

May 1976

The Preservation of Life

Richard A. McCormick

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

Recommended Citation

McCormick, Richard A. (1976) "The Preservation of Life," *The Linacre Quarterly*: Vol. 43: No. 2, Article 6.
Available at: <http://epublications.marquette.edu/lnq/vol43/iss2/6>

The Preservation of Life

Richard A. McCormick, S.J.

Father McCormick is on the staff of the Center for Bioethics at the Kennedy Institute and a widely known author in the field of medical-moral problems. He is also a member of the Editorial Advisory Board of the Linacre Quarterly.

Edward G. Kilroy, M.D., has devoted his lead editorial¹ to a consideration of the basis on which decisions to treat or not to treat should be made. My concern here is the conceptual clarity concerning what Dr. Kilroy calls "three methods of ethical analysis available." It seems to me that Dr. Kilroy has only confused the matter.

For purposes of clarity I should like to rehearse briefly what he regards as the available options. First, there is the use of the terminology "ordinary" and "extraordinary" means. This approach, he says, has lost much of its usefulness "because of the necessity of their application on a situational basis." (This wording is unfortunate. The application of these terms has always been "situational," sc. relative to time, place, availability of medicine, care, patient's condition, etc.) Secondly, there is a guideline centered on the potential for human relationships. This Dr. Kilroy

took from my *JAMA* article.² He sees this as a criterion based on the assessment of the individual's prospective quality of life. Dr. Kilroy rejects this—though the basis of his rejection is not absolutely clear. At one point he says such considerations "expose the individual and society to a perilous path." At another he argues that the application of such a criterion "would require a degree of omniscience quite beyond the limits of any known human agency." Thirdly, Dr. Kilroy sees the proper method as that "restricted to considerations of therapeutic benefit for the patient." More precisely, he words the matter as follows: "the decision for therapy should be based solely on whether this form of medical therapy can be expected to restore the ill or defective child to that state of health for which the therapy was planned."

I would agree with Dr. Kilroy that the terms "ordinary" and "extraordinary" are not too helpful. They are code terms for other judgments. Paul Ramsey has recently pointed out that for all practical purposes these terms mean "imperative" and "morally dispensable." He rightly insists that they are, "as classifications, incurably circular until filled with

concrete or descriptive meaning."³ We have always known that, I believe. But what has happened in our time is that the crucial underlying judgment (what Ramsey calls "concrete or descriptive meaning") is increasingly focused on a single element: benefit to the patient.

Dr. Kilroy has stumbled into conceptual confusion precisely at this point. He attempts to contrast "benefit to the patient" with a criterion anchored in the potential for human relationships or experience, as if the two were different—the former being non-perilous, presumably because it steers clear of quality-of-life considerations, whereas the latter, involving such quality-of-life considerations, must be rejected. I wish to show here that this distinction or contrast will not stand up and that those who speak of "benefit to the patient" are unavoidably involved in quality-of-life criteria, whether they use the word or not. The term "quality of life" scares people, largely I suppose because of its association with a destructive history and its possibly abusive interpretations. Perhaps we can find a better term. But to suggest that "benefit to the patient" is not only a better term but a different concept because it avoids quality-of-life considerations is to play the ostrich. This needs to be made very clear here. And for this reason I shall try to word the matter in a variety of ways.

First of all, let me point out that increasingly both ethicists

and others are speaking of "benefit to the patient" precisely in terms of quality-of-life considerations. Item: moral theologian Sister Margaret Farley, writing in Yale University's occasional journal *Reflection*,⁴ notes that if it is proper to consider means more or less extraordinary in "relation to the capacities for fullness of life in an individual infant, then it is the case that we are basing decisions for treatment or non-treatment on 'quality of life' considerations." Farley regards this as inevitable "if one stands within a tradition that values every person and every human life, but values physical life in relation to other human values." It is obvious that Farley considers this—as do I—to be at the heart of the Catholic tradition on this matter.

