On

Proportionality

in the care for sick and dying people

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ABOUT NORMALITY

Prof. R. Spaemann

In the context of the problem of life-prolonging measures for dying or irreversibly comatose patients, the distinction between ordinary and extraordinary measures plays a decisive role. There is a broad consensus about the fact, that we owe all ordinary measures to those human beings at all times and until their death – unlike extraordinary measures.

There we have an area of discretion and the necessity of an appreciation of values. The omission of extreme effort is not the equivalent of "killing by omission". If we neglect to bring a 90 year old, mortally ill patient to a special hospital in the USA, to prolong his life for 2 months, it does not mean to kill him. The medical duty to fight for life always ends with a capitulation.

Modern medicine makes it possible, to delay this capitulation continually. But dying is a part of life. And we are not the masters of life and death. The physician has to capitolate early enough to make sure, that he does not make a humane dying impossible. That each omission of a possible prolonging of life is killing, is especially pretended by supporters of euthanasia, like Peter Singer and Ernst Tugendhat.

The motive is clear. Provided that each renouncement of a prolonging of life is killing, we are killing permanently anyway, and the active killing is nothing else but what we have already accepted. Peter Singer means to impress on us, when he is writing, that it

would not make any difference after all, whether a mother let her child die of hunger or asphyxiated it with a pillow. Yes, that makes no difference.

But it makes a difference, whether she lets her child die of hunger or whether she renounces to give it antibiotics in the case of imminent death, which is definitively coming. That means, that it makes a decisive difference, if she obtains something normal or abnormal / extra-normal. I have now replaced the term of the "ordinary" by the term of the "normal". Because what is to be challenged here, is the concept of normality. It depends on this concept, how we judge the omission legally and morally.

Objections are raised against the concept of normality from different sides, on the hand by utilitarians and consequentialists like Peter Singer, on the other hand by Habermas and his followers. Consequentialism states a duty of the human being to optimise the world. The only criterion for the moral judgement of an action is, whether it contributes to the optimisation more than each possible alternative action.

In the philosophical tradition God alone was in charge of the *bonum universi*. It was not even allowed to human beings to usurp this prerogative of God. The human being is standing in an *ordo amoris*, which is structured by finite relations of proximity and distance and by professional duties. So according to Saint Thomas it is the task of the magistrate to search for an absconding criminal to punish him. It is the task of the criminal's wife to help him, when he is hiding. Namely the wife has to care for the *bonum familiae* and the magistrate for the *bonum civitatis*. God's will appears *post factum*, in the fact that the man is either captured or not. But neither the wife nor the magis-

trate are let in these plans. Therefore they do not have the right to hinder the other from the fulfilling of his duty. The magistrate is not allowed to punish the wife for her help and the wife is not allowed to become a terrorist to save her husband.

Normality is the frame in which finite beings move and have to move. However this is rejected by utilitarianism. When two children have been falling into the water and I can only save one, Peter Singer supposes, that we should save the more worthy and not our own child. That means that there is nothing like an *ordo amoris*.

Habermas' objection against the normative meaning of normality is the breakdown of National Socialism. At that time for Habermas and his friend Apel it was a breakdown of what they had experienced as normality in their youth. And their slogan became: "Normality, never again!" Never again an application of norms, that do not owe to a preceding universal discourse, but build the frame for our actions unquestionably. People like me, who grew up in a different milieu, experienced things totally differently. For them the NS regime was a revolutionary break with any humane *ethos* or civilisation and the year 1945 was the return to normality. So normality is apparently no last and unquestionable fundament of human acting. There can be wrong and right normality. But normality is founding a precedent. This precedent is confutable.

However in the case of a conflict the duty to give justification is on the side of the one who believes that he should act against this precedent. (I am just thinking of the Constitution of the Sacred Liturgy of the 2nd Vatican Council. It says that no change of the old liturgy is allowed, if it is not justified by a considerable

and definitely foreseeable benefit for the church. The old liturgy, the applicable normality, does not have to justify itself. It is the reformer who has to justify each innovation. Needless to say, that the reform of the liturgy carried out later, did not follow this instruction of the council).

Normality is a condition for all life on earth. It does not have its paradigmatic place in the dimension of mind, neither in the dimension of physical, inanimate nature. For the mind there is only unconditioned truth and there are only unconditionally applicable moral norms. And in the physical dimension laws of nature, which can be formulated in mathematical terms, do apply without fail. Where a star drifts from its calculated course, it is not the star which has made a mistake, but we either have to take note of a fact so far unknown or we have to revise our theory. Furthermore laws of nature do not have any normative meaning for human acting. We have to allow for them, because otherwise acting is not possible at all. However their knowledge only has an instrumental meaning for our acting. They always have the form of "if… then ...” and do not commit us to anything. They only describe and do not answer the question "why".

The laws that structure life are of quite a different nature / are quite different. They are not formulated in mathematical terms, they do not apply without fail, but they answer the question "why". They explain to us, for example, why birds fly from the north to the south in winter. It is because they usually find food there. In contrast, that their voyage sometimes ends up in the nets of Italian bird catchers is no explanation for the flight. Normality is a teleological, not just a statistical category. Even if most of these birds actually had such a sad end, this end would still be without any

worth for an explanation of this end. For the theorist of evolution only the supposition, that this once has been different, is useful.

Normality is, as I said, not a purely statistical category. It rather has normative connotations. If 90% of a population suffers from headaches, we will not be trying to adapt the other 10% to this condition; we will do it the opposite way around. Chronic headaches will never become ‘normal’. Though the "*hos malista*" of Aristotle, and the "*ut in plurimus*" of Saint Thomas respectively, are deemed to be indications for the accordance between behaviour and essence. And for non-human creatures this actually holds true. That it also applies to human beings is a popular opinion. Hence the corrupting impact of the "*Così fan tutte*". When it appeared, the Kinsey-report had a corrupting effect in the USA and far beyond, because it showed, how the statistically normal sexual behaviour diverged from what US-citizens called good and creditable. This discrepancy between the real behaviour and the officially applicable and accepted moral standards is indeed characteristic for all High Cultures. Christianity is able to explain this discrepancy by means of the theory of original sin.

You can also talk about hypocrisy in this context Then you should add, however, that according to La Rochefoucauld, hypocrisy is the bow of vice to virtue and according to Gomez Davila the disappearance of hypocrisy is the most certain indication for the moral decadence of a civilisation. Though hypocrisy is parasitic. Where it increases, it smothers the moral, of that it is living after all.

For two reasons the normality of behaviour is indispensable for human beings. First because it allows a

stability of mutual expectations of behaviours. Without such, acting would not be possible. Relating to the inanimate nature that surrounds us this reliability is founded in the laws of nature. Rules of normality are in accordance with the laws of nature, where life and especially where free creatures are concerned. Secondly: rules of normality allow acting due to the fact that they relieve of reflections. Who would have to reflect about the principles of morality and about utility rootedly before any action, would never get acting. By far most of the norms that lead our acting are long ago determined by moral and custom. The orders of a legitimate authority usually must be followed and their legitimacy must be assumed. So the presumption of legitimacy is on their side.

This is also the sense of the *lex artis* in medicine and of the medical professional *ethos*. The physician must not think about the functional and moral demands before each of his measures. Lex artis and professional ethics unburden him. But those precedents are computable. There are situations, in which important reasons against prevailing normality are so exigent, that we are obligated to deliberate autonomously. You must not obey every military order. And when it became clear to Franz Jägerstätter, who recently was beatified, that Hitler's war was an unjust war, he refused to become Hitler's soldier and incurred the execution. Everybody, his village, his priest, his bishop, wanted him to comply with normality and not to think, that he alone knew the Christian duty.

Normality is indispensable for our acting. Still, it is not the last criterion of what is wrong and what is right. There are cases, in which it abandons us. In the case, that scientific civilisation causes such dramatic changes, that the traditional rules of the professional *ethos*

do not function anymore. In the case occurring today, that the capability to prolong human life endlessly with various prosthesis is growing constantly. The traditional rule of the medical professional ethos, to save life as long as possible in any case, cannot hold any longer, if the possible becomes boundless. In such cases, we have to rethink and redefine normality.

However here it shows now, that we have to deal with a double normality of human: a natural and a sociocultural one. Both are antagonistic towards each other. It is an essential part of the natural normality of human beings to be concretised in a historical, sociocultural normality. The human being is a speaking creature by nature. However there is no natural language, but the linguistic nature of man must be unfolded in a variety of historical languages. The unity of humankind only appears in the possibility to translate all human languages in other languages mutually, - even though there is always a loss of information.

An example for the sociocultural reshape of natural normality is the definition of the so-called "minimum living wage". In the juridical practice in European countries, the TV set is part of this minimum. It is not allowed to seize the television of a defaulting debtor. People like me, who do not own a TV set, show that this is obviously not a natural normality.

This becomes even more evident in medicine. The standards of normality change with the medical progress. What has been luxury once, is now belonging to the indispensable repertoire of the physician and the hospital. The question is, whether the cultural relativity of the standards of normality is unlimited, or whether something like the human nature is also con-

tinuing in civilisation to build postulates and set boundaries.

To answer this question, we have to step towards a third level, in addition to the other two levels of normality, from where something like an absolute norm, a meta-norm can be constituted. This is the level of personality. It is not identical to human nature. There are also non-human persons. Persons do not form an own species. The word "person" has a normative connotation. It is used to characterise a creature as an end in itself. All actions and omissions concerning a person must be such, that the involved person is never just a mean for the end of other persons, but that it is respected as "someone" to whom we are always accountable for the consequences of the actions that concern him. This metanorm is indifferent against normality and the abnormal. But normality is indispensable for the application of the norm. The person namely just exists as an owner and bearer of a nature. And the respect for a person as an end in itself can only be operationalized, when, dealing with its nature, it is respected it in its integrity.

Nature in itself has a teleological and therewith a normative structure. But as persons we surmount the mere natural. Not because it is a nature, but because it is the nature of a person, its final structure constitutes something like categorical duties. On the one hand the duty, to unfold its cultural dimension, to let it take part in a linguistic and a cultural community. On the other hand however the duty, to make the cultural normality compatible with the natural one. In the process of civilisation in Europe, since Plato, since Christianity and again in the age of enlightenment, "naturalness" becomes a cultural ideal. Thus, more and more all the forms of presenting oneself, all forms of fash-

ion, that deform the natural body strongly, disappear in the world, meanwhile undisciplined expressions of physicalness are turned into a taboo.

But let us come to a conclusion. In how far do these thoughts contribute to the consideration of the question, which live-prolonging measures for moribund people are always demanded, which measures require an appreciation of values and which should not be allowed. The metanorm of human dignity demands a primacy of the interest of the patient in the answering of all three questions. Other interests must be strictly subordinated. This especially holds true for the topic of organ transplantation. It is not allowed to dispose of a body in behalf of others, until the patient is unequivocally dead, according to indisputable criteria. And this only applies if the patient has agreed in advance. It is not allowed to do anything which amounts to killing him. Still it is also not allowed, to let the answer to the question, whether he should be kept alive artificially and when the corresponding measures should be abandoned, depend on the interest in a transplantation and to hinder him dying, because his organs are needed some days later.

