

authority it is meant to prevent."<sup>63</sup> It will also deprive the People of God of the fruits of open and honest reflection on the behavioral implications of their faith. They have a right to this. Therefore, I exhort my theological colleagues to stay the course and to embrace, with both humility and courage, their public critical function.

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#### SANCTITY OF LIFE, QUALITY OF LIFE, AND SOCIAL JUSTICE

In two areas of moral theology, the Catholic tradition has had an asset in its flexibility: the responsibility to sustain individual human lives, and the just distribution of the material and social resources which contribute to the "common good." Moral analysis in the former area is newly tested by medical technology which prolongs life in four related instances: seriously abnormal newborns; adults who are critically ill, comatose, or dying; the withdrawal of artificial nutrition and hydration; and the special case of a competent adult, Elizabeth Bouvia, who demands medical cooperation in refusing artificial sustenance. In all cases an important consideration is whether "quality of life" is a morally defensible criterion for withdrawing, withholding, or providing treatment, and if so, what that criterion means and how it is to be applied.<sup>64</sup> These issues of health care are seen increasingly to involve the just distribution of scarce resources, and to manifest the inevitable interdependence of the "indi-

<sup>63</sup> As in note 26 above. As these "Notes" were being finalized, the first section of a two-part essay on dissent by Germain Grisez appeared in the *Homiletic and Pastoral Review* ("How to Deal with Dissent," 87 [Nov. 1986] 19-29). It is an astonishing account, for all practical purposes tracing every malaise in the Church to dissenting theologians. Hundreds of theologians would have to spend thousands of hours doing nothing but dissenting all over the place to wreak the monumental havoc ("cancer in the vital organs of the Church") Grisez finds permeating the Church.

<sup>64</sup> Space constraints force limitation to the literature of 1984-86 (esp. 1985-86) on ethics of withholding treatment. For earlier materials see Richard A. McCormick, "Notes on Moral Theology: 1983," *TS* 45 (1984) 115-19, and a survey article by Kenneth Kipnis and Gailynn M. Williamson, "Nontreatment Decisions for Severely Compromised Newborns," *Ethics* 95 (1984) 90-111. Debates of direct killing (suicide and euthanasia) include Jacques Pohier and Dietmar Mieth, eds., *Suicide and the Right to Die* (Edinburgh: T&T Clark, 1985); Concilium vol. 179, no. 3 (1985) on moral theology; E. Drewerman, "Von Problem des Selbstmords oder: Von einer letzten Gnade der Natur," Part 1, *Studia moralia* 21 (1983) 315-50; and Part 2, *ibid.* 22 (1984) 17-62 (both with English summaries); Theo Beemer, "Je leven: In de waagschaal of op de weegschaal?" ("A Catholic View of Suicide"), *Tijdschrift voor theologie* 24 (1984) 36-54 (English summary); Johan Van Snick, "Het levenseinde: Eigen keuze in relatie tot de anderen" ("Euthanasia and the Tension between Self-Determination and Interpersonal Relationships"), *ibid.* 25 (1985) 385-401 (English summary); and Pope John Paul II, address at the Catholic University of the Sacred Heart, Sept. 6, 1984, *The Pope Speaks* 29 (1984) 352-55.

vidual" and "social" sides of Catholic moral theology. The resulting challenge for normative ethics is to preserve the values expressed by phrases such as "dignity of the person," "sacredness of life," and "equal respect," while at the same time giving due consideration to values such as "distributive justice," "common good," and "option for the poor." Consistent ethical correlation of both sorts of values needs also to be embodied in practical social policies which allow individual decision-makers to respect the lives immediately at hand, but which also place particular medical decisions in the larger perspective of their social impact, especially on those with restricted access to life's ordinary necessities.

### *Infants*

Many factors make the situation of the newborn in crisis different from that of the adult. A window onto the shock, uncertainty, pressure, and emotional stress of the neonatal intensive-care nursery is provided by the focus section of a new journal, *Second Opinion*.<sup>65</sup> Difficulties frequently noted are the elusiveness of reliable prognosis, the inclination of specialists to treat aggressively certain aspects of an infant's condition without evaluating the total picture, the necessity that parents or other adults act as proxies, and the conflicts of judgment and value among those in a position to choose. The infant's unrealized and unpredictable potential seems to tip the balance in favor of life; yet, the infant possesses in actuality few of the most distinctive characteristics of human beings.<sup>66</sup> Is ability to survive a sufficient indicator in favor of treatment, or is reasonable expectation of some minimal level of "quality of life" also

<sup>65</sup> Vol. 2 (July 1986); published by the Park Ridge Center, an Institute for the Study of Health, Faith, and Ethics, Park Ridge, Ill. Such realities are communicated by Rex C. Buchanan, "77 Days: A Father's Journal," 64-91; William G. Bartholome, M.D., "Imperiled: A Case Study," 12-17; and three pictorial essays on "The NICU: Medical Realities," 10-11; "The NICU: Family Involvement," 40-41; and "The NICU: The Providers," 62-63. Nancy K. Rhoden compares decision-making strategies in the U.S., Great Britain, and Sweden in "Treating Baby Doe: The Ethics of Uncertainty," *Hastings Center Report* 16, no. 4 (1986) 34-42. See also William F. Carr, "Clinical Sessions and Health Care Ethics," *Linacre Quarterly* 53 (1986) 36-78, for an observer's report of decisions at Georgetown University Hospital.

<sup>66</sup> Robert F. Weir, "When Is It Justifiable Not To Treat?" *Second Opinion* 2 (July 1986) 48-50; David S. Levin, "John T. Noonan and Baby John Doe," *Philosophy in Context* 14: *Medical Ethics*, ed. Richard M. Fox (Cleveland: Department of Philosophy of Cleveland State Univ., 1984) 35-41. In a provocative exploration of the concept "person" in relation to brain-damaged individuals, G. R. Gillet suggests that it is not a formal definition of a class, but a notion acquired through interaction with others, comprising personal identity, quality of life, and responsibility for self ("Why Let People Die?" *Journal of Medical Ethics* 12, no. 2 [1986] 83-86).

necessary? Estimated potential for the development of characteristics such as rationality, self-consciousness, and ability to love may be relevant not only to the status of the newborn in the human community, but even to whether continued life is in his or her best interests. Beyond the child's interests, is it morally legitimate to consider benefits and burdens to his or her parents and family, or even to broader communities responsible for medical, social, and economic support? If adequate support almost certainly will be lacking, in what way is that fact relevant to the child's quality of life?

