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Preserving Life

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Editor's note: Father Gerald Kelly, S.J., has covered the Catholic attitude regarding the ordinary means of preserving life and the extraordinary measures necessary to prolong existence in the Medico-Moral-Problems *series of booklets published by The Catholic Hospital Association. These publications are now in the process of complete revision and we have asked permission to print, in advance, the following as a combined article for* Linacre Quarterly *readers. Inquiries continue to reach us regarding these topics and a reprint will be prepared for distribution at the Federation Exhibit during the A.M.A. convention this June. Questions pertinent to these subjects were the most frequently asked during the session last year.*

THE ORDINARY MEANS OF PRESERVING LIFE

Euthanasia usually implies the use of some positive means to end life: e.g., taking poison, a lethal dose of some drug, and so forth. But death can also be brought about in a negative way: i.e., by not taking or giving something which is necessary for sustaining life; and in some cases this failure to take or give what is necessary for preserving life is equivalently euthanasia. That is the general meaning of n. 22 of *The Ethical and Religious Directives for Catholic Hospitals* published by The Catholic Hospital Association: "The failure to supply the ordinary means of preserving life is equivalent to euthanasia." A complete explanation of this directive calls for an explanation of *ordinary* and *extraordinary* means of preserving life, as theologians use these terms, and also for an explanation of the duties of patients and doctors regarding the use of these means.

Meaning of Terms

Doctors and theologians are apt to attach different meanings to the terms, "ordinary" and "extraordinary," as J. E. Drew, M.D., and John C. Ford, S.J., pointed out in their article, "Advising Radical Surgery: A Problem in Medical Morality," *Journal of the American Medical Association*, Feb. 28, 1953, pp. 711-716. Thus, as regards physicians, Dr. Drew and Fr. Ford write: "To the physician ordinary signifies standard, recognized, orthodox, or established medicines or procedures of that time period, at that level of medical practice, and within the limits of availability. Extraordinary signifies, from the physician's standpoint, a medicament or procedure that might be fanciful, bizarre, experimental, incompletely established, unorthodox, or not recognized."

Theologians use these terms in a different sense; and it is important to note this because the directive follows the theological meaning. As regards various hospital procedures, the theologian would say that *ordinary* means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience. For example, suppose that a patient whose health is normally good has pneumonia. This patient is now facing a crisis; but from our experience we have every reason to believe that we can bring him through the crisis by means of certain drugs, such as penicillin, and the use of oxygen for a time. Once he passed the crisis he would be well on the way to complete recovery. Here we seem clearly to be dealing with *ordinary* means; for the use of the drugs and oxygen in these circumstances does not involve excessive inconvenience; and there is a very reasonable hope of success.

In contradistinction to ordinary are *extraordinary* means of preserving life. By these we mean all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit. For example, consider a case like this. A young woman has a rare cardiac ailment. There is a chance of curing her with an extremely delicate operation; but it is only a chance. Without the operation, she may die on the table or shortly afterwards: but she also has a chance, though considerably less than an even chance, of surviving and of being at least comparatively cured. This operation seems to be a clear example of an *extraordinary* means of preserving life, especially because of the risk and uncertainty that it involves.

Another example. A patient, almost 90 years of age, has a cardiorenal disease and has been in a coma for two weeks, during which time he has received intravenous solution of glucose and some digitalis preparation. This coma is apparently terminal. In such a case, is the continued use of glucose and digitalis to be considered an ordinary or extraordinary means of preserving life? The answer may not be entirely clear and beyond debate; but I believe that moralists would generally say that, though the use of the glucose and digitalis would be ordinary means if it were merely a matter of tiding a patient over a temporary crisis, yet in the present case the actual benefit they confer on the patient is so slight in comparison with the continued cost and difficulty of hospitalization and care that their use should be called an *extraordinary* means of preserving life.

