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Catholic Treatment Ethics and Secular Law: How Can They Cohere?

Abstract

Central elements of Roman Catholic treatment ethics include: 1) that rejection of treatment with the intent of hastening death (even for a good end) is ethically equivalent to active euthanasia with the same intent; 2) a distinction between morally obligatory “ordinary” treatment and morally optional “extraordinary treatment”; 3) that the quality of the patient’s life is not be a legitimate basis for rejecting treatment; and 4) that extraordinary treatment is not forbidden, but optional, and that it is the patient or the patient’s legal surrogate—not the doctor—who has the right to choose or reject it.

Despite these principles, even in a cultural climate fully sympathetic to Catholic treatment ethics, it is appropriate as a legal matter to maintain the doctrine of informed consent under which it is possible for patients or their surrogates to reject life-preserving treatment, including for unethical reasons. It is normally impossible to enforce in practice in the external forum a differentiation between rejection of treatment for ethically acceptable and ethically unacceptable reasons. By contrast, in cases of direct killing, such as assisting suicide, the intent to cause death is unmistakable (as opposed to accepting an increased risk of death as a foreseeable but unintended consequence of pursuing a good end).

In a pluralistic society Catholic ethics cannot be legislatively enforced on the ground that they are compelled by Catholic teaching. However, the basic principles of Catholic treatment ethics may be justified based on logic and widely accepted norms of human equality independently of revelation or ecclesiastical authority. Particularly in protecting the right of individuals to choose and obtain life-saving medical treatment regardless of their “quality of life,” and in suicide prevention, secular law can and should be congruent with key aspects of Catholic health care ethics.

1 Catholic Treatment Ethics and Secular Law: How Can They Cohere?

Thomas J. Balch

Introduction

Among the most controversial yet common contemporary ethical issues are those concerning the provision or withholding of medical treatment, especially life-preserving health care. What does the Roman Catholic Church have to say about treatment ethics, and how can that ethics appropriately interact with secular law in non-sectarian society?

I. Catholic Treatment Ethics

A. Intent to Cause Death or Double Effect?

The first principle of Catholic treatment ethics rejects “*Euthanasia* [which] *in the strict sense* is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering.”¹ It deserves emphasis that omission of treatment necessary to preserve life with the intent to cause death is treated as forbidden euthanasia just as much as is direct killing.²

An unethical act or omission may not validly be used as a means to a good end.³ Thus, for example, being with God in heaven might certainly be regarded as good by Christians, and for sinful mortals only through and after death can that end come about. However, it is not ethical to kill oneself or another in the hope and with the intent of hastening entrance into heaven. Therefore, rejecting life-preserving treatment for Grandma with the motivation of ‘letting her go to God’ would flatly contradict this principle.

There is, however, a critically important distinction between doing or omitting something in order to accomplish an unethical objective, and doing or omitting something in order to accomplish a good objective, while regretfully recognizing and accepting that the act or omission increases the risk of an undesirable consequence. There are courses of action or deliberate omission in which, in the words of the Sacred Congregation for the Doctrine of the Faith’s *Declaration on Euthanasia*, ‘death is in no way intended or sought, even if the risk of it is reasonably taken’.⁴

Sometimes known as the principle of double effect, this recognition is really a matter of common sense. Driving an automobile is risky. There were 1207 road deaths in Australia in 2015.⁵ Anyone who takes to the road in a car risks a fatal accident. Yet driving to the store to get groceries, knowing that involves a certain risk of death, is not ethically equivalent to

1 Pope John Paul II, Encyclical *Evangelium Vitae*. English translation: *The Gospel of Life* (25 March 1995) §64 (emphasis in original) (Hereafter, EV).

2 Cf. Sacred Congregation for the Doctrine of the Faith, *Declaratio de Euthanasia*. English translation: *Declaration on Euthanasia* (5 May 1980) II http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_c\hich\af0\dbch\af40\loch\af0_on_cfaith_doc_19800505_euthanasia_en.html: ‘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.’

3 *Catechism of the Catholic Church*, §§1756, 1789.

4 *Ibid.* III.

5 Australian Government Department of Infrastructure and Regional Development, Bureau of Infrastructure, Transport and Regional Economics, *Road Deaths Australia—Monthly Bulletins* https://bitre.gov.au/publications/ongoing/road_deaths_australia_monthly_bulletins.aspx.

driving one's automobile off a steep cliff in order to commit suicide. Indeed, it is hard to imagine any human activity that does not incur some foreseeable risk of death. Even remaining in bed cannot escape the risk of death from fire or earthquake—and if one never rose from it, one would certainly increase the risk of death from starvation and dehydration.