Case precedents (Baby Doe of Bloomington, Ind., and Baby Jane Doe of Port Jefferson, N.Y.), federal intervention (the DHHS "Baby Doe Rules," abrogated in June 1986 by the U.S. Supreme Court), a new law (the Child Abuse Amendments, passed by Congress in 1984, and the DHHS guidelines for their interpretation) have been detailed frequently<sup>67</sup> and will be familiar to many from daily press coverage. Less clear are similarities and differences among cases, and consistent lines of legal and moral analysis. What is certain is that the two key court cases differ significantly, although in each a parental decision to withhold life-sustaining treatment was challenged with a law suit. From a moral point of view, the prognosis for the baby makes a difference. While Baby Doe had a repairable digestive-tract deformity and Down's syndrome, Baby Jane Doe suffered spina bifida, hydrocephaly, and microcephaly, which were predicted to result in serious, permanent physical and mental impairment. The now-overturned DHHS regulations, by mandating treatment of "handicapped" infants under the aegis of nondiscrimination, largely begged the question whether a handicap can be relevant to the patient's best interests. As Moskop and Saldanha state it, "The policy assumes . . . that noncomatose, nonterminal life is always preferable to nonexistence; it expressly prohibits consideration of the future quality of life of the infant."<sup>68</sup> Representatives of pediatric specialties<sup>69</sup> observe

<sup>67</sup> See Mary B. Mahowald, "In the Interest of Infants," *Philosophy in Context*, 9-10; Brian Johnstone, "The Sanctity of Life, the Quality of Life, and the New 'Baby Doe' Law," *Linacre Quarterly* 52 (1985) 258-60; Dennis J. Horan and Burke J. Balch, "Infant Doe and Baby Jane Doe: Medical Treatment of the Handicapped Newborn," *ibid.* 45-76; John C. Moskop and Rita L. Saldanha, "The Baby Doe Rule: Still a Threat," *Hastings Center Report* 16, no. 2 (1986) 8-14; legally most up-to-date: George J. Annas, "At Law: Checkmating the Baby Doe Regulations," *Hastings Center Report* 16, no. 4 (1986) 29-31, and "Supreme Court 'Baby Doe' Ruling Will Have Little Effect on Catholic Hospitals," which gives a concise legal history and cites the Supreme Court Opinion (*Catholic Health World* 2, no. 14 [1986] 1, 4).

<sup>68</sup> Moskop and Saldanha, "The Baby Doe Rule" 9.

<sup>69</sup> David K. Stevenson, M.D., Ronald C. Ariagno, M.D., Jean S. Kutner, Thomas A.

not only that often it only gradually becomes evident that continued treatment is unlikely to further the "best interest" of the child, but also that parents and medical-caregivers are the best judges of best interests,<sup>70</sup> and that "the familial and societal contributions to the 'quality of life' cannot be excluded."<sup>71</sup>

### *Quality of Life*

If quality of life is to be used as a criterion in the determination of "best interests," then a key and difficult question is, what is to constitute a life of minimally acceptable quality (seen, to the extent possible, from the child's perspective)? Developing a position put forward over a decade ago, Richard McCormick suggests that a life with a quality which would be to the child worth preserving is one which holds out the prospect of a level of consciousness adequate to participation in human relationships.<sup>72</sup> McCormick links his criterion of "relational potential" to the Roman Catholic tradition as expressed by Pius XII, arguing that physical life is an important but limited value, serving to make possible the attainment of a more important good: love of God and neighbor. When that good is for physical reasons not accessible, then medically-dependent life may be permitted to end. In recent restatements McCormick emphasizes the grounding of his norm in religious themes and dispositions (the Christ-event, God's healing grace, the cross, providential care)<sup>73</sup>; that it is not a social-utility standard; that the lifelong interests of the child should predominate; and that, while parents are the most appropriate proxies, their decision must be subjected to an "objective" standard (reasonable expectation of relational potential).

Some respondents to McCormick's proposal follow and interpret it, others modify it, others dispute and reject it. Most importantly, the discussion quickly fans out to include other incompetent individuals. In

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Raffin, M.D., Ernie W. D. Young, "The 'Baby Doe' Rules," *Journal of the American Medical Association* 255 (1986) 1909-12.

<sup>70</sup> J. K. Mason and David W. Meyers, "Parental Choice and Selective Nontreatment of Deformed Newborns: A View from Mid-Atlantic," *Journal of Medical Ethics* 12, no. 2 (1986) 67-71, argue that in both the U.S. and U.K., parents have primary responsibility, should and generally do adhere to the infant's welfare, and that this does not always entail indefinite prolongation of life.

<sup>71</sup> Stevenson et al., "The 'Baby Doe' Rules" 1912. Marcia Angell, M.D., "The Baby Doe Rules," *New England Journal of Medicine* 314 (1986) 642-44, also defends proxy refusal for infants of therapy not in their long-term interests. See follow-up, "Correspondence: The Baby Doe Controversy," *NEJM* 314 (1986) 707-8; William G. Bartholome, "Imperiled" 39.

<sup>72</sup> The original statement is "To Save or Let Die," *Journal of the American Medical Association* 22 (1974) 172-86; also published in *America* 130 (1974) 6-10.

<sup>73</sup> McCormick, "The Best Interests of the Baby" 19-20.

the first category, James J. Walter argues the suitability of McCormick's relationality standard as a "public policy option."<sup>74</sup> Walter interprets McCormick as moving from humanity's "essential sociality" to a normative moral order in which reasonably discerned "best interests" are that which patient-centered care ought serve. Both "natural inclinations" and "the Christian story" are claimed to reveal human flourishing as consisting in relationships, without the potential for which prolonging life is an offense against human dignity.<sup>75</sup>

Some of the difficulties in claiming (as Catholics do frequently) that any particular policy of medical care is consistent with or even mandated by Christian commitment are confronted directly by the Lutheran theologian Karen Lebacqz. She prefaces her use of Exodus to illumine NICU decisions with a caveat: "I do not presume . . . that these resources . . . will be applicable for those from other faith traditions or for all struggling believers within my own tradition."<sup>76</sup> Focusing on the experience of the parents, Lebacqz selects "the paradigmatic wilderness wanderings of the ancient Israelite people" to interpret disruption of normalcy, uncertainty, loss of control, loss of identity; and to suggest that parents, like the Israelites, have to redefine their reality and their hopes, and to share in a decision-making process with their medical "leadership."<sup>77</sup> Lebacqz's sensitive development of her images demonstrates the fruitfulness of the ethicist's return to Scripture, but also reveals the particularity of the biblical world view, better realized through immersion in the details of narrative than in the abstraction of broad theological themes from the texts.

