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Euthanasia and Natural Law

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The subject of euthanasia seems to be confused even to the point where some authors in the past have understood it to mean dying in the state of grace.

Usually, euthanasia means mercy killing, that is the deliberate taking of a human life to end suffering, although the term sometimes is extended to killing others such as newly born children who are profoundly retarded.

I will maintain that in a natural law perspective, at least in the tradition of Thomas Aquinas, euthanasia is always wrong. I would also suggest that killing terminally ill patients cannot be separated in principle from killing other persons; that is to say, although the issue can be discussed in regard only to the terminally ill, whatever principle governs the terminally ill is likely to be applied to others. Finally, I would like to draw the implications of the principles governing euthanasia as they clarify the ethics of treatment and non-treatment of the terminally ill, which is sometimes wrongly associated with euthanasia.

The Wedge

Let us consider the second point first: when stated as the proposition that euthanasia is wrong because it will be extended to others than the terminally ill, it is called the wedge argument. The argument, when it concede that killing of the terminally ill may be acceptable in itself but becomes unacceptable because of its consequences, is philosophically weak. As Cahill points out "... each act must be judged right or wrong primarily in itself and only secondarily in its relations to other acts... the range of effects of an act cannot be extended indefinitely..." This criticism can be seen as a variant on the principle of double effect.

A good instance of this type of wedge argument might be the reasoning advanced a decade ago by some Catholic writers to the effect that if all legal constraints on contraceptives were dropped and the latter became universally available, there would be a move to legalize abortion. While both the writers in question, and, as it turned out, some advocates of population limitation, saw abortion as another step in the same direction (of denying the purpose of the family or of
controlling the demographic explosion), there is certainly a clear qualitative difference in the methods and their moral implications.

Joseph Fletcher, who favors voluntary euthanasia of the terminally ill as well as involuntary euthanasia of monstrosities at birth and mental defectives, but not involuntary euthanasia of all who are a burden on the community, makes a point of rejecting the wedge argument in his defense of voluntary euthanasia. Fletcher recalls Chesterton's remark that the proponents of euthanasia are likely to broaden the object of their concerns from those who are a nuisance to themselves to those who are a nuisance to others. He dismisses this line of argument with the observation that it hangs on vague concepts such as weakening our moral fiber and the importance of life. Ironically, part of Chesterton's point was, no doubt, the vagueness of the concepts which justify euthanasia. This is not to say — given the intensity of Chesterton's feelings about suicide — that he would have proposed the wedge argument in the sense of regarding the killing of the terminally ill as something acceptable. Surely, elucidating a philosophical principle operative in one case, through its consequences in others, is as old as the dialectic of Plato. Surely, there is a heuristic intent in linking voluntary euthanasia to involuntary euthanasia, if the same principle is understood to be operative in each case.

Chesterton in his polemic on another issue, sets forth a defense of the wedge argument: "And these people (i.e., his opponents who favored eugenics) most certainly propose to be responsible for a whole movement after it has left their hands. Each man promises to be a thousand policemen. If you ask them about how this or that will work, they will answer, 'Oh, I would certainly insist on this'; or 'I would never go so far as that'; as if they could return to this earth and do what no ghost has ever done quite successfully — force men to forsake their sins. Of these it is enough to say that they do not understand the nature of a law any more than the nature of a dog. If you let loose a law, it will do as a dog does. It will obey its own nature, not yours. Such a sense as you have put into the law (or the dog) will be fulfilled."

What is therefore at issue is whether the principle involved in voluntary euthanasia can be contained just in that situation. That is what Cahill, who is not only more cautious than Fletcher, but develops a different set of arguments, tries to do. Fletcher justifies euthanasia because, "Incurable pain destroys self-possession and disintegrates personality." He quotes with approval the final words typed by a woman dying of cancer, who committed suicide, explaining that this is a fundamental right "when all usefulness is over, when one is assured of an imminent and unavoidable death." Cahill declares that for the terminally ill patients there comes a point when "... his or her life is past the point of possible restoration to a quality which would sup-
port significant pursuit of the highest human values”\textsuperscript{8}; when “... it is impossible to continue to pursue human values for which the Creator intended life to serve as the condition.”\textsuperscript{9} Or again, “Life can fail to constitute a sufficient condition for the fulfillment of human values...”\textsuperscript{10} The Encyclopedia of Religion and Ethics defines euthanasia as a theory that justifies killing a person “in certain circumstances, when owing to disease, senility or the like, a person’s life has permanently ceased to be either agreeable or useful...”\textsuperscript{11}

I have quoted at some length from Cahill as well as Fletcher to suggest that both incur in the same danger or ambiguity underlined by the Encyclopedia. There are all sorts of people whose lives are not useful or agreeable, besides the terminally ill. There are cases other than terminal illness where personality disintegrates, where all usefulness is over, let alone where the quality is lacking which would support significant pursuit of the highest human values. There are lives other than those of the terminally ill which do not constitute sufficient condition for the fulfillment of human value. In other words, Fletcher and Cahill are not convincing in showing that the wedge argument is invalid. Their philosophical rationales would not seem to justify the restrictions they wish to place on the subjects of euthanasia.