The second question is, which life-prolonging measures are always demanded. Here the dualism between natural and cultural normality plays an important role. The possibilities of the *prolonging* of life have dramatically increased by the medical progress. Thus the standards of normality have changed. That does not mean, that all that is possible already belongs to the standard. This is especially prevented by the limitation of means, the limitation of disposable organs, but also and particularly the limitation of financial means, of appliances and money. You have to keep that in perspective. For economical reasons it is

impossible to make all actual therapeutic options existing anywhere available to anybody at any time. A selection is demanded and its criteria will not be independent from cultural normality. At the same time human dignity demands to justify these criteria to the concerned persons.

There is still the question: which are these criteria? Firstly, you have to say, that the meta-norm of human dignity demands to respect the wish for life of every human being, if the technical means to fulfil this wish are disposable. Admittedly, you have also to respect, if a human being, whose end is not far off and whose organism cannot perform the required activities for living any longer, does not want to make use of the means for prolonging his life. That does not have to do anything with suicide. In light of the ambivalence of natural normality between the pursuit of self-preservation and the inevitability of death, it is the right of the human being to welcome death and the right of the Christian to wish with the apostle Paul: "to depart, and to be with Christ", [Übers.: King James Bible, Phil, 1.23,24].

Furthermore there are the following thoughts: nature has tied the survival of the human species to free actions, namely eating, drinking and cohabitation. Not breathing on the other hand, which is done involuntarily. Therefore it is a *peccatum contra naturam*, to feed human beings artificially or to force a woman to become pregnant by enforced cohabitation or enforced in vitro fertilisation. The human person *is* not its nature, it *has* its nature and this having of a nature is its being. The tendencies of this nature are given to freedom as a material and they constitute duties in dealing with them.

But what about life-prolonging measures, interventions and medications for moribunds, who are enabled to utter their will and whose presumptive will is not accessible by any advance directive? We cannot communicate with them as persons any longer. We just have to deal with their organisms. Only in this organism they are given to us. That means, that the natural normality becomes the only guiding principle for us to deal with them. This natural normality makes the distinction between "ordinary" and "extraordinary" measures possible.

The human being in this last stage does still assert a claim: a claim on the alleviation of his suffering, on hygiene and above all on the degree of personal attention and care, from which we can suppose, that it might still feel somehow pleasant for him. But when the organism is not capable of the essential vital functions any longer and the person cannot impose its will on the organism, then it is time, to let that human being go. Total parenteral nutrition, artificial respiration and the administration of antibiotics should not belong to the standards of normality in the professional ethics. Those measures should be reserved for extraordinary cases where the duties *prima-facie* must give way to superior principles, like the principle of the minimisation of suffering. However the avoidance of suffering from starvation and suffocation must be weight up against the suffering because of an agonising prolonging of the dying. The more so as the palliative care helps us here today. It is quite a different matter, when suffering from starvation is caused by an apnoea test, which serves for the diagnosis of death. There is namely another way to achieve this diagnosis, which is to wait for some hours. Hours, that are demanded by deference anyway. And if you do not want

to wait, hoping for a transplantable organ, it means that you accept the potential suffering from starvation, in an interest, which is not that of the dying person. But this should not become a part of our cultural normality and the medical professional *ethos*.

ORDINARY AND EXTRAORDINARY MEANS OF THE PRESERVATION OF LIFE: THE TEACHING OF MORAL TRADITION[1]

Paulina Taboada, MD, PhD
Adjunct Professor, Director of the Center for Bioethics,
Pontifical Catholic University of Chile

SUMMARY

This work undertakes two fundamental aspects:

1. The historical development and the essential content of the traditional distinction between the 'ordinary' and 'extraordinary' means of the conservation of life.
2. Some inadequate forms of interpretation and application of the traditional teaching in the field of contemporary medical ethics.

The formal origin of the traditional distinction between 'ordinary' and 'extraordinary' means of preserving life can be found in the great commentators of Saint Thomas Aquinas of the XVI Century. The advances of medicine during the Renaissance obliged the moralist of the time to approach the question of the moral limits of preserving health and life. Thus the traditional teaching arose which affirmed the existence of a 'positive' moral duty of preserving health and life by way of using medical treatments that offer a reasonable hope for beneficial results (*spes salutis*) and that does not involve a physical or moral impossibility for the individual (*quaedam imposibilitas).* Both conditions must

be met simultaneously for the means of the preservation of life to be considered 'ordinary' and, therefore, morally obligatory. When at least one of these conditions is not fulfilled, the treatment is considered 'extraordinary' and its use is morally elective for the individual (relative norm).
The actual use of this teaching has been confirmed by the Magisterium of the Church during the 20th century, before the complex ethical dilemmas that contemporary medical practices have presented. The magisterial documents stress the importance of understanding and applying this classical doctrine in light of the unconditional respect that is due to all human life – from conception to natural death – by reason of its ontological dignity (given as much by its origin as by its destiny). This anthropological concept offers the hermeneutical key for an adequate application of the traditional teaching to particular cases. Outside of this context, it is easy for the content of the traditional teaching to be interpreted and applied in an inadequate way, as demonstrated by a brief analysis of four forms of interpreting this doctrine in the field of contemporary medical ethics.

I. INTRODUCTION [2,3]

The moral tradition of the Catholic Church has made a significant contribution to respond to the question of the limits of the duty of preserving health and life by proposing the distinction between means which are 'ordinary' and 'extraordinary'. The organizers of this Congress have asked me to offer a brief review of this traditional teaching. In order to accomplish this review, a doctor with philosophical formation – like myself – cannot fail to ask himself about the way in which this doctrine is presented, in light of the bioethical lit-

erature and the medical practice of today. A quick search of the principal medical databases (e.g. PubMed, MeSH, etc.) allows one to find close to a hundred references.[4] It could seem that the classic distinction between ‘ordinary’ and ‘extraordinary’ means had been incorporated into the language of contemporary medical ethics.[5] Nevertheless, the literature shows evidence of certain ambiguities and inconsistencies in the interpretation and application of the traditional teaching, which goes to show that its content is not always adequately understood. Therefore, in what follows I will refer fundamentally to two aspects: 1. The historical development and the essential content of the classic distinction between ‘ordinary’ and ‘extraordinary’ means of preserving life. 2. Some forms of inadequate interpretations and applications of this teaching in the field of medical ethics today.

II. HISTORICAL DEVELOPMENT AND ESSENTIAL CONTENT OF THE TRADITIONAL DISTINCTION BETWEEN ‘ORDINARY’ AND ‘EXTRAORDINARY’ MEANS.

A historical and systematic review of the traditional distinction between ‘ordinary’ and ‘extraordinary’ means does not need to depart *de novo* today. Fortunately, we counted on excellent contributions of authors like Mons. Daniel Cronin[6] (Archbishop of Hartford, USA), North American Jesuit priests Gerard Kelly[7] and Kevin Wildes[8] and - more recently - Mons. Maurizio Calipari[9]. With the contributions of these authors and others as the fundamental basis, I will briefly summarize the historical development and the essential content of this traditional teaching.[10]

2. 1. Historical and systematic analysis of the

traditional teaching.

The existence of a 'positive' moral duty of caring for health and life – one's own and another's – has been recognized since the origins of Christianity. Already in the writings of Saint Basil (329 – 379) we find paragraphs destined to praise the art of medicine as a divine gift that permits us to heal the sick.[11] Nevertheless, having medicine in mind, Saint Basil condemned "whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around the concern for the flesh."[12] This quote invites a theological reflection of the limits of the moral duty to preserve (physical) life, a reflection that the moralists of the 16th Century would carry out, developing the traditional distinctions between 'ordinary' and 'extraordinary' means.

2.1.1. Discourse on suicide and the distinction between 'positive' and 'negative' precepts.

For the development of this teaching, the moralists of the tradition were fundamentally based on the previously expounded concepts of Saint Thomas Aquinas (1225 – 1274) in his analysis of suicide and mutilation (questions 64 and 65 of the Secundae Secundae).[13] The analysis of the Angelic Doctor demonstrates that not only a moral 'negative' obligation to not deprive oneself voluntarily of one's own life (through suicide) exists, but there also exists a 'positive' obligation to use the necessary means to preserve (physical) life. This idea will give origin to the theological reflection on the 'positive' duties related to the care and preservation of health and life (one's own and another's). Following Saint Thomas, the tradition has made the dis-

tinction between the 'affirmative' precepts (*bonum est faciendum*) and the 'negative' precepts (*malum vitandi*) of the natural law, proposing that the 'negative' prescriptions are always obligatory in every circumstance (*semper et pro semper*), while the 'affirmative' precepts always obligate, but not in every circumstance (*semper sed non pro semper).* The reason is that the affirmative precepts (*bonum est faciendum*) impel us to do everything that is possible in a determined situation, but this could be limited by proportionately grave causes that, therefore, justify it. On the contrary, the 'negative' precepts (*malum vitandi*) do not admit limits to their fulfillment. The prohibition against doing a moral evil is always valid and obligatory in every circumstance, being that nothing could excuse us from the obligation to abstain from committing a moral evil.[14] This basic distinction between negative and affirmative precepts also applies to the good of human life and the moral duty to preserve it.[15]

2.1.2. Medical advances of the Renaissance and the development of the traditional teaching.

The formal application of these concepts to the question about the limits of the moral obligation to preserve health and life by means of the use of medical therapies began to materialize from the recent systematic approach of the 16th century, thanks to the work of some famous commentators of Saint Thomas Aquinas, such as Francisco de Vitoria, Domingo de Soto and Cardinal Juan de Lugo, to name just a few. The medical advances of the Renaissance required the moralists of the time to directly approach the question of the causes that could exempt a Christian from the moral duty of preserving health and life by means of recourse to the new therapies that medicine was beginning to offer. One may recall that it was precisely in

the 16th century that Vesalio (1514 – 1564) published his book *De humani corporis fabrica* (1542), which originated the study of anatomy as we understand it today; Harvey (1578 – 1657) made the discoveries that led him to propose the theory of the circulation of blood; and Sydenham (1624 – 1689) published his book *Observationes medicae* (1676), with a systematic description of diseases, in that way, introducing the method of scientific observation to clinical practice.

