

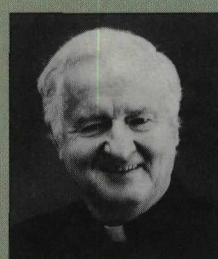
Withdrawal of Life Support: Mistaken Assumptions

BY REV. KEVIN D. O'ROURKE, OP, JCD

In a recent issue of the *Linacre Quarterly*, well-known moral theologian Germain Grisez presented the case of a woman in a permanently unconscious condition.¹ According to the woman's husband, in a "sort of living will," she stated that, in case of terminal illness, she did not want to be kept alive "by any means other than those required by Catholic moral teaching." Because the nursing home care for the wife severely depletes the family's income, the husband wonders if nutrition can be removed while continuing hydration, even though this would shorten his wife's life.

Grisez responds that the woman is not terminally ill and thus the living will is not operative. Moreover, because she is not terminally ill, the husband "does not have the right simply to direct that the wife be given only water," because this would amount to killing his wife. Grisez maintains that removing life support "would manifest a lack of human respect and familial love." He suggests that the family take the wife home and enlist the help of family and friends, knowing that the woman will die sooner than she would in the nursing home.

Aside from the ill-advised clinical aspects of the suggested solution, several questionable ethical assumptions underlie it. Grisez states the correct principle, namely, "The Church does not teach that there is an obligation to do everything possible to sustain any person's life. Sound principles of morality do not entail it and in practice nobody acts on it."² Unfortunately, because of mistaken assumptions—assumptions echoed in opinions expressed recently by episcopal conferences³—Grisez requires that the life of the person in a permanently unconscious condition be prolonged beyond need. Instead of removing life support that prolongs her existence, Grisez would keep her alive in a debilitated condition, limiting care in a nursing home and thus hastening her death. Even though Grisez admits that the Church has no explicit teaching in this



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regard,⁴ he imposes the burden of continued care on the family, not even considering the alternative opinion, which would allow the immediate withdrawal of life support from those in a permanently unconscious, or persistently vegetative, state. Grisez's opinion is opposed by other ethicists⁵ and by almost every group of healthcare professionals that has addressed this question.⁶

"TERMINAL ILLNESS" MISCONSTRUED

It seems the first misconception leading to the decision to be overly aggressive in caring for the permanently unconscious person proceeds from Grisez's analysis of the term "terminal illness." He states that the permanently unconscious person is not terminally ill: "Nobody is terminally ill unless he or she either is plainly dying so that death in a very short time can be predicted with certainty, or is suffering from some disease or injury which predictably will be the cause of death."⁷

A more nuanced concept maintains that a terminal illness is one from which death will result if medical means to prevent or delay death are not used. Whether to use the means to prolong life is the heart of the moral issue—not whether death is imminent and inevitable. Grisez's concept of terminal illness is inaccurate because it analyzes the person's condition *after* life-prolonging therapy has been applied, rather than *before*. If the decision to continue or withdraw life support is made *after* life support has been applied, as is often the case because of emergency medical care, the decision must be made *as though* the life support had not been applied.

No other assumption makes sense; it is verified by the well-known principle in medical ethics that no ethical difference exists between withholding and removing life support.⁸

In this case, the woman in question does in fact have a terminal illness; that is, she will die of the injury causing the permanently unconscious condition unless some form of life support is used. The injury to the cerebral cortex, which

impedes her ability to chew and swallow food, will cause death unless life support in the form of artificial hydration and nutrition is applied.⁹ The question is, then, Do we have a moral obligation to resist or reverse the pathological condition by using artificial hydration and nutrition?

BENEFITS AND BURDENS

In Catholic tradition, the moral obligation to prolong the life of a person with a terminal illness rests on the answers to two separate questions:

- Will the means to prolong life offer a reasonable hope of benefit to the patient?
- Will the means to prolong life impose an excessive burden?¹⁰

Clearly, when care givers remove life support because of either of the above questions, the intention intrinsic to the action (*finis operis*) is not to kill the patient. Rather, the intention is to cease a useless activity or to avoid imposing a severe burden on the person. Thus the question is not, Can her life be prolonged? but rather, Is there a moral obligation to prolong her life?

If prolonging life offers no benefit to the patient, then the moral obligation to prolong life ceases to exist. Grisez implies that because of the "intrinsic goodness" associated with human life, life must be prolonged even if the patient will never recover from the unconscious condition. Does Grisez's abstract concept of "intrinsic goodness" have any meaning insofar as moral decision making is concerned? What benefit does prolonging life offer to the permanently unconscious patient? Surely it does not enable this person to pursue integrated human function, which John Finnis presents as the purpose of moral life.¹¹

Moreover, "intrinsic goodness" is associated with persons whether they are living or dead. Intrinsic goodness results from one's relationship to God.¹² Thus a person's "intrinsic goodness" is not denied or depleted if he or she is allowed to die because therapy would not be beneficial or would impose an excessive burden. Grisez's position assumes people cannot express love or solidarity with a person unless life is prolonged until death is imminent and inevitable. Do not Christians continue to love those who have died and are now related to them in the communion of saints?

