Forgoing Life Conservation: A Case Study

Mr. Jay is a 75 year old man, who has been in the hospital for about a week, was admitted for difficulties in swallowing and eating. He had been admitted previously for brief stays on and off for four months with various complaints. For the last three and a half months, he has been cared for in a convalescent facility. His elderly wife was caring for him at home prior to that time. He was diagnosed with Alzheimer’s Disease almost a year ago, after exhibiting symptoms for several months. At this time he still recognizes his wife and adult children, but dementia is progressing rapidly. He had a series of heart attacks in 1983, and now has a pacemaker. Because of increased hand tremors, a shuffled gait, and arms held flex to the waist, the attending physician believes he may be suffering also from Parkinson’s Disease (which can also cause dementia). Mr. Jay has also developed difficulties in urinating; prostate problems are suspected.

Because of Mr. Jay’s overall degenerative condition, the attending physician would rather not pursue aggressive diagnostic and therapeutic procedures. He has given Mr. Jay a poor prognosis, and has asked Mrs. Jay’s consent for DO NOT RESUSCITATE (DNR) orders. Assuming that the physician’s prognosis is medically accurate, is it morally acceptable in Church teaching for Mrs. Jay to consent to DNR orders for her husband? Is it permissible to forego other treatments as well?

Relevant Church Teaching

In his address to the International Congress of Anesthesiologists, Pope Pius XII included the following teaching:

“Natural reason and Christian morals say that man (and whoever is entrusted with the task of taking care of his fellowman) has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health . . .

“But normally one is held to use only ordinary means—according to circumstances of persons, places, times and culture—that is to say, means that do not involve any grave burden for oneself or another (emphasis added). A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends” (Pope Pius XII, “The Prolongation of Life”, November 24, 1957, The Pope Speaks, Vol. 4, 1958, pp. 393-398).

Responding to the increased public concern about euthanasia, the Vatican responded with a statement which built on the earlier remarks of Pope Pius XII:

“If there are no other sufficient remedies, it is permitted, with the patient’s consent, to have recourse to the means provided by the most advanced medical techniques, even if these means . . . are not without certain risks. It is also permitted . . . to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient’s family, as also of the advice of the doctors who are specially competent in the matter. The latter may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering.

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out of proportion with the benefits which he or she may gain from such techniques (emphasis added).

"It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide: on the contrary, it should be considered as an acceptance of the human condition (emphasis added).

"When inevitable death is imminent is spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted" (The Vatican 1980 Declaration on Euthanasia, No. 4).

Application

Informed Consent

Mr. Jay is not considered competent to make the decision on his own. Therefore, Mrs. Jay is the next appropriate decision maker. Mrs. Jay must realize that, as Mr. Jay’s surrogate decision maker, she is exercising his right of informed consent. This means that she is obligated to make decisions based on medical indication and other relevant ethical principles, and upon Mr. Jay’s expressed wishes when he was still competent. In the absence of such explicit directives, she should make an honest interpretation of how Mr. Jay would have decided if he were still competent (his implicit wishes), and finally, according to what a “reasonable person” would want (i.e., a person of sound mind and good moral character) that would be to his best interests. This presumes some degree of closeness and familiarity with the patient as a basis for such an appraisal, and also presumes Mrs. Jay’s own good character. The physician’s recommendation appears to be a reasonable request. If Mrs. Jay desires greater certitude, she should ask for a second opinion. However, it is important to note that moral certitude need only be based on probability, not on mathematical precision.

A Decision To Forgo Treatment

When Pope Pius XII spoke of "ordinary means" he was referring to a relative evaluation: "according to circumstances of persons, places, times and culture—that is to say, means that do to involve any grave burden for oneself or others." Likewise, "extraordinary means" refers not to medical techniques considered in and of themselves, but to those techniques or treatments which constitute an investment in instruments and personnel or an excessive burden in disproportion to their expected results for this patient, at this time, under these circumstances.

One is normally obliged to do everything one reasonably can to maintain a person’s life, but not when those things employed to that end offer the patient little or no reasonable hope for recovery, or not when their burden is in disproportion to their benefit, or not when their use is excessively risky. An "ordinary medical procedure" may be either ethically ordinary (that is, morally obligatory) or ethically extraordinary (that is, morally optional), depending on the aforementioned conditions. It is unnecessary to make a moral distinction between withdrawing and withholding a treatment: "one cannot impose on anyone the obligation to have recourse to a technique which is already in use but carries a risk or is burdensome" (emphasis added).

