present typical views that oppose the approach of forming substantial «Quality of Life» criteria by offering a contrary view of life as an intrinsic good. Germain Grisez, for his part, presents a further objection by charging that instrumentalizing bodily life—central to McCormick's substantial «Quality of Life» criterion—brings with it, necessarily, an unacceptable anthropological dualism.

1. McCormick—Life as Instrumental Good

The debate over substantial «Quality of Life» criteria began in the 1970's. McCormick contributed to this debate by penning the essay *To Save or Let Die*, which brought to the forefront many deeply felt concerns and issues involving «Quality of Life», asserting the need to make critical bioethic decisions within the «Quality of Life» ethic: «Briefly, if we must face the frightening task of making quality-of-life judgements—and we must—then we must face the difficult task of building criteria for these judgements». ³⁸ But he still maintained that it is essential to «proceed with great humility, caution and tentativeness», seeing that when one deals with such critical issues, «it is better to err on the side of life», thus seeking to avoid the charge that, for him, the life could have no value³⁹.

McCormick looks to steer a middle course between a perceived rigid stance of a «Sanctity of Life» ethic that verges on vitalism, and the other extreme of a reliance only on the concrete details of each case, that is an approach without general norms of any kind⁴⁰. McCormick begins with the Judeo-Christian attitude toward human bodily life: it is neither an absolute good, nor useless when frustrating or burdensome. He continues with his view of that tradition: «The middle course that has structured Judeo-Christian attitudes is that life is indeed a basic and precious good, but a good to be preserved precisely as the condition of other values».⁴¹

McCormick comes to his criterion of *capacity for interpersonal relationships* by beginning with the magisterial pronouncements on means and ends in prolonging life. After quoting Pius XII on the higher more important end, McCormick asks two questions: «First, what are these spiritual ends, and this ‘higher, more important good?’; and how is its attainment rendered too difficult by the use of extraordinary means to preserve life?»⁴²

To answer the first question, he frames this higher good in terms of the love to be shown to God and to neighbor. He marks the sense of the identification of love of neighbor with love for God, and continues:

The good our love wants to do to Him and which he enables us, can be done only to the neighbor, as Karl Rahner has so forcefully argued. It is in others that God demands to be recognized and loved. If this is true, it means that, in the Judeo-Christian perspective, the meaning, substance, and consummation of life is found in human *relationships*, and the qualities of justice, respect, concern, compassion, and support that surround them. Second, how is the attainment of this ‘higher, more important (than life) good’ rendered ‘too difficult’ by life-supports that are gravely burdensome? One who must support his life with disproportionate effort focuses the time, attention, energy and resources of himself and others not precisely on relationships, but on maintaining the condition of relationships. ... The importance of relationships gets lost in the struggle for survival⁴³.

What is now extraordinary is that which will render this relationship impossible to achieve. Judgements are made about the condition, rather than the means, of prolonging life: a «Quality of Life» perspective. After reviewing some examples of circumstances which traditionally were used to show how *means* became extraordinary, McCormick asserts for these that «often enough it is the kind of, the quality of life thus saved (painful, poverty stricken and deprived, away from home and friends, oppressive) that establishes the means as extraordinary. *That* type of life would be an excessive hardship for the individual». ⁴⁴ Traditional use of the principle of double effect concentrated on the intention toward the immediate effects, the burden the use of the means would bring about. McCormick looks toward the continued life itself as the burden to be avoided, a life incapable or so burdened that one cannot exercise one's relational capacity. Of such a life, it «can be said to have reached its potential». ⁴⁵ And in a different article: «The issue here is this: In weighing the burden-benefits of a treatment, is it the burden of the treatment only (e.g. its pain, expense, etc.) that is legitimately considered, or may we include in the assessment the burden of continued existence itself? In other words, may the quality of life preserved be a proper dimension of the calculus?» ⁴⁶

In essence, bodily life without capacity for personal relationships, for McCormick, provides no benefit for the person. He explains:

Concretely, if 'life' means *only* metabolism and vital processes, then what is meant by saying that this is a 'good in itself'? If that means a good to be preserved independently of any capacity for conscious experience, I believe it is a straightforward form of vitalism —an approach that preserves life (mere vital processes) no matter what the condition of the patient. One can and, I believe, should say that the *person* is always an incalculable value, but at some point continuance in physical life offers the person no benefit. Indeed to keep 'life' going can easily be an assault on the person and his dignity. Therefore, phrases such as 'the good of life in itself' are misleading in these discussions. ⁴⁷

Paris⁴⁸ also views capacity for spiritual function as normative: «Ordinary means are those which are not disproportionately costly, burdensome or painful, and —this is the important part— they must also offer substantial hope of benefit to a person, not simply to his liver, lungs or heart. What we are to be valued for is our personhood, and if this treatment cannot offer substantial benefit to the person, not just to his or her chemistries, it is extraordinary and need not be applied». Paris here is making explicit in these quotes his opinion that human bodily life is not a good in itself. To determine its goodness, we must look to the qualities that life possesses: «to make these decisions we must consider the ‘quality of life’ of our patients».⁴⁹ However, Paris apparently believes it to be self evident that unconscious personal existence is not a proportionate good; he does not enter into argumentation, rather in his articles presents graphic examples of poor «Quality of Life».

2. *May and Bleich —Life as Intrinsic Good*

Thus, while McCormick sees life as a good that is conditioned by its quality, that is, by the benefit that it offers to the bearer, others hold a more basic view that life is a ‘basic good’. This ‘basic good’ is intrinsic to persons, and is among the many basic goods *of* persons. The following presents as typical of a number of authors, the views of Catholic theologian William May, and Jewish Physician David Bleich.

a) May —Life is Intrinsically Good

William E. May supports a contrary position, stating: «Human bodily life is a great good. It is a good *of* the person and intrinsic to the person and is not a mere instrumental good or good *for* the person».⁵⁰ Clearly he does not deny the difficulties with caring for such patients, but adds: «But such care is not without its benefits. Since it is necessary to sustain life, such care benefits the nondying patient by serving this fundamental personal good —human life itself— which, as we have explained, remains good in itself no matter how burdened it may become due to the patient’s poor condition».⁵¹

May attacks the «Quality of Life» approach that discounts the obligation to provide means, even «ordinary» means, due to the poor quality of the patient's life. He points out the difficulty in maintaining such a position, while at the same time professing to hold out also for respecting life. He charges such a «Quality of Life» ethic as being incompatible with true appreciation and respect for the person to be included in the intention when acting:

Moreover, if we judge that someone's life is so burdensome that there is no longer any obligation to preserve it, are we not in essence saying that this person's life is no longer good, but now has become a disvalue, a burden, and that, consequently, the person would be better off dead than alive? This seems to be clearly implied when McCormick asserts that '*that* type of life would be an excessive hardship for the individual.' The burden which needs to be lifted is not the burden of a treatment, but the burden of a life. And this is lifted only when the person is dead. In my opinion, McCormick's proposal denigrates the inherent value of human bodily life, regarding it as a good *for* the person, not as a good *of* the person. It is good only so long as it serves as the condition for what McCormick regards as truly human or personal goods, namely relational goods whose existence is dependent upon one's conscious awareness of them⁵².

May counters that in McCormick's view: «life itself, in the sense of physical or biological life, is what an older terminology would have called a *bonum utile*, not a *bonum honestum*». ⁵³ McCormick responds to this by arguing: «First one could say that life is a good to be preserved insofar as it contains some potentiality for human experience is not to make life a *bonum utile*, or merely a useful good, and therefore a kind of negotiable thing. Rather it is to talk about our duties —and especially the why of those duties— toward the preservation of the *bonum honestum*, that is a good in itself, the dying human person, and to admit that these duties may differ depending upon the conditions of that *bonum honestum*». ⁵⁴

This response appears weak, because if one is ready to admit something to be a good in itself, one should be ready to also admit

that such a good should oblige, then, at least the ordinary means, that is, those within the reach of persons without excessive burden and which are useful, (i.e., not futile). And once the means have been qualified to be ordinary, the use of such means should not be predicated on the condition of the patient, as the condition will not change, in the Christian perspective, the 'good in itself' to a disvalue for anyone involved. McCormick offers an additional response:

Second, and perhaps even more to the point, it could be counterstated that the usage of 'useful good' and 'good in itself' plays upon the ambiguity of the term 'life'. 'Life' can itself mean two general things: (1) a state of *human* functioning, (or capacity thereof), of well being; or (2) the existence of vital and metabolic processes with no human functioning or capacity. We do not, in Christian perspectives, preserve these functions *for their own sake*; we are not vitalists. In this second sense of 'life', then, one could argue that it is indeed a useful good only, though it is not clear to me how such terminology illuminates the matter⁵⁵.

This second response has its problems as well. To lay the charge of vitalism toward those who would maintain biological life, is to miss the point that where human bodily life exists, there also exists the person. Treating the live human body as «mere human biological life», would be to take on either a form of dualism, where the person is viewed as apart from his body, or a form of actualism, which recognizes the person to exist only when a state of human functioning can be measurably detected, usually according to tests for cognitive function. Moreover, vitalism implies the preservation of life at *all* costs as an absolute good, whereas May enjoins only ordinary means. Furthermore, to regard human biological life as a useful good is to veer toward disrespect for the person, for all personal life is a good in itself.

b) Bleich —A Judaic View

David Bleich comes to many conclusions similar to those of May. In presenting a Jewish position, he posits that the «reason» for the

fifth commandment could conceivably be to counter euthanasia, active or passive. He sees the moral judgement that murder, for ignoble reasons, as wrong, is able to be grasped by man by the light of his own reason. «Revelation is necessary precisely because the act is prohibited even in those situations in which man's moral faculty, if left to its own devices, would not recognize the deed as repugnant, viz., when the taking of human life constitutes euthanasia». ⁵⁶ Although the Judaic tradition is not equivalent to vitalism, it does consider that «Human life is not a good to be preserved as a condition of other values but as an absolute, basic, and precious good in its own stead. The obligation to preserve life is commensurately all-encompassing». ⁵⁷ Bleich argues that despite the decline in health and faculties, and accompanied by suffering, God's dominion and glory, incomprehensible and mysterious, demands that life be respected, and this precludes intentional acts or omissions to terminate human life.

Through a *reductio ad absurdum*, Bleich also brings out logical consequences: if life is an instrumental good, then when it can no longer lead to the basic goods, the acceptance of euthanasia, active or passive follows. This would embrace not only the permanently unconscious, but all others not able to achieve the integral human fulfillment; such patients could be eliminated with moral impunity. The inherent repugnance leads one to question the major premise, that life is not a *bonum per se*. ⁵⁸ As well, the Christian sense of suffering, as redemptive and of great value, is stripped of all meaning.

3. The Reasonableness Standard

The question of whether life is an instrumental good or an intrinsic good is but one controversial point raised by McCormick in his particular «Quality of Life» view. Another concerns the method by which a consensus would be obtained so as to obtain substantial operational criteria for the actual bioethic cases. McCormick proposes that such a consensus exists through community goals and priorities placed on life, in a given culture and epoch. For his part, Walter examines this as a workable public policy in an ethically pluralistic society.

As to how to assess the relational capacity criterion, McCormick prefers a «reasonableness» standard that would be «what most of us,

in similar circumstances, would do—as reasonable people with healthy outlooks on the meaning of life and death». ⁵⁹ Walter ⁶⁰ attempts to base public policy on this substantive criterion of relational potential as enunciated by McCormick. He notes the process to begin with the normative anthropology: «the meaning, substance and consummation of life are found in human relationships». Our human flourishing is done in community with others. Walter takes into account that, for McCormick, Christian revelation does not give us concrete moral judgements on how to achieve this, rather that the Christian story and symbols focus us on the transcendental human goods that bear directly on this human flourishing. For the basic direction on concrete acts, however, insights are available by all humans. It is here where McCormick locates the reasonable person standard. Walter interprets this standard as expressing that set of human insights considered normative.

This formal criterion, the reasonable person standard, is admitted as distinct from the substantive criterion of relational potential towards which it will be directed. «The judgement of reasonable people is not *constitutive* of the rightness of the decision. It is merely *confirmatory* that the criterion is close to the mark». ⁶¹ The judgement of the best interests of an incompetent patient, as normative, is then based on this reasonable person standard, and interpreted by it.

A difficulty arises when one stops to ponder about what is the content of the reasonable person standard. In order to enclose more than circularity, (i.e., reasonable person standards are those that reasonable persons hold and should be normative because they are, by definition reasonable), one must specify what presumptions one uses to define reasonableness, and rationality, especially if this term is intended to be anchored to a wide *secular* base, prescinding from the theologically understood natural law. Johnson writes of the continuing difficulty in encountering such firmness when departing from such secular philosophic premises. ⁶²

Walter provides further premises of McCormick's reasonable person standard: «Because our moral reasons are historically conditioned, the set of normative insights can fluctuate between advance and decline depending upon our society's historical-cultural situation». ⁶³ This, however, presents questions: on what basis can we actually qualify

such fluctuations as advances or declines if not by a standard transcendent of history and culture? Pragmatism and relativity in ethics comes up against the notion generally held that there is an objectivity to right and wrong, not just a correct process to be followed. Clearly an ethical base must be logical, but what are the premises of the rationality? How are we to judge these premises against those who hold other premises? Is the response only to be that what is right or reasonable is that which is being held by most?

