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Principles of Life-Death Decision-Making

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The extensive use of modern medical technology has caused great concern regarding the care of the terminally ill in our health care facilities. Thus, the concern for the rights and dignity of the dying patient has become affixed with the euthanasia dilemma. As most of the recent literature points out, the word euthanasia means "happy or good" (eu-) death (thanatos). However, many writers in the area of medical ethics, such as Paul Ramsey, believe that the term "euthanasia" is misleading because it is often synonymous with mercy killing, the direct termination of one's life. Dr. Ramsey suggests that it is "better to invent terms such as agathanasia or bene-mori (happy or good death) to convey the ethics and practice of only caring for the dying if this is what is meant."¹ Others, such as Arthur J. Dyck, prefer the term benemortasia in order to clarify the distinction between terminating a life and allowing or permitting a person to die.²

Besides reformulating terms, many ethicists are becoming

aware of the philosophical presuppositions underlying ethical considerations regarding death. For example, some of the proponents of voluntary euthanasia identify human with "free to choose;" thus an individual has absolute freedom to choose his own death. This position says much about the nature of humanhood and the purpose of life. In an article entitled "Euthanasia" Peter Riga states:

The arguments for positive and negative euthanasia, for all practical purposes, are academic because we have already decided the moral issue of human life: moral norm has become the will of man as determinative and not the mystery of man who must be protected and respected if any society is to have any cohesiveness. Secular humanism has won hands down and the only question left to the Christian is how will he react as an individual and as a community.³

The distinctions and arguments for both euthanasia and benemortasia have no meaning unless we address ourselves first to the meaning of human life and death. This article, then, will attempt to explicate a Judaeo-Christian approach to life-death decision-making through a reflection on the mystery of humanhood and its implications for human life and death.

I. The Purpose of Humankind

The traditional definition of man as a rational animal is inadequate. Yet science has been laboring out of this limited scholastic definition since its origin in

Greek philosophy centuries ago. How one views a human being will certainly predicate in some way how one will relate to that being. Rabbi Abraham Heschel gives us a more biblical view of man when he writes:

Who is man? A being in travail with God's dream of a world redeemed, of reconciliation of heaven and earth, of a mankind which is truly His image, reflecting His wisdom, justice and compassion. God's dream is not to be alone, to have mankind as a partner in the drama of continuous creation. By whatever we do, by every act we carry out, we either advance or obstruct the drama of redemption; we either reduce or enhance the power of evil.⁴

This Christian vision of man should be based upon the biblical perception of humankind called from all eternity to be a partner with God in building the future of creation. A human being is a being in dialogue with God and fellowman. God wishes to save us and make us holy, not as individual human beings without any mutual bond, but as a group of people bound together to serve him in justice and in truth.⁵ If this is true, then man can never be defined, conclusions can never be reached, moral decisions should never be made that do not consider man in that total context of relationship with God and relationship with fellowman. This Judaeo-Christian vision of man has significant implications for human life and death.

II. Implications for Human Life and Death

A. Physical Life is not the Greatest Value.

For the believer there has always been more to existence than just biological life. The traditional definition of death in theology as "the separation of body and soul" is inadequate in calling attention to the positive reality that death signifies for the believer; death is not the end but a process of growth. Yet, the body-soul dualism of Greek philosophy still continues to influence the health care delivery system in the United States. Dr. Elisabeth Kubler-Ross has pointed out that dying people are given the greatest care of their biological and physical needs, yet are left alone in their hospital beds fearful and frightened.⁶ The biblical view of man is not a soul imprisoned in a body, but rather man is viewed as a unified being—a whole person. As Karl Barth writes, "A person's soul is the specific life of this person and is to be distinguished from his body (flesh) but not separate from it."⁷ Thus, in the biblical view a human person is a totality, a composite and cannot be dissected into parts. Any care of the sick and dying must take a wholistic approach and not merely center on one aspect of a person's being. Therefore, to squeeze every ounce of life out of a body is not in keeping with the biblical view of man.