A problem still under discussion in relation to McCormick's proposal is refinement of a more precise notion of a minimally acceptable potential for relationships.<sup>78</sup> More recently, McCormick has incorporated the suggestion of Edmund Pellegrino<sup>79</sup> that "best interests" includes medical good, patient preferences, the good of the human as human, and "the good of last resort," the good in which one finds the ultimate meaning of life.<sup>80</sup> Philosopher Robert Weir further specifies this elusive standard by

<sup>74</sup> James J. Walter, "A Public Policy Option on the Treatment of Severely Handicapped Newborns," *Laval théologique et philosophique* 41 (1985) 239-50.

<sup>75</sup> *Ibid.* 246.

<sup>76</sup> Karen Lebacqz, "Imperiled in the Wilderness," *Second Opinion* 2 (1986) 27.

<sup>77</sup> *Ibid.* 27-31.

<sup>78</sup> E.g., McCormick, "Best Interests" 22. See also Mahowald, "In the Interest of Infants" 16.

<sup>79</sup> Edmund D. Pellegrino, M.D., "Moral Choice, The Good of the Patient, and the Patient's Good," in *Ethics and Critical Care Medicine*, ed. J. C. Moskop and L. Kopelman (Dordrecht, Holland: D. Reidel, 1985) 117-38.

<sup>80</sup> McCormick, "Best Interests" 22-23.

reaching for better philosophical categorization: "beneficial treatment" can be immediately helpful, corrective, curative, or therapeutically experimental. "Harms" can include interference with interests, impairment of mental and psychological welfare, or physical injury.<sup>81</sup> Weir defends selective nontreatment decisions, preferably made on the basis of "diagnostic categories" rather than of *ad hoc* evaluation of individuals, since this policy would best meet the tests of nonmaleficence and justice. A secondary and supplementary method, to be used within some established diagnostic categories (spina bifida) or outside the parameters of established categories (multiple anomalies), is reliance on the view of primary decision-makers that certain treatments are morally "optional" because "nonbeneficial or possible harmful."<sup>82</sup> Weir warns of the ethical and legal possibility of wrongful life suits against neonatologists and others who prolong life without sufficient medical and moral cause.<sup>83</sup>

In an essentially philosophical translation of McCormick's theologically-grounded view that life is an instrumental value serving the ends of higher, interpersonal values, Susan Braithwaite and David Thomasma develop criteria within a general "anti-cruelty policy" on "foregoing life-sustaining treatment."<sup>84</sup> This policy is based on a patient-centered judgment about the overall anticipated quality of the patient's life subsequent to therapy. State the authors:

To perpetuate the effects of a hopeless injury, without prospect of benefit, is an act of commission from which we are morally constrained . . . By hopeless injury we mean a condition in which there is no potential for growth or repair; no observable pleasure or happiness in living aside from immediate and transitory physical satisfaction; and a total absence of one or more of the following attributes

<sup>81</sup> Weir, "When Is It Justifiable?" 54–56.

<sup>82</sup> *Ibid.* 59.

<sup>83</sup> *Ibid.* 60. See also Bonnie Steinbock, "The Logical Case for 'Wrongful Life,'" *Hastings Center Report* 16, no. 2 (1986) 15–20.

<sup>84</sup> Susan Braithwaite, M.D., and David C. Thomasma, "New Guidelines on Foregoing Life-Sustaining Treatment in Incompetent Patients: An Anti-Cruelty Policy," *Annals of Internal Medicine* 104 (1986) 711–14. In an essay published almost simultaneously, Thomasma develops the notion of a "rational treatment plan" as one which takes into account medical standards and consensus, patient preferences, the effects of the particular treatment proposed, and also general quality of life ("Philosophical Reflections on a Rational Treatment Plan," *Journal of Medicine and Philosophy* 11 [1986] 157–65). Using "quality of life" as a standard for selection among treatment options, for competent or at least conscious patients, Alan Cribb attempts a balance between subjective and objective elements. While not every patient preference is reasonable, it is valid to consider the individual combination of physical, psychological, and social factors of which the treatment plan will be a part ("Quality of Life—A Response to K. C. Calman," *Journal of Medical Ethics* 11, no. 3 [1985] 142–45).

of quality of life: cognition or recognition, motor activity, memory or awareness of time, consciousness, and language or other intelligent means of communicating thoughts or wishes.<sup>85</sup>

Unfortunately, they try to illustrate their definition with the case of a severely retarded teenager with cancer, who, however, does not seem to fall within the above parameters, since it is reported that there was “an obvious social bond between the patient and his family and nurses.”<sup>86</sup> What the case may illustrate best is the difficulty of developing any hard and fast “guidelines” with which to steer decision-makers through the moral morass in which they must necessarily navigate when bringing about death.

One important modification of the “best interests” and “quality of life” tests as represented by McCormick is the more explicit introduction of social and economic considerations into the determination of long-term prospects for a critically-ill newborn. McCormick expressly prefers to avoid such factors but feels constrained at least to phrase the question, “do the sometimes staggering costs of neonatal intensive care mean that at some point the economics of care determine the meaning of best interests?”<sup>87</sup> Others are more direct and (unlike McCormick) include the psychosocial setting as well as the financial one. Gary E. Jones, debating with John Arras’ insistence that socially induced burdens are morally irrelevant to treatment decisions,<sup>88</sup> asks: “If parental neglect, social rejection, or poor care due to inadequate funding cause life to be not worth living, would they not be as significant to the child as his purely medical problems?”<sup>89</sup> Jones agrees with Arras that the “desired result” is “equitable treatment for poor, institutionalized infants,” but still holds that it “is simply not clear” that, given present conditions, justice to individual infants does not require consideration of the socioeconomic support they actually stand to receive.<sup>90</sup>

The danger of a slide toward social-utility evaluations causes some authors to resist strongly any “quality of life” language whatsoever. Protestant ethicist Arthur J. Dyck is concerned that infants not be judged in terms of social worth, and advises that “Infants with disabilities

<sup>85</sup> Ibid. 711.

<sup>86</sup> Ibid. 712.

<sup>87</sup> McCormick, “Best Interests” 21.

<sup>88</sup> John D. Arras, “Toward an Ethic of Ambiguity,” *Hastings Center Report* 14, no. 2 (1984) 25–33.

<sup>89</sup> Gary E. Jones, “Non-Medical Burdens of the Defective Infant,” *Philosophy in Context* (n. 66 above) 29.

<sup>90</sup> Ibid. 32.

are to receive the same care expected for infants generally.<sup>91</sup> Prolife lawyers Horan and Balch set the "right to life" of handicapped children off against a parental "private decision" based on their judgment of the quality of the child's life and of "the degree of burden he or she will pose for their family or society."<sup>92</sup> A joint statement of the American Jewish Congress and the NCCB's Committee for Pro-Life Activities<sup>93</sup> affirms the "sanctity" and "dignity" of human life, and acknowledges that parents may feel pressured by economic constraints, but asserts that nondiscrimination excludes withholding treatment "merely" because a person is handicapped. Although any quality-of-life language is avoided, handicap still is regarded as relevant if "it substantially decreases the benefit or increases the burden of a particular treatment." Thus the "benefit and burden" factors usually associated with quality of life are retained in the moral evaluation, although the phrase is avoided, along with what are to some its unfortunate social and political implications.

