

BIOETHICAL DECISIONS TO END LIFE

The literature on decisions to forego life-prolonging treatment for the patient with a fatal or severely debilitating medical condition continues to proliferate. Can one hope to add to the probings and sortings performed on the already voluminous debates of years past?¹ Current authors continue to nuance the now classic Roman Catholic distinction between "ordinary" (mandatory) and "extraordinary" (optional) means of life support,² and to do so in reaction to developing uses of medical technology and to court cases regarding removal of treatment. But despite continuity in the way issues are framed, recent literature also bears distinctive colorations. Taking an ever higher profile are artificial nutrition and hydration, direct euthanasia, and the economic consequences for those at the margins of the health care system of an aggressive war against the deaths of irremediably fragile patients.

First, one catalyst to the "extraordinary" or "disproportionate" means debate has been withdrawal of artificial sustenance from individuals in a "persistent vegetative state" (PVS),³ highlighted last year by the Supreme Court's decision in *Cruzan*. Second, end-of-life decisions have shifted ever more decisively onto new ground with the burgeoning vigor of an international movement to legalize direct euthanasia. In 1984, the Netherlands Supreme Court virtually removed legal sanctions against physicians performing euthanasia. Thirdly, contemporary Catholicism's emphasis on the "preferential option for the poor" increasingly draws attention to potential conflicts between the perceived medical needs of

¹ Responses in recent "Notes" are Richard A. McCormick, S.J., "Notes on Moral Theology: 1983," *TS* 45 (1984) 115-19; and Lisa Sowle Cahill, "Notes on Moral Theology: 1986; Sanctity of Life, Quality of Life, and Social Justice," *TS* 48 (1987) 105-23. A bibliographical essay is James J. Walter, "Termination of Medical Treatment: The Setting of Moral Limits from Infancy to Old Age," *Religious Studies Review* 16 (1990) 302-07; see the 163-page international and interdisciplinary bibliography, *La morte, il morire oggi/Death and Dying Today*, published by the Gruppo di Ricerca "Active Aging" (Rome: Università Cattolica del Sacro Cuore, Facoltà di Medicina e Chirurgia "A. Gemelli," 1989). The present essay will represent primarily journal literature of 1988-90, especially debates within Roman Catholicism.

² The standard formulation is Gerald A. Kelly, S.J., *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1957) 128-41.

³ In a focus section on PVS, the *Hastings Center Report* (18/1 [1988] 26-47) featured Susan M. Wolf, Ronald E. Cranford, Baruch A. Brody, Paul W. Armstrong and B. D. Cohen, and Daniel Wikler. Cranford estimates 5,000 to 10,000 PVS patients in the U.S. Although they have permanently lost the capacity for consciousness, the intact brainstem maintains heartbeat and respiration, allowing them to survive for up to 20 years or even longer in a "vegetative" state. In most cases, fluids and nutrition are provided by medical means such as nasogastric tubing or gastrostomy ("The Persistent Vegetative State: The Medical Reality [Getting the Facts Straight]" 31).

those enjoying access to relatively high levels of treatment, and distributive justice in providing a "decent minimum" of care to all. Should the rationing of health care which is now accomplished de facto by race and socioeconomic class be resituated on some more rational foundation? This triad of interdependent issues will structure the analysis to follow.

Cruzan

In June, 1990, the U.S. Supreme Court ruled in the case of 32-year-old Nancy Cruzan,⁴ doomed to PVS by a 1983 car accident, that only competent persons have a right to refuse life-saving medical treatments. Conversely, artificial sustenance may be withdrawn from the incompetent only when there exists "clear and convincing evidence" that their wishes to that effect were once expressed. The belief of Cruzan's parents, relying on testimony of a friend of their daughter, that she would not want to be kept alive in her present condition, was deemed insufficient to warrant the removal of her feeding tubes. On the other hand, the *Cruzan* decision does imply a right to refuse life support via advance directives or designation of a durable power of attorney.⁵ *Cruzan* has been criticized both by those who regard any withdrawal of feeding as morally tantamount to mercy-killing, and by those who would guarantee to physically devastated incompetent patients the right of refusal recognized for competent persons in similar conditions. The case highlights two issues: the definition of "extraordinary," disproportionate, optional means for patients in PVS or comparable conditions, especially whether feeding itself can ever become a morally dispensable form of care; and whether decisions to refuse or discontinue treatment can be undertaken on behalf of incompetent patients who have not had the foresight to prepare a reliable indication of their preferences.

A response of Richard McCormick opens onto these issues.⁶ Negatives are that *Cruzan* distances the decision-making prerogative from the family setting;⁷ that no protection whatsoever is afforded to those who

⁴ The majority opinion in *Cruzan* appears in *Origins* 20 (1990) 127-32. See also John J. Paris, S.J., and Frank E. Reardon, J.D., "Cruzan v. Director. Missouri Dept. of Health, Cruzan v. Harmon," *Clinical Ethics Report* 4/1 (1990) 1-8.

⁵ On advance directives, see David Greaves, "The Future Prospects for Living Wills," *Journal of Medical Ethics* 15 (1989) 179-82; Ezekiel J. Emanuel and Linda L. Emanuel, "Living Wills: Past, Present, and Future," *Journal of Clinical Ethics* 1/1 (1990) 9-17; John Miles, J.D., "Catholic Healthcare Facilities Can Give Patients Advice on Advance Directives," *Health Progress* 71/8 (1990) 48-51, 54; and Benedict M. Ashley, O.P., "The Medical Directive," *Ethics and Medics* 15/11 (1990) 3-4.

⁶ Clear and Convincing Evidence: The Case of Nancy Cruzan," to appear in *Midwest Medical Ethics* (Kansas City, Mo.: Midwest Bioethics Center).

⁷ Arguing that other states need to develop better surrogate decision-making procedures involving the family are William H. Colby, Pete Busalacchi, and Joanne Lynn and Jacqueline Glover, all in *Hastings Center Report* 20/5 (1990) 5-7, 10-11.

have never been competent; that the demand for clear evidence from the patient to cease life-preserving measures might deter from initiating them at all; and that the affirmed state interest in preserving life seems to apply indiscriminately to the preservation of biological life as such.⁸ But positively, the decision provides only that "Missouri's heightened evidentiary requirement was not unconstitutional," not that every state must require an equal burden of proof;⁹ and that a "liberty [not privacy] interest" in refusing treatment does exist. But McCormick finds the Court's analysis vulnerable: it disallows any "quality of life" dimension in balancing Cruzan's interests with those of the state. "The urgent question is the evaluation of life in a persistent vegetative state. Is such a life a value to the one in such a state? Is its preservation a benefit to the patient and therefore a state interest?" McCormick concludes that, for patients who are irreversibly comatose (e.g., in PVS), the presumption should be against treatment. He voices a strong conviction that the public would be virtually unanimous in rejecting artificial nutrition as of no benefit to themselves were they ever in a state like that of Cruzan. McCormick implies that "substituted judgment" for incompetents, based on individual "wishes," is really no substitute for objective "best interests" criteria, including quality of life considerations.¹⁰

Some pro-life advocates disagree. James Bopp, president of the National Legal Center for the Medically Dependent and Disabled, assumes that it "can hardly be disputed" that if feeding can prolong Cruzan's life, then feeding is in her "best interests."¹¹ Not only does he claim that feeding in itself is not economically or physically burdensome, but he also isolates it from any broader quality of life judgment. Mark E. Chopko, general counsel for the United States Catholic Conference, grants that, although the morality of feeding in Cruzan's case is "debatable," "there

⁸ Dennis Brodeur agrees that the Court overemphasized the state's interest in preserving life, preempting the family as decision-maker ("The Ethics of Cruzan," *Health Progress* 71/8 [1990] 42-47).