Biblical evidence establishes that God was considered immortal and man mortal. God

opted for man and, therefore, man is called in this life to opt for God. It is in being co-partners with God that merits eternal union with God. Barth writes, "After man's death, God will be the future only of what man will have been—the hope that shines on this his limited and now completed existence as such. It will be God's concern and his only concern that this his mortal being put on immortality."⁸ Thus, modern theology must begin with this positive scriptural view of man in explicating a theology of death.

B. Human Life has Meaning in Relation to Others.

Man is not merely an individual or an island unto himself. The answer to who we are embraces all humankind. Therefore, *life-death decisions cannot be made on the basis of an individual's physical needs alone*. These decisions must be made in light of the effects they will have upon family and society. The Christian view of a human being is a being who finds meaning in being for others. Therefore the "we have a right to do with our bodies what we want" or "we can make decisions in terms of our own needs and comfort" attitudes are highly individualistic and in direct contradiction to the Christian vision of man that speaks about living for and with others. "Greater love than this no man has than he lay down his life for his friends." (John 15:13) This realization calls for the recognition that moral decisions are not mere-

ly individual decisions but must be made against a broader context—human beings are relational beings.

C. Human Life is not Temporal but Transcendent.

Scriptural evidence and Christian tradition have established that man is a transcendent being—a being called to unlimited growth in the love of God and fellowman. This growth far surpasses what reason or science alone can determine.

Eye has not seen nor ear heard, or has it even entered into the hearts of man the things that God has prepared for those who love him. (1 Cor. 2:9)

Does this transcendent view of human life pervade our reflection and the practical life-death decisions we make when it comes to a question of prolongation or termination of life? Life-death decisions can't consider man simply in terms of his temporal destiny. Physical life cannot be the ultimate end value by which we make decisions or evaluate our success. Eternal hope has to be the characteristic of those who embrace a wholistic and Christian vision of man as God's "agents of hope actualizing the good as they share in the development of history and in the building of the human community."⁹

D. Human Life is Ultimately Precious.

Biblical evidence is explicit about God calling each of us to existence with a divine message and plan. Each person is unique.

Each life is ultimately precious because each has received a divine summons and all have a place in the mission of the world. Each has been called by God to fulfill that mission. What this means in regard to life-death decisions, whether at the beginning of life or at the end, is that we can never evaluate or make those decisions in terms of degree of development, in terms of an ability or talent that one creature promises over others. Our dignity, worth and value are based on an invitation to life extended by God himself. In terms of ethical considerations this means that all human beings are called to unlimited growth in love with God and fellowman as unified relational beings. It is this view of man that will enable us to come to a more complete understanding of human death.

III. Human Death

In our society the current life-death decision-making is in terms of viewing human life as a biological phenomenon. One such proof of this can be found in the widely clinical definitions of death in use today. To define death as the cessation of respiratory, cardiac or brain activity can never fully be the total reality of human death. Death is a process that involves the total person, not just one's body. Rev. Anthony Kosnik states it in another way:

To diagnose medically that a person is in irreversible coma is not to pronounce this person dead. Using cessation of brain activity as a criterion of death is to make a theo-

logical judgment that the essence of man is in his consciousness; such a view comes not from the laboratory but from the belief system. To define death in terms of the irreversible cessation of vital functions or brain activity is like defining daylight as the cessation of nighttime. It may be true, but it is a far cry from the total reality that is occurring.¹⁰

When a culture identifies clinical death with personal death, as ours does, one reduces man to an empirical phenomenon that can be clinically verifiable and tested.