John R. Connery argues, against McCormick, that it is not appropriate to interpret the traditional distinction of ordinary and extraordinary means in terms of a relationality criterion. Inferring appropriately that McCormick's discussion of infants could be extended to other life-prolonging situations, Connery objects that the consideration of the overall future quality of a person's life is a new factor in evaluation of "extraordinary" (optional) means of life support; this "quantum leap" in the tradition involves one who decides to forgo treatment in directly intending to cause death (the equivalent of "euthanasia").<sup>94</sup> According to Connery, McCormick is "adding a quality of life norm to the traditional quality of treatment norm already in place."<sup>95</sup> Connery argues that traditional interpretations of "extraordinary means," as those involving excessive burden to the patient, had reference to the impact of the use of that particular treatment on the condition of the person. Connery objects to general assessment of quality of life apart from treatment, if it is then used as a warrant for forgoing a treatment which does not itself add substantially to the burden of life.<sup>96</sup> Connery notes also that the

<sup>91</sup> Arthur J. Dyck, "The President's Commission for the Study of Ethical Problems in Medicine: Its View of the Right to Life," *Linacre Quarterly* 52 (1985) 115.

<sup>92</sup> Horan and Balch, "Infant Doe" 45. See also Orville N. Griese, "Applying the Child Abuse Amendments of 1984 to Actual Cases," *Ethics and Medics* 10, no. 7 (1985) 3, who accepts consideration of "benefits" but not "quality of life."

<sup>93</sup> "Treatment of Handicapped Newborns," signed by Edward M. Bryce and Michael Wyszogrod, *Origins* 15 (1985) 192.

<sup>94</sup> John R. Connery, "Quality of Life," *Linacre Quarterly* 53 (1986) 26, 31-32.

<sup>95</sup> *Ibid.* 21.

<sup>96</sup> John R. Connery, "In the Matter of Claire Conroy," *Linacre Quarterly* 52 (1985) 321-28.



traditional test of optional means neither demanded that burdens clearly outweigh benefits, nor that they be limited to physical pain. Any “excessive” burden was enough to disqualify a treatment as “ordinary,” and burden “would include other hardships—cost, or anything else the patient would consider burdensome.”<sup>97</sup>

Connery is explicitly concerned that quality-of-life considerations will be merged with social-utility considerations. He worries, “it seems contradictory to rule out personal worth as a criterion and, at the same time, include the patient’s quality-of-life with treatment. It is not easy to see the difference between the two.”<sup>98</sup> However, it is arguable that quality of life is precisely the issue of stake in the traditional definitions, even though the sphere of its consideration is limited to the impact of a particular means. This boundary functions practically as a “wedge blocker” or “slope stopper.” As Connery observes, neither expense nor burden to others is definitively excluded by the tradition. The present task for moral theology appears to be a more precise (and possibly expanded) definition of the proper scope of quality-of-life considerations—not their exclusion. If considerations of social impact can be advanced in terms of “justice,” it may be possible to forestall a slide into mere “social utility.”

Like Connery, Brian Johnstone expresses concern about possible implications of a “quality of life ethic,” which he thinks “rejects the equality of human persons,”<sup>99</sup> He also wonders whether it is true that a life without relationships is not a good to that “person.”<sup>100</sup> Johnstone prefers a “‘sanctity of life’ ethic,” which he sees as phrasing the problems not in terms of value of life but in terms of extent of duty to preserve life, and thus as manifesting greater respect for fundamental equality. The

<sup>97</sup> Ibid. 325. Cf. Gerald Kelly, *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1957) 135, in which is found the “classic” definition: “in terms of modern medical procedures, extraordinary means of preserving life are all medicines, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience, for the patient or for others, or which, if used, would not offer a reasonable hope of benefit to the patient.”

<sup>98</sup> Ibid. 325. Michael E. Allsopp voices similar concerns about McCormick’s original “relational potential” standard, seeming to see it as inconsistent with “Revelation”; see “The Defective Infant: Christian Standards,” (London) *Tablet* 238 (1984) 688–89. In “Early Management and Decision-Making for the Treatment of Myelomeningocele at the University of Oklahoma Health Sciences Center: Observations Clinical and Ethical,” *Linacre Quarterly* 53 (1986) 56–65, Allsopp approvingly perceives a recent stronger stress by McCormick on the best interests of the infant.

<sup>99</sup> Brian V. Johnstone, “The Sanctity of Life, the Quality of Life and the New ‘Baby Doe’ Law,” *Linacre Quarterly* 52 (1985) 261.

<sup>100</sup> Ibid. 263.

center of the sanctity-of-life standpoint is what the patient can be assumed to desire, given our common humanity. One assumes, for instance, that a reasonable moral agent would not choose to continue in a life whose physical "pain and suffering" would exceed "human moral strength";<sup>101</sup> the reasonable patient would not want to impose a disproportionate burden on his or her family.<sup>102</sup> Johnstone's commitment to language which safeguards against utilitarian thinking is evident, but his position seems to be the practical equivalent of McCormick's approach via a reasonable construal of best interests. Dennis Brodeur comments prudently: "If terms like 'quality of life' and 'sanctity of life' are used correctly, they need not be perceived as polar opposites. One can maintain the sacredness of life and avoid arbitrary and false judgements while also considering the quality of a person's life as he or she pursues the ends or goals of life."<sup>103</sup>

### *Adults: Special Problems*

In infants' cases, parents are readily identified proxies, in consultation with physicians, and barring judicial intervention. Obviously, the child will not have expressed a prior view, and his or her interests will be determined by attempting a reasonable and objective assessment of treatment options, life prospects, and perhaps economic and social costs. Adults, however, may have previously made known their preferences. If not, then resort must be had to a reasonable interpretation of best interests; if so, then determination of appropriate care may be simplified by recourse to previously-expressed patient choice. The so-called "living will" is one instrument for such expression and has been legalized in various forms in several states. Some authors, like Robert Barry and Thomas J. O'Donnell, see this legislation as a tool of "the euthanasia movement,"<sup>104</sup> invoking language such as "a right to die" to "soften up . . . resistance to . . . merciful murder."<sup>105</sup> More realistically, they point out that key terms of such legislation, such as "incompetency," "terminal illness," and "extraordinary treatment," are inadequately defined; that

<sup>101</sup> Ibid. 268.

