The Catholic Tradition on Forgoing Life Support

Rev. Kevin D. O’Rourke, O.P.

The phrase “ordinary and extraordinary means to prolong life” is familiar to many people inside and outside of the health-care profession. From an ethical perspective, there is general agreement that ordinary means must be used to prolong life when fatal or terminal illness threatens and extraordinary means may be forgone in the same circumstances. It sounds simple. Yet the application of these terms in clinical situations is never simple, either for people who will be making these ethical decisions or for health-care professionals, the doctors, nurses, and pastoral care advisors who will assist patients or their families in making these decisions. Theoretical, emotional, and ethical confusion often accompanies ethical decision making in these circumstances and beclouds the hearts and minds of decision makers.

This article seeks to dispel some of the reasons for confusion and difficulty in applying these terms. I shall begin with a short history concerning the development of these terms (I); then I will consider the difference between suicide, euthanasia, and allowing to die (II); the difference between comfort care and medical life support (III); the meanings of the terms ordinary, extraordinary, proportionate, and disproportionate (IV); the criteria for forgoing life support1 (V); and when (VI) and by whom (VII) the decision to withhold or remove life support should be made. In the course of the article, I will present some variant connotations that often lead to conflicting interpretations and disparate conclusions in clinical situations.

I would like to add a word of thanks to my colleagues, Rev. Benedict Ashley, O.P., and Rev. Patrick Norris, O.P.

1 “Forgoing life support” implies withholding or removing life support. The phrase was popularized by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions (Washington, DC: United States Government Printing Office, 1983).
I. Origin and Evolution of the Terms

Whether life must be pursued above all other goods and at all times was studied extensively by theologians for the first time at the University of Salamanca in Spain in the sixteenth century. Before this time, in difficult circumstances people of faith often made decisions to forgo the medical or surgical means that might prolong human life, but their decisions were more the result of necessity than of theological analysis. The sixteenth century was a time of extensive change. The New World had been discovered, and missionaries were sending back questions to the University concerning the rights of native peoples and their conquerors. Printing with moveable type had been perfected in the prior generation. On the European continent, nationalism was developing, and the Reformation and Counter-Reformation were taking place. Most significant for our purposes, medicine was starting to develop as a science. It was determined that life could be shortened or prolonged by reason of occupation, diet, medical procedures, and drugs.

A leader in the development of the theology of “death and dying” was Francisco de Vitoria, a Dominican theologian, called the Father of International Law,\(^2\) who taught at the University of Salamanca. When commenting upon the writing of St. Thomas Aquinas, especially in regard to homicide and abstinence, he stated some theological principles that have endured to contemporary times.\(^3\) For example:

- Human life is a great gift from God; a great good but not an absolute good, nor the ultimate good.
- Man is not the master of life, but should use all fitting means to prolong life. If the means to prolong life are not fitting or if they impose an excessive burden, they need not be utilized.
- The ultimate human good is friendship with God. All human acts should be ordered toward this ultimate end.
- God does not desire us to be interested in a long life; he wishes us to be interested in a good life.
- It is one thing to kill oneself; it is a different thing to not prolong life.

Other theologians at Salamanca followed and developed the thought of de Vitoria concerning the duties in regard to prolonging life.\(^4\) It seems that Domingo Bañez, O.P., toward the end of the sixteenth century, coined the terms *ordinary* and *extraor-
dinary means to prolong life. In the ensuing centuries, the teaching of the Salamanca theologians was very important in developing moral teaching concerning the prolongation of life. The concepts mentioned above were applied to new methods in medicine and surgery, but the foundational principles were never challenged by later theologians. The consensus of theologians through the centuries in regard to use and removal of life support led to the first authentic papal teaching in this regard, by Pope Pius XII in 1957. This statement was followed by the Declaration on Euthanasia in 1980, issued by the Congregation for the Doctrine of the Faith (CDF) and approved by Pope John Paul II. More recently, Pope John Paul II also spoke about the removal of life support and the care of the dying, being careful to distinguish between the removal of unnecessary life support and euthanasia. Finally, the bishops of the United States have applied the teaching of the Church to issues involving Catholic hospitals and nursing homes in the Ethical and Religious Directives (ERD).