Karl Rahner expresses a positive Christian approach to death: "What is human in death is that one's personal self-affirmation and self-realization achieve an absolute determination."¹¹ Ladislaus Boros further elucidates this thought: "In death we achieve total self-encounter, universal presence to the world and a meeting with God making our first completely free personal act possible."¹² These insights explain death as a mystery, a positive transformation of life—a change, not a cessation or termination of life. For the believer death is that final, definitive, irreversible orientation of our relational life towards God and fellow man.¹³ At death a person's orientation and relationship with God and others is fixed at least in terms of that fundamental direction—that one's transcendent life has taken. Death is the total self-realization and self-affirmation of who we are created to be.

Our attitude toward death has been that of fear. This fear be-

came more paranoid when theologians and fiery preachers contemplated the so-called celestial realms taking mental inventories of the furniture of heaven and the temperatures of hell. Patrick Fannon summarizes the recent theological reinterpretation of eschatological symbols. This interpretation refuses to limit eschatology to the "hereafter" and seeks to relate these symbols to everyday life "which affirms that our eternity is shared and molded in the life that we live here and now."¹⁴

It is this added faith dimension of the process of death that can help us overcome the fearful clinging to physical life that has justified our excessive efforts of preserving physical life at all costs. Rather, we are called as believers to live the promise of eternal life that is the ultimate significance of death.

IV. Ethical Principles Concerning Life-Death Decisions

A. Respect Life.

From the Judaeo-Christian perspective of humankind as "being in travail with God's dream of a world redeemed,"¹⁵ God has absolute dominion over life. It is God who gives ultimate meaning to life. Life is a gift from the Creator and, therefore, we cannot do with life as we please. As co-partners with God in the continuous drama of creation we must be about building a future for all of redeemed mankind! We are stewards of God's gift of life and, therefore, interpreters of God's will in difficult situations.

We are not masters over the gift of life; rather human life is ultimately precious, to be revered as "mystery" and whose most substantive meaning and value is relational. Therefore, respect for life is an absolute principle without exception and morally binding upon all in each and every life-death situation and decision!

B. Thou Shall not Kill.

The fifth commandment has largely been interpreted as a negative prohibition against the intentional taking of innocent life without due proportionality. In regard to medical ethics, this meant that one could not use positive means of intervention. Scripture scholars have found through their studies of the Decalogue that the fifth commandment originally prohibited the ancient Israelites from taking the law into their own hands and inflicting violence or death upon their fellow Jews without approval of the law, the community or God. This commandment did not prohibit all taking of human life as is evident in the biblical accounts of wars, but the fifth commandment did instill a positive respect for human life as having inalienable worth.¹⁶ No life was to be arbitrarily terminated by individual private decision. However, there is a long history of the Church's acknowledgement of man's right to take life in certain instances i.e., just war, capital punishment, legitimate self-defense, in the line of duty as a police officer or presidential body guard, and in con-

flict of life situations such as the Christian martyrs who chose to die out of love for God. What the fifth commandment has traditionally meant in the context of life-death decisions is that we cannot indiscriminately terminate human life for selfish, utilitarian, or purely merciful reasons.

C. Euthanasia in All Its Forms is Forbidden.

Directive number 28 of the Ethical and Religious Directives for Catholic Health Care Facilities explicitly states:

Euthanasia ("mercy killing") in all its forms is forbidden. The failure to supply the ordinary means of preserving life is equivalent to euthanasia. However, neither the physician nor the patient is obliged to the use of extraordinary means.¹⁷

Father Gerald Kelly in 1954 gave a definition of ordinary and extraordinary means that is still widely used by moralists today:

As regards hospital procedures, 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.¹⁸

The example that Father Kelly uses is that of a normally healthy patient who is facing a crisis of pneumonia yet has a reasonable hope for recovery by means of certain drugs (penicillin) and oxygen.¹⁹

E. Extraordinary Means May Be Used.

In contradistinction to ordinary means of preserving life are extraordinary means:

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.²⁰

An example of using extraordinary means would be the case of a 90 year old man hospitalized with a serious cardiac ailment and who has suffered cardiac arrest nine times in the last month. To continue to use the defibrillator to shock the man back into existence would be an extraordinary means of preserving life because of the lack of reasonable hope of recovery.