<sup>102</sup> Ibid. 264-67.

<sup>103</sup> Dennis Brodeur, "Feeding Policy Protects Patients' Rights, Decisions," *Health Progress* 166, no. 6 (1985) 43. Brodeur refers to an earlier essay by John Connery, "The Clarence Herbert Case: Was Withdrawal of Treatment Justified?" *Hospital Progress* 65, no. 2 (1984) 32-35, 70.

<sup>104</sup> Robert Barry, "The Dark Side of Living Wills," *CGA World* 6, no. 2 (summer 1986) 20-21.

<sup>105</sup> Thomas J. O'Donnell, "Guidelines for Legislation of Life-Sustaining Treatment," *Linacre Quarterly* 52 (1985) 205.

documents prepared in advance of the critical situation can short-circuit sensitivity to special needs; and that they encourage "a pure patient autonomy model."<sup>106</sup> John Paris, on the other hand, revokes previous opposition to living wills, in view of a technological attitude which subjects patients to inappropriate treatments. In order to support morally-valid decisions to forgo "extraordinary means," legislation may be necessary.<sup>107</sup>

The NCCB Committee for Pro-Life Activities provides an outline for acceptable legislation, based on a "stewardship of life" ethic recognizing a limited duty to preserve life.<sup>108</sup> Its religiously-sponsored definition of extraordinary means appeals to human "dignity" and so can ground policy in a society "founded on" belief in "the inalienable right to life." Ten guidelines affirm the right to receive treatment as well as to refuse it; the need to balance interests, including social concerns, in refusing treatment; a preference for consultation instead of "living wills"; the freedom of conscience of the physician; discontinuation of treatment only when it "secures a precarious and burdensome prolongation of life for the terminally ill patient," and does not amount to a "deliberate act or omission designed to cause a patient's death"; and a "presumption" in favor of "basic measures," including hydration and nourishment. The concluding sentence holds up "the sacredness of human life." At least four aspects of this statement are of note: quality-of-life language is again avoided, even while "benefits" and "hardship" are the criteria of treatments; social factors, such as the interests of the state and of the medical profession, are set out as limits on the right to *refuse* treatment, but not to the right to receive it; discontinuation of treatment is put in the context of terminal illness; a distinction is made between ending treatment which attains only "a burdensome prolongation of life" and any act or omission which "causes" a patient's death. The analysis behind the last formulations is not clear. Certainly, traditional definitions of extraordinary measures did not limit them to terminal illness. Next, unlike

<sup>106</sup> Barry, "Dark Side" 21.

<sup>107</sup> John Paris, "Living Will Legislation Reconsidered," *CGA World* 6, no. 2 (summer 1986) 18-19. This is a summary of an earlier essay by John J. Paris and Richard McCormick, "Living Will Legislation, Reconsidered," *America*, September 5, 1981, 86-89. Susan M. Krason begins a critical survey of legislation in "The Anatomy of 'Living Wills'—Part I," *Ethics and Medics* 11, no. 10 (1986) 1-2; to be continued in a subsequent issue.

<sup>108</sup> "Guidelines for Legislation on Life-Sustaining Treatment," available from the National Conference of Catholic Bishops, 1312 Massachusetts Avenue, Washington, DC 20005. The document cites the 1980 Vatican declaration on euthanasia; see the recent repetition of some of the declaration's themes by John Paul II in "Life and Death," address to scientists assembled by the Pontifical Academy of Sciences, Oct. 21, 1984; see *The Pope Speaks* 30 (1985) 351-54.

Connery, the authors do not appear to equate the "burden" definitive of such a means with the burdensomeness of the treatment itself, but with that of the life which is subsequently prolonged (including any burdensomeness of treatment). Yet without this limit it is not clear when they consider the omission of treatment to be "deliberate" and to "cause" a patient's death. It might be more fruitful to phrase the issue in terms of proportionate and disproportionate burdens (rather than in terms of the sort of intention one has to avoid them), since the most obvious mark of an immoral omission is a lack of "excessiveness" in the burden offered as a reason for not sustaining life.

The NCCB Pro-Life Committee also has addressed proposed uniform legislation on termination of treatment (the Uniform Rights of the Terminally Ill Act).<sup>109</sup> Its statement distances the bishops from active support and is limited to pointing out problems, while recognizing that the social policy task is "complex and difficult." For instance, the Committee calls for a clearer definition of "terminal illness," and criticizes "the Act's bias toward withdrawing treatment." As in its earlier statement, the Committee insists on a "strong presumption" in favor of artificial sustenance, and on maintaining all pregnant women. Some problems with the earlier document remain. Specifically, the Pro-Life Committee's extreme caution to avoid any appearance of legitimating unjust causation of death hampers its commendable attempts to balance obligations toward life against their limits. As a consequence, the call for better definitions is offset by unclarity about what it would mean to "intend to cause death" by an act of omission. It seems evident that any decision to withdraw treatment because of "burdensomeness"—whether of treatment itself or of life after it—entails a judgment not just that the treatment is to be avoided but that death would be better than the treatment's consequences. Further, the social ramifications of treatment decisions must come to be seen (and addressed) in their full complexity, not only in light of the threat that social policies and social attitudes can present to individual lives and the physician-patient relationship. Lives can be damaged equally, in their quality and in their very continuance, by policies and attitudes which focus on the "inviolability" of other, extremely debilitated lives, for whom great expenditures can do very little. Descriptive accounts from the medical literature demonstrate the pitfalls of medical practice in the absence of clear, socially-supported policies which acknowledge both resource shortages and the importance

<sup>109</sup> NCCB Committee for Pro-Life Activities, "Statement on Uniform Rights of the Terminally Ill Act," June 1986, available from the NCCB, 1312 Massachusetts Avenue, Washington, DC 20005.

of distributive justice. Several articles deal with the medical and moral ramifications of instituting DNR orders in ICU's.<sup>110</sup> Physicians making *ad hoc* resource-allocation decisions must reconcile conflicting loyalties to patients and to prudent and proportionate resource use.<sup>111</sup> One way to avoid the moral ambiguities both of individual-physician judgment and of advance declarations would be to accomplish earlier consultation of physicians with patients, and broader consultation among physician, family, and staff.<sup>112</sup>

### *Artificial Nutrition and Hydration*

The persistent questions about burdensomeness, intention, "causing" death, providing care, and quality of life are even more acute in debates about artificial sustenance than in those about other sorts of treatment termination. Highly publicized court cases—*Conroy*, *Jobes*, *Herbert*, *Hier*, *Brophy*—make this evident.<sup>113</sup> The March 1986 statement of the AMA

<sup>110</sup> Jack E. Zimmerman, M.D., William A. Knaus, M.D., Steven M. Sharpe, M.D., Andrew S. Anderson, M.D., Elizabeth A. Draper, R.N., and Douglas P. Magner, "The Use and Implications of Do Not Resuscitate Orders in Intensive Care Units," *Journal of the American Medical Association* (1986) 351–56; "Correspondence: 'Do Not Resuscitate Orders,'" *ibid.* 3114–15; Helene Levens Lipton, "Do-Not-Resuscitate Decisions in a Community Hospital: Incidence, Implications, and Outcomes," *JAMA* (1986) 1164–69. See also the combination of burden to patient, to staff, and hence to other patients, which led to the decision to end dialysis for a retarded man: I. M. Jessima, "Report of the Joint Ethico-Medical Committee on the Case of Derek Sage," *Catholic Medical Quarterly* 36, no. 4 (1985) 210–13.