4. «Quality of Life» and Dualism

While there are evident difficulties with the reasonable person standard, there are still other complications that come with McCormick's «Quality of Life» approach. Certain anthropological assumptions are inherent in the view that bodily life is a good *for* the person. The unity of the person is a characteristic of both universal experience and explicit Judeo-Christian teaching. Grisez examines this anthropologically, and finds it wanting. Wildes, however, defends an instrumentality based not on ontological distinctions, but rather on categorical conceptual distinctions, and applies this particularly to PVS patients. This view, however, appears confused, and does not convincingly dislodge the criticism levelled by Grisez.

a) Grisez —«Quality of Life» Is Dualistic

Grisez takes special exception to the consideration of human bodily life under the aspect of instrumentality, following the criticism of McCormick's analysis made by May. Grisez shows an inescapable affront of this position towards the anthropological unity of the human person:

In denying that 'mere physical existence' is inherently good, O'Rourke, McCormick, and all who share their views presuppose that a person's life has only the status of an instrumental good —something which human persons have and use for their specifically human purposes, but, nevertheless, something which remains really distinct from what human persons are. For if O'Rourke and McCormick

did not presuppose that human life is only an instrumental good, they could not hold it pointless to preserve a person's life unless 'some degree of cognitive-affective function' can be restored or 'other values remain attainable'. But a person's life is not merely an instrumental good. It is the very actuality of his or her living body, and —although human persons also have spiritual powers and acts which cannot be reduced to bodily capacities and functions— a human being's living body *is* the bodily person. To deny this is to accept a position which requires some sort of dualistic theory of human persons —that is, a theory according to which human beings are inherently disembodied realities who only have, inhabit, and use their bodies⁶⁴.

Grisez expands upon dualism, showing how we must reject it. It is untenable in that it cannot explain the unity that we all perceive in our very selves. Pope John Paul II states similarly that such a conclusion, the ability to perceive normatively human bodily life as apart from the person, as stemming from a proportionalist moral theory, «does not correspond to the truth about man and his freedom. It contradicts the *Church's teachings on the unity of the human person*, whose rational soul is *per se et essentialiter* the form of the body».⁶⁵

b) Wildes —Category of Instrumental Good

Without denying the essential unity in being of man, Kevin Wildes seeks to reconcile the advantages that one could realize with the instrumentalist view of life, with the anthropological difficulty raised by Grisez. Thus, Wildes argues for a *conceptual* dualism, basing himself on distinctions made by Dewey, in an attempt to overcome the difficulties that arise with ontological dualism⁶⁶. He charges: «The absurdity that they [Finnis, Grisez, and Boyle] demonstrate rests on the assumption that the dualism of life and person is necessary ontological. But why must this be the case? Could there not be a conceptual distinction of the two without having a commitment to an ontological dualism? There is a significant difference between drawing a conceptual distinction and holding that the conceptual

distinction has ontological status, that is that the distinction implies the existence of two substances». ⁶⁷

It is difficult to follow the argument of Wildes and Dewey. Parent, friend, physician, neighbor, perhaps would be examples of conceptual distinctions. But these terminologies are also partial in their scope, not universal, that is, a man is a friend to one and a father to another, and neither to a third, and none of these capture the fundamental whole of the person. It seems rash to base life and death decisions on partial concepts which admittedly do not embrace the whole of the reality addressed. Wildes is careful with his language, stating that a mentally disabled person may reach the p.v.s. level or be materially equivalent to a p.v.s. patient. In those cases, the categorical understanding of human life would argue that there is no obligation to sustain the life of such a patient by medical means. Does this imply, however, which means if any, still must be employed ethically, since the bodily life will not instrumentally support integral human fulfillment? Does this conceptualization of human life into «biological life of a human being, one's integral fulfillment, and the pursuit of goods as conditions of that fulfillment» give us normative direction as to how to treat human life? Wildes concludes that we can still view the basic goods as practical reasons, but bodily life remains instrumental. It is not clear how one does not end up instrumentalizing as well other basic human goods, such as friendship, truth knowledge, excellence in performance, peace and fraternity as conducive to one's integral fulfillment. It does not seem possible to balance «the pursuit of goods as well as conditions (necessarily instrumental) of that fulfillment». ⁶⁸

The conceptualization of biological life as *only* a necessary condition of human, personal life, necessarily regards bodily life as instrumental, and not a basic good. Wildes acknowledges the unity of body and soul to be constitutive of the person. There are no human persons, however, without bodily life. There is a difficulty then for young children (who do not yet act for ends), and PVS patients: is their life to be conceived as an instrumental good, until they can or are achieving the higher goods? In attempting to answer this question, Wildes raises a number more, when he states: «It seems crucial to remember that the brain is the integrating organ for the human being. It is the proper

matter of the faculty of the rational soul. When it is medically clear that the matter has been destroyed, then it seems impossible to argue that a substantial union of body and soul remains or that an obligation to sustain life remains». ⁶⁹ The new questions appear as at what point could we say that living body before us, quite *apparently* a human being, has ceased being a personal human being and can now be regarded as a supported cadaver?

Grisez and Boyle respond to this attempt to evade the instrumentalist dualism:

A very philosophical attempt to escape from the dilemma takes the following form. Perhaps the human self is in theoretical truth only one entity but for practical purposes has to be regarded as two entities —a living organism and a person, the former merely instrumental and the latter an end in itself. The difficulty with this attempt is that if one treats as two in practice what what one maintains to be one in theory, there seems to be no single perspective to use in distinguishing and relating the theoretical and the practical perspectives. If one says that what is existentially many is *really* one, then moral life seems to rest upon a false assumption, a kind of fiction at odds with reality. If one says that the two perspectives are *equally valid* and merely distinct, the question arises how they can be distinct enough to avoid being incompatible while being unified enough to allow oneself or any self to think and talk about ‘my life’ and ‘my dignity’.⁷⁰

III. DOUBLE PATHOLOGY

The debate in the preceding sections over distinctions, notions and nuances introduced by the teleologic approach raises a further question concerning the role that «Quality of Life» can play in determining the proportionality of means, and is highlighted in the question: to what extent should the proportionate means for a certain

condition be evaluated in the light of other health complications? This is the case of a person who suffers from two lethal pathologies⁷¹. Clearly the principles involved are those of proportionality itself, especially the time of life to be expected with the adage *parum pro nihil reputatur*, and the magnitude of the benefit summed up in *nemo ad inutile tenetur*.

1. Presentation of the Question

Several authors support the view that in certain cases the fatal pathologies constitute a relativizing factor with respect to normative injunction to always utilize proportionate means. Kelly, Ramsey and Callahan are among those who expound such a view. A critique of this position follows.

Kelly brings up the question of double pathology relativization when he discusses De Lugo's concept of *parum pro nihil reputatur*, regarding food, noting it to be a natural means for sustaining life, while the other authors speak of remedies, something artificial.

Kelly presents a case study of McCarthy who appears to be one of the first to consider the question:⁷² a patient with diabetes and terminal cancer, with a remaining life expectancy of six months. McCarthy insisted that the diabetes be considered apart from the terminal cancer; to do otherwise would fix the immediate intention as one of shortening life. In his analysis, Kelly states first, that insulin use alone appears to be an incontrovertible ordinary means, and its use would hardly approach a moral impossibility, except in very unusual cases. «This seems to be a clear case of a reasonable hope of success: a combination of slight difficulty plus high probability, if not moral certainty, of checking the disease indefinitely».⁷³ In the case of the concurrent pathologies, though basically agreeing with McCarthy,⁷⁴ Kelly expresses also his doubts:

[T]his problem provokes another question: namely, is a person who suffers from two lethal diseases obliged to take ordinary means of checking one of them when there is no hope of checking the other? In other words, granted the

presence of the incurable cancer, can the insulin be said to still offer a reasonable hope of success? Must we consider the diseases separately, or should we consider the patient's total condition? I see no perfectly clear answer to these questions⁷⁵.

It is not clear that Kelly is focusing on medical means alone, seeking to determine the moral impossibility that they might involve, and the hope of benefit that they hold out. Rather, it seems that the «Quality of Life» is theoretically a factor to be considered. He does not expressly indicate the circumstances that might relativize the insulin, such as the imminent onset of grave pain from the cancer. Kelly's query is central to the double pathology question: should the otherwise proportionate means be relativized by the existence of a second pathology?

He continues by presenting a possible relativizing factor: if the two pathologies have connections, that is to say, if there were grave interactions, or if they really are complications from the same basic disease⁷⁶. Although some contend that this question with its «Quality of Life» slant has always been part of the theologic heritage, and is to be resolved in favor of less suffering of the patient, it seems that only recently has medicine offered the possibility to diagnose and separate divergent fatal pathologies⁷⁷.

Ramsey, in his analysis of this question raised by Kelly and McCarthy, takes further note of the effects of interaction, and develops this idea through one of his central notions: moral analysis should center on the patient as a person, and not only focus on diseases singularly. The patient is a unity, in which the diseases occur:

Doctors do not treat diseases, though they often conquer them. They treat patients, and here finally all fail. If a diabetic patient need not prescind from the cancer in determining her obligation to start or continue to use insulin, the reason is that she is one flesh in which both diseases adhere. If to use insulin for her is quite useless, it is surely contraindicated. To move beyond the interrelation of the ills to which all flesh is heir requires that we move to *the flesh* that is heir to

all its ills, indifferent to whether these ills are connected or physiologically unrelated. It is this flesh, and not the diseases one by one, that is the subject of medical treatment. The truth is enough to undercut the bondage of conscience to the imperativeness of 'customary' or 'usual' procedures for treating single diseases⁷⁸.

Ramsey appears to sympathize with the relativizing factor more strongly than Kelly, though he is not in favor of proceeding at will in the matter. He refers to De Lugo's treatment of *parum pro nihil reputatur*, and later acknowledges that a meaningful length of time for life would oblige the then proportionate means⁷⁹.

Callahan is currently one of the strongest voices in favor of the double pathology relativization, but in his distinct form. He has argued extensively for common sense moderation in the use of ever more sophisticated technology⁸⁰. This is not because of any anti-technological stance, but rather because of «our culture's obsession with technology, which so often leads us to use it unthinkingly and insensitively».⁸¹ He counsels us to hesitate before rushing to do all that we can, seeing that nature might provide, in a concurrent pathology, a more gentle death, than that which ultimately would be faced should means be applied. He urges:

... we must learn to be more opportunistic about death, as physicians used to be. If we see a person dying, and that person is beset, for example, by pneumonia or some other opportunistic infection, we should remember that antibiotic treatment would likely set this person up for a lingering death. We should seize upon this means of dying that would bring upon a better rather than a worse death and be prepared to embrace it⁸².

He questions whether physicians must always use their knowledge and skill to conserve lives. He sees the medical tradition as not necessarily embracing such an obligation. In this way he contend that more often it must be taken into account that the patient's welfare may not indicate that a certain pathology be combatted; rather,

admitting the patient's mortality we can «bring disease as a cause of death back into the care of the dying».⁸³ Clearly one extreme, that Callahan wishes to avoid, is that of excessive, overzealous treatment, out of proportion with the result to be expected, an intervention that, for example, would hold out the promise of very little additional time of life for all its burdens. However, what is not clear in these authors, is how one could protect from a swing to the opposite extreme, that of opting for a sweet death, or a 'Catholic euthanasia', that gives excessive room for abuse in the determination of proportionate time of extended life or of the burdens of suffering.

2. Discussion of Essential Elements

a) Fatal Pathology

Besides the distinction of artificial and natural means, the notion of fatal pathology is central to the teleologic approach championed by O'Rourke. The present author joins Vaccari in questioning the solidity of the concept of fatal pathology, especially as applied to PVS patients. The discussion leads naturally to a question treated in a subsequent section, that of the determination of proportionality in the case where concurrent fatal pathologies exist.

This limit on the ethical obligation to prolong the life of the permanently unconscious is linked, in O'Rourke's analysis, with what constitutes a terminal patient, and what is a fatal pathology⁸⁴. He develops the notion of a terminal condition, separating out the concepts of a patient with a «fatal pathology» and patient that is «imminently dying». Thus, a patient with acute kidney failure has such a «fatal pathology», but due to effective hemodialysis, cannot be considered to be «imminently dying». The concept of fatal pathology, as presented by O'Rourke and others,⁸⁵ denotes any disease or lesion that, if left untreated, will cause death; a more current understanding would hold the same, but with the understanding that no cure or treatment exists for the condition.

The obligation toward patients who are 'imminently dying' remains quite clear for most Catholic authors. What O'Rourke is trying to distinguish is the obligation that we have toward those with a 'fatal

pathology', but are *not* 'imminently dying'. The fatal pathology assigned to PVS patients, for example, is the inability to chew or swallow, a fatal condition if not circumvented by tube assisted feeding. Since O'Rourke assigns no benefit to permanently unconscious life, he applies his limits of obligation directly to these cases, as he allows that one can morally abate feeding in these cases and allow the patient to die:

Grasping the distinction between causing death and allowing a pathology to take its natural course because there is no benefit to the patient in circumventing or removing the pathology, is a fine distinction. Yet it is a real and firm distinction, as those who have experienced clinical decisionmaking will avow. In 1957, when Pope Pius XII stated that respirators could be removed if they were of no benefit to the patient, he did not expect the patients to live after the removal of the respirators⁸⁶.