⁹ In an excellent ethical and legal overview, Robert F. Weir and Larry Gostin maintain that physicians often feel constrained by legal uncertainty to act conservatively, but the implications of the Cruzan decision are actually narrow ("Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients: Ethical Standards and Legal Liability for Physicians After Cruzan," *Journal of the American Medical Association* 264 [1990] 1846-53).

¹⁰ Law professor Charles Baron agrees: "What actually drives death decisions in PVS cases is an objective test based on the convergence of 'best interests' and economic criteria. 'No one would really want to go on like this, so what is the point of expending all this effort and money?'" ("On Taking Substituted Judgment Seriously," *Hastings Center Report* 20/5 [1990] 8).

¹¹ James Bopp, Jr., "Choosing Death for Nancy Cruzan," *Hastings Center Report* 20/1 (1990) 43. In the same issue, see articles on *Cruzan* by Susan M. Wolf, Giles Scofield, and Ira Mark Ellman.

should be a presumption favoring such basic means for human life."¹² Unaddressed is the issue whether the nature of nutrition as "basic" changes when it is artificially infused. And Chopko's assertion that Cruzan is not "terminally ill" is open to question. She does have a pathology which will lead certainly to death, absent medical intervention. The criterion "terminal illness" may not be useful in addressing proportionate means, since a potentially death-dealing condition is assumed in *any* case in which death would follow an act of omission. "Terminally ill" must either denote only patients for whom *there is available* no life-prolonging treatment, or else *every* patient whose death would ensue on omission of treatment is "terminally ill."

Artificial Nutrition and Hydration

A substantial literature on foregoing life supports provides a backdrop against which to ponder the problems that *Cruzan* magnifies. Guiding questions include: (1) Should the proportionality of any given means be evaluated only in terms of its own immediate effects on patient welfare, or also in view of the *overall condition* and prospects of the life which that means sustains? (2) Is "*quality of life*" a valid consideration and a helpful category in making a determination that a means of life support is or is not an excessive burden to the patient? What factors or characteristics of human life could be considered relevant components of quality? Ought quality of life judgments be made by proxy, or only by the patient? (3) In either case, is excessive "burden" wholly relative to subjective preferences, or is the judgment accountable to some *objective frame of reference*? (4) What is the meaning of the term "*person*," and how do attributions of personhood function in decisions to provide or forego treatments for incompetent individuals? (5) How does a *social justice* context influence the morality of using life-prolonging medical means?

Two basic schools of thought have emerged within Catholicism: an absolute or strong presumption in favor of feeding; and a presumption that the worth of feeding is seriously compromised if total quality of life is very poor.¹³ Both viewpoints claim consistency with Catholic "tradi-

¹² Mark E. Chopko, Letter to the Editors, *Commonweal* 117 (1990) 402. Chopko's response follows a set of essays by John Collins Harvery, Kevin P. Quinn, and Sandra H. Johnson, "When Should the State Step Aside?: Terminating Treatment for PVS Victims," *Commonweal* 117 (1990) 286-94.

¹³ See Michael D. Place, "The End of Human Life: Ethical and Public Policy Questions," *Chicago Studies* 27 (1988) 257-70. Place helpfully places Catholic writers (theologians Barry, Connery, McCormick; lawyers Horan and Grant; and a 1987 statement prepared by the Pope John XXIII Center) and some positions of the U.S. hierarchy in four groups, reflected in my analysis. Place suggests that, given lack of consensus, the Church need not support any public policy to make legally impossible what may be morally legitimate.

tion" on ordinary and extraordinary means. That tradition has held that *either* physical uselessness or "burdensomeness" is sufficient to make a means optional, even if in its absence death will result.¹⁴ But the precise meanings of these terms are disputed.

The *first* group exhibits a high-profile "pro-life" commitment, and also fears that extending "extraordinary" means to include feeding, even when medically administered, could create a threat to others with disabilities. It comprises three related positions: (a) withdrawal of feeding from incompetents is never justified;¹⁵ or, (b) following the lead of the late John Connery, it can be justified only if the use of the specific means in and of itself is burdensome or useless to the patient.¹⁶ (c) Others give the latter view a more stringent formulation by claiming that provision of food and fluids cannot be a burden to an unconscious person. It is optional only when "useless" for one of two reasons: the person is imminently dying, or is no longer able even to assimilate the nourishment provided.¹⁷ Representing a *second* perspective are authors who do not perceive a commitment to deter abortion and euthanasia as inconsistent with the possibility that artificial feeding may be useless or burdensome in relation to total quality of life, and hence not morally required. Like McCormick, they propose a presumption *against* feeding the permanently comatose, permitting refusal by proxy.¹⁸

A major recent contributor to the position in favor of mandating nutrition and hydration is Robert Barry, O.P. In a representative article which includes a historical survey of theological precedents, Barry focuses on nutritional support for nondying (PVS) patients. He poses the ques-

¹⁴ This is essentially the formulation of Gerald Kelly, S.J., (see n. 2).

¹⁵ Robert Barry, O.P., "Feeding the Comatose and the Common Good in the Catholic Tradition," *The Thomist* 53 (1989) 1-30.

¹⁶ A recent example is the April 27, 1989, Pastoral Statement of the Florida Bishops, "Life, Death, and the Treatment of Dying Patients," *Origins* 19 (1989) 47-48. A less clear example is the "Interim Pastoral Statement on Artificial Nutrition and Hydration" issued May 7, 1990 by 16 of the 18 Texas bishops and the Texas Conference of Catholic Health Facilities (*Origins* 20 [1990] 53-55). The latter makes the criterion the "use of the means themselves," but includes burdens to "family, care provider or community," then concludes by reiterating that the primary concern is "the *total* well-being of the person in need" (italics added). A sidebar lists 18 related *Origins* texts.

¹⁷ The statement of the Pope John XXIII Center (see n. 13).

