

QUAESTIO DISPUTATA

ORDINARY AND EXTRAORDINARY TREATMENTS: WHEN DOES QUALITY OF LIFE COUNT?

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[Editor's Note: Kevin Wildes recently argued in this journal that the distinction between ordinary and extraordinary treatments requires judgments about quality of life. The author of this response suggests that Wildes is correct in his general claim about the nature of these judgments, but that he fails to note the important moral issues that arise when others must make treatment decisions for incapacitated patients. Then quality-of-life judgments are inappropriate; they must be avoided in order to respect that patient's actual condition.]

KEVIN WILDES has argued in a recent note that the distinction between ordinary and extraordinary treatments involves judgments about quality of life, that some recent statements by Roman Catholic bishops have failed to see this, and that, as a result, their judgments about feeding and hydrating patients in a persistent vegetative state have been flawed.¹ Wildes is correct, I believe, when he says that choices patients make about their own treatment involve judgments about quality of life, but he fails to take account of the substantially different moral situation that arises when others make treatment decisions for incapacitated patients. Once we see this, we may be considerably more sympathetic than he is to those episcopal statements that are critical of decisions to deny food and water to patients in a persistent vegetative state.

The basic distinction between ordinary and extraordinary treatments is nicely expressed by Wildes in a summary statement: "A treatment is morally obligatory if and only if it offers a benefit and does not impose burden. Neither condition is sufficient by itself."² Putting it in terms of what is nonobligatory, we can say that a treatment may be refused if it is either useless or burdensome. Both of these judgments

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¹ Kevin W. Wildes, S.J., "Ordinary and Extraordinary Means and the Quality of Life," *TS* 57 (1996) 500-12.

² *Ibid.* 511.

are relative to the condition of a particular patient at a particular point in time. What is useless treatment for one patient may be useful for another; what was once useful treatment for a patient may cease to be so when progression of the disease has made a marked change in his or her condition. A burden that one person considers too great to bear may not seem unbearable to another. Thus, we can rightly say, as Wildes does, that deciding to refuse a treatment is not necessarily deciding to end one's life. It may, rather, be a decision about how to live. Of the several life choices available to patients, they may choose a life that is shorter but relatively less burdened by treatments. But still, they choose life. Nor is there any need to object to Wildes's desire to characterize such choices as "quality of life" choices. Several life choices are available. The character and duration of these lives differ in various ways which might reasonably affect a person's preference for one or another. And from these the patient chooses one that will be his or her life.

So far so good. What Wildes does not explore, however, is how best to characterize such choices made by patients. Insofar as he occasionally turns to the language of "proportionate or disproportionate" treatments and the language of "weighing" burdens and benefits, he uses a metaphor that may deceive us. Patients making such choices may consider the importance to themselves of personal aspirations still unrealized, the burden and expense of proposed treatments, their responsibilities to others—and countless other factors significant in their lives. But these competing factors are not being "weighed," for they are incommensurable, and the scale on which they could be weighed does not exist. In short, when such patients choose to accept or refuse treatment, they are not making a discovery about some single right choice to make in their circumstances. Precisely because these determinations are, as Wildes underscores, patient-relative, such patients are making a *decision*. The patient determines, within the limits available, his or her being. Two people similarly situated may make different decisions; yet both may be choices of life. He chooses a life that is shorter but relatively free of painful treatments. She chooses a life that is somewhat longer but more painful. Neither makes a discovery about what everyone in similar circumstances must choose or even about what he or she *must* choose. Both make decisions about who they will be. Or, if we insist on using the language of "discovery" and "weighing," we must mean that the relative weight of the conflicting goods is known—and known *only* for the person deciding—after the decision has been made. The only discovery we make in such circumstances is a discovery of something about ourselves, the kind of people we will be because we have so chosen. A life of "poor quality" is simply a life that we would not, given alternatives, choose for ourselves.

Because this is what it means to take seriously the patient-relative character of decisions about treatment, a large gap opens up in Wildes's argument. He consistently blurs the important distinction

between refusing treatment for oneself or refusing it for another. If Wildes's refusal of treatment expresses something of the person he has chosen to be, it does not tell us what treatments I ought to accept or refuse. And, more important here, it does not tell us anything about what treatments should be given to or withheld from patients who are unable to participate in their own treatment decisions. To suppose that decisions about their treatment should somehow mirror his choices or mine is merely to impose one vision of a choiceworthy life upon a subject who has not, and cannot, make that vision his own or her own.