Thus, if there exists a fatal pathology, the question for O'Rourke is not «is death imminent?» but rather, «do we have a moral duty to remove or circumvent that fatal pathology?» For this position, the resolution in each case would involve not only the burdens and benefits of means, but also of life:

A hopelessly ill patient's situation may be stable and not perceptively deteriorating. For instance, a severely or irreversibly demented patient may be 'hopelessly' ill, but medically he is not in terminal illness, because the mental illness is not life threatening. Another example would be a paraplegic or quadriplegic patient. It would be wrong not to treat these patients for pneumonia or some life-threatening infection and thereby not to stabilize their health. Terminal illness, on the other hand, means that the illness is progressing, treatment cannot restore the health of the patient, and medical intervention can only prolong the dying process or maintain purely vegetative existence⁸⁷.

It is this vegetative existence that is an example of a life that constitutes a burden for not only the afflicted person, but also the family and society. To «prolong the dying» is considered ineffective; no cure is expected. This notion of dying is at odds with the common notion. One is not considered dying for years except in a rhetorical way; such a condition is rather a chronic illness of a person who is not dying.

He presents the PVS case as illustrative of the fatal pathology approach. The PVS condition is portrayed as one that brings with it, necessarily, an inability to chew and swallow. Specifically O'Rourke cites the case of Nancy Cruzan as example of this⁸⁸. However, as a standard benchmark, the PVS condition does not appear to be so useful for serving as the model for fatal pathology analysis. Others, such as the AMA, grant much more leeway for PVS patients' abilities: «Cardiorespiratory activity, swallowing, and digestive and other non-neurological vital functions are usually preserved to the extent that standard nutritional and supportive measures will sustain life indefinitely. Persons in PVS ordinarily require neither long-term respiratory support nor circulatory assistance to survive».⁸⁹ Likewise, Cranford substantially concurs in this prognosis that PVS patients often retain the ability to swallow:

Because PVS patients often have an intact involuntary swallowing reflex in addition to intact gag and cough reflexes, it is, theoretically, and in rare cases, practically possible, to feed these patients by hand. However, this usually requires an enormous amount of time and effort by health care professionals and families. If the patient is positioned properly, and food is carefully placed in the back of the throat, the patient's involuntary swallowing reflex will be activated. However, the overwhelming majority of patients are given fluids and nutrition by nasogastric tubing, gastrostomy, or other medical means⁹⁰.

As such it is not clear that we can rotundly claim a fatal pathology exists concurrently with all PVS patients; indeed the court testimony in the *Cruzan* case indicates that Nancy Cruzan retained swallowing

ability for some time after her accident. Tube feeding was initiated precisely to facilitate long term care. In fact an explicit decision was made *not* to verify in any way if swallowing ability remained; Cranford testified that spoon feeding is withheld in such cases as being «morally repugnant», and «would be totally inconsistent» with what was wanted⁹¹.

Thus we can conclude that caution is warranted: just as the decision to decline nutrition and hydration does not necessarily indicate an intention to cause death, neither in the case of PVS patients and other mentally incapacitated is such an action (abatement) always morally indicated.

Given the wide range of PVS symptoms with differing severity, a difficulty exists. Some in a PVS retain the ability to chew or swallow, as did Marybeth Cruzan for many years, and we are held by the teleological analysis of O'Rourke to give them nourishment, as their condition does not exhibit fatal pathology symptoms. The fact remains that their facility for seeking life's purpose is in no degree different from the case of those where such ability to chew or swallow has been lost. The obligation to feed is predicated on such accessibility to spiritual function, not directly on the ability to chew or swallow. Clearly the burdens of feeding must be examined, but the burdens of manual feeding exceed by far those of artificial conveyance. If the patient contracts a secondary pathology, such as a pneumonia, are the proportionate means of simple antibiotics to be considered optional? Is the pneumonia a new «fatal pathology», since the antibiotics will not cure the PVS condition? Such a conclusion is not easily derived from application of the principle of double effect, but rather perhaps from the view that *nemo ad inutile tenitur*, considering life in a PVS as useless or of no benefit. But the required manual feeding is just as proportionate to the cure as the antibiotic. From this view it appears that the «fatal pathology» approach may hide an intention for passive euthanasia. This will be treated in a subsequent section.

Michael Vaccari questions the validity itself of the concept of fatal pathology. He sees nutrition and hydration as means to conserve life, and conceives the distinction between treatment and care to be less important, since our obligations are framed in terms of conserving

life. Fatal Pathology is presented as both over-inclusive and under-inclusive: over-inclusive in that it cannot be limited to a PVS with fatal pathologies, rather it applies to such a wide range of illness that the question to forego nutrition and hydration becomes the standard rather than the exception; under-inclusive in that it fails to apply in certain cases involving the decision to forego treatment that were covered by the traditional approach. Vaccari concludes that fatal pathology approach is inadequate, because it focuses the analysis on factors unrelated to the effectiveness or burdensomeness of treatment. He asks: «Do fatal pathologies have characteristics that are relevant to the usefulness / burden analysis? Are treatments for fatal pathologies always burdensome or useless or more often burdensome or useless than treatments for nonfatal pathologies?»⁹² Concluding that it is not the case, he charges that O'Rourke's approach fails to resolve the moral question involving intentionality.

Vaccari makes this all more evident by summarizing O'Rourke's procedure: First, one is to ask: is there a fatal pathology? Second, will the applications of means for the fatal pathology be effective in restoring or maintaining the ability to strive for life's purpose? And, if effective, do they involve excessive burden? If the lead question, however, does not cover all life support treatment cases, one is to resort to the analysis of burdens and usefulness. But here Vaccari retorts: «If one's decision is not made on the basis of the fatal nature of the pathology, then the methodology proposed by Fr. O'Rourke adds nothing to the analysis».⁹³ Why introduce the first question at all?

b) Proportionality of Life Itself

The first two foregoing sections, the teleologic approach and double pathology relativization, bring up the issue of the proportionality of means (involving their benefits and burdens) when faced with poor «Quality of Life». Life is normally conceived as a benefit, but what about life without consciousness? A number of authors explicitly nuance the primary focus of the *Declaration on Euthanasia* on means, adding that a further benefit must accrue to patient: consciousness as a basic minimum. Life in a PVS is seen as not sufficiently doted to be considered as a «benefit» proportionate enough to normatively oblige life support. Other authors maintain that life is a good, and that

ordinary means are obligatory despite the condition of the patient, as long as they are useful and do not imply excessive burden.

The key question becomes: *Is bodily life, without consciousness, a good?* The proliferation of articles about the «Quality of Life» of PVS and anencephalic patients underscores the belief that these can be included in such a category. If this can be established in the affirmative, *a fortiori*, obligations can be deduced for other debilitated conditions, as unconscious human life is seen as a minimum state. If so, also all ordinary means to conserve that life are indeed useful, they keep the person alive. Moreover, if it is a basic good, indeed a great good, then it is like a moral absolute, falling within the gambit of the positive and negative sides of the fifth commandment, *thou shalt not kill*.

A «Quality of Life» ethic, however, typically argues that life is not an absolute good, but good for other goods. In fact, that mere bodily life alone is no benefit at all. Thus from this, the input of the «Quality of Life» ethic requires that the «ordinary» means are not always obligatory, because the good of bodily life is not seen as proportionate to the available means, however easily they can be applied.

After an introductory discussion on the specific angle of monetary burdens for PVS patients, which is important for deciding the proportionality of life support, The view of the Magisterium is presented, along with the opinions of a number of theologians: Griese, Moraczewski, Meilaender, Smith and O'Rourke.

The analysis of the benefits and burdens of given treatments necessarily include their economic dimensions. Thus treatment which is affordable, or assisted sufficiently by state intervention may establish a means as proportionate for one case, while in a identical case, such monetary factors could constitute an insurmountable burden. Much disagreement have surfaced over the financial burdens that PVS patients produce. Grisez gives argumentation that for developed countries, the financial burden for maintaining incapacitated patients frequently does not constitute a moral impossibility⁹⁴. Cranford notes that the cost of maintaining PVS patients can vary considerably, and cites such costs in 1988 for Minnesota as ranging between \$19,000 and \$25,000 per year⁹⁵. Phillip Boyle presents costs higher by an order of magnitude, representing maintenance by total perenteral nutrition, which is not necessarily typical for a PVS patient, because of its

exorbitant expense⁹⁶. Bopp noted that in the *Cruzan* case, the actual costs (in 1988) of her feeding (7.8\$ per day) were 2.6% of maintenance costs, with total costs at 110,000\$ per year⁹⁷. With the varying institutional costs and insurance coverage, it does not appear conclusive that all PVS maintenance is extraordinary, as some claim.⁹⁸ The fact that tube feeding would cost considerably less than spoon feeding is noticed by May and others who state that with proper supervision, home hospice care for permanently unconscious persons can often be carried out by people without profession training, once feeding tubes are in place. This, however, is not to claim that such care does not involve burdens or substantial commitments⁹⁹.

Besides the financial aspects, there are further questions about the basic issue of the proportionality of supporting «mere» human life. There have surfaced suggestions that nutrition and hydration are not ethically obliging depending on the «Quality of Life», while other aspects of ordinary care continue to bind. Callahan, for example, in an early article, maintained this posture, and spoke out on the need to continue food and water, even if were only a gesture of our solidarity, and «a tolerable price to pay to preserve—with ample margin to spare—one of the few moral emotions that could easily be called a necessary social instinct».¹⁰⁰ Yet such an appeal is weak, and gives way to expediency. Many secular writers, such as Steinbrook and Lo, after placing nutrition and hydration on a par with CPR, mechanical ventilation, dialysis, and antibiotic therapy, claim that, for difficult cases, it should not be considered as part of «ordinary care» and similarly assert that caring should be shown by plans other than food and water¹⁰¹. The question is literally one of life and death, and thus takes on a particular importance for Catholic ethics, and for exhortations for public morality.

The Magisterium and magisterial advisory bodies have examined the question of just what care would be proportional to life itself. The year following the publication of the *Declaration on Euthanasia* (1981) in an effort to aid pastoral efforts toward those critically ill, the Pontifical Council Cor Unum (an advisory body for the Magisterium, but not magisterial *per se*) produced another document which reflected the points of the *Declaration*. It addressed, more in depth, a number of medical aspects and responsibilities of the medical profession. The

publication of this document, produced in 1976, was delayed until the issuance of the Declaration *on Euthanasia*. The document reiterated that although extraordinary measures are of an optional nature, the obligation still exists of applying the «minimal» measures:

On the contrary, there remains the strict obligation to apply under all circumstances those therapeutic measures which are called 'minimal': that is, those which are normally and customarily used for the maintenance of life (alimentation, blood transfusions, injections, etc.). To interrupt these minimal measures would, in practice, be equivalent to wishing to put an end to the patient's life¹⁰².

This passage clarifies that the *normal care* referred to in the Declaration *on Euthanasia* includes nutrition and hydration. It is important to point out such distinctions, so as to give content to what is to be considered proportionate to life, even when such life is quite debilitated. As well, to deny or withdraw an ordinary or proportionate means itself, would constitute euthanasia; further intentions could not sufficiently inform such an act so as to make it licit. On the other hand, it is important to distinguish this basic care from the excessive concern for this earthly life, that might lead to excessive and inordinate treatment. Thus the Magisterium, in the Declaration, has stated that: «Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of 'over-zealous' treatment. Here one does not will to cause death; one's inability to impede it is merely accepted¹⁰³. And it continues stating that decisions should be made by the patient if he is competent, or if not, by legally recognized proxies, who are to decide to the interests and mind of the patient.

Certainly one does not consider food and fluids in itself specifically as medicine to cure dementia or a comatose condition, rather as a means that is ordinary in many cases for the conservation of whatever life regardless of its condition. Such an approach was taken by the Pontifical Academy of Sciences (another advisory body for the Magisterium) when it stated in 1985: «If the patient is in a permanent,

irreversible coma, as far as can be foreseen, treatment is not required, but all care should be lavished upon him, including feeding». ¹⁰⁴ Thus a distinction was made between medical care, which could become disproportionate, and a basic care that is always proportionate for the conservation of life (assuming it is neither medically futile, nor involves a moral impossibility). This is more apparent when one reads further commentary by this same Academy: «God intends the development of science for the good of man. When science can provide a means of conserving a man's life which can be a supplement to a natural means, then this artificial means would seem to be obligatory. It is true, however, that whereas natural means in general are ordinary means, artificial means of conserving life can be quite often extraordinary means and thus not obligatory. When artificial means are ordinary means, then they are obligatory». ¹⁰⁵ Thus, the Academy, after rejecting the agglomeration of basic care into the medical treatment category, continues by rejecting a *per se* normative distinction between artificial and natural, relying on the determination of proportionality as the ethical source for normative decisionmaking.