This ambiguity is further reflected when involuntary euthanasia is discussed, whether directly or by implication: cases such as the irreversibly comatose, the almost unconscious, or more generally the incompetent patient. Without rejecting involuntary euthanasia, many authors retreat from it in the context of a discussion of how to frame a euthanasia law, where they choose to discuss voluntary euthanasia. Fletcher sees the restriction of euthanasia to those who are presently able to consent as a kind of political concession. One author remarks, “My own appraisal, however, is that guardians are not legally obliged to follow prior instructions in assessing an incompetent patient’s best interest.”\textsuperscript{12} Cantor apparently means that the family (say) could reverse a comatose patient’s request to be killed, but it would seem that once the guardian’s authority were established, it would cut both ways. Hence, the tendency to skirt the issue of involuntary euthanasia may itself be a tacit concession of the cogency of the wedge argument. On the one hand, the patient who is comatose is past pain, beyond despair, and does not, it seems to me, die with more dignity sooner than later. His case is different from that of the person overwhelmed with pain, unless one sees them both as instances of valueless life. On the other hand, the advocates of euthanasia who make their judgments in terms of quality of life, are hardly in a position to give a principled (as opposed to tactical) rejection of involuntary euthanasia because that would be valuing less the continued life of someone still able to make choices than that of someone unable to make choices.
The heart of the case for euthanasia is the situation of the agonizing terminally ill patient. Even here, it is odd in a way that Fletcher chooses as an example Dean Jonathan Swift whose final illness lasted eight years. At what point were his attendants supposed to have known that his end was near? At what point should they have allowed Swift, always a morbid personality, to seize a knife or poison? And is this not a case where modern pharmacology would probably have eased the agony?

The wedge argument, some versions of which are philosophically inadequate, is a favorite weapon of such strong opponents of euthanasia as the Sassones and Paul Marx. In fairness to publicists such as the Sassones and Marx, however, it must be pointed out that they do not concede that killing of the terminally ill is licit in itself, becoming illicit through its consequences; hence they do not propound the wedge in the objectionable form. They are trying to teach, to make a social and political argument. As the Sassones point out, the wedge argument is a mainstay of the U.S. Supreme Court's decisions on matters relating to free speech and religious liberty. On this level, it becomes quite appropriate to introduce considerations such as the anguish of many patients, their possible distrust of physicians if euthanasia is legalized. The wedge argument is hardly novel, and as an empirical prediction applied to euthanasia, it may well be true (I believe it is), however infelicitous it sounds if read as a rigorous philosophical statement.

Aquinas

It has been suggested that there is a natural law basis for euthanasia in Thomistic anthropology, which Aquinas inconsistently did not see. The positive explanation of the sanctity of life is, according to this critique, contained in the principle of totality which on the one hand, involves the subordination of the parts of the body to the health of the whole, but on the other, "... as it is actually used by Catholic theologians and writers on medical ethics, includes the subordination of the physical aspect of man to the whole ‘person’ which also includes his spiritual aspect." Consequently, it would seem most inconsistent for any theologian (i.e., in the Thomistic tradition) ... to interpret moral dilemmas according to a principle of human totality which neglects not only man's supernatural goal, but his natural goal of mature integration of body and spirit."17

On the other hand, it seems rather odd to invoke precisely the principle of totality to justify separating body and soul. For what it is worth, the person — man — is a union of body and soul according to Thomas. What we actually have, I think, is a justification of sacrificing the body for the good of the soul, so that the statement of Thom-
istic anthropology is somewhat muddled.

In any case, St. Thomas knew no science called anthropology, although one may reconstruct a philosophical anthropology from his works, but did know a science of ethics, and it is on this plane that we must deal with euthanasia.

