NOTES

THE DUTY TO PRESERVE LIFE

Some time ago I published an article entitled "The Duty of Using Artificial Means of Preserving Life."[1] Though the entire article was intended to stimulate discussion, the conclusion indicated two points that seemed to merit special consideration: namely, that even ordinary artificial means might not be obligatory for the patient when they are relatively useless, and that a physician's professional standards might call for efforts to preserve life that exceed his strict duty to his patient. My present purpose is to give briefly some of the reactions to my suggestions, as well as some further observations of my own, particularly with reference to the physician's duty. My intention is still to promote discussion, not to draw final conclusions.

USELESS MEANS

Theologians have responded favorably to the suggestion that even an ordinary artificial means need not be considered obligatory for a patient when it is relatively useless. It was proposed, however,—and I agree with this—that, to avoid complications, it would be well to include the notion of usefulness in the definitions of ordinary and extraordinary means. This would mean that, in terms of the patient's duty to submit to various kinds of therapeutic measures, ordinary and extraordinary means would be defined as follows:

Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.

Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.

With these definitions in mind, we could say without qualification that the patient is always obliged to use ordinary means. On the other hand, insofar as the precept of caring for his health is concerned, he is never obliged to use extraordinary means; but he might have an extrinsic obligation to use such means, e.g., when his life is necessary for the common good or when a prolongation of life is necessary for his eternal salvation.

The foregoing definitions do not avoid all difficulties. There is always difficulty in estimating such factors as "excessive," "reasonable hope," "proportionate benefit," and so forth. But this difficulty seems inherent in

[1] THEOLOGICAL STUDIES, XI (1950), 203–20.

all attempts to make human estimates, and it is doubtful that we can ever attain to a formulation that will entirely remove this problem.

THE DOCTOR'S DUTY

It has been said that the doctor's duty is parallel to that of his patient. In my article I pointed out that this is not correct, because the patient may, if he wishes, use extraordinary means and, unless his desire is clearly unreasonable, his physician must accede to it. Hence, the doctor's duty towards his patient should be stated thus: he must use all means that the patient is obliged to use, as well as all means that the patient reasonably wishes used.

Is the doctor's duty completely stated in terms of his patient, or has he a duty towards his profession which may, at times, demand even greater care to preserve life than would be included in the contract with the patient? My article intimated that the physician's professional standards are associated with the common good and that the necessity of preserving high standards might create an obligation to do more to preserve life than would be demanded merely by the physician–patient relationship. Theologians with whom I have discussed the question are inclined to agree with this; nevertheless, some are of the opinion that the physicians' standards are occasionally unreasonably high and that their endeavors to preserve life sometimes impose an expense and strain on relatives that are entirely unnecessary.

Professional standards must first be formulated before they can be evaluated, and for the formulation we must turn to the medical profession itself. Through correspondence and discussion with conscientious doctors, as well as through reading, I have tried to obtain accurate statements of their standards. I have thus far found two statements, one of which represents a moderate attitude, the other an extreme attitude. It may be interesting if I state these attitudes and then attempt a comparative evaluation, with a view to promoting further thought and discussion.

The following expression of the moderate attitude was already quoted in these pages:

> I believe that some distinction should be made between an active attitude designing to end life and a passive attitude which allows a hopeless patient to die and does not involve the use of futile gestures. It seems to me that the doctor's job is to keep such a patient as free as possible from suffering either physical pain or mental anguish. This is quite different from deliberately ending his life, which seems to me contrary to the whole ethos of our profession.[2]

[2] *Ibid.*, XII (1951), 66, citing Willard L. Sperry, *The Ethical Basis of Medical Practice* (New York: Paul B. Hoeber, Inc., 1950), p. 134.

