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Quality of Means, Quality of Life and Euthanasia

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Editor's note: This article is being published posthumously to set the record straight. It is published in response to misstatements by Richard McCormick in an article in America (March 14, 1992). This article, which had been accepted by America in July of 1987, was never published by them. Father Connery's clear, concise reasoning is even more important in light of the Pennsylvania Bishops' statement on fluids, nutrition, and euthanasia.

In their article on withdrawing nurture and fluids, "The Catholic Tradition" (5/2), McCormick and Paris wrote that I maintained that long term use of a nasogastric feeding tube could be very burdensome in the Conroy case, and therefore optional. They added that in the Brophy case I argued against removing a gastric tube, urging that we do not fall into a "quality of life" standard. I would like to call attention to a few important nuances in my position. As presented, it sounded somewhat simplistic, if not inconsistent, and certainly not very suasive.

The authors were on target in pointing to the limitation the Catholic tradition put on the duty to use means to preserve life. Those who followed my argument in the cases for which I wrote testimony (Brophy and Jobes) knew that it was based strictly on the tradition that the use of a means to preserve life becomes optional if excessively burdensome or if useless. I felt that long term use of a nasogastric tube could become very burdensome, and if so, would be optional on this score. It was less clear, although not impossible, that a stomach tube of itself would over time become generally burdensome. Nor did the evidence in the Brophy (also Jobes) case seem to indicate that the stomach tube was becoming burdensome. The argument seemed rather to focus on the condition of the patient, the claim that the patient was in an irreversible coma, persistent vegetative state, etc. It never became clear that the gastric feeding was in itself an extraordinary means.

My concern about yielding to quality of life considerations was related to the actual arguments being used to justify removing the tube in the Brophy (and the Jobes) case. As just pointed out, they were not derived from the difficulty of the means as such but from the difficulty or uselessness of the life of the patient.

Briefly, those advocating withdrawal were arguing that the quality of life of the patient (e.g., in an irreversible coma, although not terminal) was such that there was no reason to continue it. The only reasonable solution was to bring on death, and this was the intention in removing the feeding. In my opinion this constituted intended euthanasia by omission.

What was disturbing is the fact that this was not recognized as euthanasia. Most of the literature on the duty to preserve life, living wills, etc., explicitly condemns euthanasia when done by positive act. But there seems little sensitivity to the fact that withdrawing treatment, etc., for quality of life reasons might constitute euthanasia. The underlying reason for this insensitivity is probably the failure to define euthanasia or its parameters. This results in a tendency to identify it with some positive act, with subsequent failure to detect it in the omission of treatment for quality of life reasons as such. The same document which condemns euthanasia will frequently authorize such omissions.

Church Traditions

The condemnation of euthanasia is also a long standing tradition in the Church. My complaint about the present article is not that it mistakenly asserts as traditional a right to withhold treatment, but that it glosses over a second tradition, the condemnation of euthanasia, thus muting an essential limitation on this right. In my judgement this tradition is also very important and seems much more in jeopardy.

Quality of life can indeed be a legitimate consideration in judging moral obligations to preserve life, but only if it affects the means, i.e., makes them useless or very burdensome. Thus, if a person is actually dying, and death is imminent whether a certain means is used or not, such means will be useless. Or if a patient does not have full use of his senses, the defect can make a means to preserve life very burdensome. But if it does not make the means useless or burdensome, the quality of the patient's life will not remove the obligation to use the means. Thus, quality of life may not make antibiotics any more useless or more burdensome for the comatose than for the conscious.

One cannot argue, as some would like, that a means could be judged useless if it did not cure the disease. Certainly, if some particular means would not prolong the patient's life, it would be useless. *But if feeding kept the patient alive indefinitely, it could not be considered useless even though it did not cure a particular disease.* The whole sense of the question: Can a means be considered useless? has to do with preserving life. *If it will preserve life, it is useful.* One may judge that the life itself is useless and conclude that it is useless to prolong it. But this is a judgment about the uselessness of the life, not the uselessness of the means. *The means remain useful to do what they always do: preserve life.*

The tradition of which the authors speak with such favor had to do with quality of means, as described above. The duty to use means to preserve life depended on the quality of the means. If the means were excessively burdensome or useless, they were not of obligation. This limitation did not extend to the quality of life as such.

Pius XII put this, at least in part, in terms of interfering with a higher good. He said that it would be permissible to forego means to preserve life because making them obligatory would interfere with a higher good. In other words, pursuing life or health with some particular means could become optional if some higher good is at stake. Such means would become extraordinary.