These discoveries made the development of new treatments possible, as – for example – surgical amputation. Confronted with the medical advances of the Renaissance, moralists were faced with the necessity of exploring the limits of the moral obligation to preserve health and life through the use of these new techniques. Thus, among the concrete problems that presented themselves there was, for example, the doubt as to the moral duty of subjecting oneself to a surgical amputation in an age when asepsis and the anesthetic technique were not known. Among the commentators of Saint Thomas who approached the 'new' moral problems, Francisco de Vitoria (1483 – 1546) stands out and his writings set the basis for the development of the traditional teaching that distinguishes between 'ordinary' and 'extraordinary' means. In his famous *Relectiones Theologiae,* Vitoria treats some moral problems linked to the preservation of life through the ingestion of food. In agreement with Aquinas, his arguments favoring the existence of a moral obligation to receive nourishment is based on the natural inclination of self-preservation, in the love of oneself and the evil of suicide.[16] In a famous passage, Vitoria affirms:
"that if a sick person is able to take nourishment with the hope of life, he has the obligation to take it, just

as he must be given it if he is not able to do so himself. […] if the decline of the spirit is so great and the alteration of appetite is much, so much so that the infirm is able to take nourishment only with great trouble and almost a certain torment, than it can be considered an impossibility and one is excused from sin, at least mortal sin, especially when there is little or no hope for life."[17]

Therefore, in spite of affirming that a moral duty of self-preservation through the taking of nourishment exists, Vitoria holds that an infirm person could be excused from mortal sin if he is experiencing a moral impossibility in fulfilling that duty, especially if his hope for life is little or none. In agreement with the mentality of that time, Vitoria centers his fundamental analysis on the moral obligation of the infirm person. This focus is characteristic of the moralists of the Renaissance, who were interested in identifying those elements that could excuse a person of mortal sin in the case that one did not draw upon the use of the 'new' means of preserving life that medicine put at their disposal. From this perspective, centered on the duties of the infirm, Vitoria contrasts the moral obligation of nourishing oneself with the obligation of using medical treatment and he concludes that:

"…Medicine and nourishment are not the same. Nourishment is part of the
ordered means for animal and natural life, but not medicine, and man does not
have the obligation to make use of all the possible means of preserving life, but
only the means ordered towards life.

Second, it is one thing to die of the lack of nourishment, that which is ascribed to man [...] but it is another thing to die under the power of an illness that has invaded the body naturally. In that way, to not eat

would be to kill oneself; but to not take medicine is to not impede the death that is already approaching […] one thing is to not prolong life, but it is another thing altogether to cut one's life short. The second is always illicit, but not the first. Thirdly, that if someone was to have the moral certitude that through medicine their health would recover and without it they would die, it does not seem that they can be excused from mortal sin."[18]

The analogy of the moral duty to nourish oneself – introduced by Vitoria in *Relectio de Temperancia* – leads him to propose that the justification of the obligation to use medical treatments is founded on the 'moral certainty' of its eventual benefits, understood as the possibility of recovering health and of preventing an inevitable death. On the other hand, in *Relectio de Homicidio,* Vitoria holds that even in those cases in which recourse to medicine could serve to prolong life for a short while, a person could be exempt from the moral duty to use it if the conditions exist that cause a 'moral impossibility' such as – for example – excessive expense:

"[...] In the case that has been presented, I believe that the person is not obligated to give all his patrimony to preserve life [...]. The result is that, if one becomes so sick as to have no hope for life, admitting that a certain valuable medication might procure hours or even days of life, he would not be obligated to buy it, but it would be sufficient to utilize the common remedies."[19]

2.1.3. Nature of the 'ordinary' means.

In this way, in the writings of Francisco de Vitoria we find the explicit recognition of the requisites that the tradition has recognized as the foundation of the moral

obligatory nature of 'ordinary' means of preserving life:

1. the hope of a reasonable benefit (understood as recuperation of health or the prevention of an avoidable death). The moralists of the tradition usually designate this requisite with the Latin expression, *spes salutis*, which in contemporary medical literature could respond to – the much debated – criteria of 'benefit' or the scientific-technical 'usefulness' of the measure;[20] and

2. the absence of a physical or moral impossibility in its utilization on the part of the individual (designated by the Latin expression *quaedam impossibilitas)*. [21]

Tradition holds that both conditions must be met simultaneously for a means to be defined as 'ordinary' and – therefore – morally obligatory.[22] Thus, among the expressions that the moralists of the tradition utilized to describe the nature of 'ordinary means' are:[23]

- "the hope of beneficial results" (*spes salutis*);
- "common means"(*media communia*);
- "in accordance with the proportion of one's state in life" (*secundum proportionem status*);
- "easy means" (*media facilia*); and
- "means that are not difficult to obtain or use" (*media non difficilia*)

It is notable that, to describe the 'ordinary' means, in the classical texts 'negative' formulations are frequently used, in the sense of defining as ordinary means those whose use does *not* have the typical characteristics of the extraordinary means.[24] Given that – as we will see further on – the principal elements that connotate the 'extraordinary' character of a means of preserving life refer to different difficulties that are linked to their use, a recourse that the moralists of the tradition utilize to describe the 'ordinary' character of a means of preserving life was precisely the negation of

grave difficulties (physical or moral).

2.1.4. Nature of the 'extraordinary means' and causes of moral impossibility..

Developing this idea, the moralists of the Renaissance[25] put forth important efforts to identify the diverse causes of physical and moral impossibility that a person could experience in the utilization of means to preserve life. Thus, for example, analyzing the problem of moral obligation of subjecting oneself to surgical amputation (in the preanesthesia era), Domingo de Soto (1494 - 1570) concludes that the superiors of a religious order could not obligate their subordinates – interfering under the vow of obedience – to resort to interventions that would cause an enormous pain (*ingens dolor),* so no one would be obligated to suffer such torments (*cruciatus*) to preserve one's life.[26] In this way, the identification of the diverse causes of physical or moral impossibility that a person could experience in utilizing the 'new' medical treatments of the Renaissance served so that the commentators of St. Thomas would develop and necessitate progressively what is contained in the teaching of moral tradition regarding the limits of moral duty to preserve life through the distinction within 'ordinary' and 'extraordinary' measures.

Among the possible causes of the physical impossibility, we can mention that the measurement is simply not available or that it cannot be utilized; that the physical conditions of the infirm are incompatible with its use; etc.[27] Among the expressions that the moralists of the tradition utilized to designate the causes of the moral impossibility stand out:[28]

- "Ultimate effort" (*sumus labor*) and "extremely difficult means" (*media nimia dura*);
- "Certain torment" (*quidam cruciatus*) y "enor-

mous pain” (*ingens dolor*);

- “Extraordinary cost” (*sumptus extraordinarius*), “valuable means” (*media pretiosa*) y “exquisite means” (*media exquisita*);
- “Severe horror” (*vehemens horror*).

It is like this that the traditional teaching originated that holds that a means of preserving life that involves at least one of the four elements of ‘moral impossibility’ for the individual or that is not capable of offering a hope of beneficial results, should be considered ‘extraordinary’ and – therefore - morally non-obligatory (facultative). On the contrary, those means which are capable of offering the hope of beneficial results (*spes salutis*) and that do not impose excessive burden on the patient (*summus labor)*, should be considered ‘ordinary’ and – as a consequence – morally obligatory.
As an anecdotal fact, I just mentioned that it was Domingo Bañez (1528 – 1604) who – in 1595 – introduced the terms ‘ordinary’ and ‘extraordinary’ in the debate over the moral obligatory nature of the means of preserving life.[29] Therefore, it was just at the end of the 16th Century when the moralists began to articulate their teachings through the expressions ‘ordinary means’ and ‘extraordinary means’.[30]

2.1.5. Absolute norm vs. relative norm.

From what has been said so far it is clear that, in accordance with the teachings of tradition, the distinction between ‘ordinary’ and ‘extraordinary’ does not refer primarily to the type of means in general, but more so to the moral character that the utilization of the means has for the person in particular. It has to do with the distinction focused on the person of the infirm and his moral obligation to care for his health and life.[31] Therefore, the elements that should be taken into consideration to determine the grade of moral ob-

ligation of a determined means of preserving life, more than describing the technical aspects of the means in question, tend to characterize the particular situation for how it affects the infirm. It makes sense to ask, then, if to define the 'extraordinary' (i.e. non-obligatory) character of a means of preservation of life it would be enough in a concrete case to identify some element that causes a physical or moral impossibility for a person in particular (relative norm) or if it would have to refer, more so, to those circumstances that cause an impossibility for all human beings in general (absolute norm). In accordance with the tradition, it would be enough to adopt the 'relative norm' at the hour of defining the 'ordinary' and 'extraordinary' means of preserving life. However, it is necessary to make some clarifications. In a case where a physical impossibility exists it is not difficult to conclude that the person can be excused from the duty to preserve life, in accordance with the classic aphorism 'no one is obligated to the impossible' (*nemo ad impossibilia tenetur*).[32] However, when it concerns a moral impossibility one should take into account the distinction between negative and affirmative precepts. Given that the first is always obligatory and in every circumstance (*semper et pro semper*), it would not fit to justify an action that directly violates a negative precept, not even by offering as proof a supposed moral impossibility to be able to do it in another way. But when we refer to the positive duties related to the care and preservation of life, the existence of a moral impossibility could exempt its fulfillment.[33] It is, therefore, in the area of the positive duties pertaining to the preservation of life where it would be sufficient with adopting the 'relative norm' to define the 'ordinary' character (i.e. morally obligatory) or 'extraordinary' (non-obligatory) character of a means.[34] That is to

say, what is 'ordinary' or 'extraordinary' for one patient in a determined clinical condition, could not be so for another patient in a similar situation, including for the same patient in other circumstances.[35]

2.1.6. Theological Foundation of the traditional teaching.

Another question that we should analyze in relation to the content of the traditional teaching refers to its foundation. Following Saint Thomas, the moralists of the tradition understood the moral duty of preserving life in the context of the virtue of justice and, in particular, of commutative justice.[36] As a matter of fact, Aquinas approached the theme of suicide in his treatment of the virtue of justice.[37] It should not surprise us – therefore – that in analyzing the foundations of the moral duty to preserve life, Cardinal Juan de Lugo, S.J. (1583 – 1660) emphasizes the radical difference that exists between the dominion that man has over things and the dominion he has over his own life. Thus, while a person can insist that things belong to him, it would not be correct to insist that his life belongs to him in an equal way. Given that life is a gift, the person does not have perfect dominion over it, but is more its administrator.[38]

The (physical) life is recognized by the moralists of the tradition as a fundamental and primary good of the person, but not as an absolute good, therefore only the eternal beatitude can be considered an absolute good.[39] The classic teaching that distinguishes between 'ordinary' and 'extraordinary' means affirms that the positive duty to preserve and advance this primary good (the physical life) admits some circumstancial limits (such as all the positive moral prescriptions). However, given the importance of the value that is in play – the life of a person – it requests that

every reasonable effort be made to safeguard it. Therefore, only proportionately grave causes could exempt one from the positive duties related to the preservation of life. Health, in so far as the positive quality of the physical life, also merits being conserved and guarded. "There thus subsits the duty to cure oneself and to be cured."[40] The traditional distinction between 'ordinary' and 'extraordinary' means offers the criteria to establish the limits of this positive moral obligation, affirming that it is morally obligatory to use 'ordinary' treatments and that the use of 'extraordinary' treatments is morally facultative. Nevertheless, an adequate understanding and application of the traditional teaching to particular cases is supported in the premise that every human life merits an unconditional respect – from conception to natural death – by reason of its ontological dignity. At the margin of this anthropological conception it is easy for the content of this traditional teaching to be interpreted and applied in an inadequate form, as it occurs with some frequency nowadays.

2. 2. Incorporation of the traditional teaching in the documents of the Magisterium.

The traditional teaching, proposed by the moralists of the 16th century, was transmitted during approximately five centuries without great variations. Its actual validity has been officially recognized by the Catholic Church, that in the 20th century has incorporated this doctrine into some magisterial documents. Given that the pronouncements of the Magisterium have been analyzed in depth by Professor John Haas (in this volume), I will limit myself to offer here a brief enumeration of some of these documents, with the proposition of emphasizing the confirmation that the Church has given to the traditional teaching in the

context of the advances in contemporary medicine, advances which undoubtedly present 'new' and complex challenges to the question about the limits of the moral duty to preserve life.