Virtually all treatments for a life-threatening illness or injury have side effects and risks, some of which may themselves threaten death. For instance, a surgery that is likely to increase the chance of preserving life in the long term may also be susceptible to complications that could end it in the short term, such as a blood clot or hemorrhage while on the operating table. Treatments for conditions that harm health but are not themselves life-threatening may carry risks of causing or hastening death. Depending on the concrete circumstances, either choosing or foregoing such treatments might be done for reasons that do not amount to intending death, even when a heightened risk of death from the decision is reasonably foreseeable.⁶

As a committee of bishops from the United States has put it:

[W]e are called by our moral tradition to ask ourselves: ... [W]hat am I trying to achieve by doing it? We must be sure that it is not our intent to cause the patient's death—either for its own sake or as a means to achieving some other goal such as the relief of suffering.⁷

To phrase it another way, is the action or omission being chosen *because of* or *in spite of* the increased risk of death? Whatever the probability that death may result, is the decision-maker sincerely *hoping* that death will – or will not – be the consequence.

B. Is Treatment Mandatory or Optional?

A second principle of Catholic treatment ethics is the widely familiar distinction between 'ordinary' medical treatment that is ethically mandatory and 'extraordinary' medical treatment that is ethically optional. There are two prongs involved in assessing whether particular treatment is ordinary or extraordinary: treatments may ethically be foregone either if 'they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family.'⁸ It is helpful to characterize these two aspects as separately evaluating 1) what treatment is proportionate and 2) what duty of care for oneself or others is reasonable to expect rather than supererogatory. Far from being idiosyncratic sectarian positions unique to health care decisions, these reflect common sense norms regularly relevant outside the field of health care.

1. Judging Proportionality

Regarding the first prong, in the encyclical *Evangelium Vitae*, § 64, Pope John Paul II wrote:

6 Cf. Marzen, O'Dowd, Crone, & Balch, "'Suicide: A Constitutional Right?'— Reflections Eleven Years Later', *Duquesne Law Review*, 35, 1996, 268-70.

7 National Conference of Catholic Bishops' Pro-Life Committee [United States of America], 'Nutrition and Hydration: Moral and Pastoral Reflections', *Origins*, 21:44, 9 April 1992, 705.

8 EV §65.

[T]here is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement.

Similarly, the *Declaration on Euthanasia* observes:

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.⁹

In discussing the principle of double effect, this article has already pointed out that decision-making about what medical treatments to employ normally involves a balancing of the chance of success against the risks of side effects and complications. Often it is quite difficult to choose among alternative treatments, taking into account the patient's other medical conditions and degree of resilience or fragility, as well as what is known or unknown about the probability of benefit versus that of untoward consequences. The higher the probability of successful life-preserving effect and the lower the risk of negative consequences, the more likely it is that the treatment should be judged proportionate and hence ethically obligatory. Conversely, as the probability of success falls and the probability of negative consequences rises, the treatment is more likely to be disproportionate, and therefore ethically optional. So long as there is genuinely no intent to cause or hasten death, under the standard of proportionality there may often be a large gray area in which different people might strike different balances in judging which treatments are proportionate or disproportionate in particular cases. '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, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case.'¹⁰

Is this not a matter of common sense followed in many activities of daily living? Parents, with an obligation to see to the education of their children, must weigh and balance many factors in choosing to what schools to send them, including their academic quality, how well they match the children's talents and needs, their cost and their convenience. With an obligation to provide ourselves and those for whom we are responsible with adequate nutrition, we constantly balance the expensiveness, desirability, and healthiness of different food choices. In fulfilling the obligation to support ourselves and our families, we weigh our capabilities, interests, opportunities, the remuneration available, and numerous other factors in judging what jobs to prepare for, apply for, and accept.

2. What Duty of Care Is Reasonably Expectable?

The other prong of analysis in distinguishing between ordinary and extraordinary treatment asks, in effect, what duty of care is reasonably expectable. The classic statement of this factor is by Pope Pius XII:

⁹ SCDF, *Declaratio de Euthanasia*, IV.

¹⁰ Ibid.

[N]ormally one is held to use only ordinary means [to prolong life] – according to the circumstances of persons, places, times, and culture – that is to say, means that do not involve any grave burdens for oneself or another. A stricter obligation would be too burdensome for most men¹¹

Consider a different context: a grocery store has a duty of care to keep its aisles free of obstructions that might cause a customer to slip and fall. But the store is not an insurer, nor does it have strict liability for any and every injury that a customer might incur by slipping and falling in an aisle. It only has a reasonable duty of care. So if a customer is injured by slipping on a piece of lettuce that has fallen from the displayed produce, that doesn't necessarily mean the store has violated its duty of care. If it can show that its employees swept the aisle with reasonable regularity, it will not be liable. In effect, the store owes an *ordinary* duty of care toward its customers, but not an *extraordinary* one. Now, there is no mathematical formula to determine how frequently the aisle must be swept. In a trial in which the injured customer sought recompense from the grocer, it would be up to the jury, after hearing testimony about such things as what is the usual practice in the industry, to decide what standard of sweeping is reasonably expectable.