It ought to give pause that St. Thomas who employs the principle of totality to justify amputation of an ailing member for the health of the whole organism and indicates that a wise doctor may allow a patient to incur a lesser infirmity to cure a greater disease, nevertheless declares that it is never licit to mutilate oneself for one's spiritual good, e.g., by castration, even though spiritual health is more important than bodily health. It is wrong to kill oneself to avoid sin. More fundamentally, the principle of totality would be inapplicable in matters relating to human life since Aquinas reiterates that man is not ordained to himself as a totality but to something outside of himself. Our last end is not something of man.

The governing principle in St. Thomas is that it is never licit to kill the innocent. More specifically, suicide is always a mortal sin (a concept to which we will return later). This is so firstly, because by nature each thing wishes to conserve itself and self-destruction goes against charity to oneself. Furthermore, we injure the community of which we are part by killing ourselves. Thirdly, we arrogate to ourselves a divine prerogative and sin against God, Who is Lord of life and death. The three points are not independent. The third is easiest to emphasize, because the second wrongly understood lends itself to a pragmatic interpretation, and rightly understood requires a comprehension of the first reason, which in turn is put in perspective by the third.

The central issue, then, is that life is a gift of God. It belongs to God in a special sense. Death, Aquinas says, is the most terrible of things, the final evil. These phrases are taken from Aristotle's Nicomachean Ethics. Now, Aristotle is talking about facing death bravely and nobly. It is possible to read his words psychologically although it is equally clear that the psychological reaction to death has a real justification. Whereas Aristotle's brave man should overcome this fear, the suicide contemplated by St. Thomas clearly does not fear death. Nor would St. Thomas agree that "nothing is thought to be any longer good or bad for the dead." The appropriation of Aristotle's phrases is thus a way of saying that human life is an absolute.

True, there are certain situations in which it is licit to kill, but Aquinas does not view those cases with enthusiasm. He is at pains to point out that Christ (Who as God had dominion over life and death) did not kill Himself, although He did not impede His death. His persecutors were the sufficient cause of His death. A cleric may not
make war although the war is licit. A cleric may not kill evil-doers. A man who has sentenced someone to death — properly and justly it is understood — is irregular, that is, he may not be ordained a priest. Indeed, this irregularity follows even if a person kills in self-defense without intending to kill.

This last point is worth insisting upon: in the much more significant case of killing in self-defense, one is not supposed to try to kill; this is held legitimate only for someone acting in a public function (e.g., judge, executioner). One may use only as much force as is necessary even to defend one’s own life, although one is not required to be overly cautious in defending one’s life. It must be remembered that this (along with the controlling principle that it is never licit to kill an innocent person) is the precise context in which St. Thomas makes the point that an action may have two effects, self-defense and killing an attacker, which is licit because only self-defense is intended.

There is no way on earth to read a justification for euthanasia into that article of the *Summa*. Indeed it is word chopping to suggest that there is more than one effect when one kills someone to end his suffering. (On the other hand, clearly, the principle of double effect does apply when pain suppressing drugs are administered with the knowledge that they may shorten the life of the greatly weakened terminal patient; this is obvious, among other reasons, because we would do approximately the same for a non-terminal patient.)

When we speak of absoluteness, we are using what for St. Thomas is a logical category. Normally St. Thomas does not employ that category in expressing moral judgments. He does tell us that the first principles of natural law are altogether unchangeable. The precepts of the Commandments are absolutely not subject to dispensation. That is the language of moral absolutes. Most often, absolute moral values are formulated negatively. They are, of course, referred to as mortal sins, things one simply should not do, although some sins are worse than others. Since the primary factor that specifies morality of an action is its object, it is most un-Thomistic to try to distinguish between moral evil and, say, the action of killing an innocent person. Notice, we are talking about killing, not about avoiding death. The absolute obligation is to not murder. Nowhere in Aquinas (or any other medieval) is there the slightest suggestion that there is an absolute obligation to avoid death, which is impossible to begin with, and in many instances wrong.

There is no question that there is a serious obligation to preserve one’s life insofar as that is possible. This is held to be right and normal. If God is Lord of life and death, it would seem necessary at some point to accept the advent of one’s death, even if death is only regarded as a punishment.
Since, as St. Thomas judiciously notes, unlike lawyers who should not defend desperate (because unjust) cases, doctors may earn great praise by taking desperate cases, the question arises as to what are the limits of responsibility of the doctor in regard to treatment of the terminal patient. The general framework within which this question is asked is that it is never licit to kill an innocent person; life is to be conserved; but death at some point may be accepted as the will of Providence.