It is important to note that ordinary and extraordinary means should not be evaluated solely in terms of what is common or unusual. There can be no simple list of ordinary or extraordinary means that neatly categorizes modern medical procedures into two comprehensive pigeon holes. Rather, the determination of what is ordinary and *must be used* with what is extraordinary and *may be used* will need to be made in each instance in light of these suggested criteria:

1. The Clinical Condition and Prognosis of the Patient.

Medical judgments should be made as to the condition and

prognosis of the patient. Is there reasonable hope for recovery? Is this a critical care situation or a terminal care situation? A critical care situation is one where there is uncertainty about the patient's prognosis and the care given is for the purpose of prolonging life. For example, a victim of an automobile accident is brought to a hospital emergency room with severe brain damage and the physicians assess the amount of cerebral injury but are not certain that the patient will respond to treatment. The procedures and methods of treatment are for the purpose of supporting and maintaining life. Terminal care situations would be those cases where there is no favorable prognosis or reasonable hope for recovery; for example, a person in an irreversible comatose condition.

2. Reasonable Desires of the Patient and Family.

Death is not simply a passive process but the supreme moment of involvement and self-expression of which all of life has been a preparation.²¹ The patient needs time to prepare for death, time to take care of his or her personal matters. The medical staff must be completely honest with both the patient and the family members. Thus, if possible, both the patient and the family members should be involved in the life-death decision-making process. If we are truly relational beings, then the patient and family ordinarily are better evaluators of the relational meaning of life

and better interpreters of God's will for them. However, the patient and family cannot reasonably and responsibly make these decisions without clinical input. Pope Pius XII emphatically points out that the patient and family have rights and duties to be involved in life-death decision-making.

The technique of resuscitation which concerns us here does not contain anything immoral in itself. Therefore the patient, if he were capable of making a personal decision, could lawfully use it and, consequently, give the doctor permission to use it . . . The rights and duties of the family depend in general upon the presumed will of the unconscious patient if he is of age and "sui juris." Where the proper and independent duty of the family is concerned, they are usually bound only to use ordinary means. Consequently, if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply.²²

It is the responsibility of the health care team to properly inform and prepare the patient and family for death. Care given must be committed to the total well being of the patient.

3. Societal Considerations.

As was previously stated, as relational beings we cannot make life-death decisions in terms of our own individual needs and desires. We must take into consideration the effect the means used

in the care of terminally ill persons will have upon the hospital and the community. Could not an over-extensive use of respirators and other life-sustaining equipment continue to skyrocket costs of health insurance prohibiting the poor and indigent from sharing in health insurance benefits? With excessive prolonging of death do we not deprive other sick people the necessary beds and medical equipment needed for their recovery? We cannot make moral decisions in a vacuum. What we do has a profound effect on many others. Should not the effect of our actions upon society be a very important moral consideration?

In light of the preceding considerations some guidelines can be drawn regarding the use of ordinary and extraordinary means. In critical care situations, every reasonable effort in relation to the patient's condition and prognosis, and the legitimate desires of the patient, family and society is to be made to support and maintain life. In terminal care situations: a) if the patient is conscious, particular attention should be given to provide the emotional, social and spiritual support the patient may need to prepare well for death. Appropriate measures may be taken to relieve pain and to assure that the basic bodily processes are continued without undue stress or difficulty. Special efforts to maintain or prolong life need not be encouraged if the patient so indicates. b) if the patient is ir-

reversibly comatose, special efforts to maintain, prolong or revive a mere biological existence ought not to be encouraged, and with the consent of the family, all artificial means that may be supporting life may be withdrawn.