Recent magisterial writings continue to make the precision between «ordinary» or «basic» care and medical treatment. Pope John Paul II has distinguished basic care from medical treatment, and has envisioned such basic care as proportionate to the conservation of life. Thus even when a person has a serious illness «[it] does not dispense from the valid therapeutic task of sustaining life *nor* from the administration of the *normal* means of *vital support*. Science, even when it is unable to heal, can and should care for and assist the sick». ¹⁰⁶ And in a later address, he similarly condemned the practice as unacceptable, «...not even when it is the parents themselves, in the throes of emotion and disappointed in their expectations, who request euthanasia by means of suspension of treatment and nourishment». ¹⁰⁷

Most recently, in *Evangelium Vitae*, the Pope touched briefly again on this content of basic care, where, speaking of eugenic abortion, he continued with the theme of handicapped newborns: «Following this same logic, the point has been reached where the most basic care, even nourishment, is denied to babies born with serious handicaps or illnesses. The contemporary scene, moreover, is becoming even more alarming by reason of the proposals, advanced here and there, to justify

even infanticide, following the same arguments used to justify the right to abortion. In this way, we revert to a state of barbarism one hoped had been left behind forever». ¹⁰⁸ Here, it again appears clear that the Pope has advocated nutrition and hydration as care that is proportionate to the good of life, unless it is truly futile.

The Catechism of the Catholic Church makes it clear when it states: «Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted». ¹⁰⁹

Among the theologians, GRIESE puts in context the earlier magisterial pronouncement by Pope Pius XII (Allocution of November 24, 1957). Against those who hold to a «Quality of Life» approach, he quotes an earlier address of the Pope to give more breadth to his view on the value of bodily life: «Is it not false pity which claims to justify euthanasia and to remove from man purifying and meritorious suffering, not by a charitable and praiseworthy help but by death, as if one were dealing with an irrational animal and without immortality?» ¹¹⁰ He concludes thus, that basic care must always be provided to the person, unless it is medically futile or otherwise involves moral impossibility.

It is also precisely this «ordinary care» that GRIESE maintains the Congregation for the Doctrine of the Faith intended in order to precisely establish such «ordinary care» as nominally inviolable. Distinctions such as artificial or natural, for GRIESE, would carry no moral weight, but rather would defer to the analysis of proportionality:

The *Declaration on Euthanasia* (1980) makes no distinction between feeding in the natural manner vs. feeding by artificial means when it states that ‘ordinary cares which are due to the sick person’ are not to be interrupted. In accord with a respected Canon Law guideline, ‘where the law does not distinguish, we should not distinguish’ (*ubi lex non distinguet, nec nos distinguere debemus*), this would mean that food and drink are not to be interrupted regardless of the means employed at the time when the patient approaches the imminent-death status.... To say that basic care, such as feeding, can be discontinued automatically if the patient is unable to receive sustenance by way of mouth would be at

variance with the precise concept of 'euthanasia' as clarified in the Holy See's Declaration on Euthanasia¹¹¹.

Besides basic care, Griese develops the notion of a supplemental means as opposed to a substitutive means for artificial nutrition and hydration¹¹². To see better the distinction between supplement and substitute, some examples might serve: for kidney ailments, diuretic stimulants or urinary catheters (supplements), and kidney dialysis (substitute); for temporary digestive tract disorders, sub-clavian vein total perenteral nutrition (substitute) vs. peripheral perenteral nutrition (supplement or substitute); for respiratory ailments, mechanical respiration (substitute) vs. enriched oxygen supply (supplement). Thus the argument is made that for the disorder of swallowing impairment as found in some PVS patients, tube feeding is supplemental, whereas total perenteral nutrition is substitutive. The substitutive could be considered extraordinary *per se*, the supplemental such only *per accidens*. Thus Griese gives as a principal argument that the patient permanently on a respirator usually is totally incapable of breathing on his own, thus there might be no obligation to *prolong* the life of the patient. In tube feeding however, the alimentary system is not incapable of utilizing and benefitting from the artificial feeding:

The alimentary system is still partially functional; the patient is still able to digest and assimilate food and fluid. The inoperative or dysfunctioning aspect of the alimentary system—that is, the incapacity to ingest and swallow nutrition and fluids—can be bypassed without excessive burden or pain so that digestion and assimilation can continue. When and where such an effective bypass mechanism is available, both as to installation and as to maintenance, there is a moral obligation to use that *supplemental* means so as to *conserve* the life of the individual....¹¹³

Thus because of this moral obligation, the lethal factor in the case of discontinuing an effective *supplemental* aid, should not be identified with the patient's existing and underlying fatal pathology, but with a

new and different pathological condition, which for PVS patients, could be starvation and dehydration, caused by deliberate denial of the staff of life: food and fluids.

Moraczewski disagrees with the precisions made by Griese concerning supplemental and substitute means. He simply equates the use of artificial nutrition and hydration to that of a respirator, and thus concludes since one can determine the respirator to be an extraordinary means, similarly one can dispense with artificial nutrition and hydration with moral impunity, all other factors equal.¹¹⁴ Moraczewski also shares the opinion that unconscious life is not a benefit, and does not meet the criterion of *spes salutis*:

Now for the difficult question: is it of benefit that a person be maintained alive in a permanent and profound comatose state? ... What benefit is it to the irreversibly comatose *patient* to be maintained alive? There may be benefit to others, perhaps to society as a witness presumably to the dignity and the sanctity of life. But is it? True one may not kill the patient directly, one may not intend directly the patient's death. But if water and nutrition are removed from a patient, is this not a direct killing of the patient? No. Rather it is the concurrent pathology which prevents the patient from chewing and swallowing the food¹¹⁵.

Meilaender and Smith argue in favor of basic care in a common sense fashion. Meilaender maintains that to distinguish, for the permanently unconscious, between optional nutrition and hydration on the one hand, and mandatory hygienic care, such as routine positioning to prevent pressure sores and skin lesions, as envisioned by the President's Commission, on the other, does not seem to make sense. Both would seem to be covered under basic human dignity or fall together: «Yet it is hard to see why such services (turning the person regularly, giving alcohol rubs, and the like) are standard nursing care when feeding is not. Moreover, if feeding cannot benefit these patients, it is far from clear how they could experience bed sores as harm».¹¹⁶ This same objection is voiced by Smith. He rejects distinctions that see nutrition and hydration as distinct in importance

from pain control, skin care, personal hygiene, maintenance of comfortable room temperature, etc. He unveils the contradiction apparent in such passive euthanasia situations. «Does the fact that food and water (nutrition and hydration) is conveyed by a tube differ essentially from the fact that room temperature is also conveyed by artificial tubes and pipes?... If there is no objection to avoidable starvation by omission of tube feeding, what then is the objection to avoidable lethal pneumonia by turning off the artificially conveyed heat in a hospital room in Rhode Island in January? Indeed, in terms of time alone, the former (starvation) is a much, much slower death and dying than the latter, at least in January in Rhode Island».¹¹⁷ Thus they contend, if these other items of care are considered proportionate and becoming of personal dignity, it would seem to follow that nutrition and hydration also ought to be considered obligatory.

O'Rourke, however, speaks of the need for bodily life to grant benefits to the person: «Once again, the severity or lack of pain is not the determining factor in making the decision whether or not to prolong life. What we seek to assess when making this ethical decision is the burden that would result if life were prolonged, not the burden that the therapy used to prolong life would involve... Again we are called upon to assess the burden of prolonged life, not the burden intrinsic to the means to prolong life»¹¹⁸. In the traditional teaching, the benefits and burdens are assessed from an analysis of the proposed means, as this would be the requirement for the traditional application of the principle of double effect. O'Rourke suggests that this assessment be extended also to the burden that a life would entail.

This will raise a particular question: what is to be meant by the benefits, referred to in the category *spes salutis*, that should be gained? O'Rourke has decided against the proposition that human bodily life is one of these benefits. On the statement of bodily life as a good, O'Rourke writes:

This statement is questionable on two grounds. First, is prolonging life in a persistent vegetative state 'a great benefit'? ... The opinion of the AAN is that no benefit derives to the patient. Viewing the prolongation of life in a permanently

unconscious state as a 'great benefit' makes human life an absolute good, something clearly contrary to the Catholic teaching in regard to the prolongation of life¹¹⁹.

As well, O'Rourke questions the value of mere bodily life when he brings up the issue of the benefits or burdens that must accrue to the *others*, namely family and society. He makes the point that even if one were to grant that the burden to the patient might be acceptable, the family could suffer sufficiently, over a long period, to amount to a sizeable burden. He remarks: «Would it be unreasonable to a loving person to consider it a severe burden to keep watch over and nurse a person in a permanently unconscious state? The burden to the family is more than financial. There is the psychic pain of seeing a loved one in a debilitated, unconscious condition from which he or she will not recover».¹²⁰ Thus, O'Rourke alludes to the *Declaration on Euthanasia* that specifically mentions that not only personal patient burdens are to be evaluated, but also those of the family and society.

c) Effective and Useful Means

After investigating the burdens and benefits of conserving life, a final section of applications debates the issue of whether means for patients are to be considered as medical treatment or as basic care, indispensable for all life. The former would fall under a certain autonomy, while the latter would seek to invoke a certain necessity or obligation. Connery argues for keeping the notions of medical treatment separate from basic care. Brodeur argues that making the distinction between treatments and care masks the issue of treating the patient in a dignified manner. O'Rourke, in the following section, gives his version of the role of effectiveness as an element to be incorporated into proportionality.

John Connery provides responses in the «Quality of Life» vs. «Sanctity of Life» debate dealing with: the differences between feeding and treatment; the connection between means and cures; the proper use of the principle of double effect; and the scope of «Quality of Life» judgements. In this first issue, Connery makes the distinction between nutrition and hydration, and medical interventions:

There is clearly a difference between eating and drinking and medical treatment. Medical treatment is aimed at curing a disease. Eating and drinking are not aimed at curing disease, but at sustaining life. Medical treatment is therapeutic, eating and drinking are not basically therapeutic. So there is no doubt that eating and drinking, and medical treatment are two different procedures, although artificial feeding seems to be a combination of both¹²¹.

The question remains if the difference between the two are morally relevant, that is, can we be held to always give food and water, and be limited in giving medical treatment? Given in the case of medical treatment, if the treatment is useless in curing the disease, it is not morally obligatory. But here the question is raised, since nutrition and hydration will not cure the disease either, can we forego it in the same manner? This is the position of O'Rourke. Here the difference between medical treatment and nutrition and hydration is accentuated. Thus speaking of the fact that useless means are not morally obliging, *nemo ad inutile tenetur*, Connery argues:

Today, however, this principle is not properly used. It is used to free one from an obligation to use means if it would not cure disease. Thus, if a particular disease is irreversible, some would want to argue that it would be permissible to withdraw even nutrition and hydration, since they could not reverse the disease. But this ignores the whole meaning of the question, which is about the duty to prolong life, not the duty to cure disease¹²².

Thus it is argued that one cannot regard the medical means under the same aspect as nutrition and hydration, as they have different purposes. Obviously if feeding were to become futile, it would no longer be binding, as Connery makes clear:

One cannot argue, as some would like, that a means could be judged useless if it did not cure the disease. Certainly, if some particular means would not prolong the patient's life,

it would be useless. *But if feeding kept the patient alive indefinitely, it could not be considered useless even though it did not cure a particular disease.* The whole sense of the question: Can a means be considered useless? has to do with preserving life. *If it will preserve life, it is useful.* One may judge that the life itself is useless and conclude that it is useless to prolong it. But this is a judgement about the uselessness of the life, not the uselessness of the means. *The means remain useful to do what they always do: preserve life*²³.

Connery expounds clearly in his writings the role of intention in the correct use of the principle of double effect. For the intention would be one of the major factors in distinguishing a morally licit act from suicide or homicide. Respect for life never allows the latter two, which can happen in two ways: «(1) if death is the only immediate effect of some act or omission, or (2) if death is intended either as a means or an end».¹²⁴ Thus, if the act or intention does not fall into these defects, one can resolve morally the issue of treating and feeding:

It would not be reasonable to demand that a patient accept one and not the other. Indeed foregoing either would be wrong, as pointed out above, if death was the only immediate effect, or if it was intended. The assumption is that neither is or has to be the case. Death is not the only immediate effect. If a means (treatment or feeding) is excessively burdensome, refusing treatment has another immediate effect —avoiding the burden of the treatment (or feeding). If this is what the patient intends, omitting eating and drinking could be justified as a legitimate application of the principle of double effect. He is not doing something wrong in itself, he does not intend the evil effect, and he avoids the burden which eating involves¹²⁵.

Connery distinguishes those who use the traditional means approach from those who employ a «Quality of Life» ethic by the way they apply the principle of double effect. For ultimately those who sustain the quality of the patient as normative look beyond the immediate effect of medical treatments and other applications such as feeding. So Connery writes:

Some are looking not only at the means but also at the patient. They would like to distinguish between ordinary and extraordinary patients, as well as between ordinary and extraordinary means. The underlying reason is that they would like to make an allowance for extraordinary patients that would be independent of the allowance for extraordinary means. In other words, they would like to withdraw or withhold treatment on the basis of the quality of life of the patient as well as the quality of means. Thus, if the quality of life of the patient was below a certain standard, they would argue that the means of preserving life could be withheld or withdrawn even apart from any consideration of their burden or capability of prolonging life¹²⁶.