This common sense approach applies to all sorts of duties of care. If a neighbor's child drowns in a backyard pool, is the homeowner responsible? If the pool was unfenced, probably the homeowner did not take what would be regarded as ordinary care with an 'attractive nuisance'. But if there was a high, padlocked chain fence, and the child used a bolt cutter to get in and subsequently drowned, probably the homeowner would be deemed to have met the standard of ordinary care. Even if it could be argued that a motion detector rigged to an alarm might have prevented the tragedy, it is likely that installing such a system would have been above and beyond the standard of ordinary care.

To take an example of religious duty, although there is an obligation for Catholics to attend Mass on Sundays, they need only make ordinary, not extraordinary, efforts to do so. If one is 250 kilometers away from the nearest church, there is probably no duty to travel that far to attend it, even though it would be possible to drive there and back.

The same basic idea applies to the second prong for differentiating between ordinary and extraordinary medical treatment. To take an extreme example, suppose a patient has a rare heart disease. Further suppose that Russian President Putin has the same disease, and Moscow doctors have developed a treatment for it that is only available at a hospital near the Kremlin. To fly to Moscow to seek it would be over and above the ordinary duty of care. On the other hand, if there is a routine treatment for the disease available at every major hospital from Melbourne to Darwin and Brisbane to Perth, there is a much better case for saying that seeking it is part of the ordinary duty of care (although in some circumstances the treatment might still be deemed extraordinary under the first prong of proportionality analysis).

C. Quality of Life as a Basis for Withholding Life-Preserving Treatment

A third principle is that an alleged poor 'quality of life' of a patient is an unethical basis for denial of life-preserving medical treatment. In the words of Pope Francis:

¹¹ Pius XII, 'The Prolongation of Life: Allocution to the International Congress of Anesthesiologists,' (24 November 1957), *The Pope Speaks*, 4:4, 1958, 395.

In fact, in the light of faith and right reason, human life is always sacred and always ‘of quality’. There is no human life that is more sacred than another – every human life is sacred – just as there is no human life qualitatively more significant than another¹²

In an official letter on ‘Quality of Life and Ethics of Health Care’, Pope John Paul II emphasized:

[T]he human person should be recognized and respected in any condition of health, infirmity or disability. ... However, in our time the meaning which the expression “quality of life” is gradually acquiring is often far from this basic interpretation, founded on a correct philosophical and theological anthropology. Indeed, under the impetus of the society of well-being, preference is being given to a notion of quality of life that is both reductive and selective: it would consist in the ability to enjoy and experience pleasure or even in the capacity for self-awareness and participation in social life. As a result, human beings who are not yet or are no longer able to understand and desire or those who can no longer enjoy life as sensations and relations are denied every form of quality of life.¹³

Similarly, in an allocution he said:

I feel the duty to reaffirm strongly that the intrinsic value and personal dignity of every human being do not change, no matter what the concrete circumstances of his or her life. A man, even if seriously ill or disabled in the exercise of his higher functions, is and always will be a man, and he will never become a ‘vegetable’ or an ‘animal.’¹⁴

Consequently, as noted by the bishops’ committee from the United States as cited earlier:

A means considered ordinary or proportionate for other patients should not be considered extraordinary or disproportionate for severely impaired patients solely because of a judgment that their lives are not worth living.¹⁵

To put it another way: if a treatment would be considered ordinary for a virile young man in his 20’s, then it should not be deemed extraordinary for a woman with Down Syndrome or an elderly man with Alzheimer’s disease. And just as it would be unethical to

12 Pope Francis, Allocution *Ad Associationem catholicorum Medicorum Italiae*. English translation: Address of His Holiness Pope Francis To Participants in the Commemorative Conference Of the Italian Catholic Physicians’ Association On the Occasion of its 70th Anniversary of Foundation Address to Association of Italian Catholic Doctors (15 November 2014).

13 Pope John Paul II, Letter: *Praesidi Pontificiae Academiae pro Vida occasione studiorum Conventus de qualitate vitae et salutis ethica missus*. English translation: Letter to the President of the Pontifical Academy for Life on the Occasion of a Study Congress on ‘Quality of Life and Ethics of Health’ (19 February 2005).

14 Pope John Paul II, Allocution *Ad catholicos medicos de curatione aegrotorum en stato <<vegetativo>> versantibus*. English translation: Address to the Participants in the International Congress on ‘Life-sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,’ (20 March 2004) §4 (Hereafter, Acm).