II. The Difference between Suicide, Euthanasia, and Allowing to Die

For Christians, and for many others as well, human life is considered to be a gift from the Creator, and the control of human life implies stewardship, not absolute autonomy. Human life may be compared to the talents given by the master to his servants, which he expects them to invest so that there will be a proper return (Mt 25: 14–30). Hence, this gift of life must be used wisely and prudently to strive for the purpose of life. As Thomas Aquinas stated, “Every man has it instilled in him by nature to love his own life and whatever is directed thereto; and to do so in due measure, that is, to love these things not as placing his end therein, but as things to be used for the sake of his last end.”

found in friendship with God and living with Him forever. However, the time may come in a person’s life when he is reasonably convinced that life is coming to an end, because of an internal threat to homeostasis and the conviction that prolonging life by additional medical treatment will not bring him closer to God. Family members or legal proxies may also be called upon to make a decision of this nature for patients who are unable to speak for themselves (see section VII below). In these circumstances one may decide that prolonging life is not the best investment of energy, time, or money that can be made in the time remaining. Seeking to prolong life in such a situation may not benefit the patient and may interfere with the pursuit of other, more important goods or duties. Hence, if further therapies to prolong life “do not offer a reasonable hope of benefit or entail an excessive burden” insofar as attaining the purpose of life is concerned, they may be refused. The intention inherent in an act of this nature does not constitute suicide or euthanasia. Rather, it is an act whose moral object may be accurately described as “allowing to die for legitimate reasons.” When a person chooses to have life support withheld or removed in such a case, or when the decision is made by a proxy, the decision maker is not making a choice in favor of death. Rather, an indirect choice is made about when the patient will die, “taking into account the state of the sick person and his or her physical and moral resources.”

Suicide occurs when the intention inherent in the human act (the moral object, purpose, or finis operis of the act) is self-destruction. Euthanasia occurs when the intention inherent in the act is to end the life of another person, with or without the consent of the person, and the motive (or finis operantis) for the act is to alleviate or eliminate suffering. In euthanasia, the act of killing may be accomplished by commission or omission; that is, by performing a lethal act or by withholding some life-prolonging therapy which should be utilized. The Declaration on Euthanasia defines such an act in the following manner: “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.”

Clearly, whether euthanasia has occurred cannot be discerned simply from the physical result of commission or omission of a medical act. Rather, the moral object of the act must be determined. To reject additional medical efforts which do not correspond to the actual circumstances of the patient (that is, aggressive care) is not to reject life itself or the God who gave it, but is simply to reject efforts that will not

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12 United States Conference of Catholic Bishops, Ethical and Religious Directives, nn. 56, 57.

13 I have borrowed the term “intention inherent in the act” from Elizabeth Anscombe. I believe it does away with the ambiguity which sometimes results if the term “intention” is used in regard to the moral object, and also for the goal of the agent. See G. E. M. Anscombe, Collected Philosophical Papers, vol. 3 (Oxford: Blackwell Publishing, 1981), 86.

14 Congregation for the Doctrine of the Faith, Declaration on Euthanasia, IV.

15 Ibid., II.
help to complete the task of striving for the purpose of life. As Pope John Paul II declared:

The refusal of aggressive treatment is neither a rejection of the patient nor of his or her life. Indeed, the object of the decision on whether to begin or to continue a treatment has nothing to do with the value of the patient’s life, but rather with whether such medical intervention is beneficial for the patient.  

This act, which is contrary to euthanasia, is aptly described as “allowing to die for legitimate reasons.” These legitimate reasons are either “no hope of benefit” or “excessive burden.” Both euthanasia and allowing to die have the same physical result: death of the patient. But they have a radically different moral significance.

Pope John Paul II explained the distinction between allowing to die and euthanasia in the following manner:

Euthanasia must be distinguished from the decision to forgo so-called “aggressive medical treatment,” in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. … To forgo extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.

When comparing euthanasia and the elimination of pain as death approaches, the teaching authority of the Church has clarified the issue on several occasions. If analgesics are given to control or eliminate pain (intention inherent in the action), this is not an act of euthanasia, even though the medication given may indirectly shorten the patient’s life. This is an application of the principle of double effect. There is concern that the life of patients afflicted with terminal cancer might be shortened by the use of morphine or other analgesics, but research seems to indicate this seldom happens.