¹⁸ See James J. Walter and Thomas A. Shannon (n. 37). A precedent is the work of Richard A. McCormick ("To Save or Let Die," *America* 130 [1974] 6-10). Basically adopting McCormick's criterion of potential for affective relationships, John B. Balsam, O.P., seems to narrow its scope to patients who are already terminally ill. However, he is willing to put irreversibly comatose individuals in that category, since they are "caught up in a dying condition," "staved off" only by modern technology. Of course, this is true of anyone who has a disease which would prove fatal were it not for modern medicine. But Balsam makes the "decisive" criterion not the terminal condition as such, but some ability to attain "the purpose of human life and living" via "cognitive-affective function" (272).

tions whether the withdrawal of "assisted feeding" entails the direct human intention and causation of death, albeit by "omission" (rather than permitting death to result from the underlying disease); whether "quality of life" can justify killing by omission; and whether artificially provided feeding is "a medical treatment" or "an aspect of normal care," and hence always mandatory.¹⁹ Barry argues that traditional authors only rarely and reluctantly justify the refusal of food and drink which can sustain life. Of particular interest is Gerald Kelly, given his influence in defining ordinary and extraordinary means, and his position that it is acceptable to withhold artificially administered nutrition from a comatose patient nearing death.²⁰ Barry rejects Kelly's position on artificial feeding, since the measure would be "useful" in alleviating the specific pathology to which it is directed (the inability to consume food and water), and in extending life at least briefly.²¹

But it is plausible to interpret Kelly as broadening usefulness beyond extension of life as such by compensating a single impaired function, to include one's state of life as a whole. Kelly envisions that a diabetic person with cancer might legitimately forego insulin in view of the presence of the latter disease. "I am not sure we are justified in stating that the patient must prescind from the cancer in determining her obligation"; the cancer "throws some doubt" on whether the insulin offers "a reasonable hope of success."²² Particular impairments and their remedies are not isolated but interdependent components of the total welfare of the patient. The bare prolongation of life is not a good always capable of mandating whatever means are necessary to secure it. Moreover, it is not necessarily the case, as Barry suggests, that withdrawal amounts to "abandoning" unconscious terminal patients, and even cancelling all their "moral rights." It is precisely the question whether genuine concern for the welfare of the patient in such a situation mandates or precludes the continuance of life by means of artificial feeding. To say that it does

¹⁹ "Feeding the Comatose" 2-3. See also John M. Grondelski, "Removal of Artificially Supplied Nutrition and Hydration: A Moral Analysis," *Irish Theological Quarterly* 55 (1989) 291-302. Grondelski contrasts two pieces, siding with the second: (1) John Paris and Richard McCormick, "The Catholic Tradition on the Use of Nutrition and Fluids," *America* 156 (1987) 356-61; and (2) a statement, "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," whose 80 signatories included Robert Barry, Brian Johnstone, Germain Grisez, and William E. May (*Issues in Law and Medicine* 3/3 [1987] 203-17). The former argues, contrary to Barry, that Catholic tradition supports removal of feeding from the comatose; the latter thought such feeding to be required in almost all circumstances.

²⁰ "The Duty of Using Artificial Means of Preserving Life," *TS* 11 (1950) 220.

²¹ "Feeding the Comatose" 13.

²² Kelly, "The Duty of Using Artificial Means of Preserving Life" 216.

not require it presupposes that the disqualifying criteria of uselessness or burdensomeness apply to the total state and prospects which medical measures enable or fail to enable.

Barry not only explicitly rejects the consideration of life as a whole in defining "burden," but also maintains that to cause death by removal of artificial nutrition is to directly *intend* death itself as one's goal, creating the moral equivalent of mercy killing. Likewise, the late Dennis J. Horan, an activist Catholic pro-life lawyer, refers repeatedly to the removal of artificial feeding from non-terminal comatose patients as "deliberate starvation" representing insidious cultural and legal acceptance of euthanasia.²³ A counterinterpretation could see the intention as avoidance of a dehumanizing existence. When artificial sustenance is omitted, the patient is in fact "permitted" to die of the inability to take in food and water. On the latter view, the withdrawal of artificial nutrition and hydration would not be the same as "starving" the patient; it would be medically and morally comparable to the removal of a respirator. To turn off a respirator certainly deprives the body of a necessity for survival as essential and basic as food: air. Yet Catholic ethicists since Pius XII²⁴ have not viewed the removal of a respirator as always the equivalent of "suffocating" a patient. Barry rejects this comparison, replying hyperbolically that "it would make virtually all other forms of nursing care medical treatments as well."²⁵ Barry is surely right that respirators are much more sophisticated than nasogastric tubes or urinary catheters (which he sees as more analogous). But respirators and feeding tubes have in common one key trait: they are technical means of supplying the body with life-essential substances after it has lost the capacity to intake them on its own.²⁶ Hence the intransigent question. Once feeding requires artificial and at least somewhat invasive means, is it adequate to regard it as simply "basic nursing care" (Barry's phrase) like hygiene and

²³ "Hydration, Nutrition, and Euthanasia: Legal Reflections on the Role of Church Teaching," *Linacre Quarterly* 55/4 (1988) 32-46; published also in *The Catholic Medical Quarterly* 40 (1989) 57-69.

²⁴ "Anesthesia: Three Moral Questions," Address to the Italian Society of Anesthesiology, Feb. 24, 1957, *The Pope Speaks* 4 (1957) 33-50.

²⁵ Barry, "Assisted Feeding and Pro-Life Zealotry," *Homiletic and Pastoral Review* 89 (1989) 30-53, a rejoinder to Joseph J. Farragher, S.J., "Overzealous Pro-Lifers Can Hurt the Pro-Life Cause," *Homiletic and Pastoral Review* 88/8 (1988) 69-71.

²⁶ Rev. Edward J. Bayer, "Intubation of the Irreversibly Comatose: A Response to Robert Barry, O.P.," (*Linacre Quarterly* 55/1 [1988] 80), notes that "absolute physical necessities" must be distinguished from the "contrivances" which deliver them (80). Grondelski, "Removal," thinks that in the respirator patient a key difference is that "integrated functioning has ceased" (298). But this would be true only of patients who, having suffered destruction of the brain stem, are "brain dead," not in PVS.

shelter? One might just as well see universally mandated feeding as capitulation to a depersonalizing technologic imperative.²⁷

A brief but insightful offering lifts artificial nutrition beyond the battle to define it absolutely as *either* medical treatment *or* basic care. Steven H. Miles, M.D., offers experiential vignettes in which feeding bears vastly different social meanings: an “automated feeding ward” in a public hospital for the chronically mentally ill; a dying man whose wife requests that he receive a medically “pointless” IV symbolic of “a nurturing, faithful relationship”; and a comatose cancer patient whose family insists that she receive a meal tray “as a mealtime offering.” Miles concludes that feeding “is morally defined in a broader, non-medical, cultural experience,” and forms “an integral part of sharing the experience of human passage.”²⁸ Either mandated nourishment or the dismissal of all feeding of the comatose as irrational is unbalanced. Though taking a stronger stance in favor of the obligation to feed, Germain Grisez too displays the social significance of feeding. Feeding the comatose “maintains the bond of human communion with them,” “a personalistic good,” “the good of human solidarity.”²⁹ Grisez seems to avoid absolutism by indicating that feeding of the comatose could be stopped in a case of dire communal economic constraints; or when the patient has left a clear directive renouncing it. (Grisez repeatedly refers to that which is foregone as “care.” It would be better to clarify that for various reasons care can cease to include feeding.) Of course, even those who argue either that not to feed is to starve, or that to feed is to unacceptably burden the patient, can have in view the goal of humane caregiving. But the genuinely relational nature of care is obscured when its moral meaning is identified absolutely with certain means of providing it.