15 National Conference of Catholic Bishops’ Pro-Life Committee, Op. Cit.

withhold even extraordinary treatment *because of an intent* to cause or hasten death, it would also be wrong to withhold even extraordinary treatment *for the reason* that the patient's quality of life is said to be poor – because that would amount to the same thing. If the reason life-preserving treatment of any type is denied is because the patient's quality of life is considered poor, that is tantamount to withholding it with the motivation of shortening that person's life because it is allegedly not worth living and the patient (or the patient's family or society) would be better off if she or he were dead.

Pope John Paul II warned of the consequences of such analysis:

[T]o admit that decisions regarding man's life can be based on the external acknowledgment of its quality, is the same as acknowledging that increasing and decreasing levels of quality of life, and therefore of human dignity, can be attributed from an external perspective to any subject, thus introducing into social relations a discriminatory and eugenic principle.¹⁶

The fundamental equality in value of all human beings was reaffirmed by the Congregation for the Doctrine of the Faith in its 2008 "Instruction *Dignitas Personae* on Certain Bioethical Questions," when it wrote:

[T]he reality of the human being for the entire span of life, both before and after birth, does not allow us to posit either a change in nature or a gradation in moral value, since it possesses full anthropological and ethical status. . . . This value belongs to all without distinction. By virtue of the simple fact of existing, every human being must be fully respected. The introduction of discrimination with regard to human dignity based on biological, psychological, or educational development, or based on health-related criteria, must be excluded.¹⁷

D. The Optional Nature of Extraordinary Treatment

A fourth principle of Catholic treatment ethics is that extraordinary treatment is optional for patients, not forbidden. It is not uncommon to encounter the misunderstanding that assumes extraordinary treatment is actually unethical.¹⁸ In one of the allocutions most commonly referred to as the initial source for the modern development of the understanding of Catholic treatment ethics, Pope Pius XII said, '[O]ne is not forbidden to take more than the strictly necessary steps to preserve life and health so long as he does not fail in some more important duty.'¹⁹ The 1980 *Declaration on Euthanasia* explained, '[I]t is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity.' Indeed, the declaration said that withdrawal of extraordinary means requires the

16 John Paul II, Acm §3.

17 Sacred Congregation for the Doctrine of the Faith. Instruction *Dignitas Personae*. English translation: *Instruction Dignitas Personae on Certain Bioethical Questions* (8 September 2008) §§5, 8.

18 See, e.g., Anne Orne-Smith & John Spicer, *Ethics in General Practice* (Abingdon, Oxon: Radcliffe Medical Press, 2001), 197; I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Clarendon Press, 1988), 318.

19 Pope Pius XII, 'The Prolongation of Life: Allocution to the International Congress of Anesthesiologists,' (24 November 1957), *The Pope Speaks*, 4:4 (1958), 395-98.

patient's consent: 'It is also permitted, with the patient's consent, to interrupt these means'²⁰

II. The Ethical Obligations and Rights of Health Care Providers

What is the role of the conscience of the health care provider? A doctor might assert either that a patient is rejecting treatment the doctor has a moral obligation to provide, or else that the patient is seeking treatment the doctor has a moral obligation to deny.

The Catechism states that while 'A human being must always obey the certain judgment of his conscience' it is important that 'Conscience must be informed and moral judgment enlightened' and 'formation of conscience' is to be 'guided by the authoritative teaching of the Church.'²¹ '[I]t can happen that moral conscience remains in ignorance . . . and makes erroneous judgments. . . . This ignorance can often be imputed to personal responsibility. This is the case when a man "takes little trouble to find out what is true and good" [R]ejection of the Church's authority and her teaching . . . can be at the source of errors of judgment in moral conduct.'²² Under Catholic teaching, therefore, the conscience of a health care provider ought not to be misled by either ignorance or rejection of elements of that teaching.

A. When a Patient Rejects Ordinary Treatment

A doctor might well conclude that a patient is rejecting ordinary medical treatment that the patient has an ethical duty to accept. Certainly the doctor can and should counsel the patient to accept the treatment. But what if the patient adamantly refuses?

Later in this article, we will consider whether the secular law ought to require treatment in such circumstances.²³ But what of the conscience of the doctor? In 1957, Pope Pius XII clarified the duties of the physician:

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 can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission.²⁴

Thus, a physician's conscience formed in accordance with Catholic teaching would not dictate a duty to force even ordinary treatment on an unwilling patient, or to preclude continuing to provide health care to a patient who has rejected certain ordinary treatment.

B. When a Health Care Provider Seeks to Deny Requested Treatment

Let us turn to the opposite case. Today it is often contended that medical personnel or facilities may ethically choose to refuse to provide life-preserving treatment to a patient

20 Sacred Congregation for the Doctrine of the Faith. *Declaratio de Euthanasia*. English translation *Declaration on Euthanasia* (5 May 1980), IV.