### III. The Difference between Medical Therapy and Basic Health Care

Before discussing in detail the criteria for removing life support, for the sake of clarity let us distinguish those medical or surgical procedures which are employed to prolong life from those activities that furnish comfort care, sometimes called basic health care or minimal care. In the former category are all medical and surgical procedures designed to combat illness and disease and alleviate pain. Usually, these procedures require the expertise of medical professionals in order to be utilized. In

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16 John Paul II, “To the Participants in the 19th International Conference,” n. 4.

17 John Paul II, Evangelium vitae, n. 65.

18 Pius XII, “To the 9th National Congress of the Italian Society of Anesthesiology” (February 24, 1957), Acta Apostolica Sedis 49 (1957); John Paul II, Evangelium vitae, n.65; Congregation for the Doctrine of the Faith, Declaration on Euthanasia, III.


the latter category are those activities that may not improve the health of the patient, but which demonstrate human compassion and respect for the person. For example, people who are suffering from illness or disease, no matter what their cognitive-affective function, should be bathed and kept clean and free from pain. Thirst and other effects of dehydration should be controlled insofar as possible. If they are in pain, analgesics should be administered even though health cannot be restored.

Some procedures of palliative care seem to be a combination of comfort care and medical care.21 In recent times, different opinions have been put forward as to whether assisted nutrition and hydration (ANH) for people in a permanent vegetative state (PVS) amounts to comfort care or a medical procedure. For example, Pope John Paul II affirmed in a recent papal allocution that ANH for PVS patients is “normal care” and a “natural means of preserving life, not a medical act.”22 The Multi-Society Task Force on PVS, on the other hand, maintained that ANH is a medical procedure,23 as did the U.S. Supreme Court.24

Clearly, the method by which ANH is delivered is a medical procedure, especially if installing the feeding tube involves surgery, as it often does, and if the patient must be monitored by health-care professionals in order to prevent infection and aspiration pneumonia. But the material conveyed via ANH procedures to sustain nutrition for PVS patients may be assigned fittingly to the category of basic health care, or normal comfort care. As John Connery, S.J., stated, “artificial feeding seems to be a combination of both [medical treatment and basic health care].”25 Whatever this type of care is called, it is important to note that the moral norms for forgoing it are the same as those for forgoing medical care: no hope of benefit or excessive burden. For example, moving a person to prevent bed sores is basic or comfort care. But if death is imminent, there is no need to move the patient, because it would not offer hope of benefit. Or the patient may be so fragile that to move her would cause intense pain or even a fracture. Moving her may be omitted because it is an excessive burden.

It seems that the 2004 papal allocution maintains that ANH is a benefit for a person in PVS. But contrary to many statements referring to it, the allocution does not preclude the consideration of excessive burdens that might rule out the use of ANH therapy. As the Australian Catholic Bishops’ Conference stated in response to the papal allocution of March 20, 2004:

In particular cases, however, the provision of nutrition and hydration may cease to be obligatory, e.g., if the patient is unable to assimilate the material pro-

vided or if the manner of the provision itself causes undue suffering to the patient, or involves an undue burden to others.  

In the allocution of March 20, 2004, Pope John Paul II spoke of “the heavy human, psychological and financial burden” for the family. The cost of nursing care for a PVS patient, for example, may be excessive, even though the cost of nutrition might be minimal.

IV. Comparison of Terms: Ordinary and Extraordinary, Proportionate and Disproportionate

For centuries, the terms ordinary and extraordinary were used for determining the use of life support. If the medical therapy was ordinary, there was a moral obligation to use it; if it was extraordinary, its use was optional. In 1980, the CDF suggested in the Declaration on Euthanasia that the terms proportionate and disproportionate might be more accurate than ordinary and extraordinary. In order to signify the meaning of both sets of terms, the Declaration added:

In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

It seems the main reason for the suggested change in terminology arose from the tendency to interpret the terms ordinary and extraordinary in an abstract or generic manner; that is, the decision whether a medical means to prolong life was ordinary or extraordinary was often made without reference to the condition of the patient. Using the terms in an abstract or generic sense, only the cost, usual effectiveness, availability of a medical device, and potential pain inflicted would be considered when designating a medical or surgical procedure as ordinary or extraordinary. The overall condition of the patient was not considered until after the terms of ordinary or extraordinary care had been decided. This would often result in confusing terminology. The means in question might be considered ordinary in the abstract, but this designation would be changed to extraordinary once the condition of the patient had been considered. Thus, a respirator or a feeding tube might be designated as an ordinary means to prolong life, but after consideration of the patient’s condition, it might be considered extraordinary.