Item: the study of a multidisciplinary group published in *Pediatrics*.⁵ In summarizing its reflections the group noted: "Neither physicians nor parents are obliged to initiate or to continue actions which do harm to the well-being of a newborn infant. That well-being consists generally in a life prolonged beyond infancy, without excruciating pain and with the potential of participating, in at least a minimum degree, in human experience." The study continued: "Should it be necessary, in the case of disagreement between parents and physician, to seek legal judgment, whether to continue or to terminate care, the court should weigh heavily *the prognosis regarding quality of life*

and the injunction 'do not harm.'" (Emphasis added)

Item: a recent article by Norman L. Cantor, professor at Rutgers University School of Law.⁶ Professor Cantor points out that in his decision Judge Muir equates what is "in the best interests" of Karen Ann Quinlan with "remaining life," no matter how dismal that might be. Cantor could not accept that and wrote: "I can perceive of no benefit to a patient from being preserved in a totally insensate state, with no prospect of ever regaining consciousness. Moreover, the patient's expressions concerning criteria for a satisfactory or tolerable existence ought to be shown great deference in determining that patient's 'best interests.'" Increasingly this is the way these problems are being discussed.

Secondly, let me turn to a recent pastoral letter of the German bishops to show that "benefit to the patient" is a notion inextricably tied to quality-of-life considerations. On June 15, 1975, a pastoral letter of the bishops of the Federal Republic of Germany was read in all the churches. It was concerned with euthanasia and care for the dying. At one point the bishops noted that a death worthy of man means that "not all medical means are used if death is artificially postponed by doing so. This is the case, for example, when life can, in fact, be lengthened by means of medical measures, an operation perhaps, but when, unfortunately, despite the operation, or as a consequence

of it, the sick person will suffer from severe physical or mental disturbances in the period thus wrung from death. In this situation the decision of the sick person not to undergo another operation is to be considered morally justifiable."⁷

The bishops then pose the question about the moral duty to use indefinitely artificial supports such as the respirator. Their answer is extremely interesting and will unpack the point I am making. They state: "As long as there is any possibility of the sick man recovering in this way, we will have to use all such means. Also, it is the duty of the state to ensure that even costly apparatus and expensive medicines are available for those who need them. It is quite another matter when all hope of recovery is excluded and the use of particular medical techniques would only lengthen artificially a perhaps painful death."

"Recovery" — A Complex Term

Now what is to be noted here is the term "recovery." The possibility of recovery determines, in the bishops' statement and, I believe, in Dr. Kilroy's formulation, whether certain life-supports and interventions need be used or not. If recovery is possible, they should be used. However—and this is crucial to the point I am making—the term "recovery" is not quite as simple as it might at first seem. "Recovery" can mean at least three things: 1) return to the state of health enjoyed

prior to illness, a full state of health; 2) return to a lesser state, perhaps one characterized by "severe physical or mental disturbance"; 3) return to spontaneous vital functions without consciousness. All of these represent forms of recovery in the sense that death has been stayed. Now it seems clear that if the bishops would not deem obligatory (for the patient) the medical interventions that produce the latter two categories—a point they explicitly make—then they would not include them under the term "recovery." This means that "recovery" necessarily implies a certain level of recovery or quality of life. For if the means need not be used by the patient and the reason is that they do not produce "recovery," then the term clearly means not just staving off death, but also a certain quality of life. What the term "recovery" really means, then, in the bishops' statement, is *sufficient* recovery. Now that is, I submit, a straightforward quality-of-life judgment. Our concern, then, should not be precisely to avoid quality-of-life considerations in decision-making—a thing we simply cannot do in our times, and never really could—but to place such considerations within the value perspectives of the Christian tradition.

