August 1990

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Recommended Citation

May, William E. (1990) "Criteria for Withholding or Withdrawing Treatment," *The Linacre Quarterly*. Vol. 57: No. 3, Article 11.

Available at: <https://epublications.marquette.edu/lnq/vol57/iss3/11>

Criteria for Withholding or Withdrawing Treatment

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Introduction: My purpose here is to set forth the criteria for withholding or withdrawing treatment. To put it another way, it is concerned with distinguishing treatments which the Catholic tradition has called "ordinary" or, more recently, "proportionate" (morally obligatory means of preserving life) and treatments which the Catholic tradition has called "extraordinary" or, more recently, "disproportionate" (morally non-obligatory means of preserving life). But before discussing these criteria, it will first be helpful to set forth briefly some guiding principles and presuppositions relevant to the question of caring for the sick and dying. I will then note relevant Church teaching on the distinction between "ordinary" and "extraordinary" means of treatment, following this with a critique of some influential contemporary interpretations of this teaching which I believe are very mistaken and mischievous, and finally set forth objective criteria for distinguishing between "ordinary" and "extraordinary" means, i.e., criteria for withholding or withdrawing treatment.

I. Basic Presuppositions and Principles¹

1. 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.

2. It is possible to kill innocent persons by acts of omission as well as by acts of commission.² Whenever the choice to withhold or withdraw a treatment carries out a proposal, adopted by choice, to end life, the omission of such treatment is an act of killing by omission.

4. Euthanasia, or the deliberate killing of the innocent for motives of mercy, is not morally justified by reason of its merciful motives.

5. Like other killing of the innocent, euthanasia can be carried out by

acts of omission ("passive euthanasia") as well as by acts of commission ("active euthanasia"). The distinction is morally irrelevant.

6. Competent persons have the moral and legal right to refuse any "extraordinary" treatment, i.e., any treatment which is useless or excessively burdensome; nonetheless, they must exercise great care in reaching the judgment that a treatment is useless or excessively burdensome. This is necessary both in order to avoid any intention to end life on the grounds that it is devoid of intrinsic worth and in order to fulfill properly the obligation to respect human life.

7. Likewise, those who have the moral duty to make decisions for the noncompetent (e.g., infants or the permanently unconscious) have a moral right to refuse any useless or excessively burdensome treatment for them. This right, however, must be exercised with great care in order to avoid the temptation, unfortunately not uncommon in our society, to devalue the lives of the noncompetent or to regard such persons chiefly in terms of the utilitarian values they represent. Too often, unfortunately, the judgment that a treatment is useless or excessively burdensome does not reflect serious consideration of the objectively discernible features of the treatment, but is an expression of attitudes toward the life being treated.

8. Human life can be burdened in many ways. But no matter how burdened it may be, human life remains inherently a good of the person.³ Thus, remaining alive is never rightly regarded as a burden, and deliberately killing innocent human life is never rightly regarded as a benefit.

II. Relevant Church Teaching

Here I wish to call attention to two major documents of the Church's Magisterium which are relevant to our consideration of the distinction between "ordinary" and "extraordinary" means. The first is an important statement made by Pope Pius XII in 1957 in addressing a congress of anesthesiologists. In the course of his remarks, Pius had this to say:

But normally one is held to use only ordinary means [to prolong life] — according to the 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 some more important duty.⁴

This statement of Pius XII is obviously relevant to the distinction between "ordinary" and "extraordinary" means of treatment — and to the criteria for determining whether or not it is morally appropriate to withhold or withdraw treatment. He indicates, in this statement, that "ordinary" medical treatment is that kind of treatment which offers some reasonable hope of benefitting the subject without imposing unacceptable burdens on the subject or others, whereas "extraordinary" medical treatment is

treatment which imposes unacceptable burdens on the subject and/or others. The pope himself did not address the *specific* criteria for distinguishing between treatments which are ordinary and those which are extraordinary. Rather, he outlined a general approach that seems clear enough, but one which obviously requires more specification.