26 Bishops Committee on Doctrine and Morals (Australian Catholic Bishops’ Conference), Bishops Committee for Health Care (Australia), and Catholic Health Australia, “Briefing Note on the Obligation to Provide Nutrition and Hydration” (September 3, 2004), n. 3, http://www.acbc.catholic.org.au/documents/2004090316.pdf.


29 Congregation for the Doctrine of the Faith, Declaration on Euthanasia, IV.

Connery and Thomas O’Donnell, S.J., mention some theologians who used this abstract or generic form of determination, though Connery states that overall, “the sensitivities of the individual were taken into account.”

Clearly, the more accurate designation of moral responsibility in choosing or rejecting medical or surgical procedures rests upon a diagnosis of pathology and prognosis of possible effects of medical care.

Since the Declaration on Euthanasia was issued, the terms *proportionate* and *disproportionate* have been used as synonyms for *ordinary* and *extraordinary* by Catholic theologians, but they have not supplanted the original terms. Hence, in this study, I shall use the terms *ordinary* and *extraordinary*, but will always insist that a determination cannot be made concerning the moral obligation to use a particular therapy until the condition of the patient and the potential effect upon the patient is known, insofar as possible. Thus, I shall use the term in the “relative sense,” as indicated by O’Donnell.

The tendency to use the terms *ordinary* and *extraordinary* in an abstract manner can still be found in the writings of some physicians and other health-care professionals, and very frequently in the conversations of people who must make decisions for loved ones concerning the use or removal of life support. Therapies which, in the abstract sense of the term, were at one time experimental or extraordinary and later became standard or ordinary care include, for example, blood transfusions and angioplasties (surgical reconstructions of blood vessels). But whether such a therapy should be utilized or may be withheld or withdrawn from a particular patient cannot be determined from the moral perspective until the condition of the patient is factored into the decision. Thus, in any oral or written discussion concerning life support, the meaning of the terms must be made clear at the beginning in order to avoid confusion later on.

V. The Criteria for Forgoing Life Support

The phrase “forgoing life support” refers to withholding and withdrawing life support. The criteria for withholding life support are the same as those for withdrawing life support that is already being utilized. In the latter case, however, the emotional response is more intense, because it usually implies that the patient will die shortly after medical therapy is withdrawn.

The specific criteria for distinguishing between ordinary and extraordinary or between proportionate and disproportionate medical therapy are the hope of benefit that the therapy offers, and the burden imposed by the therapy upon the patient, the family, and the community. Pope John Paul II expressed the same criteria in this

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33 Ashley and O’Rourke, *Health Care Ethics*, 442.

way: “The possible decision either not to start or to halt a treatment will be deemed ethically correct if the treatment is ineffective or obviously disproportionate to the aims of sustaining life or recovering health.”35 In general, the benefits sought through medical care are the preservation or restoration of health and the alleviation of pain. In short, the goal of medicine is to promote optimal functioning, given the person’s physical and mental capacities.36 Medical therapy does not always result in a cure. It does not always improve or restore health or prolong life. Often it merely circumvents, abates, or alleviates an illness or disease, but does not eliminate it.

While medical care is directed primarily toward physiological or psychological functions, it often offers social or spiritual benefit indirectly. The benefit of medical care enables one to pursue the goods of life. These goods may be physical, psychological, social, or spiritual. These are proximate goods, explicitly or implicitly ordered toward the ultimate good of life, friendship with God. These proximate goods are often more prominent in the minds of persons as they evaluate hope of benefit associated with particular medical therapies. For example, when making serious medical decisions, people ponder what effects the therapies will have upon their health, their vocations, and their families.

Would this surgery improve my overall well being and allow me a more pain free life? Would this medicine enable me to cope with the stress of life more adequately? Will the medication or surgery enable me to return to work? Will this therapy enable my loved one, for whom I am the proxy, to regain consciousness, or will it simply prolong a comatose condition? Finally, how expensive will the medical procedure be? What other goods would the family have to forgo if we invest in this medical therapy? Thus, economic, psychic, and social goods more often are the immediate concern of decision makers. They are all included under the general category of hope of benefit. But these goods are at least implicitly ordered to a higher good. As Pope Pius XII stated in his famous declaration on life support in 1957, “Life, health, all temporal activities are in fact subordinated to spiritual ends.”37