- It is well known that – in the year 1957 – Pope Pius XII applied the classic distinction between 'ordinary' and extraordinary' means in his speech to a group of anesthesiologists, who he advised on the moral obligation of the use of the (then) 'new' techniques of cardiopulmonary resuscitation.[41]

- In the year 1981, the Sacred Congregation for the Doctrine of the Faith promulgated the Declaration *Iura et Bona* (on Euthanasia).[42] In the fifth part of this document it refers to the distinction between 'ordinary' and 'extraordinary' means in the context of the decisions of limiting therapeutic efforts at the end of life, proposing – for the first time in a magisterial document – the alternative use of the terms 'proportionate' and 'disproportionate' therapies (principle of therapeutic proportionality).[43] It affirms that "it is licit to be satisfied with the normal means that medicine can offer"[44] and that "before the imminence of an inevitable death [...] it is licit in conscience the decision to renounce some treatments that would solely procure a precarious and painful prolongation of existence."[45] It also emphasizes the duty to not interrupt the "normal duties to the infirm in similar cases."[46]

- A little later, in the same year 1981, the Pontifical Counsel *Cor Unum* promulgates a document on "Ethical questions relative to the gravely ill and the dying".[47] In this document – known for its French name *Dans le Cadre* – the distinction between 'ordinary' and 'extraordinary' means is also utilized and it specifies that to search for the global efficacy of a means of preserving life it should be taken into account as many quantitative elements as qualitative. It insists on the

moral obligation of utilizing the so-called 'minimal' care, defined as those means that in normal conditions are destined to maintain the life of a person (as, for example, nourishment).[48]

- In 1995, the Pontifical Council for the Pastoral Assistance of Health Care Workers, publishes the Charter for Health Care Workers,[49] in which is proposed – among other things – that the distinction between 'ordinary' and 'extraordinary' means (or 'proportionate' and 'disproportionate' means) does not only apply to decisions at the end of life, but also in whichever situation during the length of a person's life in which the question of the moral obligation of utilizing a medical therapy is contemplated.[50]

- The same year 1995, His Holiness Pope John Paul II publishes the encyclical *Evangelium Vitae*, which is without a doubt the most important magisterial document that confirms the traditional teaching. This encyclical distinguishes the fundamental difference that exists between euthanasia ("Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used [51]") and the rejection of the so called 'aggressive medical treatment' (that is to say, the recourse to "medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family"[52]). The conclusion is that "to forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death."[53]

- Another document – undoubtedly very important – is the Catechism of the Catholic Church, which confirms this doctrine by affirming that "it makes sense to eval-

uate if the therapeutic means that are available are objectively proportionate with respect to the perspective improvement”.[54]

III. INADEQUATE INTERPRETATIONS AND APPLICATIONS OF THE TRADITIONAL TEACHING IN CONTEMPORARY MEDICAL ETHICS.

If it seems that the distinction between ‘ordinary’ and ‘extraordinary’ means of preserving life has been incorporated into the language of contemporary medical ethics[55] and it is mentioned with some frequency in biomedical literature as a criteria capable of orienting decisions to limit therapeutic efforts, an updated review shows that this distinction is not always understood and applied adequately. In what follows I will briefly summarize some of the forms in which – in my opinion – the content of the traditional teaching is being inadequately interpreted and applied today, seeking to give evidence of the reasons that lie behind these ambiguities.

3. 1. Inadequate interpretation of the significance of the terms ‘ordinary’ and ‘extraordinary’.

As the British moral theologian Dunstan[56] affirms, in an article published in the Dictionary of Medical Ethics, the significance of the terms ‘ordinary’ and ‘extraordinary’ means has a different connotation for doctors and moralists. Among health professionals it is frequent that the expression ‘ordinary means’ is equated with the idea of ‘common’, ‘habitual’, or ‘non-exceptional’ therapies, while the term ‘extraordinary

means' refers to those therapies that are 'uncommon', 'non-habitual', 'exceptional' or that 'that are still found in an experimental stage'. As a matter of fact, this is the interpretation of the terms that, for example, the American Medical Association (AMA)[57] and the President's Commission for the Study of Ethical Problems and Behavioral Research of USA propose.[58] It is not surprising, therefore, that the prevalent attitude among doctors is to interpret the distinction between ordinary/extraordinary as the difference between usual/unusual, equating the 'ordinary' measures with the so called 'standard therapies' according to pathology.[59]
Although this interpretation has some relation with the distinction between 'ordinary' and 'extraordinary' proposed by the moralists of the tradition, it seems evident that the simple reference to the 'usual', or to that which is considered 'standard therapy' for a determined clinical condition, would not be enough to determine if that therapy is or is not morally obligatory for a particular patient. Thus, for example, the antiretroviral therapy is actually the standard therapy for the treatment of the HIV infection. Just the same, it could happen that a particular patient could be physically or morally helpless to be able to undergo legitimate therapy (as it has in fact occurred in the hospital).[60] In these circumstances, the utilization of that therapy would not be morally required for that particular patient, though its use is what is habitually done in those cases. Thus, despite being the standard therapy, it would be treated as an 'extraordinary' measure for that particular patient (relative norm).
Therefore, to equate the ordinary/extraordinary distinction with the duplicate usual/unusual supposes to incur a logical error, as some contemporary authors have shown.[61] In fact, it would not be correct to infer a

moral obligation based off the mere statistical frequency that an act occurs. To derive an 'ordinary' (morally obligatory) or 'extraordinary' character (facultative) of a therapy exclusively from the frequency of its utilization in the clinic would be to incur in a 'statistical' version the naturalistic fallacy: to identify the ethic with the statistic.[62] We remember that the moralists of the tradition introduced the terms 'ordinary' and 'extraordinary' to refer to the moral character (obligatory vs. facultative) that the use of means of preserving life would have for the individual patient. In other words, gathering the significance of their Latin roots (*ordo-ordinis*), the expressions 'ordinary' and extraordinary' denote the moral 'order' or 'disorder' that the utilization of a medical therapy involves in the life of the individual patient.[63] This moral 'order' or 'disorder' refers to the place where it concedes to the moral obligation to 'cure oneself and to be cured'[64] in the wider context of the other moral obligations and of the particular circumstances in the life of a person, taking into account an adequate axiological scale. This moral connotation of the terms 'ordinary' and extraordinary' does not necessarily coincide with the idea of that which is habitually done or which occurs occasionally from a medical perspective, as I have previously attempted to demonstrate.

3. 2. Interpretation of the ordinary/extraordinary distinction centered on the means.

Another inadequate interpretation of the distinction between 'ordinary' and 'extraordinary' means – closely linked to the matter of the previous point and also prevalent in the medical area – consists in centering the distinction on the 'means' and not on the person

that utilizes those means. We intend, thus, to make a list of those medical interventions that should always be done to be considered ‘ordinary’, setting off this list with the enumeration of those interventions that fall in the area of the facultative, to be considered ‘extraordinary’.[65] Those therapies of ‘common’ use in medicine are numbered in the supposed list of ‘ordinary’ medical interventions for being relatively simple, such as – for example – antibiotics, steroids, blood transfusions, etc.[66] On the contrary, included in the enumeration of the list of ‘extraordinary’ therapies are those interventions that are only exceptionally utilized, since they are highly complex or they are still in an experimental stage, as for example, extracorporeal circulation with a hyperbaric camera, regenerative therapy with stem cells extracted for the umbilical chord, certain forms of genetic therapy, etc.

This way of understanding the distinction between ‘ordinary’ and ‘extraordinary’, centered more on the ‘means’ than on the moral duty of the person that utilizes those means, may lead one to fall into the similar error of the previous point.[67] If it is in fact true that those medical interventions which are relatively simple to implement are more likely to fall into the area of what is morally obligatory for a patient, it would not be correct to identify the simple with the ethically binding.[68] It could happen that a simple intervention, which is in itself effective, would not be morally required for a patient in a particular situation. That could be, for example, the case of a patient with an elevated level of potassium in the blood (hyperkalemia) secondary to a renal insufficiency caused by the tumoral infiltration of his ureters. Although, from the medical point of view, simple and effective means for reducing potassium in blood exist, to resort to these measures

could be morally facultative for this particular patient, who is the carrier of cancer in the terminal stage, which implies that the cause of his hyperkalemia cannot be corrected.[69]

On the other hand, to hold that the inherent values of the classification (that is to say, the morally obligatory character of 'ordinary' means and the facultative character of 'extraordinary' means) are principally related to the medical procedures in so far as this would suppose to accept that its moral character could be determined independently of the particular circumstances in which a therapy is going to be used, which does not seem reasonable.[70]

Therefore, to identify the ethically obligatory therapies ('ordinary' means) with a list of simple or commonly used medical interventions (and vice-versa) seems inadequate. In fact, the texts of the moralists never intend to offer an exhaustive and complete list of 'ordinary' and 'extraordinary' means. The references to concrete situations that appear in their writings merely have the function of giving example that seeks to show that the moral quality of 'ordinary' and 'extraordinary' cannot be evaluated in abstract, but it must be judged here and now (*hic et nunc)*, according to the specific circumstances of each patient. [71]

3. 3. Confusion between 'therapeutic proportionality' and 'proportionalism'.

A group of outstanding moral theologians of the 20th century[72] has proposed a way of ethical reasoning that is known as 'the theory of proportionality'. Ethical proportionalism – a variation of consequencialism – sustains that the moral goodness or evil of an action ex-

clusively derives from the proportion of good or bad consequences from which they continue or can continue, including in this balance some pre-moral or non-moral goods.[73] In the context of concrete situations in which good and bad coexist, which creates an ethical dilemma of difficult resolution, these authors propose that the moral judgment centers on the recognized proportion between good or bad effects, in view of the 'greater good' or the 'lesser evil', that are effectively possible in a determined situation.[74] Basing their thought on this current ethic, some contemporary bioethicists – such as Paul Schotsmans[75] and Ludger Honnefelder[76] – criticize the classic distinction between 'ordinary' and 'extraordinary' means, because they believe that these concepts solely operate in the context of the ethical model called 'act deontology'[77], for which they do not agree. For Schotsmans, for example, the principal insufficiency of the classic model is rooted in what is 'static' and – therefore – incapable of dynamically integrating in its analysis the changing perspectives that characterize the evolution of contemporary medicine.[78] To overcome this supposed insufficiency of the traditional model, Schotsmans proposes to adopt a proportionalist theory[79] that – according to this author – more than a 'system' or 'methodology' of analysis, it would consist in a way of seeing human acts in terms of the relation between the ends and the good.[80] The morality of an act should be evaluated by a differentiated mode: on the one hand, it would be necessary to consider its moral 'goodness', that would be fundamentally based on the intention of the subject (in as much as it refers to moral goods, such as benevolence, justice, etc.); on the other hand, it would be necessary to establish its 'integrity', which would result from the proportion of the foreseeable