On the scope of «Quality of Life» judgements, Connery delimits the actuation of «Quality of Life» to the means only, excluding normative «Quality of Life» judgements about the lives of the individuals. The latter is of a different species for Connery, for in using a «Quality of Life» ethic: «One is entering into an entirely different category of moral act —intentionally bring on death».¹²⁷ He explains this condition of limiting «Quality of Life» judgements only to the means:

Quality of life can indeed be a legitimate consideration in judging moral obligations to preserve life, but only if it affects the means, i.e., makes them useless or very burdensome. Thus if a person is actually dying, and death is imminent whether a certain means is used or not, such means will be useless. Or if a patient does not have full use of his senses, the defect can make a means to preserve life very burdensome. But if it does not make the means useless or burdensome, the quality of the patient's life will not remove the obligation to use the means. Thus, quality of life may not make antibiotics any more useless or more burdensome for the comatose than for the conscious¹²⁸.

Brodeur addresses the argument that states that there is a difference between treatments and care. He believes that such a difference does not confront the relation that exists between the patient's goals and values and his or her obligation to pursue life and to submit to medical treatments. The argument, it is asserted, does not take into account the goals of therapeutic interventions, and how these are related to the patient¹²⁹. Rather, such an argument is cast as forming a distinction of modality, medical or nursing, endowing this modality with moral significance. We can note, however, that this begs the question, the issue that Barry¹³⁰ and others point out, of whether such a thing as basic care can be established as proportionate for all those not imminently dying, and whether this basic care includes nutrition and hydration, taking into account the burdens of conveyance, cost, etc.

3. *The Spiritual Criterion*

a) The Proposition of O'Rourke

One of the most vocal proponents of the teleological approach is Kevin O'Rourke. His innovative position begins by nuancing certain understandings. In the analysis of Walter, the arena of «Quality of Life» has now tended to shift away from evaluating substantial qualities to the teleologic posture of O'Rourke. Perhaps we can say that, through the teleologic approach, the impasse between the notion of «Quality of Life» and «Sanctity of Life» is in one way avoided, but contentions still exist in this newer stance, which involves the ability of debilitated persons to pursue the higher good, as we shall examine. Walter outright interprets the *Declaration on Euthanasia* as supporting this teleologic vision of the spiritual pursuit of life as a formal criterion for decisionmaking¹³¹.

In such decisionmaking, normally, the distinction of proportionality is conceived to apply to those who are imminently dying, those who will die within a short time regardless of medical intervention. An obligation is generally assumed to conserve the life of those who have complications that could result in death, but could be saved through routine application of apparently proportionate means, for example, insulin for diabetes. In a change of direction,

O'Rourke emphasizes the concept of fatal pathology as an element in the ethical analysis of life conservation. For those in a PVS, the fatal pathology is the inability to chew or swallow. From here, if the means to conserve life could be determined to be disproportionate for patients with such fatal pathology, nutrition and hydration could be withheld, allowing such pathology to run its course. It is important to note that O'Rourke intends the underlying pathology concept to be in concert with the *Declaration on Euthanasia's* ban on actions that have no other finality than to end life: since with the fatal pathology concept, the withdrawal of nutrition and hydration is meant not be a decision to directly terminate the life of the patient.

O'Rourke also goes to the statements of Pius XII (Allocution of November 24, 1957) to found the basis for his statements on the obligation to support permanently unconscious bodily life. He emphasizes the remarks of the Pope about the importance of the higher good, and deduces the key criterion to be the ability to 'strive for life's purpose'. To measure up to this criterion, one clearly needs to be conscious and purposeful, and as such O'Rourke writes:

Thus when the potential for the spiritual function is no longer present, then it seems that all treatment or care efforts which would sustain physiological function are ineffective. ... Thus the goals of medicine and human life are not achieved if mere physiological function is prolonged while spiritual function is beyond the potential of the person. There is no attempt to prolong the life of anencephalic infants; why then prolong the life of people whose cerebral cortex will never again function?¹³²

Thus, since bodily life alone, O'Rourke argues, does not allow that person to attain the goals of human life (the striving for life's purpose) nor the goals of medicine (presumably the cure or return to a relatively normal existence) means otherwise considered ordinary or useful are not obligatory. Thus the previous criteria of usefulness is enlarged to become *effectiveness for promoting or regaining the spiritual function*. Thus while nutrition and hydration could be considered useful in the sense that they conserve bodily life, they cannot however

be considered effective for a PVS patient in that they are not a resource for achieving spiritual function: *all* treatment for PVS patients is ineffective, and no treatment in particular is thus binding. Thus O'Rourke puts in relief the necessity of a functioning cerebrum:

Because the mind is necessary for spiritual function, at least the potential for cognitive-affective function in some degree must be present to justify sustaining physiological function. If the cognitive-affective potential is nonexistent, the person is still a human being, but a human being toward whom we do not have an ethical obligation to prolong life¹³³.

O'Rourke concludes what the result of this determination would have on this class of individuals:

In order to pursue the purpose of life, one needs some degree of cognitive-affective function.... Hence, if efforts to restore cognitive-affective function can be judged useless, or it can be judged that an infant will never develop cognitive-affective function, then if a fatal pathology is present, the adult or infant may be allowed to die. ... This is the precise ethical justification for discontinuing artificial hydration and nutrition for people in an irreversible coma, not the fact 'that benefits of treatment outweigh its burdens', as the A.M.A. statement seems to indicate¹³⁴.

Thus, the duty of physicians, family members and society is substantially altered. For those with an intact potential or actual functioning cerebrum, the duty remains unaltered. But for those without such abilities, means before considered proportionate and obligatory, now are to be deemed useless, not because they do not sustain the person physiologically, but because of their ineffectiveness in supporting or restoring the patient to the pursuit of spiritual goals. The duty to provide life-support no longer binds anyone.

b) Criticisms of the Spiritual Criterion

The stance of O'Rourke is not only novel in its interpretation of the words of Pius XII, but also in its consideration of the proportionality of life in, say, a PVS. Not all agree with O'Rourke's position. Quay and Connery fundamentally disagree with the interpretation made of the papal statement on means. Griesse and Cronin add to this objection and take issue with the O'Rourke's notion of life that does not merit nutrition and hydration when this does not involve a moral impossibility. Ashley argues, in similar fashion to O'Rourke, in favor a teleologic interpretation. Likewise, Brodeur strongly supports the position of O'Rourke, and offers nuanced arguments in its favor.

In their opposition to the teleologic proposal of O'Rourke, Paul Quay and John Connery do not see a connection between the concession to dispense with means that interfere with the higher good, (a means that could be thus extraordinary or not proportionate to one's ultimate end), and the peculiar condition presented by a PVS patient. Quay writes:

The obvious fallacy lies in the shift from the freedom to dispense with means that would interfere with the spiritual to the freedom to dispense with the life that is interfered with. The conscious patient whose spiritual or other higher good would be put at hazard by an excessively burdensome treatment is made equivalent to a permanently demented or unconscious patient whose higher goods cannot be obstructed by any conceivable means of treatment, already being blocked by disease. The competent patient chooses the higher good, though realizing death is likely to ensue as a result. The non-competent patient has death chosen for him as the means to prevent his remaining longer in his diseased condition¹³⁵.

While conceding that the permanently unconscious and their families have a difficult lot, he suggests that the dignity and sacredness of the human person calls for treatment when it is useful for conserving life, and can be provided without excessive burden.

John Connery, following Quay's posture¹³⁶, recalls the context in which the comments of Pius XII (Allocution of November 24, 1957) were made in order to obtain a proper interpretation. Such context bespoke the obligation of using certain *means*. The duty thus concerned the quality of means, not the «Quality of Life»: «Pius XII put this in part, in terms of interfering with a higher good. He said that it would be permissible to forego means to preserve life because making them obligatory would interfere with a higher good. In other words, pursuing life or health with some particular means could become optional if some higher good is at stake. Such means would become extraordinary». ¹³⁷ Thus nutrition and hydration is not an *obstacle* to the higher good; it is not something to be removed that might prevent such a pursuit. For the PVS patient, it is no obstacle at all.

Griese argues against the teleologic posture of O'Rourke first by pointing out what he sees as a fatal flaw: the introduction of a dualistic anthropological vision of man: «No form of dualism is rationally defensible. For every dualism sets out to be a theory of one's personal identity as a unitary and subsisting self —a self always organically living, but only discontinuously conscious, and now and then inquiring, choice-making, and using means to achieve purposes. But every form of dualism renders inexplicable the unity in complexity which we experience in every conscious act. ... Therefore contrary to what O'Rourke, McCormick, and others think, human life is inherently good, so it does not cease to be good when one no longer can enjoy a degree of cognitive-affective function or attain other values»¹³⁸.

By equally reverting to the original statements of Pope Pius. His comments on the interpretation of the words of Pius XII (Allocution of November 24, 1957) reveal an appeal to the context of the document:

Some authors interpret these words of Pius XII as justification for withdrawing tube feeding from a terminal patient as a step in the pursuit of the 'spiritual purpose of life'. First of all, such an interpretation clearly is out of context. Even authors who may consider tube feeding to be a medical *treatment* should admit, from a cursory reading of the address, that the Holy Father was not referring to the

obligation to provide sustenance. He was speaking of medical treatments...¹³⁹

Griese continues by noting that these words of Pius XII taken together with the *Declaration on Euthanasia*, form a whole. It is not all that apparent in either document that nutrition and hydration could be considered distinct from the ordinary care which must never be interrupted¹⁴⁰. He points out the difference between *conserving* life and *prolonging* life: conservation of life requires food and water, that necessary for all life. He alludes to Cronin's comments on this teleological importance of *conservation* of life as distinct to the prolongation of life:

The dictate of the natural law that requires a man to conserve his own life is a serious one. It is based on the double importance of man's human life. His life is important as a divine gift over which God retains the ultimate dominion. Secondly, it is important as the means whereby man can merit his eternal salvation. Hence, self conservation is no mere heroic act, which although laudable, is not obligatory. The conservation of one's own life is not just a desirable thing which entails no serious duty. In reality, the natural law imposes self conservation as a very definite obligation from which the individual is excused only when such conservation is impossible for him either physically or morally¹⁴¹.

Cronin finds a balance in Aquinas where the prohibition against suicide on one hand is opposed to the disorder of an over-anxious concern for living and an undue love for life preserving measures on the other. Aquinas speaks of a due measure (*debito proprio*)¹⁴². It would seem that Pius XII's remarks (Allocution of November 24, 1957) captured this sense, and were meant to keep a man from subordinating his supernatural end to a 'natural' end. Such subordination would be an attempt to live one's earthly life while marginalizing one's supernatural life. One can ask: is life in a PVS detrimental to one's supernatural life? One could, however, strive for an long life, at the

cost of one's duties to others and act, as it were, in opposition to faith in the resurrection. There is a clinging to this earthly life that does damage one's supernatural life. This interpretation of Pope Pius XII's words follows the context of his address, uttered several decades ago in answer to pressing questions on resuscitation. The «teleological» interpretation of Pius XII's words, made by O'Rourke and others, is not rejected by the very text itself. But as a developed criterion, the teleological approach is clearly a particular interpretation and extension, and not a mere restatement, and even appears to be taken out of context.

Benedict Ashley, for his part, supports O'Rourke in the teleologic position. In a work on the intrinsic teleology of the human body as normative, he addresses the significance of human life that has lost the capacity for cognitive-affective function, and opines that the obligation to preserve life in such a condition is minimal¹⁴³. «To argue, as some do, that intravenous nutrition and hydration are always ordinary and obligatory if they are necessary to maintain life, on the grounds that to discontinue them is to kill the patient, or because life, even in this condition, is still an inestimable value outweighing most burdens of care, is to forget that the obligation to take means to preserve life diminishes as the value of this life, measured in terms of its intrinsic teleology, diminishes. Human bodily life by its intrinsic teleology has its value from its service to activities of the whole human person, and especially those activities which are specifically human, the spiritual activities of knowledge and free choice. When these activities become permanently more and more difficult or impossible, the corresponding obligation to preserve bodily life diminishes. ... Thus in this case as in all ethical dilemmas arising from technology the important thing is to establish intrinsic teleology as the ultimate measure of morality. This principle, philosophically coherent with empirical science, is theologically confirmed by the biblical teaching that God has created us in his image and given us a stewardship over his creation, a stewardship to be exercised creatively and harmoniously within the Creator's general purposes».

This author does not see the jump from teleology as an ethical principle to the conclusion that the obligation diminishes toward that life as its spiritual powers diminish, even less how one could be

obligated to less than ordinary means, —and by what proportion would it diminish? Where the body is, there is the person; and the embodied person has value in that God loves him. To see the value of the embodied person, or in the value of the body for the person only in terms of its ability to know and love God is to miss out on the other half.

Brodeur presents, in a summary way, the conflicting views of many authors on the duty to feed PVS patients, and concludes: «Resolution of these issues depends upon agreement on the facts of the medical description of a PVS, the ability to distinguish PVS patients from persons who are severely mentally retarded and other mentally incapacitated individuals, and the need to develop a consensus about methods and time frames to diagnose a patient in a PVS. These concerns must be correlated with a patient's values, purpose of life, and other ethical principles»¹⁴⁴.