The Duty

Every individual has the obligation to take the ordinary means of preserving his life. Deliberate neglect of such means is tantamount

to suicide. Consequently, every patient has the duty to submit to any treatment which is clearly an ordinary means; and his doctor, as well as the nurses and hospital personnel, has the duty to use such means in treating the patient. To do less than this is equivalently euthanasia — as is stated in directive 22.

It should be noted, however, that the directive is here enunciating only a *minimum:* this is the least that must be done for any patient. As a matter of fact, there are some cases in which a patient might be obliged to use extraordinary means; and there are many cases in which the doctor is obliged to use them. In the next section I shall try to indicate some norms for the use of extraordinary means in the care of patients. For the present, it seems sufficient merely to state the fact that the use of extraordinary means is sometimes obligatory.

Historical Background

It is not always easy to distinguish between ordinary and extraordinary means of preserving life. I believe that the definitions I have given would meet with substantial approval by most moralists today; yet some might prefer to phrase them somewhat differently. For instance, one outstanding theologian suggests that ordinary means would include "the medicines, nursing, etc., usually adopted by persons of the same condition of life as the patient." This is perhaps a good working rule for most cases. I believe, however, that it should be considered as merely supplementary to the definitions I have given, because my definitions more explicitly include elements that are essential to the historical development of the terms, *ordinary* and *extraordinary* means of preserving life. The medical profession should know something of this history.

The moralists who coined the terms, *ordinary* and *extraordinary* means of preserving life, were deeply conscious (as Catholic moralist have always been) of a clear distinction between the duty of *avoiding* evil and the duty of *doing good*. One must, at all costs, avoid doing what is intrinsically evil; but there are reasonable and proportionate limits to one's duty of doing good. For example, the martyrs were not ordinarily obliged to seek out their persecutors in order to profess their faith before them; but when faced with the critical choice of either denying their faith or dying they were obliged to submit to death. The reason is that to deny one's faith in the one true God is intrinsically evil — something which may never be done, even to avoid torture and death. A modern example illustrating the same matter might be the problem of childbearing in marriage. Married people are not obliged to have all the children they possibly can, nor obliged to have children in the face of great inconveniences; but they are clearly obliged to avoid contraception because it is intrinsically evil.

With this distinction between doing good and avoiding evil in mind, the old moralists approached the problem of preserving life. They were not disturbed by the problem of "mercy killing"; they know that suicide and murder are always wrong and that no inconveniences can justify them. But to preserve one's life is to do good; and the duty of doing good is usually circumscribed by certain limits. The moralists set out to make a prudent estimate of the limits of this duty. In other words, they wanted to answer the simple question that any good man might ask: "How much does God demand that I do in order to preserve this life which belongs to God and of which I am only a steward?" In answering this question, they discussed such practical, concrete things as expense, pain, repugnance, and other inconveniences.

Inconvenience

For example, regarding expense, they considered it obvious that a man would have to go to some expense in caring for his health. Yet he need not spend money or incur a debt which would impose a very great hardship on himself or his family, because this kind of hardship would be more than a "reasonable" or "moderate" care of health and therefore more than God would ordinarily demand.

And so of other things. The moralists spoke of great pain, e.g., the enduring of a serious operation in days when there were no effective anaesthetics. It took heroism to undergo such an ordeal; and the moralists prudently estimated that an individual would not ordinarily be obliged to submit to it. They spoke of other inconveniences, too: e.g., of moving to another climate or another country to preserve one's life. For people whose lives were, so to speak, rooted in the land, and whose native town or village was as dear as life itself, and for whom, moreover, travel was always difficult and often dangerous — for such people, moving to another country or climate was a truly great hardship, and more than God would demand as a "reasonable" means of preserving one's health and life.

The foregoing are merely examples of the way the older moralists considered the means of preserving life in terms of inconvenience. If the inconvenience involved in preserving life was excessive by reason of expense, pain, or other hardship to oneself or others, then this particular means of preserving life was called *extraordinary*. On the other hand, when no excessive inconvenience was involved, the means of preserving life would generally be considered *ordinary*.