21 *Catechism of the Catholic Church*, §§1790, 1783, 1785.

22 *Catechism of the Catholic Church*, §§1790, 1791, 1792.

23 See text accompanying notes 31-34.

24 Pius XII, Pope. 'The Prolongation of Life: Allocution to the International Congress of Anesthesiologists,' (24 November 1957), *The Pope Speaks*, 4:4 (1958), 395-98. Official text in *Acta Apostolicae Sedis* 49:12 (1957), 1027-33. Also see note 31 and accompanying text.

despite the choice and direction of the patient or the patient's legal surrogates to do so.²⁵ The asserted basis may be that the directed treatment is futile or ethically inappropriate. As described by the New York State Task Force on Life and the Law, 'Some physicians use "futile" narrowly, considering treatments to be futile if they would be physiologically ineffective or would fail to postpone death.... Many physicians embrace a broader, more elastic understanding of the term. ... [A] treatment might be seen as futile if it does not offer what physicians consider an acceptable quality of life. For example, in one survey, a majority of physicians agreed that for a severely demented patient with Alzheimer's disease, CPR [cardio-pulmonary resuscitation] would be "so clearly inappropriate or futile on medical grounds that physicians should be permitted to institute DNR status based on clinical judgment, without obtaining consent."²⁶

1. Futile Treatment

There can be little doubt that a physician may refuse to provide a treatment directed by or on behalf of a patient that in reasonable medical judgment is physiologically futile. Such a treatment would not in fact be effective in preventing or delaying the patient's death, so the doctor would not actually be denying life-preserving treatment. But what of a physician who believes it violates his or her conscience to provide treatment that would keep alive a patient the doctor deems to have an unacceptable quality of life? Or what if the physician judges the requested treatment extraordinary, and has a conscientious belief it is unethical to provide that extraordinary treatment?

2. Denial of Treatment Based on Quality of Life

This article has already detailed how clearly Catholic teaching rejects the view that 'decisions regarding man's life can be based on the external acknowledgment of its quality'.²⁷ It follows that a health care provider could not, based on a well-formed conscience, validly refuse to provide a patient life-saving medical treatment based on a judgment that the patient's quality of life was unacceptable.

3. Extraordinary Treatment

What about a doctor who objects that the treatment sought by the patient is extraordinary treatment?

Of key importance is that, as demonstrated above, under Catholic teaching it is the patient who may choose whether or not to employ extraordinary treatment – a point re-stated by the *Catechism of the Catholic Church*, which adds that when the patient is incompetent to do so, it is the patient's legal surrogate on whom the responsibility falls: 'Discontinuing

25 See generally Robert Powell Center for Medical Ethics, *Will Your Advance Directive Be Followed?*; Meisel, Cerminara, & Pope, *The Right to Die [:] The Law of End-of-Life Decisionmaking* §§13.03,13.07A. Also see note 18 and accompanying text.

26 New York State Task Force on Life and the Law, *When Others Must Choose: Deciding for Patients Without Capacity* (New York: n.p., 1992), pp. 196-97, quoting N. Spritz, "Views of Our Membership Concerning the DNR Issue and the New York State DNR Law," in *Legislating Medical Ethics: A Study of New York's DNR Law*, ed. R. Baker and M. Strosburg, Philosophy and Medicine Series (Dordrecht: Kluwer Academic Publishers).

27 John Paul II, Acm §3.

medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.’²⁸

But what of the *Declaration*’s subsequent statement that it is ‘the doctors who are specially competent’ who ‘may in particular judge that the investment . . . is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques’? That statement recognizes that those who are expert in providing health care are particularly capable of evaluating the burdens of treatment in comparison with its benefits, an assessment which is integral to the judgment *whether* the means are ordinary or extraordinary.

It does not alter the validity of the *Declaration*’s previous statement that extraordinary means may be interrupted only “with the patient’s consent.” Indeed, the sentence is preceded by the statement, ‘for such a decision to be made [to reject extraordinary means], account will have to be taken of the reasonable wishes of the patient and the patient’s family, as also of the advice of the doctors who are specially competent in the matter.’ The critical word here is ‘advice’. That one may give advice does not authorize one to compel the decision-maker to follow that advice.

Similarly, in context the word ‘anyone’ in the *Declaration on Euthanasia*’s statement “one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome” refers to the patient, not to a doctor attending the patient. This is clarified by the next sentence, which states, ‘Such a refusal is not the equivalent of suicide. . . .’ Suicide is, of course, *self* killing. If the term ‘anyone’ were intended to encompass the health care provider, the next sentence would logically have read, ‘Such a refusal is not the equivalent of euthanasia. . . .’