There is in any case a difference between failing to treat and killing. At worst, leaving stolen goods where they have been hidden by the thief is not the same as stealing them, nor is failing to help a person being attacked the same as attacking. Thus, it is mistaken to equate not treating or discontinuing treatment with euthanasia. Of course, a policeman would have a specific duty to report the stolen goods or to intervene in an assault, and a physician ordinarily has a specific responsibility to treat his patients; some of the limits of this responsibility are our present concern.

The most typical way of solving the problem of what treatment is obliged and when treatment may be withheld, is to use the distinction between ordinary and extraordinary means. In my comments in the August, 1977 Linacre Quarterly I suggested that this distinction may not be helpful because it depends too much on technical progress in medicine.

That is not to say that the distinction involves only a) the technical aspects of medical practice as opposed to rate of success, expense, and comfort; or b) just applies to medical ethics. The distinction is one that affects prudential judgments fairly generally, whether they be about the preservation of life or not. For example, it is a sensible precaution to make sure the doors are locked at night, and it is the responsible thing to do. It would be an extraordinary step to insure safety to barricade the door with furniture. It is extraordinary because it is both a nuisance and not necessary for the goal of personal safety. Now, what is ordinary and extraordinary may vary according to circumstances. In Boston one is well advised to leave one's car locked, and I would expect a friend to whom I lent my car to recognize his obligation to do so. By contrast, relatives who live in New Hampshire tell me that their neighbors regard the habit of automatically locking cars as a quirk of people from Massachusetts. It does not take much imagination to realize what is the source of this difference in standards for prudent behavior, nor does it require a great effort to adjust to the different situations.

There is in fact a peculiarity of Massachusetts law which is a factor in the greater theft rate in Massachusetts: most auto thefts are only misdemeanors. But it is not necessary to understand anything at all

May, 1978 193
about law to know that auto theft is a problem and to try to avoid it.

Thus it is neither a novelty nor a refinement of the ordinary-extraordinary means concept to include difficulty and mutability as factors, but in medicine the situation is rather complicated, if the accent is placed on the means of treatment and we try to involve the patient and/or family in the decision. One of the peculiarities of medicine is that the means of treatment may become ordinary, or cease to be ordinary, due to improvements in the state of the art.

In the normal run of things, cost will tend to be tied to new technical developments. If we consider cost per se as a determinant of extraordinariness (as some seem to do, perhaps to humanize what otherwise would be a technical decision), apart from reducing the issue to a macabre discussion of who has how much health insurance, we enter into a different order of things. The cost factor is not pertinent to the quality of the means, but to the possibility of using them. At the extreme, no one is held to the impossible, so the authors who listed excessive cost as a justification for omitting treatment may have been right, but for the wrong reason. It is, for instance, conceivable that someone would be unable to afford a hospital bed, but it makes no sense to say that hospitalization thereby becomes an extraordinary means of treatment.

Excessive pain is also offered as a determinant of extraordinariness, which is a similar confusion of orders. Besides, the degree of pain may not be at all related to proximity to death. Most important, if one may simplify, pain is most unbearable precisely when it is indefinite. The pains of childbirth are sometimes intense, but they are finite, and there is a point to them.

Now this last factor, which appeared in some of the common sense examples, namely reasonableness and relation to goal, may give us some clarification, particularly by comparison to difficulty. Consider the following cases: is a patient obliged to curtail all activities for several weeks to get the rest necessary to recuperate from hepatitis? Is a patient with skin cancer obliged to undergo radiation treatments to make sure that no traces are left of an extirpated tumor? Is a critically ill cardiac patient obliged to undergo heart transplant? Is a patient with bone cancer obliged to try Laetrile? It seems to me that the answer to the first two questions is “Yes” and to the second two “No.” Expense may not be a factor at all and bears no consistent relation to obligation. Inconvenience is not a consistent factor: if Laetrile were legalized and readily available, it could be easily taken, whereas radiation treatments can be nauseating. The obligation, then, stems not from difficulty or expense but from the reasonable expectation of cure. Laetrile is not recommended by competent medical authority, and heart transplants are notoriously risky. One could thus consider them extraordinary remedies, but it seems simpler to speak of their relationship to a cure. Now, in my two examples of non-oblig-
atory (or extraordinary) treatment, the lack of purpose in employing the remedies lies primarily in the defect of the remedies, but it would seem that there might be the same sort of lack of purpose and hence non-obligatoriness due to the nature of the illness.