A central problem in interpreting this statement by Pius XII has to do with the proper way of understanding what he meant when he said that life, i.e., bodily, physical life, is subordinated to "spiritual ends". I shall return to this problem of interpretation below, in commenting on views which I think are unacceptable.

A second major document of the Church's teaching authority relevant to our question is the "*Declaration on Euthanasia*" issued by the Congregation for the Doctrine of the Faith in 1980. While unequivocally condemning as absolutely immoral, suicide and all forms of euthanasia, this document reaffirmed traditional Catholic teaching that one is not obliged to use all possible means to preserve and prolong human life. It referred to the distinction between "ordinary" and "extraordinary" means of preserving life, noting that the imprecision of these terms is the cause of some ambiguity and that, therefore, some more recent writers had suggested that the term "proportionate" be used to designate means which are morally obligatory and that the term "disproportionate" be used to designate means which are not morally obligatory. It stated that no matter what terms are used to designate the distinction, it will nonetheless be possible to make a correct judgment

by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities 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.⁵

Moreover, the same document maintained that "one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which 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 which can be expected, or a desire not to impose excessive expense on the family or community".⁶ In addition, it says that "when inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment which would only secure a precarious and burdensome prolongation of life, so long as the normal care due to a sick person in similar cases is not interrupted".⁷

The precise significance of these statements will occupy us more fully below. For the present I can simply say that this document clearly implies that medical treatments judged, on objective bases, to impose grave burdens either upon the subject of the treatments or the family of the subject, or indeed, of the human community of which the subject is a

member, are not morally required and hence can be withheld or withdrawn. In assessing these burdens, moreover, it is necessary to take into account the resources, physical and moral, of the subject. It is likewise legitimate to take into account the burdens which the treatment will impose on others.

III. Erroneous Proposals for Interpreting "Extraordinary" Means

In this part of my talk, I wish to examine the views of two influential Catholic authors regarding the distinction between "ordinary" and "extraordinary" means. I regard these views as erroneous and dangerously misleading. I will first consider the position taken by Richard A. McCormick, S.J., currently professor of moral theology at the University of Notre Dame. McCormick's proposal for understanding the significance of "extraordinary" means is an example of a "quality of life" ethic that is not, in my judgment, acceptable.

McCormick, in an exceptionally influential article which was published simultaneously in the *Journal of the American Medical Association* and the Jesuit magazine *America* in 1974, and again in an article which appeared in the prestigious *Hastings Center Report* in 1977⁸, insisted that it is not possible to judge which treatments are "extraordinary" and hence not morally obligatory, without necessarily making "value of life" judgments. He wrote: "There has been a tendency to shift the problem from the means to reverse the dying process to the quality of the life sustained or preserved Granted that we can easily save the life, *what kind of life are we saving?*"⁹ (emphasis added). According to McCormick, bodily, physical life, while indeed "basic" and "precious"¹⁰, is a relative good, one "to be preserved precisely as the condition of these other values [interpersonal relationships]. It is these other values and possibilities which found the duty to preserve physical life and also dictate the limits of this duty"¹¹. In his view, the Judeo-Christian tradition holds that "the meaning, substance, and consummation of life are to be found in human *relationships* and the qualities of justice, respect, concern, compassion and support that surround them".¹² Because this is so, one can judge that bodily life is not a value to be preserved when the potential for these relationships has been lost or if it can never be attained. He maintains that "when in human judgment this potentiality [for human relationships] is totally absent or would be, because of the condition of the individual, totally subordinated to the mere effort for survival, that life can be said to have achieved its potential"¹³. He claims that the reason for withholding or withdrawing a treatment is based on a judgment about the quality of life which the treatment will preserve. Thus he says: "Often it is the kind of, the quality of, the 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"¹⁴ (emphasis in original).

There are very serious problems with McCormick's proposal that the proper way to determine whether a means is "extraordinary" or not is by focusing attention on the quality of life which is preserved by the means. The principal problem is that there is a vast difference between concluding that particular *treatment* is excessively burdensome and hence "extraordinary" and not morally obligatory and concluding that someone's *life* is excessively burdensome. Pius XII and the Vatican Declaration on Euthanasia directed our attention to the nature of the *treatments* used to preserve life. McCormick *redirects* our attention to the quality of the life which these treatments preserve. 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 something good, but has now 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 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 them.