effects and consequences of the action.[81]
From the perspective, to speak of 'ordinary' and 'extraordinary' means would end up being ineffective and so it would be preferable to utilize the terms 'proportionate' and 'disproportionate means'.[82] To justify the proportionality of a therapy, the good of health – and in extreme circumstances, including the good of life itself – it should be balanced against other active values in an 'actual system of values' (for example, containment of costs, equity, solidarity, justice, etc.).[83]
Therefore, the determination of what constitutes a 'proportionate' treatment (the 'best' care or 'adequate treatment') for a patient would be the result of a dialogue between health professionals, the patient and the insurance companies. In that way, the moral character of the therapeutic action ('proportionate' vs. 'disproportionate') would be founded on the balance of its results, the ethically correct course being that which would produce the greater good or the 'lesser evil' possible of attaining in the given situation.[84] If the intention of the subject is directed toward the good (charity, justice, etc.), that action would be morally good (independant of the proper object of the act or the moral 'species'). In this way, the proportionalist balance includes the possibility that some non-moral responsibilities associated with the therapies or with the particular circumstances of the patient could overcome the value of the life itself and justify acts which – of themselves – could end the life of the patient. In actuality, this type of 'proportionalist' interpretation of the distinction between 'ordinary' and 'extraordinary' means is very wide-spread among moralists. It is probable that its diffusion is seen as having been facilitated by the replacement of the terms 'ordinary' and 'extraordinary' means for 'proportional' and 'dis-

proportional' therapies in the last decades. On the other hand, there is no doubt that – as John Paul II indicates in *Veritatis Splendor* – the consequencialist and proportionalist ethical theories "can gain a certain persuasive force from their affinity to the scientific mentality, which is rightly concerned with ordering technical and economic activities on the basis of a calculation of resources and profits, procedures and their effects." [85] Though, - continues the quotation of John Paul II - "such theories, however, are not faithful to the Church's teaching, when they believe they can justify as morally good deliberate choices of kinds of behavior contrary to the commandments of the divine and natural law."[86]

In this way, when it is proposed in the traditional teaching and in the most recent ecclesial documents of the Magisterium to apply the 'principle of therapeutic proportionality' to the decisions to limit the therapeutic efforts,[87] the 'proportionality' is conceived from a mode that is organically integrated with the concepts of classic morals.[88] As Sulmasy affirms, an adequate interpretation and application of therapeutic proportionality demands that both the benefits and the responsibilities associated with a treatment be evaluated as a whole and weighed against the practical reasonableness of implementing the said therapy, with the understanding that the existence of a moral duty to preserve health and (physical) life is accepted.[89] In other words, to justify the 'proportionality' (a moral obligation) of a therapy, it does not seem adequate to place a set of moral and pre-moral values before the good of health and life– as proportionalism proposes – but, rather, it should be established whether elements that constitute a 'proportionally grave' inconvenience (a 'moral impossibility) exist or not so that a person can comply

with the 'positive' duty of preserving his health and his life, assuming that life itself is an 'indispensable' good. From this perspective, based on the premise that (physical) life is a primary and fundamental good over which we do not have perfect dominion, the conclusion is that the value can never be placed before a set of non-moral goods, however adverse the circumstances are. According to the negative precept, the moral duty to not commit an act that could directly violate the life and health of a human person is always and in every circumstance obligatory (*semper et pro semper).* This duty includes the obligation to maintain a certain level of minimal care or medical treatments (understood in a wide sense) that are directly related with the preservation of the (physical) life[90] and that – in principle – could never be considered 'disproportionate' or 'extraordinary'. In other words, these measures will always be 'ordinary', for it would never be licit to omit them if the life and the ontological dignity of all human persons wants to be respected.[91]

3. 4. Interpretation centered on the 'quality of life'.

To bestow a superior value to the 'quality of life'[92] as the criteria that would permit the distinguishing of the morally obligatory therapies from those that are not, is another very wide-spread form of interpreting the distinction between 'ordinary' and 'extraordinary' measures nowadays.[93] Beauchamp and Childress, for example, suggest that it would be better to replace the distinction between 'ordinary' and 'extraordinary' treatments with the distinction between "morally obligatory' and 'optional' treatments, in accordance with a balance between the benefits and the responsibilities of the patient in which the quality of life plays a cen-

tral role.[94] For these authors, the principle criterion that allows the determination of whether a treatment is morally obligatory or 'excessive' is the consideration of the probability and magnitude of its benefits, weighed against the probable burdens. In this way, the conditions that could justify violating the *prima facie* obligation that we have to treat, would be the 'futility' of the treatment or that for which the burdens exceed the benefits.

In accordance with this perspective, the distinction between 'obligatory' and 'optional' treatments admits that conditions can exist in which the value of actual living could not be adequately counterbalanced by those goods – such as happiness and pleasure – that in reality make life worth living. Therefore, the principle of non-malfeasance does not imply the obligation of maintaining the biological life, or the duty of initiating or continuing treatments in the condition of pain, suffering and discomfort for the patient. In this way, when the 'quality of life' is very bad, it could be considered that the treatment is imposing more burdens than benefits on the patient. In other words, life would not have an intrinsic value, if it were not by virtue of the goods that it permits us to experience and, especially, the happiness and pleasure that can be experienced. On this point, the argument agrees with the utilitarian position.

As a matter of fact, the utilitarian criteria of maximizing happiness for the majority of persons has found wide acceptance today, especially among Anglo-Saxon moralists and bioethicists. In the debate over the limits of the obligation to preserve life, the utilitarian argument has been manifested in the form of a strong rejection of the idea that a moral

obligation to maintain hydration and nutrition in severely demented patients or patients in

a persistent vegetative state exists.[95]
It becomes evident that this interpretation of the distinction between 'ordinary' and 'extraordinary' means contains profound deviations from the traditional teaching. Among the most important deviations, they draft a proposition of maximizing certain non-moral goods and the idea that life would only have value if it is a source of pleasure. The great acceptance that the 'quality of life' has encountered in contemporary biomedical literature as the predominant criteria in the decisions about limiting therapeutic efforts gives evidence that our societies are loosing the sense of the value of human life and the significance of being a part of the human community.[96]

IV. FINAL REFLECTIONS

Recapitulating, we can say that the formal origin of the traditional moral teaching that distinguishes between 'ordinary' and 'extraordinary' means of preserving life is found in the great commentators of Saint Thomas Aquinas of the 16th century. The advances of medicine during the Renaissance obligated the moralists of the time to directly approach the question of the limits of the moral duty to preserve health and life. In that way, the traditional teaching emerged that affirmed the existence of a 'positive' moral duty to preserve health and life through the utilization of available medical therapies when they offer a reasonable hope for beneficial results (*spes salutis*) and when their utilization does not cause a physical or moral impossibility for the individual patient (*quaedam impossibilitas)*.[97] Both conditions must be simultaneously fulfilled for a means of preserving life to be considered 'ordinary' and, therefore, morally obligatory. When at least one of these conditions is not met, the therapy is

considered 'extraordinary' and its use becomes morally facultative for the individual (relative norm). However, the tradition also affirms that the utilization of an 'extraordinary' means could be morally required *per accidens* in particular circumstance, such as – for example – when its use represents the only way a patient has to be able to comply with other superior duties, "such as those of mercy, charity and justice (to God, society and family, etc.)."[98] The actual validity of the traditional teaching has been confirmed by the Magisterium of the Church during the 20th century, in the context of the complex moral dilemmas presented by the practice of contemporary medicine. The magisterial documents emphasize the importance of understanding and applying this doctrine in light of the unconditional respect that all human life merits – from conception to natural death – by reason of its ontological dignity (given as much by its origin as by its destiny). This anthropological conception offers the hermeneutical key for an adequate prudential application of the traditional teaching to particular cases. Outside of this context, it is easy for the content of this traditional teaching to be interpreted and applied in an inadequate way, of which the brief analysis that we have made of some of the forms of interpretation of this doctrine in the area of contemporary medical ethics has given evidence.

NOTES

1 Conference dictated during the International Scientific Congress: "*Accanto al malato inguaribile e al morente: aspetti scientifici ed*

etici". XIV General Assembly, Pontifical Academy for Life (Roma, 25-27 Febrero 2008)

2 I am sincerely grateful to the President and the Board of Directors of the Pontifical Academy for Life for the invitation to participate in this International Congress, dedicated to analyzing the scientific and ethical aspects related to the care for the dying. This opportunity to put my academic work at the service of the Church and the Gospel of Life constitutes for me reason for great joy, for which I am profoundly grateful.

3 I am grateful for the valuable contributions and commentaries received from Alfonso GÓMEZ-LOBO, Alejandro SERANI and William F. SULLIVAN during the elaboration of this text.

4 It is fitting to not here that a centenary of references is not much, if it is compared with the thousands of references that should be obtained when key words such as 'utility/futility', 'do not resuscitate order', 'vital testament', etc. are consulted.

5 Cf. Editorial, *Ordinary and extraordinary means*. J Med Eth, 1981, 7 (2): 55-56.

6 Cf. CRONIN D., *Conserving human life*, in SMITH R. (Ed.), *Conserving human life*, Massachusetts: Pope John XXIII Medical-Moral Research and Educational Center, 1989: 1 - 145.

7 Cf. KELLY G., *The Duty to Preserve Life*. Theological Studies 1951, 12: 550 - 556.

8 Cf. WILDES K., *Conserving Life and Conserving Means: Lead us not into Temptation.* In: *Philosophy and Medicine* 51, Dordrecht: Kluwer Academic Publishers, 1995. Also cf. : WILDES K., *Ordinary and extraordinary means and the quality of life*. Theological Studies 1996, 57 (3): 500 – 512.

9 Cf. CALIPARI M., *Curarse y hacerse curar. Entre el abandono del paciente y el encarnizamiento terapéutico.* Buenos Aires: Educa, 2007. Also cf. : CALIPARI M., *The principle of proportionality in therapy: foundations and applications criteria*. NeuroRehabilitation 2004, 19 (4): 391 – 7.

10 The content of this section is fundamentally based on the contributions of CALIPARI, 2004, 2007, CRONIN, 1989 y WILDES, 1995, 1996, as well as in the articles of McCARTNEY J.J., *The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case*. Linacre Quarterly 1980 Aug, 47 (3): 215 – 24 y MEILAENDER G., *Questio Disputata. Ordinary an Extraordinary Treatments: When does quality count?* Theological Studies 1997, 58 (3): 527 – 31.

11 "Each of the arts is God's gift to us, remedying the deficiencies of nature...the medial art was given to us to relief the sick, in some degree at least." Cf. ST. BASIL: *The long rules* (Transl. Sister Monica Wagner). Washington D.C: Catholic University of America Press, 1962: 330-31. Citado en: ENGELHARDT T. & SMITH A., *En-of-life: the traditional Christian view*. The Lancet 2005, 366: 1047.

12 Proper translation of the citation in English: "whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around the solicitude for the flesh." Cf. ST. BASIL, *The long rules* (Transl. Sister Monica Wagner). Washington D.C: Catholic University of America Press, 1962: 330-31. Citado en: ENGELHARDT T. & SMITH A., *End-of-life: the*

traditional Christian view, The Lancet 2005, 366: 1047.