If the physician could say to a patient, "You have a 98% chance of dying within two weeks with such and such methods but a 95% chance of dying in two months with these other methods, many patients would see no obligation of accepting the new treatment (or the old one), quite rightly, I believe. Of course, no doctor can make a prediction with that kind of accuracy, but in couching remarks more cautiously, the message may change in tone. Does not the script often sound thus? "No one can be sure when any of us will die (which is not the point), but we feel your chances are very slim (in reality the speaker is convinced they are nil); there is the possibility of using this new treatment, although we can’t promise that it will cure you (in fact we don’t think it will)." The patient is thus effectively misled.44

The reluctance of the physician to use the same frankness with a patient that he would with another physician is understandable. Bearers of bad news are not welcome. Physicians are not alone in facing a situation that in much lesser degrees confronts a lawyer who must tell his clients they have no case or even a college professor who must tell a student he is not a prospect for graduate school. Perhaps some of the weight would be taken off the physician’s shoulders if we could think as Aquinas surely would have, not in terms of the patient’s right to hear the truth, but of his responsibility to hear the truth.

Some of this may sound presumptuous coming from a non-physician but Kubler-Ross remarks on the difficulties many doctors encounter in accepting the terminal illness of their patients45 and the consequent defense or coping mechanism of ordering unnecessary treatments or tests,46 which, given the state of malpractice suits, is not a purely subjective concern.

Is the discontinuation of treatment the same as refusal of treatment? This is basically a technical question. One may wonder whether intervention does not influence a situation creating a dependency that did not originally exist. So it is in the case of persons who have become dependent on a drug; so it occurs in the case of a government program. If it can be shown that a treatment has altered the patient’s ability to function autonomously by creating a dependency, it would seem to me that there would probably be an obligation to continue the treatment. Otherwise, the treatment may be discontinued under the same strictures by which it might have been initially refused. An example, I think, would be the respirator, which should be seen probably as a device to restore normal functioning (in the manner of mouth to mouth resuscitation) and may be discontinued as soon as

May, 1978
the physicians are convinced that autonomous brain and heart functions will not be stimulated.\(^{47}\)

There remains the case of the terminal patient afflicted with an unrelated curable disease. Does this new disease have to be treated even if the patient is already considered incurable, in the light of what has been said? My feeling is that in principle one should apply the standard remedies; the ordinary-extraordinary distinction will be welcome here. In practice, e.g., the case of an extremely weak, elderly patient with pneumonia, the difficulty may be to determine what illness is unrelated.\(^{48}\)

**Conclusion**

Accordingly, four points remain with us.

1. It is quite legitimate to worry about the consequences of legalizing euthanasia. It is logical to wonder to what point a principle will be extended once established.

2. Euthanasia cannot be justified on Thomistic principles. One may agree with Joseph Fletcher: “Just as we have found that it is necessary to lay aside the notion of natural law and soul because they stand in the way of ethical medical care, so we may find that we have to lay aside the notion of man, about whom so many reactionary, dogmatic, and absolute claims are being made.”\(^{48}\) But Fletcher speaks for a different world view from Aquinas.

3. On Thomistic principles, as one respects life, so also one accepts death and the analysis of which means preserving life are morally necessary and which are not, falls within that general framework. (To suggest that recognizing an absolute value in life in a Thomistic sense, would require that one use all imaginable means to conserve life, is a caricature.)

4. A great deal of what is written above is very brave words. I am in no hurry to deliver or receive some of the messages about death, which have just been declared mandatory. Some of what is written here may have a ring of harshness.

Here some perspective may help. Our age values mercy, to its great merit. This makes us sensitive to certain arguments on behalf of euthanasia. Euthanasia is, nevertheless, wrong. Other ages valued honor and dignity, to their great merit. That made them vulnerable to claims of vengeance or dueling. Dueling and private vengeance are also wrong.

**REFERENCES**


James G. Colbert, Jr., “Comment on Cahill’s ‘Reconsideration of Euthanasia’”

4. Fletcher, op. cit., p. 201.
9. Ibid., p. 60.
10. Ibid.

Cf., J. L. Fletcher, op. cit., pp. 200-201. Fletcher comments that the moral problem of euthanasia for the comatose patient becomes unreal. Also, pp. 207-208 where three different positions favoring euthanasia are set out, one voluntary and two involuntary. Fletcher is at pains to defend only the first, to explain that the third is not entailed by the first two, and leaves one class of involuntary euthanasia hanging.