A key factor motivating much resistance to viewing artificial feeding as elective is that the determination of when to forego it inevitably introduces “quality of life” considerations. If a particular means can prolong life but is still refused, then implicitly the life permitted to end has been judged in some sense not worth living. Barry and others legitimately resist purely utilitarian calculations of the value of life. Yet quality of life judgments may be defensible if they derive primarily from

²⁷ See Joanne L. Finkelstein, “Biomedicine and Technocratic Power,” *Hastings Center Report* 20/4 (1990) 13–16. On the general cultural effects of technology, see Dominic Balestra, “Technology in a Free Society: The New Frankenstein,” *Thought* 65 (1990) 154–68. On Cruzan, see Ronald E. Cranford, “A Hostage to Technology,” *Hastings Center Report* 20/5 (1990) 9–10.

²⁸ Steven H. Miles, “Nourishment and the Ethics of Lament,” *Catholic Medical Quarterly* 42 (1990) 102–07.

²⁹ “Should Nutrition and Hydration Be Provided to Permanently Comatose and Other Mentally Disabled Persons?” *Linacre Quarterly* 57/2 (1990) 32–33.

respect for the needs of the patient and if they meet relatively objective criteria. Some critics collapse quality of life and personhood, assuming that when the quality of a comatose patient's life is deemed too low to be worth sustaining through artificial means, a judgment has been made that that patient is no longer a "person." John Grondelski, for instance, accuses McCormick and others (Edward Bayer, John Paris) of "equating personhood with communicative consciousness."³⁰ John Boyle warns against suggestions that "persons who have a lower quality of life also suffer a corresponding diminishment of their human dignity and, consequently, of their claim on the care of others and the health care resources of society."³¹ It is concern for the voiceless that motivates many to equate personhood with humanity as such rather than with any distinctively human traits; and to affirm that all persons have equal moral rights. As the Texas bishops state it, "all humans" are persons made in the image of God and have "the same basic right to life."³² By comparison, some philosophers make the sine qua non of personhood a *quality* or trait at which they arrive by isolating the most distinctive human activity or activities.³³ Yet it would be a rare Catholic author who would argue that if quality of life is unacceptably low, the individuals concerned are not persons and do not deserve respect and care. In Boethius' classic, if to us enigmatic, definition, a "person" is "an individual substance of a rational nature."³⁴ Our quandary about how to articulate our moral obligations to PVS patients arises in part because they belong to a *species* of a rational nature, but have irrecoverably lost any capacity to realize that nature in their own *individuality*. Ambiguities in the term "person" are reflected even in remarks of the Pope which identify the moment of death as the time when the *physical* organism can no longer function as a unity, since he also associates personhood with the *conscious* ability to love and to seek God: "The value of life springs from what is spiritual in

³⁰ "Removal" 298.

³¹ "Quality of Life: An Ambiguous Expression," *Ethics and Medics* 15 (1990) 1.

³² "Interim Pastoral Statement" 53.

³³ An example is Baruch A. Brody, "Ethical Questions Raised by the Persistent Vegetative Patient," *Hastings Center Report* 18/1 (1988) 33–37. John A. Robertson claims that Nancy Cruzan "does not have interests that can be harmed" ("*Cruzan*: No Rights Violated," *Hastings Center Report* 20/5 [1990] 8). See also D. Gareth Jones, "Brain Birth and Personal Identity," *Journal of Medical Ethics* 15 (1989) 173–78.

³⁴ See Jack Healy, O.Carm., "The Christian Notion of Person and the Comatose Patient," *Linacre Quarterly* 56/3 (1989) 76–90; Kevin Doran, "Person—A Key Concept for Ethics," *Linacre Quarterly* 56/4 (1989) 38–49; Philip Smith, O.P., "Personhood and the Persistent Vegetative State," *Linacre Quarterly* 57/2 (1990) 49–58; and J. C. Wilke and Dave Andrusko, "Personhood Redux," *Hastings Center Report* 18/5 (1988) 30–33. Healy and Smith argue that PVS patients are persons, while Doran makes the same claim for embryos, and Wilke and Andrusko for anencephalic infants.

man . . . The body is that of a person, a being which is open to superior values, a being capable of fulfillment in the knowledge and love of God."³⁵ Surely he would not say that patients unable to know and love are beyond the pale of human respect. As a means of indicating the abiding moral claim of even the comatose, the term "person" will have either to be significantly nuanced or replaced.³⁶ Roman Catholic moral theology needs to find a way to predicate a basic value of all humans, while still permitting appropriate moral interpretation of real differences in capacity for consciousness and relationality.

James J. Walter and Thomas A. Shannon tangle with many of these problems in a recent article.³⁷ Discerning no consensus in the Catholic community about withdrawing artificial sustenance from the comatose, they note that even those who see it as elective communicate reluctance, caution and care. Their essay opens with an instructive survey of the U.S. hierarchy about the composition and role of diocesan bioethics committees and their policies on nutrition and hydration. They then move on to reconceptualize and defend "quality of life" as a criterion for removing treatments, especially for PVS patients. Although few dioceses have bioethics committees at all, Shannon and Walter find diversity in responses about whether feeding tubes are to be considered ordinary or extraordinary means. A majority indicate it "depends" on the circumstances, and tend to prefer case-by-case determinations over fixed rules.³⁸

Shannon and Walter defend quality of life as a criterion in making those determinations. Yet they are sensitive to the "fear" of potential critics that decisions "made solely on the presence or absence of certain qualities or properties that a patient's life possesses" will erode "our duties to protect innocent lives, especially of those most vulnerable in our society." To assuage misgivings, they proceed by three moves to redefine the referent of "quality." First, they reject the idea that the value

³⁵ "Determining the Moment of Death," Address to a Congress on Determination of Death, Dec. 14, 1989, *The Pope Speaks* 35/3 (1990) 207-11.

³⁶ In a substantial article, Philip Smith explains brain death on Thomistic principles. Thomas follows Boethius' definition of "person," and would also see any individual substance as a unity of matter and form, or in the human case, of body and soul. The person dies when the soul departs, i.e. when the individual no longer functions as a unity ("Brain Death: A Thomistic Appraisal," *Angelicum* 67 [1990] 3-31). Would it be possible to develop a distinction between having a human "soul" and possessing in the concrete a "rational nature" (being a person)? Could it be said that personhood disappears with rationality—but not the soul which still commands respect and protection? Can the soul continue to exist where the person does not?

³⁷ Thomas A. Shannon and James J. Walter, "The PVS Patient and the Forgoing/Withdrawing of Medical Nutrition and Hydration," *TS* 49 (1988) 623-47.

³⁸ "PVS Patient" 626, 632.

of physical life depends on any property or characteristic, or that life is in any way a "conditional" value. Rather, "all lives are of equal ontic value." They then distinguish between physical life and personhood, adding that "all persons are of equal moral worth." Finally, they insist that "quality" denotes an attribute not of *life*, but of the *relationship* between the "medical condition of the patient" and "the patient's ability to pursue life's goals and purposes, understood as the values that transcend physical life." They apparently concede that quality evaluations of life amount to a utilitarianism in which duties "are improperly grounded in what the patient earns through social accomplishments."³⁹ Instead, what they still call "quality-of-life" judgments must focus exclusively on the benefits and burdens of treatment itself "and/or" those which "will accrue to the patient as a result of treatment" or even to the patient's family and caretakers.⁴⁰

The authors' irenic and moderating effort is to be appreciated, as well as their resistance to pragmatism about life's value. But their premise that all physical lives are ontic values which are *equal* and *not conditional* may bear further discussion. In the parlance of recent moral theology, an "ontic" (sometimes "pre-moral") value exerts a *prima facie* claim in any decision, but is not absolute. It could be overridden by the competing practical claim of an equal or higher value. The only absolute or "moral" values are those amounting to moral characteristics (virtues) of the person: honesty, charity, faithfulness, etc. These can never be subordinated to any competing good; indeed goods on this highest level, the moral, could never be mutually exclusive. Conversely, to say that a good is "ontic" almost implies a conditional quality, and even an instrumental one. Ontic values are at least subservient to moral values—which is precisely the realm of value into which we enter when we talk about love and human relationships as defining quality of life.