Once we begin to see where Wildes's argument takes us, we might wish to pull back from it and, indeed, I think we should pull back just a little. Pulling back, we will be less skittish than Wildes is about "objectifying" treatment decisions. If, for example, at age 25, I refuse—on the ground that "I just don't like needles"—the antibiotics that promise to cure the pneumonia threatening my life, others should not suppose that I am simply choosing one life (a rather short one) from among the several life choices still open to me. They should quite rightly have a hard time imagining my decision to be anything other than a choice of death, which, on the position Wildes accepts, is a morally forbidden choice. So I am not utterly free (morally) to determine my being in any way I wish, and in order to make that clear we must, to a limited extent, "objectify" treatment decisions. In doing so, I do not believe we misrepresent traditional teaching. Or if we do, we do so in order to provide it with a needed corrective and development.

But a still more important "objectification" of treatment decisions is needed and appropriate. When patients are unable to participate in decisions about their treatment, when they are unable to determine their being in that way, we must decide how they should be treated. We cannot decide who they will be, not because we ought not, but simply because we cannot. All we can do is take the criteria for refusal of treatment developed by Wildes himself—that refusals are appropriate only if treatment is either useless or excessively burdensome—and apply them as best we can to decisions about treatment for patients who are unconscious or incompetent. We must objectify these decisions because we are not the subjects involved. And our own judgment about what life we would choose for ourselves from the available alternatives ought not to be imposed on subjects who cannot speak for themselves.

From this perspective the issue of providing nourishment to patients in a persistent vegetative state looks rather different. We must ask: Is the provision of such nourishment useless? Is it burdensome? How can nourishment that sustains the life of a human being be considered useless? Wildes needs to face that question squarely. Here is where the importance of the episcopal statements' references to patients who are not "imminently terminal" is important. Wildes's response that the ordinary/extraordinary distinction does not traditionally apply only to patients who are terminal is here beside the point. The point, rather, is that for a patient who is not a dying patient—who may, in fact, live

for years if fed—it is difficult to claim that such feeding is useless. Is it burdensome? It is rather hard to argue that patients in a persistent vegetative state will experience feeding as burdensome. But, then, if we withdraw care that is neither useless nor burdensome, it looks as if we are rejecting not the treatment but the life. We are deciding not to nourish these patients *so that* they will die.

Perhaps, of course, it is a burden to the rest of us to feed them. Wildes sometimes seems to flirt with such possibilities when he speaks of treatments that are burdensome to the patient or to others, but I think he means only to suggest that patients who are competent may rightly think about how much burden they want to impose on others. It is quite a different matter if we say, “We should stop feeding these patients because doing so burdens us.” It is hard to think of that as, in any sense, choosing life. On the contrary, we cease to nourish them *so that* they will die—and thereby relieve us of the burden their continued lives constitute.

I think, therefore, that it is quite appropriate to “objectify” treatment decisions for patients who cannot speak for themselves, and I doubt whether episcopal statements that do so are, in fact, departing from the traditional meaning of the distinction between ordinary and extraordinary treatments. That historical question, however, I must leave to others more qualified. If such statements do in fact depart from the tradition, they are wise to do so. For such a departure is necessary in order to respect the moral limit Wildes himself acknowledges, namely, our “perfect” obligation not to take innocent human life intentionally.

It is also mistaken to suggest that those opposing removal of feeding and hydration are somehow in thrall to “an incomplete model of medicine” or “a modern secularized view of medicine.” On the contrary, rather than abstracting the body from the person, they assume that where the living body is the person must also be. Rather than neglecting the subjective, they assume that where it is absent the choices of another subject ought not to be imposed. The person is respected precisely in his or her actual condition.

In short, Wildes’s explication and application of the traditional distinction goes astray because it fails to take seriously the difference between patients who can participate in their own decisions and patients (such as those in a persistent vegetative state) who cannot. One might, of course, argue that this gap can and will be bridged as people are encouraged to enact advance directives. We may settle for that as a social and legal compromise, but I doubt whether a satisfying defense of it can really be offered.³ If, as Wildes suggest, we ought not to isolate any single treatment decision from the context of a patient’s entire life, neither ought we to isolate one moment in life and suppose that it can

³ I try to make this case at much greater length in *Body, Soul, and Bioethics* (Notre Dame: University of Notre Dame, 1995) chap. 2.

or should be determinative of the rest of the life. But that is an argument for another time. Here I am concerned only to suggest that when Wildes writes that choices to refuse either useless or burdensome treatments are decisions "by a patient or a designated decision-maker about the quality of life" he confusingly conflates the cases of those who can speak for themselves and those who cannot. For those who can, decisions about quality of life, as long as they can honestly be understood as life choices, should be relatively unproblematic. But for those who cannot, such quality-of-life judgments made for them by others constitute a failure to honor the place they occupy and the time they have.

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