In order to give a firm basis to the teleologic theory, the preceding authors, especially Brodeur, who argue in favor of its adoption have marked out, for practical cases, PVS and anencephalic patients as indisputable examples of individuals with fatal pathologies who are not able «to strive for life's purpose». Given that such claims have life or death implications, it is fitting to examine whether the teleologic position can rightly lay claim to such a firm starting point.

Given the importance of the cognitive-affective function in eliciting moral acts, these ethicists have maintained that anencephalic and PVS patients provide clear cut cases of where a line can be drawn regarding nuancing obligations to provide otherwise proportionate care; the former would never attain cognitive-affective function, while the latter have definitively lost it. Prudence would dictate caution with this approach. It is difficult, from a philosophical view, to know in a definitive manner, the subjective situation of the person with extensive brain damage, outside of complete and sustained electro-cerebral silence or definitive death¹⁴⁵. Also from a physician's position, the diagnoses of anencephaly and PVS are not without their complications. Shewmon shows the complexity of many aspects of anencephaly: «If anencephaly were clearly distinct from all other congenital brain deformations, it should be possible to give an operational definition of it that includes all cases of anencephaly and excludes all cases of everything

else, yet such a definition has not been offered by anyone so far»¹⁴⁶. For adults with a presumed PVS, he advises caution, suggesting at least a two month observation period before offering diagnosis. He examines the clinical guidelines for PVS determination, and analyzes several cases of a PVS, including emergence from PVS¹⁴⁷. Recovery from a supposed PVS does not always indicate initial misdiagnosis¹⁴⁸.

Besides the precisions that Shewmon makes, there exists another contribution that ought to be considered in respect to the viability of the teleological approach. May takes exception, and exchanges with O'Rourke's sharp criticism concerning the practice that such an approach would set in motion. He responds to the position of O'Rourke seeking to bring out the logical consequences of his position. O'Rourke has presented the case for those lacking *all* capacity for consciousness, discerning a «patent» disvalue and burden of mere human bodily life. May, however, asks about those who do retain some cogitative capacity, although much reduced. O'Rourke has regarded these as worthy of protection, but it is not clear that by his own criteria they would escape the fate of those who lack all cogitative capacity. Thus May charges:

Many people, including some seriously handicapped children and some elderly people who are not 'with it' persons who are not actually able to judge the truth or falsity of propositions or make free choices, are not capable of striving for the 'spiritual purpose' of life. They cannot do so because, in order to do so, a person must be able to make judgements and to make free choices. But these unfortunate human beings are still persons; their lives are still good, and it is good for them to be alive¹⁴⁹.

The beginnings are small as May indicates: «Most of the cases that have attracted attention thus far have involved the severely brain damaged —those who are permanently unconscious, severely damaged by strokes, in advanced stages of dementia due to Alzheimers's or other disease, and so on. But the various sorts of damage, defect, debility, and handicap that burden human lives occur in myriad degrees, so that there are always more and less severe cases differing

from one another only by degree»¹⁵⁰. But the necessary conclusion is forceful:

Countless severely handicapped persons, including infants and the elderly, are regarded as worthless. There are many such persons who are no longer capable or will never be capable of 'reaching life's spiritual goals' or of 'realizing life's purposes'. They are not capable of doing so because they cannot engage in *human* acts, i.e., acts proceeding from the person with deliberation and choice. They are not *moral agents*. But, I submit, they are still *beings of moral worth*, i.e., persons, whose lives are irreplaceably precious and worthy of our respect and love. To deny these persons treatment on the grounds that treatment will not help them to realize life's purposes is grossly unjust and unfair. It surely cannot be what Pius XII meant¹⁵¹.

May makes the point that neither are these, with lesser degrees of cerebral capacity, whom already O'Rourke has defended as worthy of life prolongation, able to «pursue life's purpose». By what basis, then, should these be accorded protection? Certainly still there are few bioethicists who would favor abandoning all those who are effectively unable to «pursue life's purpose». This would become evident when the necessity of treatment presents itself for these. What one normally might judge to be ordinary treatments should also be obligatory for them. «Yet, on O'Rourke's analysis, they would not, for they would not be effective in helping this person to 'strive for the spiritual purpose of life'»¹⁵².

In a response to May, O'Rourke maintains that for those with diminished mental capacity, there still remain obligations to provide nutrition and hydration:

If a fatal pathology is not present, whether in the person who is mentally competent or in the person who is mentally disabled, then nutrition and hydration should be provided by others if one cannot provide these goods of life for oneself. To put it in another way, we have a positive responsibility to

prolong our own lives and the lives of others who are dependent upon us as long as our efforts to help another person are beneficial. Only when one's own life or the life of a loved one in our care is threatened by a fatal pathology do we have a moral right to ask the questions: Will attempts to remove or circumvent this pathology be effective or ineffective? Will attempts to circumvent or remove this pathology result in greater burden than benefit for the patient?¹⁵³

We can ponder, however, just how this protects from the slippery slope. How it is not the very entry to the slippery slope itself is not so clear¹⁵⁴. The standard of «the pursuit of life's purposes», would effectively lessen much of the obligation to conserve the lives of those in these states. It appears, however, to be a mere definitional barrier, given that those with *some* cognitive ability should not be evaluated in this way, when practically speaking, many do not have any more significant hope of «striving for the purpose of life», than those correctly diagnosed as PVS patients.

But, we can see that there is a wide range of mental disorders that, like a PVS, would preclude a person from the ability to seek life's purpose, that is, from the minimum cognitive affective level necessary for moral acts. Thus rather than being an admonition of slippery slope, it appears to be a logical conclusion that the requirement of ability of «seeking life's purpose» for PVS patients puts other handicapped persons in danger. The rebuttal provided by O'Rourke does not reply adequately to this charge. The cited article speaks, in reply to May, of the fatal pathology of chewing and swallowing for a PVS patient as a clearly demarcated case, but does not treat the logic that shows his interpretation is still open to the original charge. For there is a large population of retarded and demented persons in treatment centers which cannot perform human acts. What if such persons, for example, acquire an infection, easily cleared up by simple application of cheap and readily available antibiotics, but if left untreated, constitutes a fatal pathology. Is it not in effect relativizing by the condition of the patient, all means considered proportionate or obligatory by Pope Pius and by the Congregation? As a case in point, Claire Conroy was neither 'brain dead', nor comatose, nor in a

PVS state when a court order authorized removal of her gastrostomy tube¹⁵⁵. The term «useless» is not completely synonymous with «ineffective», and constitutes an addition not easily derives from the original words of the Pope. It appears that too much hinges on the interpretation of the Pope's words, which were uttered for the purpose of clarifying the extraordinary means of respirator use.

4. Resolution

If the preceding notion of the relativizing of means can be sustained, then truly a clear «Quality of Life» element is able to be derived. The obligation to use a particular means is seen already as dependent on the condition of the patient, in that the condition is part of the determinant of the burdensomeness or usefulness of proposed treatment. This new nuance would also allow one to forego means, not burdensome nor useless, in view of a better forthcoming death. The principle of double effect requires an indirect intention. But the omission of means which do not involve a moral impossibility, and by whose omission death directly follows, does not fulfil this condition.

This question has merit in that it directs one to examine the illnesses not as just separable parts, each with its ordinary cure, but also toward examining the sickness in the light of all the attendant circumstances taken as a the whole. A key circumstance is the determination of the content of *parum pro nihil reputatur*. If a given treatment allows prolongation of life but for a brief period, there is no obligation to employ it. Authors usually express imminent death as that to occur within hours. How far beyond imminent death does the principle extend? If the time to be lived is substantial, then the distinct elements might indeed be separable, and it would be an error to lump them together, or to concede relativity to ordinary means where none exists.

Thus, where two or more pathological diseases occur simultaneously, the following conditions ought to be taken into account in determining the proportionality of means: 1. if one or more, or the whole of them provoke medical futility (uselessness); 2. if an illness comes to cause a moral impossibility (burdensomeness), then the others can be foregone, provided that the latter ones do not

introduce the cause of death by their omission (*suapta natura*); 3. if the time of life gained is quite small, hours or a day or so (*parum pro nihil reputatur*); 4. if the person is spiritually prepared, or does not have obligations in justice to fulfil (eliminating a *per accidens* requirement to use disproportionate means); 5. if the aggregate of the means, considered separately as proportionate, once summed up in the light of their whole, are considered disproportionate (where the treatment in the light of the *whole* is summed as excessively burdensome). What is assumed is that the cures, considered separately would be proportionate, the other illnesses being absent as applied. The case presented earlier, of diabetes and cancer with a six month prognosis for death does not appear to exhibit the exempt characteristics. The insulin treatment could be foregone only in the face of imminent death from the cancer.



NOTES

1. R. A. McCORMICK, «To Save or Let Die», *JAMA* 229 (1974) 174.
2. P. RAMSEY, «Prolonged Dying: Not Medically Indicated», *HCR* 6/1 (1976) 15.
3. Triage: the practice, whereby the sick or wounded are sorted according to gravity, available resources, and possibilities of cure, often encountered in battlefield medicine.
4. R. A. McCORMICK, «To Save or Let Die», *JAMA* 229 (1974) 173.
This is a partial listing of the more important bibliographic works.
5. *Pius-Means*, 1030.
6. *CDF-Euth*, n¼ I.
7. *CDF-Euth*, n¼ IV.
8. In this vein writes D. CALLAHAN, «Can We Return Death to Disease?», *HCR* 19/1 (Supplement) (1989) 4: «We will need a dampening of the push for medical progress, a return to older traditions of caring as an alternative to curing, and a willingness to accept death and decline as part of the human condition (not a notable feature of American medicine)».
9. D. CALLAHAN, «The Sanctity of Life Seduced: A Symposium on Medical Ethics», *FT* 42 (April 1994) 14. In his article Callahan attacks the notion that we now have become responsible for life and death, and that we cannot blame death on nature, — a notion proposed strongly by J. Fletcher. *Vid.* «Ethics and Euthanasia», in *DDE*. *Vid.* ut supra chapter I at notes 200 and 201.
10. *Ibid.*
11. Cf. J. LYNN, J. F. CHILDRESS, «Must Patients Always Be Given Food and Water?», *HCR* 13/5 (1983) 19. They list a number of factors: simple / complex, natural / artificial, usual / unusual, non-invasive / invasive, reasonable chance / futile, proportionate / disproportionate, inexpensive / costly, of which the first four are not considered relevant in the means approach as elaborated by the consensus of magisterial teaching.
12. *Ibid.*, 21.
13. S. J. YOUNGNER, «Who Defines Futility?», *JAMA* 260 (1988) 2094-2095. In terms of goals for medical interventions, Younger lists five understandings of futility: physiological futility, postponing death, length of life, quality of life, and probability. The role of value of life becomes apparent when one considers, for the last three, questions such as: how much extended time is meaningful?; what goals are relevant for establishing quality of life?; how low must the probability be before an intervention is futile?
14. P. RAMSEY, «Prolonged Dying: Not Medically Indicated», *HCR* 6/1 (1976) 15.
15. *Vid.* IDEM, *The Patient as Person*, Yale University Press, New Haven, 1970, for his heralding the move toward patient autonomy, and IDEM, *Ethics at the Edge of Life...*, *op. cit.*, for his strong stance against «Quality of Life» judgements.

16. *CC-RAM*, 378-379.
17. Cf. *ibid.*
18. P. M. QUAY, «The Sacredness of the Human Person: Cessation of Treatment», *LQ* 59/1 (1992) 89.
19. *ARTIFICIAL MEANS*, 213-214.
20. «[Q]uod non est simile de pharmaco et alimento. Alimentum enim per se est medium ordinatum ad vitam animalis et naturale, non autem pharmacum.... [M]edicina per se etiam ordinata est ad salutem a natura...»: FRANCIS DE VITORIA, *Relectio IX, de Temperantia*, n^o 1. Cited in D. A. CRONIN, *CONSERVING*, 78.
21. Cf. *ibid.*, 78-83.
22. He also states: «However, in Vitoria's time, the development and progress of medical helps to conserve life had not reached the point where their use would give any sure hope of benefit. Hence, Vitoria is quite logical and quite correct in not demanding a person under obligation to use these artificial means»: *Ibid.*, 80-81.
23. Hyperalimentation, also called total parenteral nutrition, is a technique whereby complete nutrition and hydration is supplied by I.V. lines.
24. R. A. McCORMICK, «Caring or Starving? The Case of Claire Conroy», *America* 152 (1985) 272.
25. Cf. *CC-RAM*, 380-381.
26. W. T. REICH, «Quality of Life», in *E OF B*, 833.
27. Cf. *ibid.*, 830-831.
28. *Ibid.*, 830.
29. *Ibid.*
30. Cf. S. H. CROOG, S. LEVINE, M. A. TESTA, *ET ALII*, «The Effects of Antihypertensive Therapy on the Quality of Life», *NEJM* 314 (1986) 1657-1664.
31. *Ibid.*
32. Cf. J. WALTER, T. SHANNON, eds., «Quality of Life: The New Medical Dilemma», *Paulist Press, New York, 1990*, 78 et seq.
33. J. DE HAES, F. VAN KNIPPENBERG, «The Quality of Life of Cancer Patients: A Review of the Literature», in M. HÄYRY, «Measuring the Quality of Life: Why, How, and What?», *Theor Med* 12 (1991) 109.
34. Cf. M. HÄYRY, «Measuring the Quality...», *cit.*, 111.
35. K. C. CALMAN, «Quality of Life in Cancer Patients—A Hypothesis», *JME* 10 (1984) 124-125.
36. *Ibid.*, 125.
37. N. SARTORIUS, cf. C. E. SELAI, R. M. ROSSER, «Good Quality Quality? Some Methodological Issues», *J of the Royal Soc. of Med* 86 (1993) 440-443, at 440.
38. R. A. McCORMICK, «To Save or Let Die», *JAMA* 229 (1974) 173.
39. Cf. *ibid.*, 176: «It must be emphasized that allowing some infants to die does not imply that 'some lives are valuable, others not' or that 'there is such a thing as a life not worth living.' Every human being, regardless of age or condition, is of incalculable worth. The point is not, therefore, whether this or that individual has value. Of course he has, or rather *is* a value».
40. McCormick identifies the former approach with one such as Karnofsky, and the latter with R. S. DUFF, A. G. M. CAMPBELL «Moral and Ethical Dilemmas in the Special-Care Nursery», *NEJM* 289 (1973) 894, who state: «We believe the burdens of decision making must be borne by families and their professional advisers because they are most familiar with the respective situations. Since families primarily must live with and are most affected by the decisions, it appears that society and the health professions

should provide only general guide-lines for decision making. Moreover, since variations between situations are so great, and the situations so complex, it follows that much latitude in decision making should be expected and tolerated».