My third and final reflection touches on Dr. Kilroy's own suggested criterion, and the language he uses to describe it. He argues that the decision for therapy "should be based solely on whether this form of medical therapy

can be expected to restore the ill or defective child to that state of health for which the therapy was planned." He then applies this also to cardiac and neuro-surgical patients as follows: "The same principle of instituting or discontinuing therapy on the basis of its efficacy in achieving the goals for which it is planned is applicable to decisions regarding therapy for severely damaged cardiac or neuro-surgical patients when we discontinue respirators after it has become evident that their further use cannot possibly restore the patient to health even though the patient may have varying abilities to fulfill his potential for human relationships." And all this is stated as being different from quality-of-life criteria.

But here Dr. Kilroy must be confronted with some hard questions. There are two key notions in his presentation: 1) restoration to a state of health; 2) the condition (state of health) or goals for which therapy was planned. Now what does it mean to "restore the patient to health" or to restore "to that state of health for which the therapy was planned"? Obviously, the respirator, for example, has no plans or goals where a *state of health* is concerned. It is devised to do a certain thing regardless of what state of health or ill health the patient is in. It is the physician who has plans and goals. Therefore, "that state of health for which the therapy was planned" is a state of health aimed at or planned by the physician using

the therapy. Now clearly such a "state of health" or the "goals for which it is planned" is capable of degree—greater or lesser health, lesser or more profound ill health. Some states of health, I take it, would be states so dismal or intolerable that, although therapy could be planned to achieve them, *it need not be used*—and precisely because such a state of "health" is unacceptable. And the reason it need not be used is precisely that return to *that* state of health or level of survival is considered unacceptable. That is exactly what the German bishops had to imply when they used the term "recovery" as the controller of these decisions. And it is precisely what Dr. Kilroy must wrestle with when he talks about "restoration to health" and "goals for which the therapy was planned." If he does not get involved in such specification, if he does not distinguish between "restoration to health" and "restoration to *sufficient* health," he commits the physician to a form of vitalism (keeping life going independently of its condition or potential), that is profoundly at odds with Christian perspectives on the meaning of life. For any condition that staves off death will be "health" or "recovery." But if he does get involved in such specification, he is involved with quality-of-life considerations.

For instance, let us take a child, or an adult for that matter, whose life can be saved by surgi-

cal intervention. Let us further suppose that that life will continue for many years after the surgery—but it will be a life lived in total unconsciousness or in a semi-comatose and totally dependent state. It would be agreed by everyone, I would hope, that no one need undergo such surgery if that is the *kind of life* it will save, if that is the kind of health it will "restore." The surgery could be "planned" for that state of health; but no one need submit to such planning, though a person is free to do so. Certainly this is the Catholic tradition on this matter.

In summary, then, when Dr. Kilroy proposes as his decisional method "therapeutic benefit for the patient," he is not proposing something different from quality of life considerations. For there is always the question of what level of benefit to the patient is *sufficient* to deserve to be called a "benefit." "Benefit" like "health" is capable of definition along a very broad scale. Some "planned therapies" would produce the "benefit" of sheer survival; others would restore to full or reasonably full good health. So when Dr. Kilroy uses "benefit to the patient" as a decisional criterion and then contrasts this with quality of life criteria, he is using not a different criterion, but only different words. Furthermore, just as we can hide behind the circular phrases "ordinary" and "extraordinary," so we can hide behind "benefit to the patient." But the notable thing about such lan-

guage is that we are hating, that is, failing to come to grips with the very difficult and delicate reflections that alone can flesh out the term "benefit" to the point where it is more than an empty container. If we fail to recognize this task and fail to undertake it, the notion of "benefit to the patient" will be left an empty container, waiting to be filled by the perspectives and outlooks of the individual physician. Such perspectives can be quite different from those of the patient, and can at times be highly questionable. Therein lies the real danger.

That brings me to another aspect of Dr. Kilroy's formulation that is deeply troubling. He says that the decision for therapy "should be based solely on whether this form of medical therapy can be expected to restore the ill or defective child to that state of health for which the therapy was planned." He applies the same criterion to adult patients. Now, as noted, it is the physician who does the planning of therapy. If the sole criterion of whether treatment is to be used or not is its effectiveness in reaching "the state of health for which the therapy was planned," then the decision to use certain life supports is controlled exclusively by the physician.