**Burdens**

The burdens of medical care might also affect the pursuit of the goods that are significant in human life; thus, the burdens might be economic, physiological, psychological, social, or spiritual. Since the sixteenth century, economic burdens, extreme pain, risk of losing life, and great subjective repugnance have been the principal burdens considered.38 In order to justify forgoing life support, the burden must be judged to be excessive. Determining an excessive burden is often a difficult process. All medical care is a burden in one sense. But an excessive burden makes striving for the continuation of life, or an important good of life, a moral impossi-

35 John Paul II, “To the Participants in the 19th International Conference,” n. 4.
37 Pius XII, “The Prolongation of Life,” 398.
ity—or at least very difficult.39 Certainly, some objective norms can be set for judging burden. Theologians seek to do this, presupposing a certain degree of courage (the virtue of fortitude). Thus, direct killing of oneself or another, even to avoid suffering, is prohibited. But subjective disposition must also be considered.

At one time, some moral theologians suggested that a woman of tender conscience might find it an excessive burden to consult a male physician, and thus they thought that such a woman would be excused from consulting a physician. What may seem to be an excessive burden for one person might be considered negligible by another person. As the Declaration on Euthanasia states, “In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person’s name … to decide in the light of moral obligations and of the various aspects of the case.”40 For this reason Catholic tradition has always insisted that the patient or the proxy has the right to make the final decision concerning the refusal of health care, as we shall see in section VII. Kevin Wildes detects a retreat from this principle in regard to some recent statements of bishops’ conferences in regard to the use of ANH: “In trying to objectivize the benefits of medically assisted feeding and hydration they neglect the subjective element for determining ordinary care. The benefits of a treatment can only be determined within the context of a patient’s life.”41

Research on the burdens that people consider excessive indicates that many people would consider being paralyzed, and able to breathe only if assisted by a respirator, an excessive burden.42 Yet many people actually in this condition adjust to their situations very well and desire to prolong life by using life support.43 Thus, the ethical responsibility to consult the patient with regard to forgoing life support, and the need to afford these persons the proper counseling, cannot be emphasized too greatly. We shall have more to say about this factor when we consider personal and proxy decision making.

Future Burdens Considered

When discussing burdens, theologians consider not only the present burden associated with a particular medication or medical procedure, but also any future burden. As Connery says, “In assessing any particular means, it made no difference whether the burden to the patient was experienced before, during, or after the treatment.”44 For example, the burden associated with respirator-assisted breathing is considered by most people to be a minimal burden, especially if intubation is necessary for only a short time. However, the length of time that this burden might endure must also be taken into consideration. For example, a young athlete fractured the C3

40 Congregation for the Doctrine of the Faith, Declaration on Euthanasia, IV.
44 Connery, “Prolonging Life,” 45.
vertebra in a trampoline accident. Able to breathe only with a respirator, and now quadriplegic, he was informed two weeks after the accident that this condition would last for the rest of his life. Communicating with his family through eye contact, he convinced them to ask his physicians to remove the respirator because the prospect of living the rest of his life in this condition was an overwhelming burden. The family agreed with him. Having consulted with ethicists, the physicians brought in people who were living successfully with the same disability, but he and the family persisted in their request. After a time, the physicians ceded to their request. A less dramatic forgoing of life support often happens when a dialysis patient, experiencing severe and continual fatigue, realizes that she no longer benefits sufficiently from the treatment, determines to discontinue the treatment even though, if continued, it might prolong her life for the foreseeable future.

The financial burden resulting from prolonged medical therapy can be misconstrued. For example, the materials needed for tube feeding (i.e., ANH) are inexpensive: a rubber tube and some cans of Ensure. But installing a gastrostomy tube or a tube into the vena cava (hyperalimentation) is a surgical procedure performed in a surgical suite, and long-term nursing care will be necessary for a person with these devices. These considerations are all part of the financial burden. To set these considerations aside is unrealistic.45

Two Criteria, or One?

Are two criteria used when evaluating medical therapy, or are benefit and burden to be combined? Connery expressed a preference for keeping them separate, because they deal with different issues. “In practice, at least, the question of benefit seems limited largely to terminal cases; burden can be an issue even in cases which are not terminal.”46 From a theoretical perspective, these are two distinct criteria, and sometimes they are different in the practical situation. For instance, a patient suffering from cancer may determine that prolonging life for another ten days may be ineffective, even though there is no serious pain or financial burden. Or drug therapy for patients with AIDS may offer hope of benefit, but some patients might deem it an excessive burden because of the expense involved.