41. R. A. McCORMICK, «To Save..», *op. cit.*, 174.
42. *Ibid.*
43. *Ibid.*
44. *Ibid.*, 175.
45. *Ibid.*
46. R. A. McCORMICK, «Caring or Starving?..», *op. cit.*, 273.
47. R. A. McCORMICK, «The Quality of Life, The Sanctity of Life», *HCR* 8/1 (1978) 35.
48. *The «Quality of Life» of the patients that Paris is expounding also includes the criteria of McCormick. This opinion concedes that treatment, as well as nutrition and hydration, can be withheld from PVS patients or others who lack the 'capacity to enter into human relationships'.* Vid. J. J. PARIS, «Terminating Treatment for Newborns: A Theological Perspective», *L M & H C* 10/3 (1982) 123.
49. J. J. PARIS, «Terminating Treatment..», *op. cit.*, 122.
50. W. E. MAY, «Criteria for Withholding and Withdrawing Treatment», *LQ* 57/3 (1990) 81; *vid.* G. GRISEZ, «Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?», *ILM* 5/2 (1989) 165-179.
51. W. E. MAY, et alii, «Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons», *ILM* 3/3 (1987) 210.
52. W. E. MAY, «Criteria for Withholding..», *op. cit.*, 83.
53. W. E. MAY, «Ethics and Human Identity: The Challenge of the New Biology», *Horizons* 3 (1976) 35, cited in R. A. McCORMICK, «The Quality of Life..», *op. cit.*, 34.
54. R. A. McCORMICK, «The Quality of Life..», *op. cit.*, 34.
55. *Ibid.*, 34.
56. J. D. BLEICH, «Life as an Intrinsic Rather Than Instrumental Good: The 'Spiritual' Case Against Euthanasia», *ILM* 9/2 (1993) 140. For his discussion on the «Sanctity of Life» as an *a priori* moral value, *vid.* J. D. BLEICH, «Providing Nutrition and Hydration for Terminally Ill Patients», *ILM*.6/4 (1986) 123-124.
57. *Ibid.*, 141.
58. *Cf. ibid.*, 148-149.
59. *Ibid.*
60. *Cf.* J. J. WALTER, «A Public Policy Option on the Treatment of Severely Handicapped Newborns», *Laval théologique et philosophique* 41/2 (1985) 239-250.
61. R. A. McCORMICK, «The Quality of Life..», *op. cit.*, 35-36.
62. *Cf.* P. E. JOHNSON, «Nihilism and the End of Law», *FT* (March 1993) 19-25.
63. J. J. WALTER, «A Public Policy Option..», *op. cit.*, 243.
64. G. GRISEZ, «Should Nutrition..», *op. cit.*, 172-173. For a more detailed description of this argument, see J. FINNIS, J. M. BOYLE JR, G. GRISEZ, *Nuclear Deterrence, Morality and Realism*, Clarendon Press, Oxford, 1987, 307 *et seq.*
65. VS, n^o 48.
66. *Cf.* J. DEWEY, *The Quest for Certainty*, in J. BOYDSTON, ed., *John Dewey, The Later Works, 1925-1953, vol. 4* 1929, Southern Illinois University Press, Carbondale and Edwardsville, 1984.
67. K. WILDES «Life as a Good and Our Obligation to Persistently Vegetative Patients», in *BSD*, 148-149.
68. *Ibid.*, 150.
69. *Ibid.*, 153. This view, which asserts that human life remains, but personal life does

- not, as well is most certainly dualistic. One could conceive that a point is reached where human life (and thus personal life) no longer remains, yet the body could be externally supported. In this vein, a thought experiment from Thomism was presented by D. A. SHEWMON, which speculated upon the possibility to keep alive human bodies, (not human life) after personal death, about which speculation he urged the utmost caution. Cf. «The Metaphysics of Brain Death, Persistent Vegetative State and Dementia», *The Thomist* 49 (1985) 24-81. This is a most delicate question, which Barry and Quay seem to have misunderstood at first. Cf. R. BARRY, «Ethics and Brain Death», *The New Scholasticism* 61/1 (1987) 82-98 and P. M. QUAY, «The Sacredness of the Human Person...», *cit.*, 81, 87-88 and D. A. SHEWMON, «Ethics and Brain Death: A Response», *The New Scholasticism* 61/3 (1987) 321-344. However, others such as Wikler, prefer to directly define as dead, those such as PVS patients who have lost upper brain capacity. *Vid.* D. WIKLER, «Not Dead, Not Dying?: Ethical Categories and Persistent Vegetative State», *HCR* 18/2 (1988) 41-47.
70. *Life & Death*, 376-377. For more development of this argument, cf. J. M. BOYLE JR, G. GRISEZ, O. TOLLEFSEN, «Free Choice: A Self-Referential Argument», Notre Dame Press, Notre Dame, 1976, 110-121.
 71. *Some «Quality of Life» authors find little difficulty in resolving such cases in favor of personal preference and autonomy.* Cf. S. WANZER, ET ALII, «The Physician's Responsibility Towards Hopelessly Ill Patients», *NEJM* 310 (1984), 958; D. CALLAHAN, ET ALII, «The Sanctity of Life Seduced: A Symposium on Medical Ethics», *FT* 42 (April 1994) 14; and J. J. Paris in CC-RAM, 384.
 72. Cf. J. McCARTHY, *Irish Ecclesiastical Record* 58 (1941) 552-554. Ford concurred in this analysis. Cf. J. FORD «Notes on Moral Theology», *TS* 3 (1942) 591.
 73. *ARTIFICIAL MEANS*, 215.
 74. «I still favor Fr. McCarthy's solution to the effect that the insulin must be used; but I no longer consider this solution as certain because I am not sure we are justified in stating that the patient must prescind from the cancer in determining her obligations of using the insulin.»: *ARTIFICIAL MEANS*, 216.
 75. *ARTIFICIAL MEANS*, 215.
 76. Cf. *ibid.*
 77. McCormick gives Paris' position: «Paris maintains that a quality of life dimension has always been present in Catholic tradition. For instance, a patient with widely disseminated metastatic disease need not receive antibiotics for an intercurrent pneumonia. But, he argues 'absent the quality-of-life judgement, there could be no oral warrant for the withholding of such a simple, inexpensive and effective treatment for a life-threatening condition.'», R. A. MCCORMICK, *CC-RAM*, 384. It is not clear that this opinion forms parts of the Catholic tradition, as Paris claims, but rather an opinion extended from the statements by De Lugo on *parum pro nihil reputatur*, an neither does this opinion offer resolution on what would constitute *parum*.
 78. P. RAMSEY, *The Patient as Person*, *op. cit.*, 130.
 79. Along this line he states: «There are, of course, stages of cancer for which treatment holds out the hope of, say, ten years of relatively normal life. The diabetes of such a patient should certainly be treated. While it may be that the disease has seized him from which he one day will die, he is not yet dying from it.»: *Ibid.*
 80. Cf. D. CALLAHAN, «The Sanctity of Life Seduced...», *op. cit.*, 13-27; D. CALLAHAN, «Can We Return Death to Disease?», *HCR* 19/1 (Supplement) (1989) 4-6.
 81. IDEM, «Letter to Editor», *FT* 46 (Aug-Sep 1994) 4.
 82. IDEM, «Ethics and the Medical Ambivalence Toward Death», *Humane Medicine* 10/3

- (1994) 183.
83. IDEM, «*Can We Return Death to Disease?*», *op. cit.*, 6.
 84. «...a fatal pathology being understood as an illness, disease, or lesion which will cause death unless it is removed or circumvented». : K. O'ROURKE, «Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?», *ILM* 5/2 (1989) 182.
 85. Cf. D. BRODEUR, «Is a Decision to Forego Tube Feeding for Another a Decision to Kill?», *ILM* 6/4 (1986) 398; JJ. M. BOYLE JR, «Does the Benefit Outweigh the Burden in the Artificial Provision of Nutrition and Hydration: An Affirmative Answer», *Critical Issues in Contemporary Health Care*, R. E. SMITH ed., Pope John Center, Braintree, 1989, 64; P. J. BOYLE, «The Case for the Removal of Nutrition and Hydration from Those in a Persistent Vegetative State», *Critical Issues in Contemporary Health Care*, R. E. SMITH ed., Pope John Center, Braintree, 1989, 70-77; J. B. BALSAM, «To Sustain Life or Allow to Die?: A Medico-Moral Analysis», *Angelicum* 66 (1989) 273.
 - 86: K. O'ROURKE, «Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?», *ILM* 5/2 (1989) 196.
 87. J. J. PARIS, A. C. VARGA, «Care of the Hopelessly Ill», *America* 151 (1984) 142-143.
 88. Cf. K. O'Rourke, «Prolonging Life: A Traditional Interpretation», *LQ* 58/2 (1991) 21-22; IDEM, «Should Nutrition and Hydration...», *op. cit.*, 181-182; K. O'ROURKE, J. DE BLOIS, «Removing Life Support: Motivations, Obligations», *Health Progress* 73/6 (1992) 25-26.
 89. AMA COUNCIL ON SCIENTIFIC AFFAIRS, AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, «Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support», *JAMA* 263 (1990) 427.
 90. R. E. CRANFORD, «The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)», *HCR* 18/1 (1988) 31.
 91. Cf. R. L. MARKER, *Nancy Beth Cruzan Fact Sheet*, International Anti-Euthanasia Task Force, Steubenville, 1991.
 92. M. VACCARI, «The Inability to Swallow as a Fatal Pathology: Comments on the McHugh/O'Rourke Correspondence and the Removal of Life Sustaining Treatment», *ILM* 7/2 (1991) 163.
 93. *Ibid.*, 166. *He also adds: «What principles would Fr. O'Rourke apply to treatment decisions involving nonfatal pathologies? If the response is that the proposed treatment must satisfy the criteria of effectiveness and burden, then the entire methodology of fatal pathology collapses because all treatments are assessed in terms of burdens and usefulness. If treatments are measured in terms of burden and usefulness, then we do not need to know whether the pathology is fatal; unless the fatal nature of the pathology is relevant to the burden / usefulness analysis».* : *Ibid.*, 163.
 94. Cf. G. GRISEZ, «Should Nutrition and Hydration...», *op. cit.*, 165-179.
 95. In more detail he notes, R. E. CRANFORD, «The Persistent Vegetative State...», *cit.*, 31-32: «The cost of maintaining these [PVS] patients varies substantially by state, type of institution, and support systems. In some states, like Minnesota, daily costs are usually \$50 to \$70 per day, about \$1,500 to \$2,000 a month, or approximately \$18,000 to \$25,000 a year. In Massachusetts, the charges in Paul Brophy's case were approximately \$10,000 per month. ... First year costs are markedly higher depending on how much time is spent in an intensive care unit and at what point the patient is transferred from an acute care hospital to a chronic care facility».
 96. Cf. P. J. BOYLE, «The Case for the Removal...», *cit.*, 73-74, *vid.* note 16 on the costs of total parenteral nutrition and annual *hospital costs*, of \$100,000. For a description of