I can recall no printed statement that exactly expresses what I have called the extreme attitude; but I have heard it often in discussions and I think it is accurately formulated in these words:

> The doctor's duty is to preserve life as long as he can and by any means at his disposal. He is not the judge of life and death; but he makes himself the judge the moment he decides not to use or to cease using some available means of preserving life. Only God knows when the patient's life is to end. There is always the possibility of a miracle.[3]

There are pros and cons for each of these standards. On my part, I have found it convenient to compare their relative merits and demerits according to these six points: (*a*) euthanasia, (*b*) defeatism, (*c*) the theologians' way of computing obligation, (*d*) the "good Catholic" attitude, (*e*) effects on others, and (*f*) the doctor's conscience.

a) *Euthanasia:* Both standards uncompromisingly reject euthanasia. Nevertheless, the extreme attitude gives it a wider berth and more surely safeguards physicians from any shading into, or any appearance of, a euthanasian mentality. Those who follow the moderate standard might occasionally be too ready to consider a case hopeless and thus fail to use some ordinary means of preserving life, or they might at least create the impression of favoring euthanasia. These dangers might be slight, but they are not to be ignored.

b) *Defeatism:* Since the extreme attitude simply refuses to consider any case hopeless, it can have no part with defeatism. Does this imply that the moderate attitude is defeatist? Fairness to the medical profession requires that, before drawing this conclusion, we consider carefully what defeatism is. I should think it would be pertinent to distinguish between an incurable *disease* and an incurable *patient*. For example, it seems clear that cancer, in some forms and at certain stages of development, is at present incurable; and a physician who considers his patient hopeless because he has cancer in such a form and at such a stage, and who, therefore, ceases to prescribe remedies he knows to be useless, is not necessarily a defeatist. But defeatism would rightly be attributed to the medical profession if it ceased trying to find a remedy for the disease itself.

[3] For a similarly lofty statement, see "Mercy Killing Turns Back the Clock," by Paul L. Blakely, S.J., *America*, LXII (Nov. 4, 1939), 90. In this article Father Blakely speaks of "the law which has governed the medical profession since the profession took form, and which tells the physician that his most solemn obligation is to fight death to the end, however hopeless the battle may seem."

Perhaps the point I am making here will be clarified by these words of Dr. Frederick Loomis:

> So far as I am personally concerned, I am perfectly willing to say that my duty, as I see it, is to preserve life, to fight for a patient's life with every resource at my command, remembering always that "a man's never licked till he's licked."
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> But there comes a time when he *is* licked. If a doctor has trained judgment and experience and that desperate dislike of defeat which is instilled into each of us, he knows sometimes, because he knows his pathology, that every human thing has been done; that he cannot preserve certain life—that the decision has been taken from him.
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> And then his duty, I think, is just as clear—to make that patient comfortable by sedatives if he can, regardless of anything else and regardless of how much it takes to do so.[4]

The quotation at least illustrates the distinction between realism and defeatism. And I suspect that even doctors who theoretically profess the extreme standard would occasionally follow a more moderate and realistic line of action. I am thinking particularly of a rather typical case that was referred to me shortly after my first article was published. In an exploratory operation a physician had discovered an inoperable and incurable cancer. He could keep the patient in the hospital where his life would be somewhat prolonged by artificial means, or he could send him home to die a natural death. At home the patient could "putter around" a bit and could enjoy some of the brightness of family life, and he would be spared great expense. The doctor decided to send him home.

Very likely theologians would unhesitatingly and almost instinctively say that the doctor acted correctly. And I believe that practically every conscientious doctor I know would do the same thing, regardless of his theoretical standards. Yet, would not those who profess the extreme standard be acting somewhat at variance with their principles in admitting that there is no hope of curing the patient?

c) The theologians' way of computing obligation: Theologians are wont to distinguish between precept and counsel; their statement of obligations is usually characterized by a certain moderation. An example is the traditional estimate that an individual is obliged to use only ordinary means to preserve his life. Another example is the teaching that one must help a needy neighbor only when it can be done without proportionate inconvenience and with a

[4] The quotation is taken from *We Speak for Ourselves*, edited by Irving Stone (Garden City, N.Y.: Doubleday & Company, 1950), p. 450.

reasonable assurance of success. Also, with reference to the official duties of a priest, they teach that he is obliged to administer the sacraments when the faithful need them or reasonably request them; but the priest would generally act laudably by going beyond this, e.g., by providing many extra confession periods, by inconveniencing himself without necessity, and so forth. The civil law seems to follow a somewhat similar norm. It judges a juridical fault in terms of the "diligence of a prudent man"; it requires a doctor to use "ordinary and reasonable care and diligence in the treatment of the case committed to him."