That understanding also clarifies the meaning of the following two sentences: ‘When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger.’ The ‘such circumstances’ are the circumstances in which the *patient* has declined extraordinary treatment, or at least such a decision has been made with the consent of the patient – or, as the *Catechism of the Catholic Church* §2278 establishes, of ‘those legally entitled to act for [an incompetent] patient’. The sentences cannot validly be read as establishing that it is *doctors* who are to ‘take the decision’ to ‘refuse . . . treatment’ *without* the consent – and, indeed, *against the will* – of the patient or the patient’s surrogates.

This interpretation is reinforced by the definitive teaching of Pius XII, earlier quoted, that ‘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.’²⁹

28 *Catechism of the Catholic Church*, §2278.

29 Pius XII, Pope. ‘The Prolongation of Life: Allocution to the International Congress of Anesthesiologists,’ (24 November 1957), *The Pope Speaks*, 4:4 (1958), 395-98. Official text in *Acta Apostolicae Sedis* 49:12 (1957), 1027-33.

John Paul II has warned of the particular danger of physicians usurping the role of decision-making determining that a patient will die:

The height of arbitrariness and injustice is reached when certain people, such as physicians . . . , arrogate to themselves the power to decide who ought to live and who ought to die. . . . Thus the life of the person who is weak is put into the hands of the one who is strong; in society the sense of justice is lost, and mutual trust, the basis of every authentic interpersonal relationship, is undermined at its root.

Indeed, as patients we entrust ourselves in a strikingly dependent and helpless way to the care of medical personnel. When they cannot be counted on to try, to the utmost of their skill and available techniques, to provide physiologically effective medical treatment that we seek to preserve our lives, but instead arrogate to themselves the ultimate say in whether we are allowed to live or die the warning attributed to Dr. Christopher Hufeland applies: ‘If the physician presumes to take into consideration in his work whether a life has value or not, the consequences are boundless and the physician becomes the most dangerous man in the state.’³⁰

III. Secular Law and Treatment Ethics

Having summarized central principles of Roman Catholic medical treatment ethics, the article now considers to what extent they can or ought to be reflected in secular human law.

A. Omission of Treatment With Intent to Cause Death

The first principle described emphasizes that deliberate omission of life-preserving treatment with the intent to cause or hasten death is ethically just as much euthanasia as is taking action directly to kill the patient, as by a lethal injection or prescription. However, it is a well-established legal concept that medical treatment requires informed consent:

At common law, all competent adults can consent to and refuse medical treatment. If consent is not established, there may be legal consequences for health professionals. Under the law of trespass, patients have a right not be subjected to an invasive procedure without consent or other lawful justification, such as an emergency or necessity.³¹

Relying on this legal concept, it is certainly legally possible for a competent adult to refuse life-preserving treatment with the stated or unstated intent of causing or hastening death, and thus accomplish what, ethically speaking, is equivalent to suicide. To the extent that the law authorizes surrogates to make health care decisions on behalf of minors or incompetent adults, it is also possible for them to direct denial of life-preserving treatment to

30 As quoted by John Harvey, ‘Should Health Care Be Rationed? The Physician’s Viewpoint’, *The Linacre Quarterly* 61:1(1994), 66, 69.

31 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws (DP 81)*, §10.47.

the patient with such an intent, ethically committing euthanasia. Indeed, given the prevalence of a “Culture of Death” in contemporary society,³² rejection or denial of life-preserving treatment with the intent of causing or hastening death is unquestionably quite common.

Ought efforts be undertaken to reform the law of informed consent in an effort to prevent such cases of ethical euthanasia? The difficulty is that while medical treatment that can preserve life is frequently withheld or withdrawn with death-inducing intent, it is also possible to withhold or withdraw such treatment without such an intent, on the grounds that in the particular circumstances it is disproportionate or that providing it would go beyond the reasonably expectable ordinary duty of care, and thus that the rejected treatment is extraordinary and ethically optional.

In practice, therefore, distinguishing treatment rejection that amounts to euthanasia from rejection of treatment that is not morally obligatory very frequently depends on knowing the subjective intent of the decision-maker. Aquinas noted that ‘man can make laws about matters that are capable of being judged. But man cannot make a judgment about internal motivations that are hidden, but only about external actions that are public.’³³

Supposing that the law were to prohibit withholding or withdrawing potentially life-saving treatment when done with the intent to cause or hasten death, then, given the complexity of the factors that determine the proportionality of treatment, decision-makers could quickly learn to disguise their true intent by describing their motivation in other terms that were legally acceptable. Suppose a treatment (call it A) is judged to have a 75% chance of preserving life, a 10% chance of a complication bringing immediate death, and a 45% risk of causing serious disability, while without treatment there is a 60% chance of death within a few months. (In the real world the probabilities are unlikely to be so precise.) A decision-maker who considers death preferable to serious disability could for that reason unethically reject treatment, but might also plausibly cite the principle of proportionality as justifying an ethical choice to prefer the 40% chance of long-term life without treatment over the 10% chance of immediate death with it.