More often, in an actual case, benefit and burden are compared to each other. The end result is a statement that the medical therapy in question is either a burden or a benefit. Some authors restrict their considerations to the benefit/burden terminology and seldom consider benefit and burden as separate criteria.47 In the ERD, directives 56 and 57 distinguish between hope of benefit and excessive burden, but in directive 58 the two are combined in the discussion on the use of ANH.


46 Connery, “The Ethical Standards,” 47.

Quality-of-Life Considerations

The question is often asked whether quality-of-life considerations can be used as criteria for determining whether a medical procedure offers hope of benefit or imposes an excessive burden. But in any discussion of this nature, it is necessary to realize that quality of life is an ambiguous term; it has different connotations at different times.48 In one sense, it refers to our relationship to God. In this sense, all have the same quality of life and dignity because God loves each person. This is the sense in which Pope John Paul II used the term when he spoke against quality-of-life decisions in the allocution concerning the care of PVS patients.49

But the term is also used to measure human function. People with impaired human function are said to have an impaired or lower quality of life. Some people have impaired human function as the result of a genetic or physical anomaly. If a person with a disability of this nature contracts a serious disease, it would be highly immoral to withhold care because of the genetic or physical disability. Consider, for example, a child with Down syndrome who has a ruptured appendix. The parents’ refusal of surgery or medication to treat the ruptured appendix would be a grave violation of the child’s right to life. But there is a third meaning to the term “quality of life.” Judgments of this nature “rely on the discernment of the patient.”50 Some people have impaired function resulting from illness or disease, and for these people the quality of life is fittingly considered when benefits and burdens are assessed, as a document cited with approval in the papal allocution maintains.51 Let us suppose that one’s mother has cancer, which has metastasized throughout her body, and her kidneys begin to fail. Should we consider her overall condition as we decide whether dialysis will be beneficial for her?

In order to obviate the difficulties that arise from the use of the term “quality of life,” Father O’Donnell suggested in a private conversation that the term “quality of function” be used whenever a question arises about withdrawing life support from a person suffering impaired function from a serious illness or disease.52 Although it is difficult to change the terms used in regard to death and dying, this seems to be a far better alternative when discussing conditions resulting from serious pathologies.

VI. When Should the Decision to Forgo Life Support Be Made?

This is one of the more misunderstood questions in regard to forgoing life support. Since humans have a serious obligation to seek health in order to prolong life, they have a moral obligation to seek to overcome illness and disease, unless the means to accomplish this goal does not offer hope of benefit or imposes an excessive burden.

burden. When a less serious illness or disease is present, we often rely upon the natural homeostasis of the body to resist it. For example, many people do not take medicines or antibiotics if they contract a minor case of influenza, relying instead upon rest, liquids, and the natural resistance of the body to gradually restore health. However, when a more serious illness or disease threatens, one that might cause death if not eliminated or abated, the prudent person makes a decision to utilize medications or surgery to help the body overcome it, or at least to mitigate its effects.

Thus, the logical time to make decisions about utilizing the means to prolong life is when a person contracts a serious illness. Usually, the initial reaction to a serious illness will not involve a rejection of medical means due to lack of benefit or excessive burden. But in time, as the illness progresses, if the medical therapy is ineffective or becomes acutely onerous, a decision to reject medical means might be made for the reasons mentioned above. When decisions have to be made for persons unable to make decisions for themselves, proxy decision makers may decide to forgo life support for these reasons.

Often, people believe that life support, either for oneself or for another who is incapable of making health-care decisions, must be continued until it is no longer physically possible to keep a person alive. This implies that life support cannot be removed until the fatal disease can no longer be resisted, and that death will occur within a short time, no matter what medications or medical procedures are utilized. Physicians with this mentality often assert that life support cannot be removed because the patients are not suffering from terminal illness. This seems to be the rationale underlying a recent statement of the World Federation of Catholic Medical Associations concerning patients in a vegetative state: “VS patients cannot in any way be considered terminal patients, since their condition can be stable and enduring.”53 O’Donnell states that “there is in the medical profession an ideal which demands the fighting off of pain and death until the last possible moment.”54

