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Quality of Life

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In recent years, due to advances in medical sciences, the capability of prolonging life has been dramatically enhanced. While this is generally considered a blessing, it may also add to already existing problems. Human beings have always had to face decisions about preserving or prolonging their lives. This is not new. What is new is the relative frequency with which such decisions must be faced today . . . at both ends of life. But there is another dimension to the problem which is new today. It is the introduction of a quality-of-life consideration into the discussion. The question is: What effect does the quality of a patient's life have on his duty to preserve it? Can it be so low that it affects the obligation to preserve this life . . . even to the point of removing all obligation?

In the past, moral theologians have always admitted that the obligation to preserve or prolong life was not an absolute one; it had its limits. They discussed this duty and its limits in terms of a distinction between ordinary and extraordinary means. The obligation to prolong life would not go beyond the use of ordinary means. Generally speaking, these were means which would not be too burdensome and which would actually prolong life in a significant way. If means were excessively burdensome, or if they would not prolong life in any appreciable way, one could not impose an obligation on a person to use them.

As already pointed out, this decision must be faced with greater frequency today than in the past, since there are ways and means of preserving life today that were simply not available in the past. While some of these treatments would be classified as extraordinary, because they are very burdensome or offer no hope of benefit, some would be considered ordinary (at least for short term use), and therefore obligatory. It is the increased availability of these means that has raised the quality-of-life issue. Many patients who simply would have died in the past may now continue to live, The question is: Must they? Or may they forego treatment

available today, even though it is not excessively burdensome and will prolong life, because of their quality-of-life? Obviously, they cannot retreat into the past and pretend such means do not exist. But may they appeal simply to quality-of-life considerations in assessing their duty to preserve their lives?

Among Catholic moral theologians in this country, this question was raised initially by Richard McCormick, S.J., regarding infants born with serious defects.[1] The question was, at least in part, occasioned by an account in the *New England Journal of Medicine* of 43 seriously defective infants for whom treatment was rejected because of a poor prognosis for *meaningful* life.[2] McCormick accepted the basic quality-of-life approach but was attempting to produce more precise, and hence more secure, guidelines for making such decisions. He arrived at the following norm: if the defects were so severe that the child would never have the capacity for establishing human relations (a specifically human function), or would at least find it morally impossible to do so, the child would not be obliged even to the use of ordinary means. McCormick was speaking of infants, but the norm would obviously have to apply even to those who had reached the age when the capacity for establishing human relations should have been reached. Logic would demand that such incapacity even at this stage would remove any obligation to preserve life.

But the allowance would not apply to children with lesser defects. The obligation to use ordinary means could prevail in such cases. Thus it might prevail in the case of the ordinary retarded child, or the child with lesser physical defects.

McCormick Used Pius XII's Argument

In support of his position, McCormick used the argument Pius XII made to justify omission of extraordinary means, namely that an obligation to use extraordinary means "would be too burdensome for most men and would render the attainment of the higher, more important good too difficult."[3] The Pontiff was explaining why one could not oblige a person to use extraordinary means, but McCormick took it to mean that if the patient himself or herself would not have either the physical or even moral capacity to achieve what he considered to be the higher good (establish human relations) to which the Pontiff was referring, there would be no obligation to preserve his life. In so doing he was adding a *quality of life* norm to the traditional *quality of treatment* norm already in place. This went radically beyond anything the Pontiff had in mind.

The practicality of McCormick's norm has been questioned, since in many cases it would be most difficult to make a very precise judgment at time of birth about the eventual capability — or lack of it — of a seriously defective infant for human function. This would be even more true of a prediction of moral incapacity. In the latter case, the physical potency would be present but the handicapped person would be so distracted by his

handicap that it would be extremely difficult to relate to others in a human way. Indeed it would be difficult to make such a judgment of a person at the appropriate age. The added problem of prediction doubles the difficulty. Our primary concern here is with the acceptability of the norm, rather than its practicality. Even if it was a very practical norm, we hope to show that there are serious reasons to question its acceptability.

More recently, in an article in the *NEJM*, a quality-of-life norm was applied to a third trimester termination of pregnancy.[4] The assumption in a third trimester pregnancy is that the fetus is viable, and that therefore, termination of the pregnancy is not automatically a lethal procedure. In a particular case, however, a doctor may judge that termination of a third trimester pregnancy would be lethal. In that case we are presuming that the authors would not allow termination. We are not discussing the allowance of a lethal procedure on the basis of quality-of-life considerations. We are dealing only with the duty to preserve life.

In the past, termination of pregnancy right after viability was allowed only if the life of the mother (or the fetus) was at stake. It was not allowed on the basis of the quality-of-life of the fetus. One of the theses of the above article is that it would be permissible to terminate a third trimester pregnancy if there is total or virtual absence of cognitive function in the fetus. The authors felt that this condition was verified in the case of a fetus diagnosed as anencephalic. The article speaks of the benefits that might come to the mother from such a termination, but these do not seem to be the primary consideration. It seems clear that the basic justification for terminating the pregnancy and the risk to the fetus involved is the quality-of-life judgment made about the fetus.