Another Proposal

Another influential proposal for understanding Church teaching on the distinction between "ordinary" and "extraordinary" means of treatment has been advanced by Kevin O'Rourke, O.P., director of the Center for Health Care Ethics, St. Louis University Medical Center. O'Rourke is not, like McCormick, an advocate of a "quality of life" ethic. Nonetheless, he offers an interpretation of Pius XII's discourse on the prolongation of human life which is, in my judgment, seriously deficient and which logically leads to a quality of life ethic.

O'Rourke advances his position while commenting on the passage from Pius XII's address which we have previously examined, in particular, that portion of his talk in which Pius said that excessively burdensome treatments would "render the attainment of the higher, more important good too difficult" and that "life, health, all temporal activities are in fact subordinated to spiritual ends." According to O'Rourke, the Pope's emphasis on the spiritual goal of human life

specifies more clearly the terms 'ordinary' and 'extraordinary'. A more adequate and complete explanation of 'ordinary' means to prolong life would be: those means which are obligatory because they enable a person to strive for the spiritual purpose of life. 'Extraordinary' means would seem to be: those means which are optional because they are ineffective or a grave burden in helping a person strive

What is the problem with O'Rourke's interpretation? I would agree, for reasons to be set forth later, that a means is extraordinary if it *imposes* a "grave burden" on a person and prevents him or her from striving for the spiritual purpose of life. But I think that O'Rourke errs gravely when he claims that a means is extraordinary if it is "*ineffective . . . in helping a person strive for the spiritual purpose of life*" and that a means is ordinary precisely because it enables a person to strive for the spiritual purpose of life. Why do I think that O'Rourke errs here? 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 judgments 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 alive. If they should fall sick and be in danger of death, they surely have a right to some sort of medical treatment which would prolong and preserve their lives. Thus, for example, if an elderly individual suffering from senility — one whom everyone would regard as a noncompetent person unable to care for himself or herself — should suffer a cut artery and be in danger of dying because of loss of blood, I think it would surely be morally obligatory to stop the bleeding by appropriate medical treatments. Such treatments, in my judgment, would surely be "ordinary" or morally obligatory. 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." So something seems amiss with O'Rourke's analysis.

That this is the case is confirmed, I think, by a statement made by a priest, the Rev. Thomas F. Schindler, S.S., director of ethics of the Mercy Health Services in Farmington; Hills, MI. Schindler, who thought that O'Rourke's analysis of the distinction between "ordinary" and "extraordinary" means was excellent, came to the conclusion that

we should no longer state the ethical obligation as one of 'prolonging life.' Rather, we should refer to the obligation of maintaining a life 'capable of reaching life's spiritual goals' or 'capable of realizing life's purposes'.¹⁶

I believe that Father Schindler has accurately captured the thrust of O'Rourke's proposal. My problem is that if this is correct, then it means that the lives of 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 simply 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 realize life's purposes is grossly unjust and unfair. It surely cannot be what Pius XII meant. But unfortunately, this way of understanding what Pius XII said is becoming, I fear, more and more widespread in the Catholic community, due in part to the influence of O'Rourke.¹⁷

I thought it important to examine and criticize the proposals advanced by McCormick and O'Rourke for understanding the difference between "ordinary" and "extraordinary" means of treatment, because it is helpful to know what this distinction does *not* mean. Now I intend to shed some light on what this distinction does mean.