13 Cf. SANTO TOMÁS DE AQUINO, *Summa Theologiae*, II - II, q. 64, a. 5; q. 65, a. 1.

14 Cf. JUAN PABLO II, *Veritatis Splendor*, Ciudad del Vaticano, 1993, n. 52. Also, cf. CONCILIO ECUMÉNICO VATICANO II, *Constitución pastoral Gaudium et Spes (sobre la Iglesia en el mundo actual)*, n. 10; SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE, *Declaración Persona Humana (concerning certain questions about sexual ethics), 4: AAS 68 (1976): 80.*

15 CALIPARI, *Curarse y…* p. 159.

16 Arguing about the moral evil of suicide, the Angelic Doctor fundamentally proposed three reasons (Cf. SAINT THOMAS AQUINAS: *Summa Theologiae*, II- II, q. 64, a. 5):

- The first refers to a violation of the natural law, according to which all men love themselves and tends towards self-preservation, resisting all that could destroy him.
- The second is founded in the fact that each individual is part of a social whole. Committing suicide would be committing a wrong against the human community to which he belongs, being a privation of one of its members.
- The third reason is based on the radical relevance of all human life to God, the Creator, who he has loved and maintained in existence. Therefore, to deny oneself of life itself would be a wrong against God, assuming to himself the right to judge the value of existence itself without having jurisdiction over it, being that the judgment over life and death is God's alone.

17 Cf. VITORIA F., *Relecciones Teológicas* (trans. from Latin by Jaime Torrubiano), Argentina: Ed. Jan-

uary, 1946. *Relecciones de la Templanza,* p. 448.

Cf. Citation in Latin:

"Ad argumentum in contrarium […] secundo dico quod si aegrotus potest sumere cibum vel alimentum cum aliqua spe vitae, tenetur sumere cibum, sicut teneretur dare aegrotanti. Tertio dico, quod si animi deiectio tanta est et appetitivae virtutis tanta consternatio, ut non nisi per summum laborem et quasi cruciatum quendam aegrotus possit sumere cibum, iam reputatur quaedam impossibilitas et ideo excusatur, saltem a mortali; maxime ubi est exigua spes vitae aut nulla". Cf. VITORIA F. *Relectiones Theologicae,* Lugduni, l587, *Relectio de Temperantia* n. 1, cited in: CALIPARI, *Curarse y…* p. 96.

18 Cf. VITORIA F. *Relecciones Teológicas… Relecciones de la Templanza, p.* 449.

Cf. Citation in Latin:

"...aliud est non protelare vitam, aliud est abrumpere: nam ad primum non semper tenetur homo et satis est quod det operam per quam homo regulariter potest vivere; nec puto, si aeger non posset habere pharmacum nisi daret totam substantiam suam, quod teneretur facere". Ibid. n. 12 - "...non tenetur quis uti medicinis ad prolongandam vitam, etiam ubi esset probabile periculum mortis, puta quotannis sumere pharmacum ad vitandas febres, vel aliquid huiusmodi". Cf. VITORIA F. *Relectiones Theol…Relectio de Temperantia* n. 9, cited in: CALIPARI, *Curarse y…* p. 96.

19 Cf. VITORIA F. *Relecciones Teológicas… Relección del Homicidio, p.* 487.

Cf. Citation in Latin:

"Unde in casu posito credo quod non tenetur dare totum patrimonium pro vita servanda [...]. Ex quo etiam infertur quod cum aliquis sine spe vitae aegrotat, dato quod aliquo pharmaco pretioso posset producere vitam aliquot horas, aut etiam dies, non tenetur illud emere, sed satis erit uti remediis communibus". Cf. VITORIA, *Relectiones Theol... Relectio de Homicidio,* n. 35, in: CALIPARI, *Curarse y…* p. 97.

20 To enter into the debate about the concepts of medical 'utility'/'futility' would move surpass the limits of this work. Some references, however, could be mentioned here. Cf. SCHNEIDERMAN L., *Commentary: Bringing Clarity to the Futility Debate: Are the Cases Wrong?* Cambridge Quarterly of Healthcare Ethics. 1998; 7: 269-278; SCHNEIDERMAN L., JECKER N., JONSEN A., *Medical Futility: Its Meaning and Ethical Implications*. Ann Intern Med. 1990; 112: 949-954; SCHNEIDERMAN L., FABERLANGENDOEN K., JECKER N., *Beyond Futility to an Ethical Care*. Am J Med. 1994; 96: 110-114;

SCHNEIDERMAN L., JECKER N. et al., *Medical Futility: Response to Critiques.* Ann Intern Med. 1996; 125: 669-674; CHRISTENSEN K., *Applying the Concept of Futility at the Bedside.* Cambridge Quarterly of Healthcare Ethics. 1992; 1: 239-248.

21 Cf. CRONIN, *Conserving…,* p. 102.

22 Cf. WILDES, *Ordinary and…*, p. 506.

23 Cf. CRONIN, *Conserving…,* pp. 84 - 98. Cf. also CALIPARI, *Curarse y…* pp. 151 – 158.

24 Cf. CALIPARI, *Curarse y…* pp. 156 – 157.

25 I refer, for example, to Domingo de Soto, Luis de Molina, Domingo Bañez, Francisco Suárez, Juan de Lugo, etc.

26 Cf. SOTO |D., *Theologia Moralis, Tractatus de Justitia et Jure,* Lib. V, q. 2, art. 1 - ".. .*praelatus vero cogere posset subditum propter singularem oboedientiam illi promissam, ut medicamina admittat quae commode recipere potest. At vero quod ingentissimum dolorem in amputatione membri aut corporis incisione ferat, profecto nemo cogi potest: quia nemo tenetur tanto cruciatu vitam servare. Neque ille censendus est sui homicida. Imo vera est illa Romani vox dum crus illi aperietur: Non est tanto dolore digna salus."* In: CALIPARI, *Curarse y…* p. 97.

27 Cf. CALIPARI, *Curarse y…* p. 160.

28 Cf. CRONIN, *Conserving…,* pp. 98 - 112. Also cf. CALIPARI, *Curarse y…* pp. 158 - 166

29 McCARTNEY J.J., *The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case*. Linacre Quarterly 1980 Aug, 47 (3): 216.

30 Bañez made the distinction that, although it is reasonable to affirm that every person is obligated to use the necessary means to preserve life itself, no one would be obligated to employ 'extraordinary' means , but only those means which are common to everyone, such as giving nourishment, being clothed and using ordinary medicines. On the contrary, those means which cause unbearable pain, place an excessive burden, or cause an 'extraordinary' and disproportionate cost for the conditions of the life of the infirm (*sumptus extraordinarius*) could not be

morally binding for that person. Cf. JANINI J., *La operación quirúrgica, remedio ordinario.* Revista Española de Teología 1958; 18: 331 – 348.

31 CALIPARI recalls this idea in the following way: "What distinguishes the thought of tradition on the topic in study is the great attention that these authors have showed about the human person. It is exactly the person, in effect, with his resultant peculiar and inalienable dignity of having being created " in the image and likeness of God" and whose destination is fulfilled in plenitude in the eternal life, that is to say in the full and definitive communion with the Holy Trinity, who is firmly at the center of any moral reasoning; it constitutes the real "norm", the measurement of the beginning and of the ethical proposed analyses, whose only end is to guide the decisions and the actions of singular individuals, in a field as delicate as that of the conservation of the life, towards the achievement of the authentic and integral good of the person in need of care. " Cf. CALIPARI, *Curarse y…* p. 166-167.

32 Cf. CALIPARI, *Curarse y…* p. 160.

33 *Ibid.* p. 161

34 Cf. CRONIN, *Conserving…,* pp. 91 – 92; KELLY, *The duty…* p. 214; CALIPARI, *Curarse y…* pp. 166 – 168.

35 Cf. CALIPARI, *Curarse y…* pp. 166 – 168.

36 Cf. CALIPARI, *The principle…* p. 393.

37 Cf. SANTO TOMÁS DE AQUINO: *Summa Theologiae*, II- II, c. 64, a.5. As we have previously recalled in the argument over the moral evil of suicide, the Angelic doctor fundamentally proposed three reasons.

The third argument is based on the radical pertenence of all human life to God, the Creator, which he has love and maintained in existence. Thus, to deny oneself of one's life would be to commit a wrong against God, man giving himself the right to judge the value of one's existence, without having 'jurisdiction' over it, because the judge over life an death belongs to God alone.

38 Cf. JOHN PAUL II: *Evangelium Vitae*, Vatican City, 1995, n. 34.

39 Cf. CALIPARI, *Curarse y…* p. 167; also cf. CALIPARI, *The principle…* p. 393.

40 Cf. CALIPARI, *Curarse y…* p. 167

41 Cf. PIO XII, *Answers to some relevant questions on resuscitation* AAS 49, November 24, 1957.

42 Cf. SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH: *Declaración Iura et Bona (Sobre la Eutanasia)*, Vatican City, May 5, 1980.

43 The origin of this new terminology is ascribed to the thought of some authors that are proposed. . However, the document does not make reference to their names. Cf. CALIPARI, *Curarse y …* p. 117 +
144.

44 Cf. SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH: *Iura et Bona*, n. 28

45 *Ibid.*

46 *Ibid.*

47 Cf. PONTIFICIO CONSEJO *COR UNUM : Dans le Cadre*, Ciudad del Vaticano, 27 Junio 1981.

48 *Ibid,* n. 2.4.

49 PONTIFICIO CONSEJO PARA LA PASTORAL DE LOS AGENTES DE LA SALUD: Carta a los Agentes de la Salud. Ciudad del Vaticano, 1995., n. 64 – 65.

50 Cf. CALIPARI, *The principle…* p. 395.

51 JUAN PABLO II: *Evangelium Vitae*, Ciudad del Vaticano, 1995, n. 65.
52 *Ibid.*
53 *Ibid.*
54JUAN PABLO II: *Catecismo de la Iglesia Católica.* Asociación de Editores del Catecismo, Madrid, 1992, n. 2278.
55 Cf. *Editorial. Ordinary and extraordinary means*. J Med Eth, 1981, 7 (2) : 55-56.
56 Cf. DUNSTAN, GR. Citado en: *Editorial*, J Med Eth, 1981, 7: 55.
57 Cf. AMERICAN MEDICAL ASSOCIATION. *Principles of Medical Ethics*. Chicago, Illinois: AMA, 1981. For a critical analysis of the interpretation of the AMA cf.: FISCHER S.A., *Correspondence: "Ordinary" and "extraordinary" vary with the case*. Hastings Center Report, 1983; 13 (5): 43 - 4.
58 Cf. *The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: Deciding to forgo life-sustaining treatment*. Washington, D.C.: U.S. Government Printing Office, 1983.
59 Cf. MEYERS C., *Intended goals and appropriate treatment: an alternative to the ordinary/extraordinary distinction.* J Med Eth, 1984, 10 (3): 128 – 130.
60 The case corresponds to a real clinical situation that occurred in the Clinical Hospital of our University and that motivated a consultation of the Ethical Committee. Cf. Taboada P., *Principles of Bioethics in Palliative Care*. En: Bruera E., Higginson I., Ripamonti C., von Gurten C., *Textbook of Palliative Medicine*. London: Hodder Arnold, 2006: 85-91; Taboada P., *Ethical Issues in Palliative Care*. En: Bruera E, De Lima L, Wenk R, Farr W., *Palliative Care in the Developing*

World. Principles and Practice. Houston: IAHPC Press, 2004: 39 – 51; Taboada P., *Principios éticos en Medicina Paliativa.* En: Bruera E., De Lima L. (Eds.), *Cuidados Paliativos: Guías para el Manejo Clínico* (2nd. Ed) Washington D.C.: IAHPC/OPS: 2004: 9-14; Taboada P., *El derecho a morir con dignidad*. Acta Bioethica. 2000; VI (1): 91 – 101.