Usefulness

There is one more point to be discussed before I can give a complete idea of the historical notions of *ordinary* and *extraordinary*. I can illustrate this point by an example taken from another section of moral theology: the duty of charity towards one's neighbor.

Suppose that I see my neighbor drowning, but that I am a very poor swimmer and should have very little chance of saving him. Am I obliged to make the attempt? Catholic moralists would say that I might be heroic to try, but that I

would have no strict obligation to do so. In giving such an answer, they are simply applying a sound principle of both philosophy and common sense, namely, that no one is obliged to do what is practically useless.

Moralists have applied this same principle when discussing the duty of preserving one's own life, especially by taking medicines, undergoing operations, and so forth. As a matter of fact, we know that some of these things help, and some do not; some offer great hope of success; others offer very slight hope. The old moralists realized this too; and they introduced this element of "hope of success" into their concepts of ordinary and extraordinary means of preserving life. A means was considered *extraordinary* if it involved excessive inconvenience or if it offered no reasonable hope of benefit. A means was considered *ordinary* if it did not involve excessive inconvenience *and* it offered a reasonable hope of benefit.

The foregoing are the main points that mark the development of the moralists' discussion of ordinary and extraordinary means of preserving life. We can apply them to the vast number of artificial life-sustainers now at the disposal of the medical profession by judging two elements, *convenience* and *utility*. A medicine, treatment, etc., is to be considered an ordinary means if it can be obtained and used with *relative convenience* and if it offers *reasonable hope of benefit*. When either of these conditions is lacking, the means is extraordinary.

It should also be noted that the moralists were primarily concerned with the duty of the individual (i.e., the patient), not his doctor. They thus chose the easier course, because the doctor's problem is much more complicated. The patient is obliged to use ordinary means; as for extraordinary means, he may use them if he wishes, but, apart from very special circumstances, he is not obliged to do so.

I have heard it said that the doctor's duty is exactly the same as the patient's. This is not correct. The doctor (as well as nurses and hospital authorities and personnel) must do not only what the patient is obliged to do but also what the patient reasonably wants and what the recognized standards of the medical profession require. I shall discuss these points in the next section.

It is important to note that, though the notions of ordinary and extraordinary remain the same, their applications can vary with changing circumstances. For example, major operations used to be considered extraordinary means of preserving life on two counts: first, because the pain was practically unbearable for most people; and secondly, because the outcome was often very uncertain, e.g., because of the danger of infection. Today we have means of controlling both the pain and the danger of infection; hence, many operations that would have been extraordinary in former times have now become ordinary means of preserving life.

EXTRAORDINARY MEANS OF PROLONGING LIFE

In the preceding section it was pointed out that, in terms of modern medical procedures, *extraordinary* means of preserving life are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience for the patient or for others, or which, if used, would not offer a reasonable hope of benefit to the patient. One example given was that of a very dangerous and uncertain operation; another was the use of such things as intravenous feeding to prolong life in a terminal coma. Still another example, culled from medical literature, is the case "when life can be somewhat prolonged by a gastroenterostomy or an enteroanastomosis," as mentioned by Walter C. Alvarez, M.D., in the *Journal of the American Medical Association*, September 13, 1952, p. 91.

In concrete cases it is not always easy to determine when a given procedure is an *extraordinary* means. It is not computed according to a mathematical formula, but according to the reasonable judgment of prudent and conscientious men. Granted such a judgment, the patient himself is not generally obliged to use or to submit to the procedure. He may, with a good conscience, refuse it except in special cases when a prolongation of his life is necessary: (a) for the common good, as might happen in the case of a great soldier or statesman; and (b) for his own eternal welfare, as might be the case when he has not yet had the opportunity of receiving the Last Sacraments.

Here I want to consider the duty of the doctor to use *extraordinary* means of preserving life. Under the term "doctor," I include not only the attending physician but also all who assist him in the care of the patient, i.e., nurses and hospital personnel. To avoid unnecessary complications we shall limit the discussion to patients who are in some sense "paying" patients, i.e., those whose expenses are being paid by themselves, their relatives, an insurance company, etc. In other words, we are excluding the purely charity case in which the medical care is given *gratis*.