While the wording of the condition these authors use is different, the meaning of the requirement would seem to be close to McCormick's lack of capacity for human relations. His allowance even for the lack of moral potency may go beyond what is allowed in this case, since it would include even a person who was conscious, but so obsessed by some handicap that it would be very difficult to establish human relations. It should be pointed out, however, that the authors of the article allow termination of pregnancy where there is "virtual" absence of cognitive function. This may approximate the moral impotency of the McCormick norm, but since the authors do not elucidate the meaning of virtual, we are not sure whether it does.

In practice, McCormick's norm might, in some sense, be less difficult to apply, since the ability to establish human relations would seem to call for some ability to communicate externally. One who could not do so would not be able to establish such relations. But cognition can be present without communication. So one cannot conclude with certainty to the absence of cognition from the fact that a person cannot communicate (e.g., a person in a coma). Admission of this would seem to be implied in extending the allowance of termination of pregnancy even to the case where there is "virtual" absence of cognition.

In recent times also, the same question has been raised regarding patients in an irreversible coma (or a persistent vegetative state). If, indeed, the case is terminal (the patient will die shortly whether the treatment is used or not), since treatment will be useless, it cannot be obligatory. But in a case where treatment will prolong life and will not be excessively burdensome, it will be obligatory according to traditional norms. Some want to argue that even in this case, if the treatment does nothing more than prolong comatose life, it may still be omitted. In other words, the quality-of-life of a person in an irreversible coma automatically releases him or her from any obligation to preserve it. So if a treatment, even the most ordinary kind, will do nothing more than prolong life, they will argue that there is no obligation to use it. Briefly, there is no obligation to preserve this kind of life in itself.

Norm Applied in California Court

This norm was applied practically in a California court hearing to the case of Clarence Herbert, a 54-year-old man declared to be in an irreversible coma as the result of cardiac arrest. John J. Paris, S.J., an expert witness in the case, argued that there was no obligation to keep this person alive because he was in an irreversible coma.[5] We cannot go into this case, but the appeals judge ruled in favor of a previous decision to stop treatment of Herbert on this score. We are not interested in the legal ramifications of the case, but the judge cited as the source of his decision the position taken by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in a publication entitled *Deciding to Forego Life-Sustaining Treatment*. The judge's statement read as follows:

> . . . proportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a course of treatment might be extremely painful, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.[6]

The judge traces this opinion to pp. 82-90 of the Commission's report. It is obviously a summary statement, so it will not be found verbatim in this report. The following sentence from that section comes closest to the judgment of the court:

> So long as a mere biological existence is not considered the only value, patients may want to take the nature of that additional life into account (p. 88).

I am not sure that I could successfully interpret this sentence, but the judge seemed to feel that he was interpreting the mind of the Commission.

Briefly, according to the judge, the opinion of the Commission seemed to be that life as such (what the report calls "biological existence") is not a sufficient value to warrant the imposition of any duty to preserve it. In the present case, this means that since there is no chance to return the patient to a cognitive state, there is no obligation to keep him alive. Since this is an ethical commission, and the language used is basically ethical, one must conclude that it was not dealing on the level of legislation alone.

The judge puts the obligation in terms of proportionate/disproportionate treatment. In the Declaration on Euthanasia, the Sacred Congregation for the Doctrine of the Faith (1980) says that some use this distinction in preference to the traditional ordinary/extraordinary distinction to avoid the confusion caused by the latter.[7] The Congregation has nothing against the change in terminology, but insists that the underlying principle still holds good. In other words the criterion is still the benefit or burden of the treatment.

What is ethically objectionable in the court decision is that it departs from this principle in two critical respects: (1) it seems to make benefit the sole consideration, and (2) it makes it depend on quality-of-life considerations. If a treatment will be effective, the court considers it obligatory even if "extremely painful." But more relevant to our discussion is the judgment that prolonging the life of a person in an irreversible coma is not considered enough of a benefit to make any treatment (even minimally painful or intrusive) obligatory. In other words, the quality-of-life of this person is so low that there is no obligation to preserve it. As far as any obligation to preserve life goes, such a patient is like a dead man. In taking this stand the Court was departing not only from the distinction between ordinary/extraordinary means, but also from the principle underlying it. In making this point, however, we are not making a judgment about the rightness or wrongness of withdrawing treatment in the case involved. We have dealt with this issue elsewhere.[8] Here we are simply questioning the reason the Court gave to justify withdrawal. Our concern is that it approved withdrawal of treatment for the wrong reason.

In all of the cases described above the basic consideration in discerning the duty to prolong life was the quality-of-life the patient was leading. The argument is that life itself can be so burdensome or so empty that it ceases to be of value, or at least that its value is not sufficient to impose an obligation on the victim to preserve it.

From what we have seen, it seems clear that in the past, the duty to preserve life was related to respect for life itself as a basic good. All life deserved this respect, and it was to be shown as long as life was present. No limitation was put on the duty in this regard. No one ever suggested that the duty pertained only to those who enjoyed a certain quality-of-life or that it did not pertain to those who did not have that quality. The duty was the same for all.