61 Cf. BEAUCHAMP T., CHILDRESS J., *Principles of Biomedical Ethics*. (Fifth Edition). Oxford: Oxford

University Press, 2001: 200 -201; MEYERS C., *Intended goals...* p. 128, PERRY C., *Ordinary, extraordinary and neutral medical treatment.* Theor Med 1983, 4 (11): 43 – 56; BOLE T., *The ordinaryextraordinary distinction reconsidered: a moral context for the proper calculus of benefits and burdens.*

HEC Forum. 1990; 2 (4): 219 – 232;

62 Cf. MOORE G.E., *Principia Ethica*. New York, Cambridge University Press, 1959: 39 - 40.
Moore describes naturalists fallacy in the following way:
"I shall deal with theories which owe their prevalence to the supposition that good can be defined by reference to a *natural object* [...] and I give it but one name, the naturalistic fallacy.[...] This method consists in substituting for 'good' some one property of a natural object or of a collection of natural objects; and in thus replacing Ethics by some one of the natural sciences. "

63 Cf. McCARTNEY J.J., *The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case*. Linacre Quarterly

1980 Aug, 47 (3): 215 – 24; WILDES K., *Conserving Life and Conserving Means: Lead us not into Temptation*. In: Philosophy and Medicine 51, Dordrecht: Kluwer Academic Publishers, 1995; WILDES K., *Ordinary and extraordinary means and the quality of life.* Theological Studies 1996, 57 (3): 500 – 512.

64 Cf. CALIPARI, *Curarse y…* p. 41 – 45.

65 Cf. *Editorial. Ordinary and extraordinary means*. J Med Eth, 1981, 7 (2) : 55-56; PERRY C., *Ordinary, extraordinary…*p. 43 – 56; Meyers, *Intended goals…*p. 128-129; O'NEIL R., *In defense of the "Ordinary"/"Extraordinary" Distinction.* Linacre Quarterly, 1978; 45 (1) 37 – 40;

66 Cf. PERRY C., *Ordinary, extraordinary…*p. 43 – 56.

67 Cf. PERRY C., *Ordinary, extraordinary…*p. 43 – 56;

68 Cf. BEAUCHAMP T., CHILDRESS J., *Principles of …* pp. 200 -201.

69 The description of the case corresponds to a real situation that recently occurred in the Clinical Hospital of our University, which motivated a consultation of the Ethical Committee. Cf. TABOADA P., *Principles of Bioethics in Palliative Care*. In: BRUERA E., HIGGINSON I., RIPAMONTI C., VON GURTEN C., *Textbook of Palliative Medicine*. London: Hodder Arnold, 2006: 85-91; TABOADA P., *Ethical Issues in Palliative Care*. In: BRUERA E, DE LIMA L, WENK R, FARR W., *Palliative Care in the Developing World. Principles and Practice*. Houston: IAHPC Press, 2004: 39 – 51; TABOADA P., *Principios éticos en Medicina Paliativa.* In: BRUERA E., DE LIMA L. (Eds.), *Cuidados Paliativos: Guías para el Manejo Clínico* (2nd. Ed) Washington D.C.: IAHPC/OPS: 2004: 9-14; TABOADA P., *El*

derecho a morir con dignidad. Acta Bioethica. 2000; VI (1): 91 – 101.

70 Cf. PERRY C., *Ordinary, extraordinary…*p. 44 – 45; RACHELS J., *More impertinent distinction,* en:
MAPPS T.A., ZEMBATY J.S. (eds.), *Biomedical Ethics*, New York: McGraw Hill 1981: 335 359.

71 Cf. CALIPARI, *The principle…* p. 393: "Contrary to what is affirmed in some quarters, a careful reading of the texts of these moralists shows that they were careful not to attempt to draw up exhaustive and definitive lists of ordinary and extraordinary therapeutic means (possible references to specific medical actions present in their tracts, in fact, have a purely example-giving function), and they well brought out how the 'ordinary' or 'extraordinary' character of a therapeutic action was an ethical *quality* that can and must be fully assessed not in the abstract but in the concrete circumstances of clinical use, *hic et nunc*, and for a specific patient. All this clearly bears witness to the centrality that the classic moralists gave to the person as such in the way in which they argued and justified their ethical conclusions."

72 I refer here, concretely, to authors such as Janssens, Knauer, Fuchs, Schüller, Van de Poel, Van der Marck and McCormick

73 Cf. JUAN PABLO II: *Veritatis Splendor*, Ciudad del Vaticano, 1993, n. 74 - 79.

74 Cf. JUAN PABLO II: *Veritatis Splendor*, n. 75.

75 Cf. SCHOTMANS P., *Equal Care as the Best Care: A Personalist Approach*. En: ENGELHARDT H.T., CHERRY M. (Eds.), *Allocating Scarce Medical Resources: Roman Catholic Perspectives*, Washington, D.C., Georgetown University Press, 2002: 125 – 139.

76 Cf. HONNEFELDER L., *Quality of Life and Human Dignity: Meaning and Limits of Prolongation of Life*. En: ENGELHARDT H.T., CHERRY M. (Eds.), *Allocating Scarce Medical Resources: Roman Catholic Perspectives*, Washington, D.C., Georgetown University Press, 2002: 140 – 153.

77 The classic theory of the moral action is designated with this name, according to which the source of the morality are given by the object, the end and the circumstances of the human act. This classic theory holds that the first moral qualification of an act is given by its moral object or 'species', from which the existence of actions that are always and in every circumstance a moral evil (*intrinsese malum*) are deduced. Cf. SANTO TOMÁS DE AQUINO, *Summa Theologiae*, I-II, q. 6 – 21.

78 Cf. SCHOTMANNS, *Equal Care…*p. 134: "Traditionally, moral theology applied in this context the concepts of 'ordinary' and 'extraordinary' means. … This distinction may be adequate for static and poor medical environments, but it is no longer apt to cope with the rapid evolutions of medical technology at the moment. From a more methodological point of view, we may say that these concepts functioned indeed very well in the context of the ethical model of so-called act deontology, but they lack sufficient dynamic integration of new evolutions and changing perspectives."

79 Cf. SCHOTMANNS, *Equal Care…*p. 134: "All this makes clear that speaking in terms of 'proportionate and disproportionate' is preferable. The general dissatisfaction with the concepts of 'ordinary' and 'extraordinary means' (e.g. in situations in which good and evil coex-

ist) led many eminent moral theologians, including Janssens, Knauer, Fuchs, Schüller, Van de Poel, Van der Marck and McCormick, to explore a way of reasoning that is known as the 'theory of proportionality'."

80 Cf. SCHOTMANNS, *Equal Care…*p. 134:
"as noted by Selling, 'proportionality' is neither a 'system' nor a 'determinative methodology', but is only a way of "looking at things proportionally" (Selling 1986). According to Janssens (1980-81), proportionality is a question of relation between end and good. There must not be any intrinsic contradiction between the basic or ontic good that we want to preserve and the means we use for that end. As Knauer says, this postulate of noncontradiction between the means and the end is a central norm for determining the proportionate reason of any human act (Knauer 1965)." Las citas incluidas en el texto de Schotsmans se refieren específicamente a los siguientes textos: SELLING J., *The development of proportionalist thinking. Chicago* Studies 1986, 25: 167 – 175; JANSSENS L., *Artificial insemination: Ethical considerations*. Louvain Studies 1980-1, 8: 3 – 29 ; KNAUER P., *La détermination du bien et du mal moral par le principe du double effet*. Nouvelle Revue Théologique 1965, 87 : 356 – 376.

81 *Ibid.*

82 Cf. SCHOTMANNS, *Equal Care…*p. 136: "All this makes clear that speaking in terms of 'proportionate and disproportionate means' is preferable."

83 Cf. SCHOTMANNS, *Equal Care…*p. 136:
"we understand by 'best' of care the appropriate care for every unique patient. This implies that the

medical profession in dialogue with the representatives of patients (e.g., mutual insurance funds) must define adequate health care… the value of 'health must be balanced against other values incurrent value systems."

84 Cf. SCHOTMANNS, *Equal Care…*, HONNEFELDER, *Quality of Life…*.

85 Cf. JUAN PABLO II: *Veritatis Splendor*, Ciudad del Vaticano, 1993, n. 76.

86 *Ibid.*

87 Cf. SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE: Declaración *Iura et Bona*, 5 Mayo 1980, n. 27; PONTIFICIO CONSEJO PARA LA PASTORAL DE LOS AGENTES DE LA SALUD: Carta a los Agentes de la Salud. Ciudad del Vaticano, 1995, n. 64; PONTIFICIO CONSEJO *COR UNUM : Dans le Cadre*, Ciudad del Vaticano, 27 Junio 1981, n. 2-4; 7.2; 7.3.

88 TABOADA P., *What is Appropriate Intensive Care? A Roman Catholic Perspective.* En: Engelhardt H.T., Cherry M. (Eds.), *Allocating Scarce Medical Resources: Roman Catholic Perspectives*, Washington, D.C.: Georgetown University Press, USA, 2002: 53 – 73.

89 Cf. SULMASY D., *Double-Effect Reasoning and Care at the End of Life: Some Clarifications and Distinctions.* En: MONSOUR H.D., SULLIVAN W.F., HENG J. (Eds.), *Dignity in Illness, Disability, and Dying*. Toronto: International Association of Catholic Bioethicists, 2007: 49 – 109.

90 I refer here to measures such as hygien, hydration, nutrition, etc. Cf. HEANEY S., *"You Can't be any poorer than dead": Difficulties in Recognizing Artificial Nutrition and Hydrations as Medical Treatments.* Linacre Quarterly, May 1994: 77 – 87; ASHBY M., STOFFELL B., *Artificial hydration*

and alimentation at the end of life: a reply to Craig. J Med Ethics*.* 1995; 21 (3): 135-40. DUNLOP R.J., ELLERSHAW J.E., BAINES M.J., SYKES N., SAUNDERS C.M., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far?*

91 This idea has been emphasized in numerous recent magisterial documents: Cf. SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE: Declaración *Iura et Bona*, 5 Mayo 1980, n. 28; PONTIFICIO CONSEJO PARA LA PASTORAL DE LOS AGENTES DE LA SALUD: Carta a los Agentes de la Salud. Ciudad del Vaticano, 1995, n. 120; JUAN PABLO II: Discurso a los participantes en el Congreso Internacional 'Life-sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas.' 20 de Marzo 2004, Ciudad del Vaticano (online: www.vatican.va); SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE, R*espuestas a algunas preguntas de la conferencia episcopal estadounidense sobre la alimentación e hidratación artificiales.* Roma, 1 de agosto de 2007.