Walter and Shannon appear to want to retain the primacy of such values via their relationship between "medical condition" and pursuit of "life's goals," and at the same time to effect a rapprochement with those who denounce all quality of life judgments as suggesting that some lives are worth more than others. Can they have it both ways? It is not clear that they have invalidated quality of life judgments which are focused on patient (not social) welfare, nor is it certain that they have carved out

³⁹ They are not far, e.g., from William E. May, who insists that "Human bodily life is a great good. It is a good *of* the person and intrinsic to the person and is not a mere instrumental good or good *for* the person." But May then insists on what the formulation may demand: "remaining alive is never rightly regarded as a burden" ("Criteria for Withholding or Withdrawing Treatment," *Linacre Quarterly* 57/3 [1990] 81–82).

⁴⁰ *Ibid.* 635–36, 638–39.

an alternative which is substantially different.⁴¹ Indeed, how far is it possible to separate a medical "condition" from the life in that condition, or to separate "quality" judgments about burdens accruing overall from treatment and judgments about properties of the life which that treatment preserves?

The authors' eventual criterion echoes McCormick: "when a proposed intervention cannot offer the patient any reasonable hope of pursuing life's purposes at all or can only offer the patient a condition where the pursuit of life's purposes will be filled with profound frustration or with utter neglect of these purposes because of the energy needed merely to sustain physical life," then that intervention is against the best interests of the patient himself or herself and is unwarranted.⁴² Could the point be reached more directly by saying that all life has an ontic value insofar as it always exerts a *prima facie* (but not absolute) claim in any moral decision? There is no quality of life the absence of which can make life cease to be at least a *prima facie* value, and there is certainly no condition of life in which the person would not be valued. Yet certain pathologies and their medical treatments can make the ontic value of a life to be less, in view of the conditions it provides for realizing moral values. Thus it would exercise less influence in a decision about whether to fight disease or permit it to cause death. In any event, Shannon and Walter have advanced these issues by creating room to listen carefully to arguments from different ethico-political constituencies.

The trend is clear to include burdens to family and even society in assessing proportionality. Walters asks if "it is legitimate to include at least some of the burdens imposed on the family and/or society in assessing the patient's best interests, since the social environment can alleviate or augment the patient's experience of burden," and also whether "the interests of others," should be considered "in their own right."⁴³ The Congregation for the Doctrine of the Faith's 1980 *Declaration on Euthanasia* mentions "a desire not to impose excessive expense on the family or the community."⁴⁴ These issues open out onto the vistas of public policy, raising questions of who is to make decision about

⁴¹ In an independent essay, James Walter simply speaks of "the burden of the patient's condition (quality of life) to the patient himself or herself prior to and subsequent to treatment ("Termination of Medical Treatment: The Setting of Moral Limits from Infancy to Old Age," *Religious Studies Review* 16 [1990] 304).

⁴² "PVS Patient" 645. The formulation is essentially that of Richard McCormick (see n. 18).

⁴³ "Termination of Medical Treatment" 305. For an argument that actual quality of life will be integrally tied to contributions from home and society, see Anthony Shaw, "QL Revisited," *Hastings Center Report* 18/2 (1988) 10-12.

⁴⁴ Boston: Daughters of St. Paul, 1980, 12.

disproportionate social "burden," and how distribution of health care is to be implemented practically.

Although "burden" has been a large target of recent discussion, Kelly's criterion of "utility" or physical usefulness is also implicated by critiques of overaggressive use of measures which may do little good and even harm. One man filed a lawsuit against nursing home staff who revived him at age 84 against his explicit request.⁴⁵ The meaning and relevance of utility also comes into question when patients insist on futile treatment.⁴⁶ Some suggest that good communication between patient, family, and staff usually can produce a decision consistent with good medical practice; but in any event physicians are not obligated to order interventions expected to provide no medical benefit.⁴⁷ The moral dubiousness of ineffective treatments is compounded when their expense contributes to imbalances in health care distribution among acutely and chronically ill, dying and nondying, young and old, insured and uninsured, whites and people of color.

Direct Euthanasia

In the Netherlands, active euthanasia is still a legal offense, and can bring up to twelve years imprisonment. However, a provision that an individual is not punishable if caught in a conflict of duties with a need to act has permitted the development of a pattern of judicial precedents, consolidated by the Supreme Court in 1984, allowing physicians to practice euthanasia under strict conditions: (1) voluntariness, or a persistent and free request by the patient; (2) a "hopeless situation," or serious illness beyond recovery; and (3) consultation with a colleague, who confirms the decision-making process. Both the Royal Dutch Medical Association and a government commission have proposed that the penal code itself be changed in a more permissive direction; yet many physicians find wide toleration of mercy killing discomfiting.⁴⁸ Ameri-

⁴⁵ David Margolick, "Patient's Lawsuit Says Saving Life Ruined It," *New York Times* (3/18/90) A1, 24.

⁴⁶ Jay Alexander Gold, et al., "Is There a Right to Futile Treatment? The Case of a Dying Patient with AIDS," *Journal of Clinical Ethics* 1/1 (1990) 19-23.

⁴⁷ Nicholas G. Smedira, et al., "Withholding and Withdrawal of Life Support from the Critically Ill," *New England Journal of Medicine* 322 (1990) 309-315; Tom Tomlinson and Howard Brody, "Futility and the Ethics of Resuscitation," *Journal of the American Medical Association* 264 (1990) 1276-79; J. Chris Hackler and F. Charles Miller, "Family Consent to Orders Not to Resuscitate: Reconsidering Hospital Policy," *ibid.* 1280-83. See Barbara Springer Edwards, T. Dagi, L. O'Connell, and H. Yeide, "Withdrawal of Life Support Against Family Wishes: Is It Justified?" *Journal of Clinical Ethics* 1/1 (1990) 74-84.