As another example of skating close to involuntary euthanasia, Glanville Williams: “The only doubtful moral question upon which we have to make an immediate decision in relation to involuntary euthanasia is whether we owe a moral debt to terminate the life of an insane person who is suffering from an incurable disease.” “Euthanasia Legislation: a Response to the Non-Religious Objections,” Euthanasia and the Right to Death, The Case for Voluntary Euthanasia, A. B. Downing, ed. (London: Peter Owen, 1969), p. 147. Williams leaves the matter a question.

Cahill, “Reconsiderations,” pp. 59-60, specifically mentions the permanently comatose and those with severe damage to the neo-cortex, and while consent is not the issue at the places cited, such patients could not consent.

17. Ibid., p. 50.
18. Cf., Summa Contra Gentes III, p. 112, which indicates that the principle is a general one, whereby the parts exist for the good of the whole.

19. Summa Theologica (quoted hereafter as S. Th.) 1-2, q. 17, 4c etc.
20. Ibid., 2-2, q. 65, 1c; 2-2, q. 162, 7, ad 3.
21. Ibid., 2-2, q. 65, 1, obj. 3 and ad 3.
22. Ibid., 2-2, q. 64, 5, ad 3.
23. Ibid., 1-2, q. 28, ad 2.
24. Ibid., 2-2, q. 64, 6.
25. Ibid., 2-2, q. 64, 5.
26. Ibid., 2-2, q. 59, 3, ad 2; 2-2, q. 64, 6, ad 1; 1-2, q. 94, 5, ad 2.
27. Ibid., 2-2, q. 64, 5, ad 3.
29. S. Th., 3, q. 22, 2, obj. 2 and ad 2; 3, q. 47, 1; 3, q. 47, 6, ad 3.
30. Ibid., 2-2, q. 40, 2, obj. 1 and ad 1.
31. Ibid., q. 64, 4 c.
32. Ibid., 2-2, q. 108, 4, ad 2.
33. Ibid., 2-2, q. 64, 7 obj. 3 and ad 3.
34. Ibid., 2-2, q. 64, 7 c.
35. Ibid., 1-2, q. 16, 4, ad 2.
36. Ibid., 1-2, q. 94, 5 c.
37. Ibid., 1-2, q. 100, 8 c.
38. Ibid., 1-2, q. 72, 5 c; 1-2, q. 74, 9 c etc.
39. Ibid., 1-2, q. 72, 1 c; 1-2, q. 73, 3 resp. and c.
41. S. Th., 2-2, q. 179, 1 c.
42. Ibid., q. 85, 5 c.
43. Ibid., 2-2, q. 71, 4 obj 3 and ad. 3.
44. The script may be a caricature, but David Jenkins in David Jenkins and Louis Martineau, "Good News and Bad News," Religion and Medicine: a Discussion, M. A. N. Melinsky, ed. (London: SCM Press, 1970), p. 103, observes that news may not correspond to probability, that the physician may hide behind mere probability, and rely on comments that falling back on a reference to miracles are "an improbable evaluation of probability."
46. Ibid., pp. 251, 257, 276.
47. Paul Ramsey concurs in The Patient as Person (New Haven: Yale University Press, 1970), pp. 80-81. Ramsey, however, equates discontinuing treatment with refusing it and does not give much consideration to the possibility that the treatment may radically alter the patient's independence.
48. This discussion could be extended to other cases of withholding treatment. Here, my practical conclusion but not my rationale coincides with that of Richard McCormick, "To Save or Let Die: the Dilemma of Modern Medicine," Contemporary Issues in Bioethics, Tom L. Beauchamp and LeRoy Walters, eds. (Encino, Calif.: Dickenson Publishing Co., 1978), pp. 331-337. Reprinted from Journal of the American Medical Association, vol. 229, no. 8, July, 1974, pp. 172-176. McCormick contrasts the case of an infant born with Downs syndrome and duodenal atresia who was refused corrective surgery and allowed to starve (wrongly in McCormick's view), with that of a grossly deformed infant who died after court ordered surgery. McCormick resolves the issue in terms of quality of life and potential for human relations rather than recurring to the "highly relative" criterion of ordinariness of means. McCormick (who is not in any case dealing with criteria for deciding who should be killed) insists that he is not denying that an anencephalic infant's life is worth living. Yet it seems to me that no other construction can be placed on his distinction. However, if one considers the case of the mongoloid child, without worrying about its potential for meaningful relations, it appears that it will be able to function indefinitely if the duodenal blockage is cured. This is not the case of the anencephalic infant. So, we have again replaced or perhaps refined the ordinary-extraordinary distinction by one of expectation of cure of the fatal illness.
49. Fletcher, op. cit., p. 220.