- total parenteral nutrition, *vid.* D. MAJOR, «The Medical Procedures for Providing Food and Water: Indications and Effects», in *By No Extraordinary Means: The Choice To Forego Life-Sustaining Food and Water*, J. LYNN ed., Indiana University Press, Bloomington, Indiana, 1986, 21, 24-25.
97. Cf. J. BOPP, «Choosing Death for Nancy Cruzan», *HCR* 18/1 (1988) 38-41.
 98. Cf. T. J. BOLE III, *BSD*, 177-180.
 99. Cf. W. E. MAY, *ET ALII*, «Feeding and Hydrating...», *op. cit.*, 210.
 100. D. CALLAHAN, «On Feeding the Dying», *HCR* 13/5 (1983) 22.
 101. Cf. B. LO, R. STEINBROOK, «Artificial Feeding — Solid Ground, Not Slippery Slope», *NEJM* 318 (1988) 288.
 102. PONTIFICAL COUNCIL *COR UNUM*, *Questions of Ethics Regarding the Fatally Ill and the Dying*, Vatican City 1981
 103. Cf. CCC n^o 2278. Note: «over-zealous treatment» has the Spanish equivalent *encarnizamiento* or *ensa-amiento terapéutico*, and in Italian, *accanimento terapeutico*.
 104. PONTIFICAL ACADEMY OF SCIENCES, *Report of the Pontifical Academy of Sciences on the Artificial Prolongation of Life*, in *Origins* 5, December 1985, 415. Italian version in *Enchiridion Vaticanum*, IX, 1726-1727.
 105. *Ibid.*
 106. JOHN PAUL II, Ad Quosdam Medicos Leuch³/₄mi³/₄ Peritos Coram Admissos, AAS 78/4 (1986) 361.
 107. JOHN PAUL II, Ad Quosdam Medicos ab Omni Europa Coram Admissos, AAS 80/11 (1988) 1426.
 108. *EV*, n^o 14c.
 109. CCC n^o 2278
 110. Pope Pius XII, «Address to the International Union of Catholic Women's Leagues», Sept 11, 1947; in *The Human Body*, Daughters of St. Paul, Boston 1960, 90-91. McHUGH also sees merit in the PVS condition In the reprint: ARCHDIOCESE OF NEW YORK, «Principles in Regard to Withholding or Withdrawing Artificially Assisted Nutrition / Hydration», *LQ* 57/1 (1990) 91: «The spiritual end of life is certainly union with God, but progress toward that union can be achieved and enhanced even by the unconscious patient if that person has intended that all of his or her suffering or debilitation be offered to God in union with the suffering of Christ»: O'Rourke however opposes such a claim, K. O'ROURKE, J. DE BLOIS, «Removing Life Support: Motivations, Obligations», *Health Progress* 73/6 (1992) 24: «Because persons in PVS cannot perform human acts (i.e., acts emanating from the intellect and will) as a result of a dysfunctional cerebral cortex, they cannot perform acts that enable them 'to bear fruit here on earth', that is, to strive for the spiritual goal of life». He rejects the notion that through a sort of 'virtual intention' one can give spiritual significance to suffering that one will incur later in life, but deciding to unite such sufferings with those of Christ. Virtual intention as commonly understood, still requires the ability to elicit actual intention, assumed to be absent in PVS patients. Cf. *ibid.*, 27.
 111. O. GRIESE, *CONSERVING*, 158-159.
 112. Cf. O. GRIESE, *CONSERVING*, 164-165.
 113. *Ibid.*, 168.
 114. Moraczewski's words: «[B]oth biologically and morally there is no relevant significant difference between the use or non-use of a respirator and of tube feeding. The previously mentioned parallel may help. Oxygen, water and food are all essential for life. For a person whose respiratory system is so impaired that he cannot breathe on his own, that is he cannot bring air into his lungs, a respirator is essential to 'push and suck air

in and out of our patient's lungs'. Once in the lungs the oxygen has to diffuse from the aveoli into the blood stream which then transports it, by means of the hemoglobin molecule into the red blood cells to every part of the body.

So, too, with food and water. If the digestive system is impaired, e.g. the person is unable consciously to chew or swallow, then assistance is required. The obstacle can be by-passed by intravenous feeding, by N-G tubes, or by gastrostomy, for example. Depending on the route of administration, water and nourishment are directly introduced into the blood (IV) or are introduced into the stomach and small intestine and largely absorbed through the villi of the large bowel and then enters the blood stream.

In one case the mechanical ventilator pumps in the oxygen, and in the other, water and food are «pumped» into the body by IV or by stomach tube. Both involve the artful introduction of an essential element for human life; both would result in death if human intervention had not been introduced to compensate for the dysfunction.: A. MORACZEWSKI, *CONSERVING*, 267-268. O'Rourke likewise appeals for the consideration of artificial nutrition and hydration as evaluatively equivalent to a respirator. Cf. K. O'ROURKE, J. DE BLOIS, «Removing Life Support...», *op. cit.*, 20, 26.

115. A. MORACZEWSKI, *CONSERVING*, 257 ff.
116. G. MEILAENDER, «On Removing Food and Water: Against the Stream», *HCR* 14/6 (1984) 11.
117. W. B. SMITH, «Is a Decision to Forego Tube Feeding for Another a Decision to Kill?», *ILM* 2/4 (1986) 390.
118. K. O'ROURKE, «The A.M.A. Statement on Tube Feeding: An Ethical Analysis», *America* 155 (1986) 323 and 331.
119. K. O'ROURKE, «Should Nutrition and Hydration...», *op. cit.*, 192. AAN: The American Academy of Neurology.
120. *Ibid.*, 193.
121. J. R. CONNERY, «The Ethical Standards for Withholding / Withdrawing Nutrition and Hydration», *ILM* 2/2 (1986) 89.
122. *Ibid.*, 90.
123. J. R. CONNERY, «Quality of Means, Quality of Life, and Euthanasia», *LQ* 59/2 (1992) 6.
124. J. R. CONNERY, «The Ethical Standards...», *op. cit.*, 88.
125. *Ibid.*, 90-91.
126. *Ibid.*, 92.
127. IDEM, «The Ethical Standards...», *op. cit.*, 94.
128. IDEM, «Quality of Means...», *op. cit.*, 6.
129. *It is an allusion to remarks of Pius XII that the duties of the doctor are subservient to those of the patient; they are not independent. Vid. PIUS-MEANS, 1031. «Unfortunately, treatment categories do not acknowledge the central place of the human person in ethical decisionmaking and relegate the person to a secondary consideration in favor of whether a treatment is medical or nursing care. Moral arguments that rest on the assumption that nutrition and hydration are basic nursing care and therefore always, or almost always, morally obligatory confuse the moral argument».: D. BRODEUR, «Is a Decision to Forego Tube Feeding for Another a Decision to Kill?», *ILM* 6/4 (1986) 397.*
130. Cf. R. BARRY, «The Ethics of Providing Life-Sustaining Nutrition and Fluids to Incompetent Patients», *JFC* 1/2 (1985) 23-37.
131. Cf. J. J. WALTER, «The Meaning and Validity of Quality of Life Judgements in Contemporary Roman Catholic Medical Ethics», *Louvain Studies* 13 (1988) 207, at footnote 37.

132. *Ibid.*, 188-189.
133. *Ibid.*, 189.
134. K. O'ROURKE, «The A.M.A. Statement on Tube Feeding: An Ethical Analysis», *America* 155 (1986) 322.
135. P. M. QUAY, «The Sacredness of the Human Person..», *cit.*, 85.
136. Connery said as much in an earlier article when he said that «some would like to omit treatment, etc., in cases where the means themselves are not burdensome or useless. They would like to add to those cases where a higher good may be interfered with cases where a higher good cannot be achieved at all. This higher good is sometimes envisioned as the ability to develop human relations»: J. R. CONNERY, «Quality of Means, Quality of Life, and Euthanasia», *LQ* 59/2 (1992) 7.
137. J. R. CONNERY, «Quality of Means..», *op. cit.*, 5-9, especially six.
138. G. GRIESE, «Should Nutrition..», *op. cit.*, 173.
139. O. GRIESE, «Feeding the Hopeless and the Helpless», *CONSERVING*, 157-158.
140. Cf. *ibid.*, 154.
141. D. A. CRONIN, *CONSERVING*, 97.
142. Cf. *S. Th* II-II q. 126 a. 1.
143. B. ASHLEY, «Dominion or Stewardship?: Theological Reflections», in *BSD*, 97.
144. D. BRODEUR, «Is a Decision to Forego..», *cit.*, 403.
145. In support of this prudential doubt, one should note that, as states the AMA COUNCIL ON SCIENTIFIC AFFAIRS, AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, «Persistent Vegetative State..», *cit.*, 428: «...vegetative persons can have near-normal electroencephalograms, and abnormal electroencephalogram-blocking responses have been found in persons awake and self-aware but totally paralyzed from peripheral neuropathy». Similarly state D. L. SCHIEDERMAYER, J. LAPUMA, «Do Positron Emission Tomographic Scans Measure Quality of Life?», *Ann Neurol* 24 (1988) 288: «The conclusion that patients who can show 'emotional fluctuations' and 'infant-like tearing or smiling in response to non-verbal stimuli' can no longer think or experience pain is not supported by the data presented. This conclusion is a philosophical rather than a scientific one». These authors cite studies concerning the ability of PVS patients, anencephalics, and neonates to experience pain, *vid.* K. J. S. ANAND, P. R. HICKEY, «Pain and Its Effects in the Human Neonate and the Fetus», *NEJM* 317 (1987) 1321-1329; and M. P. MCQUILLEN, «Can People Who Are Unconscious or in the 'Vegetative State' Perceive Pain?», *ILM* 6/4 (1990) 361-371. Not all agree, such as the AAN, who in their *Amicus Curiae* brief in the *Brophy* case claimed that patients in a PVS cannot experience pain and suffering.
146. D. A. SHEWMON, «Anencephaly: Selected Medical Aspects», *HCR* 18/5 (1988) 11-19 at 11. another author, R. E. CRANFORD, «The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)», *HCR* 18/1 (1988) 29: equivalently states for adults in a PVS: «With the persistent vegetative state, however, there is no broadly accepted, published set of specific medical criteria with as much clinical detail and certainty as the brain death criteria. Furthermore, even the generally accepted criteria, when properly applied, are not infallible»: More recently a loose descriptive set of operational criteria have been proposed, mostly based on tests to determine if rational reactions or cognitive perceptions can be elicited. Cf. AMA COUNCIL ON SCIENTIFIC AFFAIRS, AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, «Persistent Vegetative State..», *cit.*, 427; and MULTI-SOCIETY TASK FORCE ON PVS, «Medical Aspects of the Persistent Vegetative State», *NEJM* 330 (1994) part 1: 1499-1508, part 2: 1572-1579.

147. Cf. C. M. DEGIORGIO, D. A. SHEWMON, «Early Prognosis in Anoxic Coma: An Analysis of the Major Clinical Criteria», *ILM* 5/2 (1989) 141-164, at 164.
148. Cf. R. E. CRANFORD, «The Persistent Vegetative State..», *cit.*, 29-30. Also *vid.* B. D. SNYDER, R. E. CRANFORD, A. B. RUBENS, *ET ALII*, «Delayed Recovery from Post Anoxic eristent Vegetative State», *Ann Neurol* 14 (1983) 152.
149. W. E. MAY, «Criteria for Withholding..», *op. cit.*, 84.
150. IDEM, *ET ALII*, «Feeding and Hydrating..», *op. cit.*, 207.
151. IDEM, «Criteria for Withholding..», *op. cit.*, 84-85.
152. *Ibid.*, 84.
153. K. O'ROURKE, «Should Nutrition and Hydration..», *op. cit.*, 182.
154. So me see a case of advanced Alzheimer's, *totally demented*, as an equivalent state to the amented, and lump them together: AMA COUNCIL ON SCIENTIFIC AFFAIRS, AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, «Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support», *JAMA* 263 (1990) 427: «If one includes patients totally demented from Alzheimer's disease and similar disorders, an estimate of the number of persistent vegetative patients in this country is approximately 15 000 to 25 000». See also page 428 where differential diagnosis is discussed.
155. Cf. R. A. MCCORMICK, «Caring or Starving..», *op. cit.*, 273.





INDEX OF THE EXCERPTUM

PREFACE.....	175
TABLE OF CONTENTS OF THE THESIS	181
TABLE OF ABBREVIATIONS	185
BIBLIOGRAPHY OF THE THESIS	189
I. PROPORTIONALITY AND QUALITY OF LIFE	197
1. <i>The Proportionality of Ordinary Means</i>	197
a) Magisterial Teaching on Proportionate Means	197
b) Proportionality —Objections and Proposals	200
c) Nuances —Artificial-Natural Means	204
2. <i>Normative Quality of Life</i>	206
a) Reich —Descriptive, Evaluative, Normative	207
b) Walter, Shannon —Nuances in Normative.....	209
c) «Quality of Life» Definitions,—Needs,Wants	210
II. SUBSTANTIAL «QUALITY OF LIFE» CRITERIA	212
1. <i>McCormick —Life as Instrumental Good</i>	212
2. <i>May and Bleich —Life as Intrinsic Good</i>	215
a) May —Life is Intrinsically Good	215
b) Bleich —A Judaic View	217
3. <i>The Reasonableness Standard</i>	218
4. «Quality of Life» and Dualism	220
a) Grisez —«Quality of Life» Is Dualistic.....	220
b) Wildes —Category of Instrumental Good	221
III. DOUBLE PATHOLOGY	223
1. <i>Presentation of the Question</i>	224
2. <i>Discussion of Essential Elements</i>	227
a) Fatal Pathology	227
b) Proportionality of Life Itself	231
c) Effective and Useful Means.....	240
3. <i>The Spiritual Criterion</i>	244
a) The Proposition of O'Rourke	244



b) Criticisms of the Spiritual Criterion	247
4. <i>Resolution</i>	255
NOTES	257