At times the position of those who oppose quality-of-life considerations is classified pejoratively as "vitalism" or "biologism." I think this charge

may well apply to those who make life a supreme value to which everything else must yield and who hold, consequently, that all possible means to preserve it must be used. But to use the term of the position of those who oppose quality-of-life considerations is to misuse it. Those who hold this latter position in no way subscribe to the opinion that all means must be used to preserve life. They admit that there is a limit to the obligation to preserve life. They simply deny that this limit is based on quality-of-life as such.

In two (termination of pregnancy, irreversible coma) of the three instances mentioned in which quality-of-life was appealed to, little argumentation was offered to substantiate the positions taken. As we have seen, McCormick, in the case of the seriously defective infant, constructed an argument from the reason given by Pius XII to show why one could not impose an obligation to use extraordinary means, but he changed the whole context of that argument, and in doing so, undermined any claim he might make to support from the Pontiff's statement. So what we have are three instances in which quality-of-life was appealed to with little or no supporting reason.

McCormick attempts to show that his position is in continuity with past tradition by offering examples of cases in which quality-of-life was a consideration even in the past. It is quite true that, in the past, if quality-of-life affected the means or treatment, it became a factor in assessing the duty to use the means. Thus, the quality-of-life resulting from a quadruple amputation would affect the duty to undergo this kind of surgery. Similarly, if the patient was dying, it would frequently render the means to preserve life useless. McCormick would argue that he is simply extending the use of quality-of-life to another situation.

Writer Explains Contention

It is the contention of this writer that moving the criterion from *quality of treatment* to *quality of life* as such is not just another step in the same direction. It is a quantum leap. As pointed out, in the past, quality-of-life was considered only in reference to means. It might make a means burdensome, or it might make it useless. In the present usage it becomes the basic consideration. Even if it does not make the means burdensome or useless, it is appealed to in order to justify what is done or not done. This involves a whole new attitude toward this issue, and one which raises serious questions.

This can be illustrated very simply with the Quinlan case. The intention in that case was to relieve the girl of the burden of long-term dependence on a respirator. It was not to bring on the death of the girl. This was made clear by the efforts (successful) to wean her from the respirator. And the goal (removing the burden constituted by the respirator) was achieved even though she lived.

When quality-of-life is in itself the basic consideration, the entire

approach is different. The intention is not to free the patient of the burden of using some means, but the burden (or the uselessness) of the life itself. The only way to achieve this goal is by the death of the patient. So when one foregoes means because of quality-of-life considerations in this sense, the intention is the death of the patient. In this respect it differs vastly from the traditional approach. In the traditional approach, death was an unintentional side-effect of foregoing the treatment. In the current use, it is the intention in foregoing the treatment. Put briefly, in the traditional approach, one was making a legitimate application of the principle of double effect. In the present approach, one of the conditions for the legitimate use of that principle is violated (the evil effect is intended), so no such justification is available.

On the contrary, given the intention of bringing on death, one is forced to the conclusion that an independent quality-of-life norm involves euthanasia by omission (or by act, in the case of the pregnancy termination). The recent *Declaration on Euthanasia* by the SCDF (1980) defines euthanasia as an act or omission which either by nature or intention brings on the death of the patient (out of mercy). Since death is intended in quality-of-life decisions of this kind, they fulfill the definition of intentional euthanasia by act or omission.

An additional problem in the use of quality-of-life norms is that, up to the present, no norm has been suggested that would clearly define the cases to which it would apply and exclude those to which it would not apply. In the present discussion we have seen it applied e.g., to a person in an irreversible coma, or in a persistent vegetative state, but there is no way to limit it to those cases. Tomorrow, it could be applied to someone with Alzheimer's disease, the next day to a person with some other serious mental or physical handicap. In other words, it puts us on a slippery slope with no braking power. This kind of norm, even if it were legitimate, would end up a menace to society because of its lack of precision.

There are those who fear that if the withdrawal of treatment is not allowed on the basis of a quality-of-life criterion, we will be overwhelmed with people living in institutions at a very low level of existence. Even if this were the case, it would not of itself justify withdrawing treatment on a quality-of-life basis, any more than it would justify simply inflicting a painless death on them. However beneficial this might be to society, it would not be permissible. But I do not think this would happen. My judgment is that many, if not most, of the decisions that are made to withdraw treatment could be justified because burdensome means are involved. Many of the means in question, even if ordinary in a crisis situation, can become burdensome when used on a long term basis. If a judgment can be made that long term use will be required, such treatment may become optional. Certainly, death is the result in any event. But it is important that it should not result from the use of a criterion as objectionable and as open to abuse as quality-of-life.

In brief, then, an independent quality-of-life norm represents a radical

departure from the past which put the emphasis on the quality of the treatment. The basic difference is in the intention. In the traditional quality of treatment norm, death is not intended but a side effect of a decision to spare the patient the burdén of a difficult treatment. In an independent quality-of-life norm, death is intended, and this is basically what makes it objectionable. It is intentional euthanasia by omission (or by act in the termination of a third trimester pregnancy). But even if a quality-of-life approach could be justified in itself, the norms suggested up to the present carry with them inherent risk of abuse because of their imprecision. Adoption will put one on a slippery slope with no braking power.

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