⁴⁸ Maurice A. de Wachter, "Active Euthanasia in the Netherlands," *Journal of the American Medical Association*, 262 (1989) 3316-19. De Wachter, head of the Institute for Bioethics, Maastricht, provides a clear, balanced review. National controversy over the

cans are also confronting the problem and expressing ambivalence. An 1988 California "Humane and Dignified Death Initiative" achieved less than a third of the signatures required to place it on the ballot, despite opinion polls evincing support among 70 percent of Californians.⁴⁹ The *Journal of the American Medical Association* published three years ago a letter from an anonymous author, claiming to be a resident awakened at night to attend a cancer patient whom he injected with a life-ending dose of morphine.⁵⁰ One empathizes with a young women suffering horrendously and with a doctor overtaken by a compassionate impulse. Still, the case was repudiated by many who saw a failure of morality, not to mention prudence, in hastily causing the death of a vulnerable stranger.⁵¹

In a brief essay, Edmund Pellegrino outlines the moral aspects of mercy-killing: the distinction between killing a patient and declining life-support measures; the limits of autonomous choice; the compatibility of physician-assisted suicide with the role of the medical care provider; and the social consequences of legalization.⁵² The first of these continues to offer intransigent analytic difficulties.⁵³ In Catholic tradition as elsewhere, the difference between killing and "allowing to die" has hinged on a supposed factual and moral difference between "directness" and "indirectness" at two levels: the action itself and the intention. The direct

policy is evident: Richard Fenigsen, "A Case Against Dutch Euthanasia," and Henk Rigter, "Euthanasia in the Netherlands: Distinguishing Facts from Fiction," *Hastings Center Report* 19/1 (1989) 22-32; and heated Dutch responses in "Letters," *Hastings Center Report* 19/6 (1989) 47-52.

⁴⁹ Allan Parachine, "The California Humane and Dignified Death Initiative," *Hastings Center Report* 19/1 (1989) 10. See also Edward R. Grant, "What in the World is Going On? A Consideration of the California Euthanasia Proposal," *Linacre Quarterly* 57/1 (1990) 58-62. On this initiative and the movement behind it, see Paul Marx, O.S.B., "Euthanasia Worldwide," *Linacre Quarterly* 57/3 (1990) 27-32. Opinion polls reveal that a majority of U.S. respondents consistently support euthanasia (Gale P. Largey and Richard N. Feil, "Knowing the Public Mind," *Hastings Center Report* 20/4 [1990] 3-4).

⁵⁰ "It's Over, Debbie," *Journal of the American Medical Association*, 259 (1988) 272. Actually, although the case has been received as mercy-killing, its wording does not make fully clear whether the doctor's motive was to kill as such or to relieve pain, even knowing that death would ensue. He or she repeats the intention to "give her rest."

⁵¹ See Mark Bloom, "Article Embroils JAMA in Ethical Controversy," *Science* 239 (1988) 1235-36.

⁵² Edmund D. Pellegrino, "Ethics," *Journal of the American Medical Association* 261 (1989) 2843-45.

⁵³ Substantive discussions occur in Raanan Gillon, "Euthanasia, Withholding Life-Prolonging Treatment, and Moral Differences Between Killing and Letting Die," *Journal of Medical Ethics* 14 (1988) 115-17; Daniel Callahan, "Can We Return Death to Disease?" *Hastings Center Report* 19/1 (1989) 4-6; Kevin O'Rourke, O.P., "Value Conflicts Raised by Physician Assisted Suicide," *Linacre Quarterly* 57/3 (1990) 38-49; and David Thomasma, "The Range of Euthanasia," *American College of Surgeons Bulletin* 73/8 (1988) 4-13. O'Rourke offers a historical review of Catholic tradition on euthanasia.

action which causes death represents a greater human involvement than an action in which one “stands aside,” along with medicine’s technologic panoply, and lets death ensue from an underlying disease. Although both actions bring the same result, there is a substantive difference in means and that difference is morally relevant. A direct *intention* to cause death would be a choice of death in itself or for its own sake, rather than choosing other goods (such as the relief of pain and suffering) to which death may be a foreseen and necessary but still subsidiary outcome. Instances of the latter sort are the administration of pain-killers which hasten death by suppressing vital functions and the withdrawal of “burdensome” technologies.

Typical challenges to the worth of the distinction between direct and indirect euthanasia take the following form. If the outcome is death, and if that outcome is not wrong or even undesirable in a given situation, why is the nature of the means morally decisive? After all, acts of omission also are wrong if circumstances and intent make death an unjust outcome. This challenge assumes that, even in cases of “withdrawing extraordinary means,” it is not always wrong to intend death as a provisional good—for this person in this situation—or at least that it is not possible fully to separate one’s intentions about death and about the relief of suffering which death provides. The argument for or against using direct means to cause it then hinges on the credibility of asserting that directness makes a factual difference in degree of agent involvement, and that that difference constitutes a morally significant factor. To prohibit euthanasia absolutely would require arguing not only that directness makes a difference, but that it is morally *decisive*, i.e., that it absolutely determines the moral quality of the act *no matter what* its circumstances might be.

A theological response to the “borderline” case where the negativity of direct involvement might be outweighed by the affliction of the patient comes from Kenneth L. Vaux. He complements the casuistry of Catholic moral theology with his more biblical and even paradoxical Protestant approach, shaped around trust in God as the “giver, sustainer, and receiver of life”; the nonultimacy of death; and “the ultimacy of grace and forgiveness.” He thinks that active euthanasia must be “proscribed in principle” but may be permitted “in exceptional cases,” as for patients “who are not dying but are suffering from the final stages of Lou Gehrig’s disease, cystic fibrosis, cerebral palsy, or other irreversible and fatal afflictions.”⁵⁴ In a contrasting vein, the physician and philosopher Grant Gillett observes that there is a “curious” discrepancy “between the intuitions of doctors, which are almost always against active voluntary

⁵⁴ “The Theologic Ethics of Euthanasia,” *Hastings Center Report* 19/1 (1989) 20, 21.

euthanasia, and the arguments of philosophers which are almost universally for it." He finds it "striking" that although doctors are convinced of the distinction between killing and letting die, "a defensible ethical difference is hard to find."⁵⁵ But Gillett regards the physician's "pause" as "serious moral evidence" rather than emotional irrationality. Declining to rest the argument against direct euthanasia on the weight of the direct/indirect distinction, he draws on a less tightly focused accumulation of negative considerations. The last events of life "are unique and valuable";⁵⁶ death must not be reduced to a last treatment for "discomfort"; a request for death begs a reaffirmation of personal worth; and the human tendency to categorize and simplify is likely to turn even carefully circumscribed euthanasia into "an item in our repertoire of acts." These reasons certainly amount to a strong case for placing euthanasia at the far margins of moral responsibility. Yet in concluding, Gillett seems not to exclude completely the possibility that a doctor "who feels bound in conscience to contravene this sanction" may "be prepared to submit his action to the deepest scrutiny that society can undertake and be vindicated by the overwhelming humanity of his act and that alone."⁵⁷

Any consideration of exceptions at the borderline poses the dilemma of social policy. Should a physician be prepared to suffer martyrdom to the common good's need for strong fences around unacceptable acts? Should *the physician* be involved in mercy-killing at all, even if it were justified? Although some argue that would erode public trust in the healer, others see hypocrisy in physicians who do not absolutely discount exceptional euthanasia, but refuse to comprehend it within faithful patient "care." As Marcia Angell observes, it is certainly "unsavory" to contemplate the creation of a special class of euthanasiasts.⁵⁸ But the bigger question is whether legislation enshrining in a certain anticipatability and emotional distance an action barely justified as marginal and desperate, would have disastrous long-run effects on attitudes toward life, death, and impairment. Dutch policy both permits and condemns the physician-as-killer, as though respectability's cloak must not be conferred even on warranted cases.