The assertion that life support cannot be removed unless a terminal illness is present is contrary to the consistent tradition in Catholic moral theology. When theologians of the sixteenth century considered questions concerning the duty to prolong life, they posited cases which did not presuppose the presence of terminal illness. Moreover, in the Declaration on Euthanasia, the question is posed, “Is it necessary in all circumstances to have recourse to all possible remedies?”55 Section IV of the declaration indicates that several circumstances may prompt a decision to withdraw life support before a terminal illness is diagnosed. Guidance for withdrawing life support even before a so-called terminal illness is present is offered:

In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the

55 Congregation for the Doctrine of the Faith, Declaration on Euthanasia, IV.
result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.56

Furthermore, the notion that life support may be forgone only if the patient suffers from a terminal illness neglects the second criteria for forgoing life support: excessive burden.

The thought that a terminal illness must be diagnosed before life support can be withdrawn was used by the lower courts in the famous Brophy, Conroy, and Cruzan cases. But these decisions were later reversed when the higher courts considered the matter more thoroughly and determined that the key issue was not whether a terminal illness was present but rather the effect of the therapy upon the patient. Some of the judges in the lower courts maintained that if death occurred after the removal of life support, the result was homicide. But the decision of the higher courts rightly inferred that if death occurred after the removal of life support, death was not the intention inherent in the action. Rather, the cause of death was the terminal illness from which the patient suffered, not the removal of life support.57

Another misleading attitude maintains that life support can be withdrawn only if death is “imminent and inevitable.” This phrase is used in the encyclical Evangelium vitae, n. 65, and is also stated in an unofficial Vatican document seeking to summarize church teaching on medical ethics.58 Of course, if death is imminent and inevitable, this diagnosis can be factored into the decision-making process. Indeed, it makes the decision whether or not to forgo life support easier. But the statement about “imminent and inevitable” death in the encyclical does not indicate that life support can be withdrawn only if death is imminent and inevitable. The encyclical quotes the Declaration on Euthanasia as the source of its teaching. As we have seen, this document envisions life support being removed even if death is not imminent and inevitable. Unfortunately, some people purporting to speak for the Church have recently focused upon this phrase and maintain that any removal of comfort care or life support that results in death is euthanasia, unless death is imminent and inevitable. This is contrary to five hundred years of theological analysis.

VII. Who Makes the Decision?

Often, it is unclear which person has the right to determine whether the means to prolong life are ordinary or extraordinary. Clearly, the physician is deeply involved in the decision. He or she must present an opinion as to whether the means in question will cure, help significantly, or have no effect upon the ailing patient. In other words, the diagnosis and prognosis are primarily the responsibility of the physician. But other circumstances, in addition to medical effectiveness, must be considered. What about expense, pain, and inconvenience? What about the spiritual condition of the patient? Only the patient or the proxy can determine these factors accurately.

56 Ibid.
58 Pontifical Council for Pastoral Assistance to Health Care Workers, Charter for Health Care Workers (Boston: Daughters of St. Paul, 1995), n. 120.
For this conclusion, the Catholic tradition does not rely upon the legal right of autonomy, as does the modern teaching of bioethics. Rather, the source of this personal responsibility is the “sacred and inviolable” character of the human person.\(^59\) Hence, the radical right to make the ethical decision concerning means to prolong life belongs to the patient. Pope Pius XII spoke to this issue:

The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general, he or she can take action only when the patient explicitly or implicitly, directly or indirectly, gives permission.\(^60\)

The ERD also speaks to this issue:

The free and informed consent of the person or the person’s surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.\(^61\)

The number of articles and books devoted to the topic of informed consent illustrate that the right of the patient to make health-care decisions is prominent in the study of bioethics.

**Proxy Consent**

The most difficult situation in regard to consent arises when the patient is incapable of decision making and a proxy must make decisions.

If the patient is too young to indicate his or her wishes, or if the patient has failed to indicate the preferred therapy as death threatens, the proxy, usually a family member, acts in the *best interest of the patient*. That is, he or she, acting with the advice of the attending physician, indicates the preferred therapy, or forgoing of it, given the circumstances. In the United States, the use of advance directives, in which the patient, when competent, names a proxy (not always a family member) to make health-care decisions when he or she is not competent to do so, is recommended. These directives have been recognized as a legitimate means of preparing for future health-care needs by the U.S. bishops’ conference.\(^62\)

When acting under the guidance of an advance directive, the proxy should seek to offer *substitute judgment*; that is, to follow the previously expressed wishes of the patient if these wishes are in accord with the teaching of the Church. However, if the circumstances are not the same as those envisioned by the patient, as often happens in crisis situations, the proxy may have to act in the best interest of the patient. In all


\(^{60}\) Pius XII, “The Prolongation of Life,” 393–398.