It seems that, in the case of Mr. Jay, resuscitation procedures would not offer him a reasonable hope for recovery, and would in fact be unduly burdensome. We can therefore evaluate such procedures—however medically accessible or easy to administer they may be—as ethically extraordinary, that is, non-obligatory. Forgoing resuscitation procedures should not be equated with euthanasia, but rather "as an acceptance of the human condition." We are not morally obligated to do everything possible to keep a person alive if such procedures offer little more than "a precarious and burdensome prolongation of life."

Nutrition and Hydration

Because of his difficulty with eating and swallowing, the physician may eventually be forced to consider whether or not it is appropriate to provide Mr. Jay with nutrition and hydration by nasal gastric tube feeding or by a gastrostomy. An IV method is very limited. Would it be ethically obligatory to resort to these means? The possibility of forgoing or withdrawing a treatment should not be based upon a prior determination that such treatment constitutes "ordinary care". Rather, the decision makers must ask if the treatment considered will cause a burden "disproportionate to the results foreseen" or, in the case of imminent death, "would only secure a precarious and burdensome prolongation of life."

The Declaration stipulates that, in the case of imminent death, "normal care due to a sick person in similar cases [must not be] interrupted." To make a prior determination that nutrition and hydration provisions always constitute "normal care" would seem to preclude the possibility that in this case they might be excessively burdensome and not without risks. It is not at all apparent that the Declaration would require such a prior determination. Would it not be rather cruel and unreasonable to restrain the patient and/or administer drugs to force the application of such procedures, when there is not reasonable hope for Mr. Jay’s recovery? It is not uncommon for a patient with Alzheimer’s Disease to pull out IV and feeding tubes,
or to scratch at the gastrostomy opening, risking infection. The physician has much to consider here. How extensive is Mr. Jay’s deteriorating condition? What are the normal consequences of the underlying pathologies? What can be done to provide him with adequate comfort care?

Forgoing Treatment or Euthanasia?

Any ethical decision to withdraw or withhold a treatment should follow a direct intention to: 1) eliminate a useless treatment, or 2) avoid a treatment whose burden is disproportionate to its benefit. We must never directly intend the death of the patient. That would constitute euthanasia:

By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia’s terms of reference, therefore, are to be found in the intention of the will and in the methods used (Declaration on Euthanasia, No. 2).

Intentionally omitting a treatment whose burden—for this patient in these circumstances—is not disproportionate to its benefit, or which would provide a useful cure for the patient as a whole, would constitute a direct intention to kill.

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“Suicide Machine”

What relationship is there between the U.S. Supreme Court’s decision in the Cruzan case and the physician-assisted suicide of Janet Adkins? (see Newsweek, June 18, 1990, pp. 47, 49). The first asserts that states can have an overriding interest in protecting life such that without specific provision for surrogate decision-making by family or others, no surrogate decision maker can act to withdraw life support systems from an incompetent person. In the second situation, Janet Adkins was neither dying or being sustained by a life-support technology and was fully competent. She had been diagnosed as being in the early stages of Alzheimer’s disease and elected to avoid the gradual deterioration typical of that disease by committing suicide.

These two situations are related as opposites. In the first situation, Nancy Cruzan had been in a persistent vegetative state for about seven years and would have soon died had she not been artificially fed from the beginning. Technologically assisted feeding was used to impede the natural consequences of the underlying pathology, namely, death. In the case of the second situation, Janet Adkins at the time was not dying although she was diagnosed to have a serious, progressive disease which ultimately (years later) would most likely have led to her death.

Causing and Allowing

It is vital to distinguish between the two situations, to make clear the difference between causing a person’s death and allowing a person to die. In the latter case the cause of death is the underlying pathology; that cause is already present and at work in the individual. In the former case, the cause of death has to be introduced from the outside; until that moment what will become the cause of death is external to the individual. Janet Adkins chose deliberately and freely to have injected—under her final control—the sedative and potassium chloride which caused almost immediate cardiac arrest and death. This is euthanasia.

Of course, that is not the whole story. Other considerations enter into the moral analysis. Even when the cause of death is an underlying pathology the question must be asked whether, here and now, in these circumstances, there is an obligation to impede the natural lethal outcome of that pathology. Morally, it is necessary to determine whether, in fact, the reasonably expected benefit to the patient exceeds the bur-

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