A Reversal of Traditional Procedures

This was the tragic error in Judge Robert Muir's decision in the Quinlan case. When Judge Muir stated that "it is a medical decision not a judicial one" and

then added that "I am satisfied that it may be concurred in by the parents but not governed by them," he completely reversed (probably unintentionally) traditional procedures. As Professor Norman Cantor points out: "This blueprint for decision-making completely reverses normal procedures. Ordinarily, treatment decisions are made by the patient, or by the patient's guardian where the patient is incompetent . . . This process accords with the venerable legal doctrine known as informed consent. Under this doctrine, a physician does not make treatment decisions and then seek the concurrence of a patient or guardian."⁸ It ought to be noted that this understanding of things is also the official policy of the American Medical Association.

I do not believe that Dr. Kilroy intended this result of his formulation. But if treatment decisions are made *solely* (as he insists) on the "efficacy in achieving the goals for which it is planned," I do not see how he can avoid a position identical to that of Judge Muir. Not only is that a reversal of time-honored procedures ultimately destructive of the notion of informed consent, but it puts a burden on the physician he should be most eager to avoid—the burden of being solely responsible for therapeutic decisions. His malpractice vulnerability is already brutally burdensome. In short, then, the decisions for therapy should *not* be based solely on "its efficacy in achieving the goals for

which it is planned," as Dr. Kilroy says, but it must also take account of whether these goals are acceptable to the patient, or to those charged with his/her care.

Actually, what I believe Dr. Kilroy ought to have pointed out to us is the difference between decision-making where adults and infants are involved. Where adults are involved, therapeutic and life-sustaining decisions can be individualized to the person. That is, the notion of "benefit to the patient" can be individualized. The adult has a past, perspectives on life and its meaning, aspirations and achievements. All these can be weighed by the patient in making life-sustaining decisions or by those who know the patient best and presumably have his best interests at heart. The infant is different. The infant has no past on which to build; he has no known perspectives, value judgments, aspirations. He has had no life. Thus, the decision cannot be individualized to such considerations as it can in the case of adults. This means two things. First, the criteria used in determining to save or let die where an infant is concerned are generalizable to all infants. Secondly, and as a consequence, the criteria used must be the strictest possible. That is, the very minimum potential for human experiencing or relationships must be seen as sufficient warrant for attempting to save. Any other view would be a racism of the adult

world, and would unjustly deprive not simply one but (by logical generalizability) many infants of their chance at life.

It is our task, and a terribly anguishing one, to discover what that minimum is. It is in such attempts that we may draw close to understanding what "benefit to the patient" means. In understanding this we shall surely be dealing with quality of life considerations—even if we call them by a different name. To fudge that matter and to continue to hide behind the unspecified term "benefit to the patient" can be as perilous to both patients and doctors as to apply unavoidable quality-of-life considerations in an abusive and wrongful manner.

REFERENCES

1. Kilroy, Edward G., "To Treat or not to Treat," *Linacre Quarterly* 43 (1976) 3-5.
2. McCormick, S.J., Richard A., "To Save or Let Die," *Journal of the American Medical Association* 229 (1974) 172-176.
3. Ramsey, Paul, "Prolonged Dying: Not Medically Indicated," *The Hastings Center Report* 6(1976) 14-17.
4. Farley, Margaret, "A Response to Dr. Duff," *Reflection* 72(1975) 11-12.
5. Jonsen, A. R., R. H. Phibbs, W. H. Tooley, M. J. Garland, "Critical Issues in Newborn Intensive Care: A Conference Report & Policy Proposal," *Pediatrics* 55(1975) 756-768.
6. Cantor, Norman L., "Quinlan Case: An Analysis," *New York Law Journal* Dec. 22, 1975.
7. "Man's Right to Life and Euthanasia," *L'Osservatore Romano*, July 31, 1975, 3.
8. Cf. fn 6.