4. Objective Criteria for Distinguishing Between "Ordinary" and "Extraordinary" Means

We will be helped to discover the criteria for withholding or withdrawing treatments (=criteria for distinguishing between ordinary and extraordinary means of treatment) by first considering non-suicidal reasons for refusing treatment which competent persons might legitimately have. As Germain Grisez and Joseph Boyle have noted,

individuals who are competent can refuse treatment upon themselves without the intent to end their own lives, which would be their motive if they appraised their future prospects and decided that they would be better off dead. Such refusal of treatment, including treatment without which life will be shortened, can be based upon *objectionable features of the treatment itself, its side effects, and its negative consequences*. An individual who has no desire to die can take such factors into account and decide that life without treatment, so long as life lasts, will be better than life with it. Such a decision is not a choice of death.¹⁸

A human person, in other words, can refuse a treatment (choose that it be withheld or withdrawn) without adopting by choice a proposal to kill himself or herself. The treatment refusal is based on the judgment that the treatment itself, or side effects of the treatment, or bad consequences of the treatment, are so burdensome that undergoing the treatment is not morally obligatory. Consequently, the treatment in question is "extraordinary."

What are some nonsuicidal reasons for refusing treatment? I think that here too the position developed by Grisez and Boyle, who seek to build on the foundations established by Pius XII and the Vatican Declaration, is worth noting. They propose that among nonsuicidal reasons for refusing treatment are the following:

First, sometimes treatment is experimental or risky . . . second, some treatment is itself painful or brings about other experienced conditions which are undesirable . . . third, in many cases, the requirements for the application of medical care would interfere with the activities and experiences which one desires during the time [of life] remaining . . . fourth, many people object to certain forms of care on the basis of some principle [for example, Jehovah's Witnesses refuse blood transfusions because they believe that this is immoral] . . . fifth, there is a

variety of reasons why persons find medical care psychologically repugnant . . . sixth, in many cases medical care for one individual makes very severe demands upon others.¹⁹

To put matters in another way, medical treatment is "extraordinary" or "disproportionate" and hence not morally obligatory if *objectively discernible features in the treatment itself, its side-effects, and its negative consequences impose grave burdens on the person being treated or on others*. Excessive burdensomeness is the major criterion, therefore, for determining whether or not to withhold or withdraw medical treatments. Excessive burdensomeness is, one could say, the genus. Species of excessive burdensomeness include the riskiness of the treatment, the excessive pain of the treatment, the severely negative impact that the treatment will have on the subject's life, treatments judged morally or psychologically repugnant, and treatments which would be too costly and severely imperil the economic security of the patient, the patient's family, or the community. One could choose to forego such treatments, even foreseeing that by doing so one's life will be shortened, without in any way intending death.

How, then, is Pope Pius's statement that "life, health, all temporal activities are in fact subordinated to spiritual ends," with the result that treatments rendering "the attainment of the higher, more important good too difficult" can be considered too burdensome? O'Rourke, as will be recalled, claimed that ordinary means are "those means which are obligatory *because they enable a person to strive for the spiritual purpose of life*" (emphasis added), while extraordinary means are "those means which are optional *because they are ineffective or a grave burden in helping a person strive for the spiritual purpose of life*" (emphasis added). As I noted previously, I think that a treatment would be extraordinary and hence not morally obligatory if the treatment itself so affected the subject that it rendered the subject incapable of pursuing the spiritual purpose of life. I believe that this is what Pope Pius XII meant in his statement. But if the person is already unable to pursue this purpose by reason of some malady which renders him or her unable to reason and make choices, the person's handicap cannot be used to justify the withholding or withdrawal of treatment. In other words, it is not morally right to deny treatments to human persons because of the "poor" quality of their lives. Yet in assessing the burdensomeness of a treatment, one can take into account the person's condition or "quality of life" insofar as this condition is related to the treatment. The late John R. Connery, S.J., put the matter well when he said that while the Catholic tradition has repudiated a quality of life ethic which would deny persons needed medical care simply on the basis of the quality of their lives, it nonetheless

traditionally allowed quality of life considerations in decisions about prolonging life *if they were related to the means themselves* (emphasis added). Thus, if a particular means . . . would cause a drastic alteration of one's lifestyle, it might not be obligatory. Such a means would be classified as extraordinary because