THE PATIENT'S WISH

How is the doctor to judge whether he is obliged to use an *extraordinary* means? The first rule for judging is indicated by Dr. Alvarez when he speaks of somewhat prolonging life by a gastroenterostomy or an enteroanastomosis: *"the wishes of the patient* should be ascertained." The words I have italicized contain the first rule concerning the doctor's duty: he must do what the patient wishes. It is the patient who has the right to use or to refuse the extraordinary means; hence, it is primarily the patient who must be consulted. Obviously there are many cases in which it is impossible to consult the patient, e.g., when he is delirious or in a coma, or when he is a small child. In these cases the right to make the decision is vested in those who are closest to the patient, i.e., husband, wife, parents, guardians. Thus, Dr. Alvarez rightly says that the wishes of the

family must be consulted when there is question of efforts at resuscitation by means of oxygen and "endless injections of stimulants" in the case of an old person who is close to death. I might add here that the relatives do not make this decision precisely in their own name, but rather as representing the patient; hence, they should try to determine what he would reasonably want done under the circumstances. (Perhaps some further distinction should be made regarding relatives and guardians who merely administer the property of the sick man and those who pay his medical bills out of their own money; but I believe such a distinction is not pertinent to our present discussion.)

There are cases, no doubt, when consultation with the patient or the relatives would be impossible, or inadvisable, or useless: e.g., when they would not understand the issues or are too much distraught to make decisions, and so forth. In such cases, it seems to me, the doctor should follow the plan previously suggested for the relatives: that is, try to make a prudent estimate of what the patient would reasonably want if he could be asked. This would mean that the doctor would do what he sincerely judged to be for the best interests of his patient. If other means are lacking for determining this, the golden rule should be helpful. What would the doctor himself want if he were in the patient's condition?

Strict Professional Standard

Thus far we have considered only the doctor-patient relationship; and what has been said may be reduced to this: the doctor should follow the expressed wishes of the patient or his representatives; and when their wishes cannot be explicitly ascertained, he should do what he thinks the patient would want or what he sincerely judges to be for the patient's best interests. Even these relatively simple rules are sometimes difficult to apply; but the problem of using or not using *extraordinary* means may be even further complicated by the question of "professional standards."

When I speak of professional standards, I mean this: is there a line of conduct dictated by his profession itself which requires the doctor to take means of prolonging life that might not be required merely by the physician-patient relationship? To make this problem more concrete, let me say that in discussions with conscientious physicians I have observed two different professional standards in this matter.

One group of these conscientious physicians believes that the doctor's duty is to preserve life as long as he can, by any means at his disposal, and no matter how hopeless the case seems to be. We can call this the *strict*, or *extreme*, professional standard. The doctors who uphold this standard admit the right of the patient or his representatives to refuse *extraordinary* means; but they think that, insofar as the judgment is left to the doctor himself, he must simply keep trying to prolong life right to the very end.

The following of this strict standard has several advantages. In the first place, it gives euthanasia the widest berth possible. Secondly, it completely avoids defeatism. These doctors not only keep trying to conquer a disease, they also keep trying to save the individual patient. And there is no doubt about it: they can sometimes show us cases in which a former patient is now alive and well two, three, or many years after he was supposed to be "hopeless." Finally, strict though it is, this standard is easiest on the doctor's own conscience because he is never forced to make the painful decision to cease using intravenous feeding, oxygen, and so forth, in the case of a dying patient.

Moderate Standard

As I said, there are many conscientious doctors who follow the *strict* standard to which reference has just been made. But there are others, equally conscientious, who believe that a more *moderate* standard should be followed. These doctors try to effect a cure as long as there is any reasonable hope of doing so; they try to preserve life as long as the patient himself can reap any tangible benefits from the prolongation. But they also think there is a point when such efforts become futile gestures; and they believe that at this point the sole duty of the doctor is to see that the patient gets good nursing care and that his pain is alleviated.

