A Proxy’s Dilemma

A ninety-year old man whom we will call Jim has been in a nursing home since his 84th birthday following a stroke which hospitalized him for a few weeks. His right side had been affected so that his right arm and leg were relatively useless. After leading an active life, his sudden sharp reduction in maneuverability left him mildly depressed. But being a resilient person, he determined to make the best of his situation by making friends with his co-residents of the nursing home and entertaining some, at least, with stories of his many trips to Europe, Africa, Japan and “down under —” Australia. The latter he found particularly enchanting because of the varied terrain, exotic animals and friendly inhabitants with whom he could communicate in English.

Gangrene

An underlying vascular pathology (“hardening of the arteries”) gradually worsened over the years and circulation in the lower legs was beginning to become impaired so that the legs became gangrenous. Concurrently, Jim’s cerebral circulation became also impaired to the point that he increasingly lost touch with his external environment. Although there were periods of lucidity, it was clear that Jim no longer recognized his son and daughter. They had been very faithful to their aging father and visited him as often as their other responsibilities permitted.

The attending physician after appropriate consultation with medical colleagues recommended that a double amputation at the level of the knee be seriously considered. For several weeks, Jim had been in considerable pain and the administered pain medication was apparently becoming less effective. The son and daughter were both assured that everything was being done to treat the circulatory problem and the developing gangrene as well as the pain.

There was, nonetheless, some question in their mind as to whether the analgesic was really reducing the pain satisfactorily. Jim’s facial expression, his moaning and bodily posture suggested that the pain was still present to a degree beyond the comfort level.

The son and daughter discussed the possibility of amputation and were clearly undecided what to do. While the amputation would remove the immediate threat to their father’s life, they wondered as to what would really be gained, especially in view of what the physician had told them. The surgery itself might hasten death, but more likely it would not. However, it would give their father another year or more of life. When queried about their father’s level of consciousness and awareness, he could not guarantee that Jim would ever regain consciousness; in fact, it was much more likely he would remain comatose.

Not feeling capable of making such a decision for their father without some help, they approached their pastor, Father Peter. After listening kindly to their problem and asking a few questions about what treatment, apart from the amputation was available, he was told that non-treatment even with comfort care would result in death fairly quickly.

Consultation Request

They asked Father Peter, “What would you do in our place?” Father Peter was quick to answer, “But I am not and cannot ever be in your shoes, or for that matter, you cannot be in mine either. You bring to these decisions,” he said, “your whole life history — what you are genetically and what you have become by the way you have lived. Your comprehensive autobiography greatly shapes your decision.” The proxy, after all, Father Peter pointed out is the one who makes the decision for another person who rightly is the decision maker, but because of being mentally incompetent at the time is unable to make any decision. It is not the physician, nurse or lawyer who decides for the patient, but one who knows the patient well, or can reasonably conclude or (continued on page 2)

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what the patient would have wanted would be able to decide. It is not what the proxy thinks is best. Although, that could be the same as what the patient would have decided. It is helpful, too, if the proxy truly loves the patient for he (or she) will desire to respect the authentic wishes and well being of the patient.

Seeing more clearly what the role of the proxy was, they were now ready to decide about the amputation. Their pastor pointed out for them that they were ethically obligated only to a medical treatment if, all circumstances considered, it could be carried out without placing a grave burden on the patient or others, and further that it was not a useless procedure.

From the surgeon, they had learned that the surgery would be done under general anesthesia, and that any post-operative pain could be controlled by analgesic medication. The surgical and anesthetic trauma, they were told, may place Jim into a full coma because of the impaired circulation. For the same reason, the physician noted that other related problems would likely occur within the next year or so. Jim’s son and daughter also realized that because of his father’s impaired level of awareness the surgery itself and the post-surgical experiences could be traumatic and constitute a grave burden. Furthermore, there appeared to be no proportion between the surgery and post-operative consequences on the one hand, and the anticipated benefits on the other. The operation would not bring any notable improvement to Jim’s condition, but only serve to slow down the irreversible dying process.

The Relevant Church Teaching

Father Peter was able to assure them that the church recognized that such decisions had to be made by families, difficult and painful as it might be. They were confirmed and comforted by the words of the church’s official teaching:

The rights and duties of the family depend in general upon the presumed will of the unconscious patient if he is of age and ‘sui juris.’ Where the proper and independent duty of the family is concerned, they are usually bound only to the use of ordinary means.

Consequently, if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply. There is not involved here a case of direct disposal of the life of the patient, nor of euthanasia in any way: this would never be licit. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of cessation of life, and one must apply in this case the principle of double effect and of ‘voluntarium in causa’ (Pope Pius XII’s address to the International Congress of Anesthesiologists, November 24, 1957, p. 3, English translation from “The Pope Speaks,” vol. 4, 1958, pp. 393-398).

Seeing their way with increasing clarity and conviction, they returned to the hospital and, having verified their father’s status, informed the surgeon that surgery would not be sought. Comfort care only was what the situation required. With that decision having been made, Jim’s son and daughter returned to their father's room and began their vigil. Within a few days he died peacefully.

Save a Life and Lose It

If human life is of so high a value that an innocent person’s life can never be directly attacked, is it permissible ever to cease life sustaining activities? At one extreme of opinions there are those who would say that life supporting treatment and procedures should be vigorously maintained until, in spite of all our efforts, the individual dies. In this manner, it is clear that our actions have not led to the person’s death. If this observation be true of medical interventions, all the more is it true of the obligation to provide food and water.

To the other extreme are those who are convinced that once life becomes a burden to oneself, a person has the right — by virtue of self-domion-to terminate his life. A “thoughtful” person would do so, of course, in a manner that would cause the least inconvenience to others.

In between, these two positions 1) of asserting the obligation to do everything physically possible to maintain life and, 2) of alleging the right to terminate one’s life at will, there is a spectrum of positions that in varying degrees limit the obligation to sustain human life.

The moral tradition of the Catholic Church on this issue is summarized well in the teachings of Pope Pius XII and John Paul II. One aspect only, however, will be considered here. In response to questions posed to him about the obligation to continue life supporting activities when the condition of the patient appears hopeless, Pius XII stated the now well-known teaching about the kind of medical intervention which were obligatory:

“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” (Pius XII, address to International Congress of Anesthesiologists, November 24, 1957; English translation, The Pope Speaks, 1958, pp. 393-398).

While the principle can be validated objectively, its application contains a large subjective and relative component e.g., “according to circumstances of person, etc.” Since the notion of “burden” implies a subjective component, namely, how an