<sup>111</sup> Percy Brazil, "Cost Effective Care Is Better Care," *Hastings Center Report* 16, no. 6 (1986) 7–8; Michael J. Strauss, M.D., James P. LoGerfo, M.D., James A. Yeltatzie, Nancy Temkin, Leonard D. Hudson, M.D., "Rationing of Intensive Care Unit Services: An Everyday Occurrence," *Journal of the American Medical Association* 255 (1986) 143–46; Allen R. Dyer, M.D., "Patients, Not Costs, Come First," *Hastings Center Report* 16, no. 1 (1986) 6.

<sup>112</sup> Cf. Susanna E. Bedell, M.D., Denise Pelle, R.N., Patricia L. Maher, R.N., Paul D. Cleary, "Do-Not-Resuscitate-Orders for Critically Ill Patients in the Hospital: How Are They Used and What Is Their Impact?" *JAMA* (1986) 233–37; Esther J. Dille, "Hospital Resuscitation Policy and the Right To Be Informed," *Hospital Progress* 67, no. 8 (1986) 8–9; Paul B. Hofmann and Frederick L. Smoot, "Care of the Comatose Patient: Building Mutual Staff Values," *Health Progress* 66, no. 4 (1985) 58–61; James F. Drane, "The Lessons of Quinlan," *Health Progress* 67, no. 6 (1986) 21; and Robert M. Veatch, "Defining the Family's Role in Treatment Decisions," *Health Progress*, 67, no. 8 (1986) 52, who cautions that society has a duty to intervene in unreasonable family decisions.

<sup>113</sup> An overview of the legal and policy implications of these cases is George J. Annas, "Fashion and Freedom: When Artificial Feeding Should Be Withdrawn," *American Journal of Public Health* 75 (1985) 685–88. Annas recommends that a legal guardian have the power to mandate withholding treatment, on the basis of patient wishes, or "best interests" based on a weighing of burdens and benefits. An earlier article, still much cited, is Joanne Lynn, M.D., and James F. Childress, "Must Patients Always Be Given Food and Water?" *Hastings*

Judicial Counsel, "Withholding or Withdrawing Life Prolonging Medical Treatment," approves termination of treatment for terminal patients and nondying patients in irreversible coma, and includes artificial nutrition and hydration among optional means.<sup>114</sup> In stark contrast stands the statement issued in October of the previous year by the Pontifical Academy of Sciences, which mandates that artificial feeding be provided in every case.<sup>115</sup>

Reviewing Catholic tradition (1949–84), James J. McCartney argues that withholding treatment, including artificial sustenance, "from terminally ill" patients can sometimes be justified, on the basis of "burdensomeness in terms of the physical, economic, psychological, or spiritual factors involved."<sup>116</sup> Yet even when treatment removed is "useless" or "too difficult to bear," the "direct intention" must not be "to kill the patient so he would no longer suffer."<sup>117</sup> Striking disagreement is voiced by Patrick Derr, who tries to distance artificial sustenance from artificial supports such as respirators and dialysis, saying that food is universally crucial to life, while the latter types of modern medical "armamentaria" are not.<sup>118</sup> Furthermore, Derr sees removal of artificial nutrition as aligned with attempts in Western society to "rid itself" of "undesirable" persons, and as eroding the integrity of the medical profession and its obligations.<sup>119</sup> Mark Siegler, M.D., and Alan J. Weisbard have similar reservations about the potential "wedge" effect of discontinuing artificial sustenance.<sup>120</sup> Protesting that removals of nutrition and fluids "bear the seeds of great potential abuse," they appear to construe "quality of life" judgments as the antithesis of "compassionate care" and to believe that physicians can and do avoid quality-of-life decisions.<sup>121</sup> Several unclari-

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*Center Report* 13, no. 5 (1983) 17–21. In the same issue Daniel Callahan expresses dissent ("On Feeding the Dying" 22–27) and Bonnie Steinbock expresses reservations about ambiguous cases ("The Removal of Mr. Herbert's Feeding Tube" 13–16).

<sup>114</sup> Statement of the Council on Ethical and Judicial Affairs of the American Medical Association, Opinion No. 2.15, March 15, 1986.

<sup>115</sup> "The Artificial Prolongation of Life," *Origins* 15 (1985) 415. The same issue (415–17) contains John Paul II, "The Mystery of Life and Death," which presents traditional teaching on use of painkillers.

<sup>116</sup> James J. McCartney, "Catholic Positions on Withholding Sustenance for the Terminally Ill," *Health Progress* 67, no. 8 (1986) 38.

<sup>117</sup> *Ibid.* 40.

<sup>118</sup> Patrick G. Derr, "Why Food and Fluids Can Never Be Denied," *Hastings Center Report* 16, no. 1 (1986) 29; supplied as "expert testimony" in the Massachusetts Brophy case.

<sup>119</sup> *Ibid.* 28–30.

<sup>120</sup> Mark Siegler, M.D., and Alan J. Weisbard, "Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?" *Archives of Internal Medicine* 145 (1985) 129–31.