V. May Positive Means Be Used to Hasten Death?

In surveying the current literature on the care of the dying one may draw the following conclusions: 1) There is agreement among theologians that extraordinary means need not be used to prolong the life of the dying. Some theologians, such as Daniel Maguire, conclude that once the death process has begun it may well be immoral to attempt through extraordinary procedures to interfere.²³ 2) Positive means may be used to minimize pain even though indirectly this may contribute to the shortening of life. 3) Regarding the morality of using positive means to intervene in the life process, there is a growing recognition that at some point the distinction between acts of commission and omission loses moral significance. Kieran Nolan concludes that "positive assistance to the dying process definitely seems to be encompassed in the reasonable understanding of the Christian and human right to die. What this positive assistance to dying means will have to be determined from person to person and not from 'case' to 'case.'"²⁴ For Dr. Paul Ramsey, positive means to hasten the dying process are used only in high-

ly exceptional cases: "a) when a patient is irretrievably inaccessible to human care and b) prolonged dying in which it is medically impossible to keep severe pain at bay."²⁵ Daniel Maguire rejects the absolute stand that direct means may never be used on the grounds that this practical prohibition has not been proved and cannot be and therefore we can proclaim moral freedom to terminate life directly in certain cases.²⁶

In regard to the conclusions of these three renowned theologians, there are some very serious questions to be considered. How does one clinically verify when a patient is irretrievably inaccessible to human care? What guidelines does one use to establish when the dying process actually begins? Even if one could clinically verify when a person is inaccessible to further care isn't there more to the process of death? It is this writer's opinion that the presumption should be in favor of the person that is still potentially alive. If we are to respect the mystery of life and death then we should admit the possibility that this person is still alive and can be of further service to his fellow man. In theory the distinction between acts of commission and omission loses moral significance in terms of a comatose terminally ill patient. However, on the human and practical plane, the ambiguity of the terms, the lack of adequate criteria for determining the beginning of the death process, and the danger to

society make widespread use of positive means to hasten death unsuitable for pastoral application at present.²⁷ 4) There is almost universal rejection of euthanasia, i.e., the termination of human life for selfish, utilitarian or mercy reasons.

It has been the intent of this paper to criticize the free will theory as the moral norm for decision-making, the body-soul dualism which still greatly influences the medical profession, and clinical evidence as the sole criterion for making decisions regarding death. In place of the above, a basic anthropology based upon the biblical view of humankind as a unified, relational, ultimately precious and transcendent being was articulated. From this theological perspective, principles and guidelines were suggested for a Judaeo-Christian approach to life-death decision making.

In light of the above discussion the following recommendations are offered: 1. The fostering of continuing education programs for medical personnel that will communicate theological, psychological and clinical insights on how to aid the terminally ill person to prepare for and to personally participate in the growth process which is death. 2. For hospitals to form special committees (or medical-moral committees) to review life-death decisions that have been made, especially the policies for "code alerts" for terminally ill and comatose patients. 3. Develop-

ment of a special task force to work in opposition of proposed Euthanasia legislation that undermines respect for life. 4. Formation of an ongoing program of conscience formation and moral development for medical personnel. This will aid in understanding the moral decision-making process.

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POSITION AVAILABLE

SEARCHING FOR FULL TIME CHAIRMAN, DEPARTMENT OF OB/GYN. TWENTY PERCENT OF PHYSICIAN'S TIME ALLOWED FOR PRIVATE PRACTICE. ACADEMIC BACKGROUND AND INTEREST IN BOTH OBSTETRICS AND GYNECOLOGY NECESSARY. MUST BE BOARD CERTIFIED. AGE: UPPER LIMIT OF FIFTY YEARS PREFERABLE. MODERN, ACTIVE AND PROGRESSIVE TEACHING COMMUNITY HOSPITAL WITH LONG ESTABLISHED RESIDENCY PROGRAMS. COMPATIBLE STAFF. EXCELLENT SALARY COMMENSURATE WITH EXPERIENCE. POSITION AVAILABLE JANUARY 1, 1976. CURRICULUM VITAE, COMMENDATION LETTERS NECESSARY.

APPLY:

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