of the permanent handicap it would cause.²⁰

In addition to burdensomeness, another criterion used to determine whether a means is morally obligatory or not is that of *usefulness*. In the Catholic tradition, a means has been judged useless or relatively useless if the benefits it provides to a person are nil (useless, in a strict sense) or are insignificant in comparison to the burdens it imposes (useless in a wider sense). Thus, the two criteria for determining whether or not it is morally right to withhold or withdraw treatments are those of burdensomeness and uselessness. The former is the major criterion insofar as the relative uselessness of many treatments is contingent upon the burdens they impose when compared to the benefits they provide. But what is most important is that these criteria draw attention to the *means* used to preserve life. Such *means* can rightly be judged "disproportionate" or "extraordinary" because of objectively discernible features in them and their side-effects, and their negative consequences on the patient's life leads one to the conclusion that their employment is either excessively burdensome or useless. But they do not lead one to conclude that the *life* of the patient-person is either burdensome or useless, for human life, however heavily burdened and devoid of utilitarian values, is always a great and precious good of irreplaceable persons.

References

1. In articulating these principles and presuppositions, I have adapted the set of such principles and presuppositions set forth by myself and others in "Feeding and Hydrating the Permanently Unconscious and Other Categories of Critically Ill Persons", *Issues in Law and Medicine* 3 (Winter, 1987), pp. 203-211.
2. "The Vatican Declaration on Euthanasia", issued by the Congregation for the Doctrine of the Faith in 1980, made this very clear when it declared that one form of killing the innocent, euthanasia, can be understood to be "an act or an omission which of itself or by intention causes death" (emphasis added), sect. II; reprinted in *Moral Responsibility in Prolonging Life Decisions*, ed. Donald McCarthy and Albert Moraczewski, o.p., (St. Louis: Pope John XXIII Medical Moral Center, 1981), p. 290.
3. John Paul II, Pope, Apostolic Exhortation, "Familiaris Consortio", n. 30.
4. Pius XII, Pope, "The Prolongation of Life: An Address to an International Congress of Anesthesiologists," 1957, as reprinted in *Death, Dying, and Euthanasia*, ed. Dennis Horan and David Mall (Frederick, MD: University Publications of America, 1980), p. 284.
5. "Vatican Declaration on Euthanasia", sect. IV, in McCarthy-Moraczewski, p. 294.
6. *Ibid.*, p. 295.
7. *Ibid.*
8. McCormick, S.J., Richard A., "To Save or Let Die: The Dilemma of Modern Medicine," "Journal of the American Medical Association" 229 (1974) pp. 172-176; *America* 130 (July 7, 1974) 6-10; reprinted in McCormick's *How Brave a New World? Dilemmas in Bioethics* (Garden City, NY: Doubleday, 1981), pp. 339-351, and "The Quality of Life, the Sanctity of Life," *Hastings Center Report* 8.1 (1978) 30-36; reprinted in *How Brave a New World?*, pp. 383-401. Subsequent references will be to the essays as found in *How Brave a New World?*
9. "To Save or Let Die," in *How Brave a New World?*, p. 345.
10. *Ibid.*

11. *Ibid.*
 12. *Ibid.*, p. 346.
 13. *Ibid.*, p. 349.
 14. *Ibid.*, p. 347.
 15. O'Rourke, Kevin, O.P., "Evolution of Church Teaching on the Prolongation of Life," *Health Progress* (January-February, 1988) pp. 28-35, at 32.
 16. Schindler, Thomas F., S.S., "Implications of Prolonging Life," *Health Progress* (April, 1988) 12.
 17. O'Rourke has developed his interpretation of Pius XII's statement in numerous essays, among which one of the most influential is "The A.M.A. Statement on Tubal Feeding: An Ethical Analysis," *America* (Nov. 22, 1988) pp. 321-323, an essay that the Society for the Right to Die, an advocacy group for legalizing euthanasia subsequently saw fit to reprint in its newsletter. See also Richard M. Gula, S.S., "Quality of Life: A Focus on the Patient's Total Good," *Health Progress* (July-August, 1988) pp. 34-39, 84.
 18. Grisez, Germain, and Boyle, Joseph, *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate* (Notre Dame, IN: University of Notre Dame Press, 1978), p. 260.
 19. *Ibid.*, pp. 268-269.
 20. Connery, S.J., John R., "Prolonging Life: Its Duty and Its Limits," in McCarthy-Moraczewski, p. 133.
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