<sup>121</sup> *Ibid.* 130.

ties which beleaguer the ongoing discussion are pinpointed by Richard McCormick in an essay on *Conroy*.<sup>122</sup> He reviews central contributions and concludes that Catholic tradition permits withdrawal of artificial nutrition, but that policy implications of so doing are serious and must be handled carefully. He observes that (1) the category “dying” is ambiguous and relative to technology available; (2) artificial hydration-nutrition has a symbolic import as “feeding” but is also medical compensation for a failed physical function; (3) the omission of any life-sustaining treatment “aims at death” only if the means is ordinary, i.e., useful and not too burdensome, which is the debated question regarding artificial sustenance; (4) “quality of life components” are “unavoidably present” in the burden/benefit balance. McCormick believes that it is essential to “draw the line at the right place,” and to err in favor of life, in the case of severely demented elderly persons like Claire Conroy.<sup>123</sup>

Applying similar insights to the AMA statement, Kevin O’Rourke observes that anticipation of “imminent death” or “terminal illness” should not figure as a key moral criterion, since, after all, all life-prolonging intervention by definition acts to circumvent a fatal pathology.<sup>124</sup> The obligation to so act depends on the patient’s ability “to pursue the purpose of life.” Though the purpose may be defined variously, all candidates—“happiness, fulfillment, love of God and neighbor, human relationships—imply some ability to function at the cognitive-affective or spiritual level.”<sup>125</sup> The burden under evaluation is that associated with striving for this purpose, not with the means in itself. In essential agreement with O’Rourke are comments of George Annas<sup>126</sup> and John Paris<sup>127</sup> on *Brophy*.

<sup>122</sup> Richard A. McCormick, “Caring or Starving? The Case of Claire Conroy,” *America* 152 (1985) 269–73.

<sup>123</sup> *Ibid.* 272–73. See also William J. Curran, “Defining Appropriate Medical Care: Providing Nutrients and Hydration for the Dying,” *New England Journal of Medicine* 313 (1985) 9440–42. Curran prefers a “best interests” (similar to McCormick), not “substituted judgement” (reliance on patient’s previously indicated preferences), and recommends the possibility of an ombudsman for nursing-home patients.

<sup>124</sup> Kevin O’Rourke, “The AMA Statement on Tube Feeding: An Ethical Analysis,” *America* 155 (1986) 321–23, 331. In the same issue Robert Drinan argues that moral ambiguities surrounding tube feeding are not likely to be soon settled by the courts: “Should Paul Brophy Have Been Allowed To Die?” *America* 155 (1986) 324–25, 332. See also Kevin O’Rourke, Commentary on the AMA Statement “Withholding or Withdrawing Life-Prolonging Medical Treatment,” *Medical-Moral Newsletter* 23, no. 8 (1986) 1–3.

<sup>125</sup> *Ibid.* 322.

<sup>126</sup> George Annas, “Do Feeding Tubes Have More Rights than Patients?” *Hastings Center Report* 16, no. 1 (1986) 26–28.

<sup>127</sup> John J. Paris, “When Burdens of Feeding Outweigh Benefits,” *ibid.* 31–32; supplied as “expert testimony” in *Brophy*.

Eugene Diamond is convinced that considerably more care needs to be devoted to "line drawing" in tube-feeding cases, lest blanket permission of withdrawal be applied to patients who are demented but not dying, under motivation of "cost containment"—far from the best interest of the patient. He warns that "The fabric of society is threatened by a drift toward the unscrupulous restriction of care out of cost benefit considerations," and fears "the slippery slope of death worship."<sup>128</sup> Despite the hyperbole, Diamond addresses valid concerns about proper valuation of life even as a biological process, and the level of cognitive-affective capacity which makes life "worth living," even to the patient. Uncertainty in this area is particularly troubling in the case of elderly persons who lose function gradually and sometimes ambiguously, and for whom the balance may be tipped against life prolongation because their potentials for personal fulfilment and social contribution are waning.

*Elizabeth Bouvia*

It is precisely "substantial benefit" which should function as the moral criterion for use of artificial sustenance. This fact comes into focus through the drama of Elizabeth Bouvia, an intelligent and articulate quadriplegic with painful arthritis, who sought to refuse food and so end in death an existence which to her was not worthwhile. Insisting on her freedom to act on this judgment, she also has sought medical co-operation in her dying process. Although the course of events continues, and her determination to die is not ultimately certain, a California appellate court has granted Bouvia the right to refuse nutrition and hydration while remaining in a health-care facility. A concurring opinion by Judge Lynn D. Compton affirmed Bouvia's prerogative to expect medical support in effecting a quick and painless death. Some see this decision as a move toward legalized euthanasia, abetted by conscription of the medical system. Robert Barry interprets Bouvia's decision as the moral equivalent of suicide by starvation, since a nasogastric tube "was just normal and minimal care."<sup>129</sup> By dismissal of any quality-of-life considerations, an important standard for evaluating the moral status of *Bouvia* is forfeited. In a balanced piece which draws on McCormick and Catholic tradition, Corrine Bayley also objects to the decision. Yet her reason is not that artificial sustenance is always an "ordinary" means, but more centrally because it accedes to Bouvia's conclusion that a life of dependency is a

<sup>128</sup> Eugene F. Diamond, M.D., "Nutrition, Hydration, and Cost Containment," *Linacre Quarterly* 53 (1986), quotations from 31, 25 respectively.

<sup>129</sup> Robert Barry, "The Elizabeth Bouvia Case: Legalizing Euthanasia by Legal Injection," *Linacre Quarterly* 53 (1986) 13.



life without meaning.<sup>130</sup> The court completely fails to employ any objective standard of quality of life beyond what Bouvia herself considers adequate and acceptable. Like Diamond and Barry, Bayley expresses concern about unlimited autonomy and a social climate increasingly receptive to direct euthanasia, and stresses that the Judeo-Christian tradition has held up not only individual dignity and freedom but the interdependence of all. Although under some medical conditions withdrawal of artificial nutrition could be justified, better medical and interpersonal support might have circumvented the demand for this outcome in Bouvia's case. When factors which reduce life's quality are not the relatively direct consequences of an irreversible physical condition, then acquiescence to death is not a morally appropriate resolution. Bayley receives support on this point from clinical practitioners Steinbrook and Lo,<sup>131</sup> who add that patients refusing life-saving therapy have neither a legal nor a moral right to assistance from dissenters from their decision.

*Individual Rights, Social Justice, and Health-Care Policy*

The Bouvia episode illustrates the dangers of American individualism, enshrined increasingly in judicial and legislative recognition of a "right to privacy" inadequately restrained by consideration of duties to oneself and others, and of the less direct effects of one's choices on the common good. The excesses of individualism have been decried frequently by those who see in termination-of-treatment decisions a danger to individuals whose social contribution is low and whose dependency is high. However, this critique manifests its own individualist bias to the extent that it concentrates on the rights of isolated patients whose social and financial circumstances permit a high level of medical and technical support.