\(^{62}\) Ibid., n. 25.
circumstances, the people assisting in care and decision making must take care to assure that dying remains a spiritual experience for the patient, rather than an expression of previous personal controversies.

**Family Concerns**

While families are often called upon to offer substitute or best-interest decisions when their loved ones are not able to make decisions for themselves, family decisions need not be totally altruistic. That is, it may happen that the family will have concerns of its own, which, if not taken into consideration, would inflict excessive burdens upon the family. This often is the case when nursing a comatose patient imposes a serious burden upon the family. The *ERD* implies that family concerns should be recognized when decisions about life support are being made by a patient (directives 56 and 57). Connery stated, “A patient would be free to omit a means to preserve life even if he did so to remove a burden from the family.”63 Moreover, Pius XII made two statements relevant to family decision making:

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 [the family] are usually bound only to the use of ordinary means.

When discussing the removal of respirators, he added,

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.64

Finally, a statement of the U.S. Bishops’ Committee for Pro-Life Activities in regard to family decisions about ANH should be kept in mind:

We should not assume that all or most decisions to withhold or withdraw medically assisted nutrition and hydration are attempts to cause death. To be sure, any patient will die if all nutrition and hydration are withheld. But sometimes other causes may be at work—for example, the patient may be imminently dying, whether feeding takes place or not. *At other times,* although the shortening of the patient’s life is one foreseeable result of an omission, the real purpose of the omission was to relieve the patient of a particular procedure that was of limited usefulness to the patient or unreasonably burdensome for the patient and the patient’s family or caregivers. This kind of decision should not be equated with a decision to kill or with suicide.65

Of course, the family does not have a moral obligation to request withdrawal of life support if it seems to be extraordinary. The family may continue care, if it does not violate the rights of other persons or facilities associated with caring for the patient. Thus, the rights of doctors and hospitals to declare that life support should be

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63 Connery, “The Ethical Standards,” 91.

64 Pius XII, “The Prolongation of Life,” 399.

withheld or withdrawn must be respected, even if the family does not wish to follow their advice.

Community Interest

The community is also mentioned as a stakeholder when decisions about life support are necessary. People belong to small and large communities. In a small community, the expense and care that a particular therapy might impose could be a factor when decisions about life support are made, because if funds are not expended for one person, they may benefit another person. In religious communities, for example, there is usually a fund to finance health care. But this fund is not an insurance fund in the strict sense; the members of the community contribute to it. Thus, if a community member requires expensive therapy, others in the community may not have access to adequate therapy, or the contributions of individual members may have to be increased.

Recently, a friend of mine who is prominent in the field of bioethics was afflicted with a serious stroke, and refused extensive therapy, stating that he did not want to expend the funds of his community upon therapy that would have doubtful success. In other words, he determined that in his condition, and given the finances of the community, such care would not offer hope of benefit and was therefore extraordinary, even though it would have prolonged his life.

At present, given the method of paying for health care in the United States, the larger community, the state, or the insurance company do not often become a significant factor in making decisions about forgoing life support. While the funding methods of state-sponsored health care and insurance companies are too complicated to discuss in this article, if care is withheld or removed from one person, there does not seem to be a direct benefit for another person, and the uninsured do not benefit from cost reduction for the insured. This situation could change if universal health care ever becomes a reality within the social policy in the United States.

The Purpose of Life

From the consideration of the Catholic tradition, several conclusions may be drawn. Decisions concerning hope of benefit and excessive burden should be made in view of the proximate and ultimate goals of human life. Euthanasia and allowing to die for legitimate reasons have the same physical result, but are vastly different from an ethical perspective. There is a legitimate distinction between basic health care and medical therapy, but the ethical norms governing their use are similar. Medical therapy may be withheld or withdrawn even if a terminal illness is not present, and even if death is not imminent and inevitable. The needs and goods of the patient should dominate the decisions of the proxy, but the needs and goods of the family and the community should not be ignored. And finally, dying is a spiritual experience which should help a person fulfill the purpose of life.

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