Often the choices will be more complex still. Consider that in most cases there are alternative possible treatments for a given disease or injury, with varying degrees of probability of success in preserving life to be balanced against varying degrees of probability of complications or side effects – including those that might themselves risk death. Suppose that besides treatment A there is an alternative treatment B with a 40% chance of preserving life, a 1% chance of a complication causing immediate death, and a 2% chance of causing serious disability. A decision-maker believing that death is preferable to life with disability could for that reason unethically choose B over A, but could also plausibly ethically choose either A or B based on the principle of proportionality.

How then, realistically, could a law prohibiting rejection of treatment with the intent of causing or hastening death be enforced? Might one envision panels of medically trained overseers reviewing in real time every case in which potentially life-saving treatments were being balanced against each other, or balanced against no treatment, trying to ferret out the underlying subjective motivation? In emergency situations when hours or even minutes may count, how could there be time for adequate due process? Who would appoint, and who

32 Cf. John Paul II, EV §12.

33 Aquinas, *Summa Theologica*, 2-1, Q.91, Art. 4.

review the decisions of, such judges? Would there be provision for appeals? Given the vast number of such situations, where would the resources – in time, facilities, and funds – be found to administer such a system? Would such resources need to be diverted from, for example, financing the very health care provision of which such a regime was intended to ensure? And considering the universal intrusiveness of such a system, would it not smack of a police state?

In the words of Aquinas, ‘[I]n human government it is right for those who are in authority to tolerate some evils so as not to prevent other goods or to avoid some worse evil from occurring’.³⁴ Even if the treatment ethics this article has described dominated the contemporary culture and could command the political and legislative power to pass laws to ensure its observance, it would be imprudent and counterproductive to attempt to construct and implement such a regime. The realistic alternative way to reduce the incidence of unethical rejection of medical treatment amounting to passive euthanasia must come from greatly enhanced education and counseling in the normative ethics summarized in this article.

B. Assisting Suicide

Supporters of the legalization of assisting suicide sometimes contend that it is irrational and arbitrary for governments to prevent lethal injections or prescriptions since they allow rejection of treatment with a similar intent of causing death. Yet that argument fails to recognize the critical distinction between the law’s ability to recognize the unmistakable death-causing intent in direct killing, and the law’s inability realistically to disentangle cases in which treatment is rejected with lethal intent from cases in which treatment is rejected for legitimate and ethically acceptable reasons. That it is impractical for the law effectively and enforceably to prevent most cases of “passive” euthanasia does not make it arbitrary for the law to protect against ethically equivalent cases of “active” euthanasia in which the problem of differentiating intent does not arise.³⁵ Just because the law refrains from attempting to act when it would be fruitless to do so does not make it irrational for the law to act when it can be effective to do so.

C. Appeal to Secular Standards

Of course, it is far from being the case that Catholic ethics, relating to health care or otherwise, pervade the contemporary culture. In a pluralistic society, relying solely on the authority of Catholic teaching is unlikely to convince secular legislators representing constituents of varying religions and of no religion. Indeed, in this context Catholic teaching documents have explicitly sought to address a wide audience extending beyond not just Roman Catholics but also beyond the members of other religions. For example, the Introduction to the *Declaration on Euthanasia* states:

It is hoped that this Declaration will meet with the approval of many people of good will, who, philosophical or ideological differences notwithstanding, have nevertheless a lively awareness of the rights of the human person. These rights have often, in fact, been proclaimed in recent years through declarations issued by International

34 Aquinas, *Summa Theologica*, 2-2, Q.10, Art. 11.

35 For a similar argument in the context of the constitutional law of the United States, see Marzen, O’Dowd, Crone & Balch, ‘“Suicide: A Constitutional Right”– Reflections Eleven Years Later’, *Duquesne Law Review*, 35, 1996, 270-74.