Sensitivity to the problem of just resource distribution, in relation to the cost of high-technology care for a few, is heightening across a range of literature—medical, philosophical, and theological. The Catholic Health Association has recently completed an important report, "No Room in the Marketplace: The Health Care of the Poor."<sup>132</sup> Centered on

<sup>130</sup> Corrine Bayley, "The Case of Elizabeth Bouvia: A Strain on Our Ethical Reasoning," *Health Progress* 67, no. 6 (1986) 44. See also Robert Steinbrook, M.D., and Bernard Lo, M.D., "The Case of Elizabeth Bouvia: Starvation, Suicide, or Problem Patient?" *Archives of Internal Medicine* 146 (1986) 161–64; George Annas, "Elizabeth Bouvia: Whose Space Is This Anyway?" *Hastings Center Report* 16, no. 2 (1986) 24–38; and Francis I. Kane, "What Nurses Profess: The Elizabeth Bouvia Case," *Health Progress* 66, no. 6 (1985) 52–55.

<sup>131</sup> See n. 130 above.

<sup>132</sup> An abridged version is published in *Health Progress* 67, no. 6 (1986) 87–89, accompanied by responses from Edward J. Ryle, Eli Ginzberg, Terrance Keenan, and Robert Morneau.

the "option for the poor" which figures prominently in the recent NCCB pastoral on economic justice,<sup>133</sup> the report presents forceful evidence of the inequities of health-care access in the U.S. Observing that "All cost containment measures are not the same,"<sup>134</sup> it broadens the context of medical-resource allocation; the social-justice issue is not cost-cutting for the benefit of insurers and for-profit medical facilities, but the larger issue of redistributing money saved in order to benefit those presently deprived not only of adequate health care but of many social goods. The report does not stop at general exhortation but provides many specific action recommendations for the CHA itself, member health facilities, parishes, dioceses, and government.<sup>135</sup> In recent addresses Cardinal Joseph Bernardin has raised similar questions, as not incompatible with the "sacredness of every life."<sup>136</sup> He points out repeatedly that there is moral inconsistency in the fact that a minority, including newborns and the dying, receive aggressive and expensive crisis intervention, while at the same time others do not have basic and preventive care (for instance, before birth).<sup>137</sup> "We must defend the right to life of the weakest among us; we must also be supportive of the quality of life of the powerless among us: the old and the young, the hungry and the homeless, the undocumented immigrant and the unemployed worker, the sick, the disabled and the dying." Government intervention, as in tax and welfare policy, may be necessary.<sup>138</sup> Philosophical essays suggest likewise that broad, revisionist policies are necessary to ensure that actual resource consumption will be directed away from high-cost, limited-benefit ex-

<sup>133</sup> See below, John Langan's segment of these "Moral Notes."

<sup>134</sup> "No Room in the Marketplace" 90.

<sup>135</sup> Peter J. Henriot goes further yet, urging that an "option for the poor" in health care implies involvement in changing other policies and institutions which affect the poor in our society ("Option for the Poor," *Catholic Health World* 2, no. 12 [1986] 20).

<sup>136</sup> "The Consistent Ethic of Life," *Health Progress* 67, no. 6 (1986) 48-51; and "Health Care and the Consistent Ethic of Life," *Origins* 15 (1985) 36-40.

<sup>137</sup> "Health Care" 38-40.

<sup>138</sup> *Ibid.* 38. While the ethics and mechanisms of redistribution are problematic in the U.S., the framework of analysis widens and becomes more complex when values and policies in other countries and cultures are examined. A shortage of resources for the elderly in Great Britain is criticized by Simon A. Brooks in "Dignity and Death: A Reply," *Journal of Medical Ethics* 11, no. 2 (1985) 84-87. Martien Prjnenburg discusses American and other theories of health-care distribution in relation to Catholic social teaching in "Rechtvaardige verdeling in de gezondheidszorg," *Tijdschrift voor theologie* 26, no. 1 (1986) 62-76 (English summary). That non-Western cultures can challenge the U.S. view of individual rights is evident in "Caring for Newborns: Three World Views" [Israel, Japan and India, Nepal and Sri Lanka] by Arthur I. Edelman, K. N. Siva Subramanian, and Rihito Kimura, *Hastings Center Report* 16, no. 4 (1986) 18-23; and John Kilner, "Who Shall Be Saved? An African Answer," *Hastings Center Report* 14, no. 3 (1984) 18-26.

penditures, and toward similar treatment for similar cases within consistently defined categories.<sup>139</sup> Reviewing recent books,<sup>140</sup> Cynthia Cohen observes that, resources being limited, the “new Orthodoxy” of patient autonomy may be about to topple.<sup>141</sup> Tristram Engelhardt and Michael Rie, in a more radical proposal, are willing to permit unequal treatment, at socially-agreed-upon levels, for those who have lost out in the “natural and social lotteries” of health, ability, and wealth.<sup>142</sup>

It is clear from the number and variety of recent contributions on forgoing life-sustaining treatment that future analyses, to be fruitful, will need to transcend some persistent polarities and aim for an integrated approach which (1) overcomes individualism, whether of the “sanctity of life” or “autonomous choice” variety; (2) distinguishes as clearly as possible between quality-of-life considerations and utilitarian views of the person; (3) explores and balances the multiple factors associated with traditional Catholic definitions of extraordinary means, especially burden to self, expense, and burden to others; (4) focuses on the extent of individual rights and duties in relation to the common good; (5) cooperates, in an atmosphere as free as possible from inflammatory rhetoric, toward social policies which distribute health care and other social goods equitably; (6) maintains respect for and fairness toward those who for reasons of social justice will not have access to the highest levels of medical technology.

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#### VIRTUE AND AMERICAN CULTURE

Can Americans make sense when discussing moral issues? Recently two major works have posed this fundamental question. Philosopher Alasdair MacIntyre comes to a negative conclusion in *After Virtue*.<sup>143</sup> In *Habits of the Heart* sociologist Robert N. Bellah and his colleagues report the disarray of our moral language, but believe it can be renewed by

<sup>139</sup> Albert R. Jonsen advises, without much optimism, against the development of the costly artificial heart: “The Artificial Heart’s Threat to Others,” *Hastings Center Report* 16, no. 1 (1986) 9–11.

<sup>140</sup> Moskop and Kopelman, *Ethics and Critical Care Medicine* (n. 79 above); and James P. Orlowski and George A. Kanoti, eds., “Ethical Moments in Critical Care Medicine,” symposium issue of *Critical Care Clinics* 2/1 (Philadelphia: W. D. Saunders, 1986).

<sup>141</sup> Cynthia Cohen, “Can Autonomy and Equity Coexist in the ICU?” *Hastings Center Report* 16, no. 5 (1986) 39–41.

<sup>142</sup> H. Tristram Engelhardt, M.D., and Michael A. Rie, M.D., “Intensive Care Units, Scarce Resources, and Conflicting Principles of Justice,” *Journal of the American Medical Association* 255 (1986) 1159; cf. 1160, 1163–64.

<sup>143</sup> Alasdair MacIntyre, *After Virtue* (Notre Dame, Ind.: Univ. of Notre Dame, 1981).