Double Effect

Technically, the tradition was able to justify omission of these (extraordinary) means within the broader context of the principle of double effect. More precisely, the death of the patient, the bad effect, could be justified by the good effect (higher good) achieved by the omission. But all this had to be carried on within the parameters of respect for life. It would be wrong to take human life, or to intend killing in some other act or omission. Even if this was done out of mercy, it could not be justified. The Declaration on Euthanasia defined euthanasia as an act or omission which either by nature or intention brought on death. If death was not intended, but an unwanted side effect resulting from pursuing some higher good, it was acceptable. But if death was intended either because it was a sole effect of the act or even as one of many actual effects, it constituted euthanasia. In other words, *it was not permissible to withhold means with the intention of bringing on death.*

For a fuller understanding of the principle of double effect, although only tangential to the present case, it might be relevant to point out that in the tradition the term "effect" was not used in a strict philosophical sense. Even if an act was a true cause of death, it did not of itself dictate the morality of this effect. Nor if it was less than a cause (a condition or occasion of the death) did it leave its morality entirely open. In either case the intention had to be taken into consideration. If the death-bringing act was placed and death was the intention, it was considered wrong, whether the act was a cause, condition, occasion or even omission.

As mentioned, some would like to omit treatment, etc., in cases where the means themselves are not burdensome or useless. They would like to add to those cases where a higher good may be interfered with cases where a higher good cannot be achieved at all. This higher good is sometimes envisioned as the ability to develop human relations. Others speak of it in terms of pursuing spiritual good, the goal of life, etc. No one has yet mentioned the use of reason as this higher good, but one wonders how far from it we may be. The norm is that if one cannot pursue this good, he has no obligation to preserve life. The classic example is that of a person in an irreversible coma, even though not terminal. Presumably, such a patient will never be able to pursue this higher good because of his condition. And if he cannot, preserving life is not considered a duty.

Usually, not only the physical capacity of achieving these goals is considered but the moral possibility as well. In other words, even though a patient may be endowed with this power, it may be too difficult for him to realize it in practice. Those who hold this position relieve the patient of the duty to use any means to preserve his life. The low quality of his life will in itself warrant the omission of

means to preserve it.

This goes beyond the tradition which Paris and McCormick rightly commend and actually puts those who follow it on a collision course with the tradition against euthanasia. Superficially, the move from burdensome means to burdensome life may not seem significant. But in the move the act in question takes on a totally new perspective. The death of the patient is no longer an undesirable effect. It becomes the desired goal of the omission, since it is the solution to the problem. In terms of the Declaration of Euthanasia it is hard to see how it does not constitute intended euthanasia by omission. In quality of means cases the intention is to spare the patient a burdensome treatment. But in these cases nutrition and fluids are withdrawn because the patient cannot pursue spiritual goals, etc. Death results from this withdrawal and is intended as the solution to the problem. If this is done out of mercy, how does it differ from intended euthanasia by omission?

Some theologians may feel that they can dissent from the teaching of the document and allow euthanasia in these cases. But if what they are holding is euthanasia, they should be willing to admit it. It should not be presented as part of Church tradition.

A secondary problem is the impossibility of applying their norm in a sufficiently precise way. If a norm is to be useful, it should be relatively easy to apply to the ordinary case. I doubt that this can be said about a norm regarding the possibility of pursuing spiritual goals, etc., especially if one is speaking of the moral capability. And if one cannot apply it easily, he cannot determine with any precision when it is permissible to withhold treatment and when it is not. In other words, he cannot accurately discern between what he considers permissible and forbidden euthanasia.

The primary problem is, of course, the fact that euthanasia as such is accepted. This problem becomes aggravated when the norm for deciding cannot fulfill its role. One is trapped into a situation in which he cannot even make a clear judgment according to his own standards about when an act becomes acceptable euthanasia and when it does not.

Conclusion

In summary, the judgment I made in the Conroy case, although not the result of a thorough analysis, was founded on solid reasoning. The judgment in the Brophy case was based on a thorough analysis of the case. On the basis of this analysis I judged that the use of the gastric tube might not be excessively burdensome even over the long haul. Nor did the evidence in the Brophy case show that it was. Rather the quality of the patient's life was appealed to. Death was the only solution to the problem and intended as such. In my opinion, in terms of the Declaration on Euthanasia, this constituted intended euthanasia by omission. There was no acknowledgement of this in the article.

MEMO June 15, 1987

To The Editor:

Having been on a ventilator and artificial feeding for two distinct periods over the past six months, I may have acquired a peculiar right to speak about them. The enclosed was originally intended as a letter to the editor. But it soon became clear that it could not be kept within these bounds. On the other hand it would not be proper to print a response of the same proportions as the article itself. So this is a compromise.

John R. Connery, S.J.