Hence the need for death to be imminent and inevitable before life support is withheld or removed is not part of Catholic tradition. An imminent and inevitable death may be a reason

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to decide that no proportionate means were available to prolong life, but a host of examples in the Catholic tradition would allow one to declare that the decision to remove life support may be made legitimately if death is not imminent and inevitable.

CONFUSION ABOUT PROXY

Given the more accurate interpretation of "terminal illness," Grisez's statement that the wife's document ("a sort of living will") is not operative because she is not terminally ill needs revision. Moreover, Grisez's interpretation of proxy consent is confusing and legalistic.

It is confusing because he intimates that if the proper legal document had been written, all life support could be withdrawn immediately. Such action would correspond to the express wish of the now-unconscious person. But if it is immoral to withdraw all life support immediately from a person in this condition, how can immediate withdrawal be justified by the presence of a "proper" legal document? Is Catholic moral teaching subservient to civil law?

His interpretation is legalistic because Grisez implies that a husband can only give proxy consent for his wife if the right is explicitly granted in a proper legal document.¹³ This conclusion misrepresents the nature of proxy consent. Grisez implies that the living will or durable power of attorney grants the moral right to make decisions for loved ones or family members. This has never been the case. The most a legal document can do is specify who will make necessary decisions. The basic right of one person to make a decision for an incapacitated person comes from our nature as loving social beings, despite what present-day legalistic practice implies.¹⁴

THE PROPER DECISION

Many people today promote physician-assisted suicide, or just plain suicide, as an alternative to overly aggressive medical care when death approaches. To combat this movement, it is extremely important that Catholic teaching be explained clearly. In brief: There is no need to wait until death is imminent and inevitable before removing life support directed at present or future pathological conditions. Rather, the proper decision depends on the hope of benefit for the patient and the degree of burden that would be imposed on the patient, family, or community as a result of the therapy. □

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NOTES

When Kauffman focuses on broad themes rather than factual itemizations, the book is much more successful. Kauffman demonstrates that religious orders provided healthcare in the nineteenth century in ways that seem surprisingly contemporary. Many hospitals under religious auspices specifically advocated liberty of religion and conscience for patients, long before the Second Vatican Council's document on religious liberty. Religious orders managed and staffed public institutions funded by local governments, and they contracted with businesses such as railroads and mining companies to care for their employees through an early form of prepaid or managed care.

Other recurring themes involve tensions or conflicts. In the initial founding of Catholic institutions, local bishops and superiors of religious orders often disagreed with the sponsors, who sometimes prevailed simply by moving ahead with their plans. Currents of anti-Catholicism sometimes led civic officials and militant Protestants to distrust Catholic sisters who served as nurses in a variety of settings. Critics feared they were more interested in proselytizing and converting than in offering nursing services. Great nursing leaders such as Dorothea Dix and Florence Nightingale, for example, thought the sister-nurses placed their religious responsibilities to Catholic patients above their nursing duties (p. 25).

Sponsors' conflicts with ecclesiastical authority or with Protestant and civic leaders forced sponsors to focus on a central question: Is Catholic healthcare mainly a vehicle for promoting the Catholic faith, or should Catholic healthcare offer the most up-to-date services that a professionally trained staff can provide? Particularly among some Catholic religious and lay nurses, the choice between faith and professionalism appeared to be an either-or choice.

Kauffman's discussion of these central issues, especially in his handling of hospital and nursing school accreditation, is

illuminating. Equally informative is his thorough account of the founding and development of the Catholic Hospital Association—today the Catholic Health Association (CHA)—and of the philosophical and policy disagreements that shaped CHA's evolution. The lines were drawn between those who favored separatism for Catholic institutions and those who favored full involvement in the pluralistic society.

A subtext emerging from Kauffman's account is the subtle sexism that has always faced Catholic women religious. Although these sisters ran the hospitals and schools of nursing, they were subject to ecclesiastically appointed superiors, hospital superintendents, and diocesan directors who usually had little or no healthcare experience. CHA, an organization that involved mainly religious women, was headed by priests until 1965 (p. 250); even then, the presidency had to rotate to a bishop's representative every other term (p. 289).

The book ends with a chapter on the questions that face our country today as we debate structures for providing universal healthcare access. Beginning with the bishops' pastoral letter of 1981 on healthcare as a right, Kauffman briefly reviews CHA documents and positions favoring national health insurance. I wish that Kauffman had been more detailed and analytical in laying out these arguments, since this issue is one of the most pressing for Catholic healthcare today and in the future. As in the rest of the book, Kauffman briefly presents both sides: Catholic opposition to insurance coverage for abortion is given as much significance in the debate as are long-held social justice principles supporting access to healthcare for all. Although as a historian Kauffman must be factual and objective, he seems to slight the history and tradition of Catholic social justice philosophy.

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