Of the two medical standards, the moderate attitude seems to be more in conformity with the traditional mildness of theologians—a mildness closely paralleled in civil law. The case is not perfectly clear, however, because we are now considering the care of the dying, and a new factor may be present which transcends the usual rule of "ordinary care."

d) The "good Catholic" attitude: I once visited a hospital for cancer patients who had been pronounced incurable. The Sisters who conduct this institution are remarkable for the simplicity and austerity of their personal lives and for their devotion to their patients. Yet I was told that in this place they never use artificial life-sustainers. They confine themselves to giving excellent nursing care, to alleviating physical and mental pain, and especially to preparing the souls of the patients for a happy death.

I have talked with many religious and with devout lay Catholics on this subject, and I have noticed that almost invariably they think along the same lines as these Sisters. They believe that the important thing is to die holily, and they frankly say that there are limits to what must or should be done in order to prolong temporal life. This is what I mean by the "good Catholic" attitude. I leave it to others to judge whether or not the expression is used correctly. But if it is used correctly, it seems to offer an argument in favor of the moderate professional standard.

e) Effects on others: It has been said—and it seems to be true—that the extreme professional standard is apt to impose excessive expense on patients and relatives without offering them any proportionate good—except the "possibility of a miracle." Moreover, besides draining the bank account, it occasions great nervous strain for relatives when they are forced to watch day after day at the bedside of an unconscious father, mother, brother, etc., whose thread of life is being kept intact by intravenous feeding, oxygen, and such things. The moderate attitude is less likely to impose such burdens.

f) The doctor's conscience: At first sight, the extreme standard might seem to be more burdensome to the doctor's conscience and to create a greater danger of scrupulosity by allowing for no distinction between duty

and counsel. This is hardly true, however, because the extreme attitude has the advantage of utter simplicity. The doctor keeps trying to preserve life as long as he can, and he takes no other factors into consideration. On the other hand, following the moderate standard faces one with the necessity of "drawing a line," of distinguishing the hopeless from the hopeful cases, and of weighing indications and contraindications for the use of artificial life-sustainers. I believe that the making of such distinctions and decisions is a greater strain on the conscience and presents a greater danger of regret and scrupulosity than does the following of a simple rule, even though the standard set by this rule happens to be very high. On this point, therefore, the extreme standard seems to have some advantage.

Another rather typical case may illustrate what I mean. A patient almost ninety years of age, suffering from a cardiorenal disease, had been in a coma for two weeks, during which time he received an intravenous solution of glucose and some digitalis preparation. The coma was apparently terminal. A member of the family asked that the medication and intravenous feeding be discontinued. With the approval of a priest, the doctor and Sisters acceded to the request, but they did so with some disquietude and they continued to be disturbed for some time after the patient's death.

As I indicated in my former article, I think the terminal coma is a fairly clear case in which artificial life-sustainers need not be used. Certainly their use is unnecessary according to the moderate professional standard. Nevertheless, the actual decision to cease using them is not easily made and—as in the case just outlined—it readily becomes a source of worry to doctors and nurses.

A TENTATIVE SYNTHESIS

Having given all the pros and cons that occurred to me, I should now like to attempt a synthesis of the best points in the two standards.

1) It is not contrary to the common good for a doctor to admit that a patient is incurable and to cease trying to effect a cure. But it would be contrary to the common good to cease trying to find a remedy for the disease itself.

2) As long as there is even a slight hope of curing a patient or checking the progress of his illness, the doctor should use every probable remedy at his command. The common good demands this rule of conduct for the doctor, and it should be followed as long as the patient makes no objection. The patient, however, is entitled to refuse any treatment that would be extraordinary.

3) When a doctor and his consultants have sincerely judged that a

patient is incurable, the decision concerning further treatment should be in terms of the patient's own interests and reasonable wishes, expressed or implied. Proper treatment certainly includes the use of all natural means of preserving life (food, drink, etc.), good nursing care, appropriate measures to relieve physical and mental pain, and the opportunity of preparing for death. Since the professional standards of conscientious physicians vary somewhat regarding the use of further means, such as artificial life-sustainers, the doctor should feel free in conscience to use or not use these things, according to the circumstances of each case. In general, it may be said that he has no moral obligation to use them unless they offer the hope of some real benefit to his patient without imposing a disproportionate inconvenience on others, or unless, by reason of special conditions, failure to use such means would reflect unfavorably on his profession.

Thus far, my own observations. I trust that my expression of them will stimulate others to do likewise.

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