One barrier against abuse via extension on utilitarian grounds is limitation to voluntary euthanasia, excluding even advance directives.⁵⁹

⁵⁵ "Euthanasia, Letting Die and the Pause," *Journal of Medical Ethics* 14 (1988) 61.

⁵⁶ For an experiential example, see George A. Kendall, "Death and Hope: A Case," *Homiletic and Pastoral Review* 89/8 (1989) 31-47.

⁵⁷ "Euthanasia" 66-67.

⁵⁸ Marcia Angell, "Euthanasia," *New England Journal of Medicine* 319 (1988) 1349-50. See also Malcolm Parker, "Moral Intuition, Good Deaths and Ordinary Medical Practitioners," *Journal of Medical Ethics* 16 (1990) 28-34. Contrast Leon R. Kass, "Neither for Love nor Money: Why Doctors Must Not Kill," *Public Interest* 94 (1989) 25-46.

⁵⁹ Angell, "Euthanasia" 1350.

As Jean Davies notes, “killing” in the usual sense is to compassionate voluntary euthanasia as rape is to “making love”⁶⁰—although one might add that even sexual intercourse requires more than voluntariness to achieve moral irreproachability. In 1988 thirty-three medical practitioners, bioethicists, and medical economists from ten countries convened at Lawrence University, Appleton, Wisconsin, to draft what they hoped could become international guidelines for medical decision-making near the end of life. A majority concluded that although requests for euthanasia “by competent patients severely and irremediably suffering as a result of incurable disease may be justified,” it nonetheless is “a separate question whether they should be honoured.” In particular, “statutory legalisation of the intentional killing of patients by physicians is against the public interest.”⁶¹ Building on the distinction between what is morally right in itself and what contributes to or detracts from the common good, many critics of euthanasia adduce the slippery slope argument, often alluding to Nazi judgments that socially useless categories of persons had no right to life.⁶² These concerns are valid. Still, for clarity of analysis, a “social danger” argument may be a good reason for prohibiting a practice, but does not necessarily speak to the intrinsic morality of individual acts. Moreover, on euthanasia as on disproportionate treatment, most advocates of “quality of life” criteria are not judging that certain persons are socially worthless or lacking in value and dignity,⁶³ but that continued life may not be in the interests of some valued persons. And as in the case of withdrawing treatment, it is important to go beyond “wishes”⁶⁴

⁶⁰ “Raping and Making Love Are Different Concepts: So Are Killing and Voluntary Euthanasia,” *Journal of Medical Ethics* 14 (1988) 148–49.

⁶¹ John M. Stanley, “The Appleton Consensus: Suggested International Guidelines for Decisions to Forego Medical Treatment,” *Journal of Medical Ethics* 15 (1989) 131. (A dissent by three signers from Israel avers that euthanasia is understandable but *not* morally justified.) On this conclusion, see Gillon, “Moral Differences” 116–117.

⁶² See V. G. Rosenblum, “The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing?” *Issues in Law and Medicine* 6/1 (1990) 3–32; C. L. Sprung, “Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments,” *Journal of the American Medical Association* 263 (1990) 2211–15; Richard Doerflinger, “Assisted Suicide: Pro-Choice or Anti-Life?” *Hastings Center Report* 19/1 (1989) 19; and William Reichel and Arthur J. Dyck, “Euthanasia: A Contemporary Moral Quandary,” *The Lancet* 12/2 (1989) 1321–23.

⁶³ Luke Gormally, e.g., confuses this issue in postulating that the doctor judging some patients “have not got worthwhile lives,” denies that “every human being . . . possesses an inalienable dignity” (“Euthanasia: Some Points in a Philosophical Polemic,” *Linacre Quarterly* 57/2 [1990] 18). Yet he is right that the source of dignity is not independence but humanity.

⁶⁴ As in the statement on “Assisted Death” of a British Institute of Medical Ethics Working Party, approving euthanasia, that the “duty to prolong life is not concerned with all forms of life, but only human life of a quality that the person concerned wishes to have prolonged” (*The Lancet* 336 [1990] 612).

and “autonomy”⁶⁵ and seek some relatively objective criteria (e.g., “severe and irremediable suffering of a physical nature”) on which to conclude that death is preferable to continued life.⁶⁶

While autonomy is an insufficient moral guide, it is no less true that some of the public outcry for a “right to die” by active means discloses a sense that appropriate control over one’s life and death may be robbed by overzealous wielders of technology,⁶⁷ too often also insensitive to needs for comfort and relief of pain.⁶⁸ However, control should be placed in the context of other human values frequently neglected in favor of the American spirit of independence and self-sufficiency. This spirit furnished the appeal to Janet Adkins, a woman in the early stages of Alzheimer’s disease, of Dr. Jack Kevorkian’s “suicide machine.”⁶⁹ There is truth in Richard Doerflinger’s objection that some euthanasia advocates see “individual freedom” as “the noblest feature” of the person.⁷⁰ An ethos of free choice can deprive the dying of a sense that dependency is human, supportable, and supported.

A deeper attentiveness to the communal context of bonds among patient, family, and caregivers has shifted Catholic thinking about death and medical care away from what once was a preponderant focus on the character of individual acts. Of course, it has always been typical of the Catholic critique of utilitarian strands of bioethics to decry the dangers of the “slippery slope.” But protection of the common good tended to rely somewhat inconsistently on casuist analyses of intrinsically evil *acts* of killing. Now both traditional and revisionist thinkers perceive more

⁶⁵ Virtually the only principle motivating George P. Smith, “All’s Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?” *U.C. Davis Law Review* 22/2 (1989) 275–419; the decisive one for Parker, “Moral Intuition,” and Englehardt (n. 66).

⁶⁶ H. Tristram Engelhardt, Jr., regards it as impossible to reach public criteria for euthanasia, absent consensus on “the good life.” Hence the state cannot intervene coercively to prevent “individuals deciding with consenting others when to end their lives” (“Fashioning an Ethic for Life and Death in a Post-Modern Society,” *Hastings Center Report* 19/1 [1989] 9). On the possibility of moral argument and policy-making across religious and moral traditions, see the Special Supplement on “Theology, Religious Traditions, and Bioethics,” *Hastings Center Report* 20/4 (1990); and Dennis Brodeur, “Ethical Decision-Making at the End of Life: The Role of Religious Traditions and Public Policy,” *America* 163 (1990) 270–71.

⁶⁷ John P. Mullooly, “Active Euthanasia: Assisted Suicide,” *Linacre Quarterly* 55/3 (1988) 9; Christine K. Cassel and Diane E. Meier, “Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide,” *New England Journal of Medicine* 323 (1990) 751.

⁶⁸ Marianne Kloke and Angelika Koopman, “Sterbebegleitung und Schmerztherapie,” *Stimmen der Zeit* 115 (1990) 463–469.

⁶⁹ Lisa Belkin, “Doctor Tells of First Death Using His Suicide Device,” *New York Times* (June 6, 1990) A1, B6.