The advantages of the strict standard are the disadvantages of the moderate standard. The doctors who follow this latter standard certainly have no sympathy for euthanasia; yet their failure to take certain means of prolonging life might at times create the impression of favoring euthanasia. They are not defeatists; yet, through their willingness to consider some cases hopeless according to present medical knowledge, they might occasionally lose a battle that the stricter doctors would win. Moreover, their occasional decisions to discontinue stimulants or artificial feeding are seldom made with perfect mental peace. Such a decision easily generates worry.

But it must be admitted that the moderate standard is not without its advantages. For one thing, it seems to be very much in accord with the traditional policy of Catholic theologians of interpreting obligations according to a reasonable limit — as we have seen, for example, in their explanation of the individual's duty of caring for his own health.

The moderate standard also seems to square with a good Christian attitude. I once asked the mother superior of a home for incurable cancer patients whether they used such things as intravenous feeding to prolong life. She replied that they did not. They gave all patients devoted nursing care; they tried to alleviate pain; and they helped the patients to make the best possible spiritual preparation for death. Many very good people with whom I have spoken about this matter think these sisters have the right idea — "the good Christian attitude toward life and death," as they call it. This is really an exemplification of the moderate standard.

Finally, it seems evident that the moderate standard is less likely to impose excessive burdens on the patient's relatives. Relatives often endure terrific strain and undergo great expense while life is being prolonged by artificial means; and in some cases — e.g., the terminal coma — very little good seems to be accomplished. The moderate standard spares them some of this strain and expense.

Conclusion

I have dwelt at some length on these two views of conscientious physicians because I wanted to make it clear that as yet there is no clear-cut professional standard regarding what I might respectfully call "the fine points" of care of the dying. I may add that among moral theologians a somewhat similar condition prevails: up to a certain point duties are clear and there is agreement on what must be done; beyond that point the rules of obligation become obscure and there is room for differences of opinion.

Some time ago, I published in the Jesuit quarterly, *Theological Studies* (June 1950, pp. 203-220), a rather lengthy article entitled "The Duty of Using Artificial Means of Preserving Life." The purpose of this article was to stimulate discussion among theologians concerning what seemed to be a cardinal problem in modern medical practice. Later, in the same magazine (December, 1951, pp. 550-556), I published a shorter article entitled "The Duty to Preserve Life," which included the points that had been brought out in our discussions. This second article concluded with a statement which substantially expresses the minds of many competent theologians. Perhaps it will help to reprint it here. It runs as follows:

1. It is not contrary to the common good for a doctor to admit that a patient is incurable and to cease trying to effect a cure. But it would be contrary to the common good to cease trying to find a remedy for the disease itself.

2. As long as there is even a slight hope of curing a patient or checking the progress of his illness, the doctor should use every probable remedy at his command. The common good demands this rule of conduct for the doctor; and it should be followed as long as the patient makes no objection. The patient, however, is entitled to refuse any treatment that would be extraordinary.

3. When a doctor and his consultants have sincerely judged that a patient is incurable, the decision concerning further treatment should be in terms of the patient's own interests and reasonable wishes, expressed or implied. Proper treatment certainly includes the use of all natural means of preserving life (food, drink, etc.), good nursing care, appropriate measures to relieve physical and mental pain, and the opportunity of preparing for death. Since the professional standards of conscientious physicians vary somewhat regarding the use of further means, such as artificial life-sustainers, the doctor should feel free in conscience to use or not use these things, according to the circumstances of each case. In general, it may be said that he has no moral obligation to use them unless they offer the hope of some real benefit to his patient without imposing a disproportionate inconvenience on others, or unless, by reason of special conditions, failure to use such means would reflect unfavorably on his profession.

All of us who sponsored this statement realize that it may need improvement and further clarification. Even as it stands, however, it should help doctors to solve these difficult cases with a realization of a certain degree of liberty of judgment and with a consequent peace of conscience.