Congresses . . . ; and since it is a question here of fundamental rights inherent in every human person, it is obviously wrong to have recourse to arguments from political pluralism or religious freedom in order to deny the universal value of those rights.³⁶

Similarly, the encyclical *Evangelium Vitae* was addressed not just to “the sons and daughters of the Church” but also appealed, “May these words . . . reach all people of good will who are concerned for the good of every man and woman and for the destiny of the whole of society!”³⁷

It is beyond the scope of this article to enter in detail into the strong arguments for laws that protect against assisting suicide and active euthanasia that are independent of religious conceptions of the sanctity of life.³⁸ Such philosophers as John Locke have advanced arguments that the right to life is logically inalienable, arguments that are quite separate from the religious view that human beings are stewards of their lives rather than sovereign over them.³⁹ More likely to gain traction in the contemporary secular debate is the empirical evidence that those who are suicidal – including people with terminal illness – are almost invariably affected by judgment-impairing, treatable psychological conditions that create “tunnel vision” blinding them to non-lethal ways to address the circumstances that lead them to see continuance of their lives as intolerable.⁴⁰ The experience of those countries that have legalized assisting suicide demonstrates that in practice legalization does not limit itself to supposedly autonomous decisions of competent adults, but extends to the imposition of nonvoluntary and involuntary death on people with disabilities.⁴¹

D. Discriminatory Denial of Life-Preserving Treatment

The third and fourth principles of Catholic treatment ethics described earlier establish that the quality of life of the patient must not motivate denial of treatment decisions, and that whether or not to obtain extraordinary treatment is an ethically optional (not forbidden) judgment to be made by the patient or those legally entitled to act for an incompetent patient rather than others (such as physicians). A particularly strong secular case can be made for laws that protect the right of patients or their surrogates to choose life-saving treatment against the wishes of health care facilities or personnel who, on the basis of a view that the patient’s allegedly poor quality of life makes it not worth living, seek to override that choice.

The Sacred Congregation for the Doctrine of the Faith has taken notice of the congruence of the Church’s moral teaching with the growth in protections against discrimination:

[H]uman history has . . . shown real progress in the understanding and recognition of the value and dignity of every person as the foundation of the rights and ethical imperatives by which human society has been, and continues to be structured. Precisely in the name of promoting human dignity, therefore, practices and forms of

36 SCDF, *Declaration on Euthanasia*.

37 John Paul II, EV §5.

38 For a brief summary, see Ben White & Lindy Willmott, *How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide*, 17-19.

39 Marzen, O’Dowd, Crone & Balch, ‘Suicide: A Constitutional Right?’, *Duquesne Law Review*, 24:1, 1985, 41-44.

40 *Ibid.*, 107-27.

41 See, e.g., Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure*.

behaviour harmful to that dignity have been prohibited. Thus, for example, there are legal and political – and not just ethical – prohibitions of racism, slavery, unjust discrimination and marginalization of women, children, and ill and disabled people. Such prohibitions bear witness to the inalienable value and intrinsic dignity of every human being and are a sign of genuine progress in human history.⁴²

As the Australian Human Rights Commission points out:

The Disability Discrimination Act 1992 protects individuals across Australia from unfair treatment in many parts of public life. The Act makes disability discrimination unlawful and promotes equal rights, equal opportunity and equal access for people with disabilities.

The Commission also has responsibilities to promote the United Nations Convention on the Rights of Persons with Disabilities, which Australia ratified in 2008.⁴³

The principle that people should not be discriminated against because of disability correlates well with the principle that they should not be denied life-saving treatment based on their ‘quality of life.’

An example of a law rooted in the non-sectarian universal principles of human equality and non-discrimination that is congruent with these principles was enacted in 2013 in a state of the United States of America. Entitled the Oklahoma Nondiscrimination in Treatment Act, its core requirement provides:

A health care provider shall not deny to a patient a life-preserving health care service the provider provides to other patients, and the provision of which is directed by the patient or a person legally authorized to make health care decisions for the patient:

1. On the basis of a view that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill; or
2. On the basis of disagreement with how the patient or person legally authorized to make health care decisions for the patient values the trade-off between extending the length of the patient’s life and the risk of disability.⁴⁴

Such an approach provides a model of how those who abide by the essential precepts of Catholic treatment ethics can find common ground in the secular arena to secure the right of the most vulnerable among us to be protected from the discriminatory devaluation of their lives and the unjust denial of life-saving medical treatment in violation of their fundamental right to live.

Conclusion

42 The Sacred Congregation for the Doctrine of the Faith, “Instruction *Dignitas Personae* on Certain Bioethical Questions,” ¶ 37, Rome, 20 June 2008. Official text in AAS 100 (2008), 1-76. English translation http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html.

43 “About Disability Rights,” Australian Human Rights Commission, accessed 27 October 2016, <https://www.humanrights.gov.au/our-work/disability-rights/about-disability-rights>.

44 63 Okla Stat. §3090.3A.

Roman Catholicism teaches a nuanced treatment ethics addressing the complexity of decisions about the provision or withholding of life-preserving treatment. While some of its ethical principles, such as the duty to accept ordinary treatment, cannot effectively be applied and enforced by secular law, others, such as preventing denial of treatment based on ‘quality of life,’ at least when that denial is involuntary, are congruent with widely accepted secular standards against discrimination based on disability.