⁷⁰ “Assisted Suicide” 16. See also Reichel and Dyck, “Euthanasia” 1322.

connections between the sociality and interdependence always valued in Church social teaching, and particular actions relating individuals. Of consequence for euthanasia is the link between creatureliness and dependency as appropriate to the human condition. John Paul II teaches that “the Christian who accepts his own death” and recognizes “his own condition as a creature” “reaches *the height* of his own human and Christian identity and achieves *his ultimate destiny*.”⁷¹ Joseph Schmucker-von Koch adds that human life does not yield its own meaning; infanticide and euthanasia are rooted in the modern idea of self-sufficiency, not the Christian one of creation.⁷² Right on target is Richard Gula’s view that “The Catholic community’s challenge in opposing euthanasia is to help convert society from an aggregate of individuals pursuing their self-interests to an interdependent covenantal community.”⁷³ Along with proper limitation of treatment, a community of care and hospitality might promote collaboration, loyalty and trust, courage and encouragement, and extend supportive care to caregivers and family as well as patients. Euthanasia will be made superfluous, not by condemnations, but by addressing the motivations to choose killing as a last resort: the fears, the distorted values, and the genuine threats medical institutions can pose to freedom and dignity.⁷⁴

Economics and Health Care Policy

A literature on health care distribution in the U.S. is developing so rapidly that mention of it here can be little more than allusive. Roman Catholics join economic questions with the social teaching of the magisterium, and with the “preferential option for the poor.”⁷⁵ A particular nexus within the sizeable volume is rationing based on age. The fastest

⁷¹ “To Recover the Meaning of Life,” address to the Bishops of Europe, October 17, 1989, *The Pope Speaks* 35 (1990) 106. He links euthanasia to technological expansion in “Letter to Medical-Moral Workers,” to a workshop for U.S. bishops, January 6, 1989, *The Pope Speaks* 34 (1989) 179–81.

⁷² “Vom Kindermord zur Euthanasie—Entwicklungselement einer Logik der Unmenschlichkeit,” *Forum Katholische Theologie* 6 (1990) 59–71.

⁷³ Richard M. Gula, S.S., “The Virtuous Response to Euthanasia: Caring Must Become the Alternative to Curing,” *Health Progress* 70/10 (1989) 24.

⁷⁴ Olivier de Dinechin, S.J., also speaks of “hospitality” to the dying in “The Case for a Medicinal Ethic,” *New Blackfriars* 71 (1990) 325–333. This special issue on AIDS appeared simultaneously in *Lumière et Vie*.

⁷⁵ Two worthwhile examples are Edward J. Mahoney, “Justice and Health Care for the Poor,” *Louvain Studies* 13 (1988) 232–51; and Joseph Cardinal Bernardin, “Health Care of the Poor,” *Chicago Studies* 27 (1988) 225–239. Mahoney contrasts episcopal teaching with philosophers including Nozick, Engelhardt, and Rawls. For an accessible presentation of facts and figures, see Lawrence E. Brandt, “The Future of Health Care in the United States,” *America* 163 (1990) 272–74, 284–85.

growing age group in the population is 80 and over; that group obviously demands more chronic and acute medicine than children and younger adults. A “vertical gap” widens between the least expensive and the most expensive patients, with a small number in the latter category consuming, by one estimate, three-quarters of funds available.⁷⁶ In favor of age-based rationing it is argued that (1) a disproportionate amount of healthcare resources are expended on relatively expensive care for a small population which stands to benefit relatively little; (2) it is better to confront constraints on healthcare spending through a rational plan than through either the present de facto class- and race-based access system, or an expectation that doctors make bedside allocation decisions; (3) the elderly would benefit more by attention to the quality of their lives throughout the aging process than by intensive and sometimes excessive care at the end of it.⁷⁷ A medical controversy exists over whether it is even appropriate to consider ICUs and cardiopulmonary resuscitation as ordinarily beneficial measures for chronically ill older people.⁷⁸

The most articulate proponent of age-sensitive treatment policy has been Daniel Callahan.⁷⁹ Callahan’s basic thesis is that “human community” should stress, not unlimited “individual needs,” but “mutual help, mutual sacrifice, and mutual limits.” The idea that access to health care can be expanded indefinitely has been encouraged by theories of justice rooted in self-interest (Rawls, Nozick). Hope that system reorganization can “avert the need for serious and organized rationing” is self-deceptive.⁸⁰ But why focus on the elderly? First, there has been a historical trend toward increased life expectancy for those over 85, along with increased illness and disability accompanying prolongation of life. It is “not evident,” according to Callahan, that “adding years to life in and of itself increases happiness or spiritual development.” “We will have to

⁷⁶ A 1980 survey, as cited in Paul L. Grimaldi, “A Call to Revolution,” *Health Progress* 71/6 (1990) 33.

⁷⁷ Robert Barnet argues that care of the elderly is overmedicalized and overinstitutionalized. Cf. “Plato on Medicine’s Role in Society: The Care of the Elderly,” *Linacre Quarterly* 56/1 (1989) 63–70.

⁷⁸ One debate is: Donald J. Murphy, and David B. Matchar, “Life-Sustaining Therapy: A Model for Appropriate Use”; W. T. Longstreth, Jr., et al., “Does Age Affect Outcomes of Out-of-Hospital Cardiopulmonary Resuscitation?”; and Peter G. Tuteur and Susan D. Tuteur, “Life-Sustaining Therapies in Elderly Persons,” *Journal of the American Medical Association* 264 (1990) 2103–10, 2118.

⁷⁹ His books, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987) and *What Kind of Life?: The Limits of Medical Progress* (New York: Simon and Schuster, 1990) are supplemented by several articles (see below nn. 80–81). “Justice Between Generations and Health Care for the Elderly” is the theme of an issue of *The Journal of Medicine and Philosophy* 13 (1988).

⁸⁰ “Allocating Health Resources,” *Hastings Center Report* 18/2 (1988) 19, 20.

ask what kind of life at what kind of cost." After a natural life span (70 or 80 years), there is not a great evil in death; to fend it off makes insufficient contribution to human welfare to warrant expenditure of healthcare funds when others, including children, are inadequately served. "The elderly can not claim an increased share of health care at the expense of those young people who themselves still need to live long enough to become old."⁸¹ Edmund Pellegrino commends Callahan in that he "argues for a communitarian rather than an individualistic or marketplace ethic as the moral foundation of health care distribution." Yet Pellegrino questions, as will others, whether it would still not be possible to find a way to provide what he sees as "needed and necessary care for all."⁸² Whether life-prolongation (often via expensive technologies) in the circumstances Callahan describes is genuinely needed or necessary is exactly the question. Callahan's age criterion will not win universal acceptance, and may never be implemented as social policy. But his challenge is to seek just and effective distribution of a limited resource expended in enormous quantities at the end of life in a society which subjects aging and death to medicalization, institutionalization, and technological interference without offering the ill or the aged genuinely communal concern.

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⁸¹ "Ethics, Aging and Technology," forthcoming in Lisa Sowle Cahill and Dietmar Mieth, eds., *Growing Old (Concilium: Moral Theology 1991)*.

⁸² Edmund Pellegrino's review of *What Kind of Life?* in *America* 162 (1990) 20–21. Marshall B. Kapp and Callahan differ on rationing's form in "Rationing Health Care: Will It Be Necessary? Can It Be Done Without Age or Disability Discrimination?" *Issues in Law and Medicine* 5 (1989) 337–68.