92 A critical analysis of the concept of quality of life and of its role in the decisions of limiting therapies far exceeds the limits of this work.

93 Cf. BEAUCHAMP T., CHILDRESS J., *Principles of Biomedical Ethics*. (Fifth Edition). Oxford: Oxford University Press, 2001; BOLE T., *Intensive Care Units (ICUs), and the ordinary means: turning virtue into vice*. Linacre Quarterly*.* 1990; 51 (1): 68 – 77; BOLE T., *The ordinary-extraordinary distinction reconsidered: a moral context for the proper calculus of benefits and burdens.* HEC Forum. 1990; 2 (4): 219 – 232;

WILDES K., *Ordinary and extraordinary means and the quality of life*. Theological Studies 1996, 57 (3): 500 – 512.

94 Cf. BEAUCHAMP T., CHILDRESS J., *Principles of …* p. 202: "We conclude that the distinction between ordinary and extraordinary treatments is morally irrelevant and should be replaced by the distinction between optional and obligatory treatment, as determined by the balance of benefits and burdens to the patient." *… Ibid,* p. 215: "Our arguments thus far give considerable weight to quality-of-life judgments in determining whether treatments are optional or obligatory."

95 CLARK P., *Tube feedings and persistent vegetative state patients: ordinary or extraordinary means?* Christ Bioeth. 2006; 12 (1): 43 - 64. CRAIG G., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far?* J Med Eth, 1994, 20: 139-143; CRAIG G., *On withholding artificial hydrating and nutrition from terminally ill sedated patients. The debate continues*. J Med Eth, 1996; 22: 147-153; DUNLOP R.J., ELLERSHAW J.E., BAINES M.J., SYKES N., SAUNDERS C.M., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far? A Reply.* J Med Eth 1995; 21: 141-143; GUEVIN B., *Ordinary, extraordinary, and artificial means of care.* Natl Cathol Bioeth Q. 2005 Autumn; 5 (3): 471-9; HEANEY S., *"You Can't be any poorer than dead": Difficulties in Recognizing Artificial Nutrition and Hydrations as Medical Treatments.* Linacre Quarterly, May 1994: 77 – 87; HICKEY J.V., FISCHER S.A., RACHELS J., *"Ordinary" and "extraordinary" vary with the case.*

Hastings Cent Rep. 1983; 13 (5):43 – 4; SHANNON T., *Nutrition and hydration: an analysis of the recent papal statement in the light of the Roman Catholic bioethical tradition.* Christ Bioeth. 2006 Apr; 12 (1): 29 – 41; TORCHIA J., *Artificial hydration and nutrition for the PVS patient: ordinary care or extraordinary intervention?* Natl Cathol Bioeth Q. 2003 Winter; 3 (4): 719 – 30; WILKES E., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far? A commentary.* J Med Eth, 1994; 20: 144-145.

96 Cf. MARKWELL H., *End-of-life: A Catholic View.* The Lancet. 2005, 366: 1132 – 35; BLAKE D.C., *Reconsidering the distinction of ordinary and extraordinary treatmente: should we go "back to the future"?* HEC Forum 1996; 8 (6): 355 – 71.

97 Cf. MEILAENDER, 1997, p. 527; KELLY, 1951, p. 550.

98 Cf. CALIPARI, *Curarse y…* p. 167.

THERAPEUTIC PROPORTIONALITY AND THERAPEUTIC OBSTINACY

John M. Haas

President, The National Catholic Bioethics Center, Philadelphia

One of the most complex areas of morality concerns decisions taken at the end of life. Every case is unique of course, not only because every human life itself is thoroughly unique but also because the circumstances surrounding that person's final days or hours will also be distinctive. It is precisely that complexity which requires the development of concepts that clarify as much as possible the application of universal principles to each unique situation of approaching death. Two of those concepts are known as "Therapeutic Proportionality" and "Therapeutic Obstinacy". But these terms must of course be seen within the larger context of medical ethics in particular and Catholic moral thought generally.

It is noteworthy that so many of the very words used in our discussions of end of life questions betray the natural law tradition so characteristic of Catholic moral thought. "Proportionate", "disproportionate", "suitable", "appropriate", "ordinary", "extraordinary" all speak to reasonableness and balance and order as these have been enshrined in Catholic moral thought. Long ago Plato asked in the *Euthyphro* whether certain actions were wrong because the gods had forbidden them or whether they were forbidden by the gods because they were wrong. There is no question that the Catholic tradition adopts the latter understanding of

the role and place of the moral law. God has not *arbitrarily* forbidden certain actions but rather has prohibited those that are wrong, those that would, if you will, violate in some way human dignity.

It must never be forgotten that the decisions taken at the end of life are on behalf of a person of incomparable worth, someone who is the very image of the Triune God, someone for whom Christ shed his own blood. But this person on behalf of whom we make decisions is someone most probably loved and cherished by others, someone who is a wife or husband, brother or sister, son or daughter, best friend or colleague. Moral theology and moral philosophy are practical sciences applied to the living reality of a human person. The decisions taken at the end of life must be ones that are seen ultimately as ones that are most reasonably ordered to the good of the dying person.

St. Thomas refers to law as an *ordinatio rationis*, an ordinance of the reason directive of behavior toward some good end.[1] We cannot even speak of a directive being a law if it is unreasonable. Catholic moral reflection on decision-making at the end of life seeks to find and to choose moral actions that would be judged to be appropriate to the end desired by any reasonable person not simply by Cathoics. To reflect on the concept of "therapeutic proportionality" in the texts of the recent magisterium one would of course begin with Pius XII and his address to physicians in 1957. Here the Pope uses the word "ordinary" to refer to those interventions to prolong life that one ought to consider morally obligatory. "But normally one is held to use only ordinary means – according to circumstances of persons, places, times, and culture – that is to say, means that do not involve any grave burden for one-

self or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult."[2] That higher good is of course the attainment of eternal life with God, or as it is stated in the health care directives of the American bishops, "our common destiny to share a life with God beyond all corruption".[3] Those means of prolonging life that one would consider to be not obligatory, that is, those that would be seen as morally optional, came to be known as extraordinary. "Ordinary" and "extraordinary" then came to be the standard terms used by Catholic ethicists to judge the morality of medical decisions with respect to prolonging life. "Ordinary" means of conserving life were morally obligatory, and "extra-ordinary" means were morally optional.

The response of Pius XII became the *locus classicus*, indeed the starting point, for contemporary discussions on the morality of decisions taken at the end of life. And it has been pointed out that in this allocution there was a greater emphasis placed upon the subjective or relative factors that determined the morality of the act rather than the anticipated results of any particular medical intervention.[4]

However, over the years health care professionals tended to understand ordinary and extraordinary more in medical terms rather than moral ones. "Ordinary" was seen as what was standard medical practice, what was statistically predictable, and what was easily accessible over against what was "extraordinary", that is, what was experimental and not yet standard medical practice. Consequently there developed the practice of using other terms to convey the meaning of ordinary and extraordinary as employed by Pius XII.

The terms “proportionate” and “disproportionate” have come to be seen and understood by many as synonymous with the moral meaning of “ordinary” and “extraordinary”. These terms “proportionate” and “disproportionate” first made their way into the formal teaching of the Church through the *Declaration on Euthanasia* (*Iura et Bona*) issued by the Congregation for the Doctrine of the Faith in 1980. The shift in terminology is addressed quite directly:

In the past, moralists replied that one is never obliged to use "extraordinary" means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of "proportionate" and "disproportionate" means. 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.[5]

The language of reasonableness and proportion permeates the *Declaration on Euthanasia*. It speaks of the “reasonable wishes of the patient”. It points out that the investment in resources and personnel have to be proportionate to the foreseen results. It speaks of the legitimacy of wanting “to avoid the application of a medical procedure disproportionate to the results that can be expected”. Medical procedures proportionate to the results expected are to be understood in terms of clinical or therapeutic proportionality.

It is interesting to note that the *Declaration* gives

quite significant weight to the medical assessment of the patient's condition and the judgment with regard to treatment made *by the medical professional* while the Allocution of Pius XII placed the emphasis on factors relative to the situation of the patient, or more subjective considerations. The *Declaration on Euthanasia* does speak of the "reasonable wishes of the patient", to be sure, but these are to be formed in their reasonableness by "the advice of the doctors who are specially competent in the matter". In fact, the *Declaration* states that the physicians "in particular" may judge that "the investment in instruments and personnel is disproportionate to the results foreseen; [the physicians] may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits he or she may gain from such techniques".

What the patient may be able to endure, what the patient may indeed consider to be disproportionate in terms of burden in the light of anticipated benefit, is certainly taken into account. But the *Declaration* appears to place even greater emphasis on the judgment of medical professionals with respect to the anticipated therapeutic proportionality of the intervention. The physician is the one best able to assess objectively the probable effects of the medical intervention in light of the prognosis based on the patient's condition and the proposed treatment. The physician determines what would be therapeutically proportionate.

The year after *Iura et Bona* was issued, the Pontifical Council *Cor Unum* issued a document "Some Ethical Questions Related to the Gravely Ill and the Dying".[6] Although the document was published after *Jura et Bona*, it had actually been prepared four years earlier

as the result of a working group convened by *Cor Unum* to deal with ethical decision making at the end of life. It acknowledged that the terms "ordinary" and "extraordinary" "are becoming somewhat outmoded in scientific terminology and medical practice".[7] However, it does not want to discard the terms because in theology they are "indispensable". This judgment is probably made because of the long use of those terms in the Catholic tradition, particularly since the modern discussion of these questions begun by Pius XII. It does suggest equivalent terms such as "care suited to the real needs" of the patient. That phrase would assuredly be seen as addressing the judgment of therapeutic proportionality.

The document from *Cor Unum* also seems to be the first one from the Holy See which makes an explicit distinction between the "subjective" and "objective" criteria that must be used in making a medical moral judgment. This document spoke to the legitimacy of trying to ascertain the concrete conditions of a person's health after undergoing a medical intervention. This, too, was regarded as appropriate matter to be subjected to the scientific judgment of health care professionals. However, the concrete conditions assessed by the physician included indeed the disposition and moral resources of the subject, the patient himself or herself. "The principle to follow is . . . that no moral obligation to have recourse to extraordinary measures exists; and that, incidentally, a doctor must follow the wishes of a sick person who refuses the measures."[8] Maurizio Calipari draws attention to the fact that the *Cor Unum* document introduces the concept of "quality of life" into the objective criteria included in the judgment of whether an intervention would constitute therapeutic proportionality. Calipari thinks that "quali-

ty of life" must fall under the heading of objective criteria because the report of the Working Group differentiates it from subjective considerations. "But the criterion of the quality of life is not the only one to be taken into account . . . subjective considerations must enter into a properly cautious judgment as to what therapy to undertake and what therapy not."

The Ethical and Religious Directives of the U. S. Bishops Aware of the fact that the *Declaration on Euthanasia* had suggested an equivalency between the terms ordinary/extraordinary and proportionate/disproportionate, the Catholic bishops of the United States incorporated this language into their *Ethical and Religious Directives for Catholic Health Care Services*. The Directives are obligatory for all those engaged in the vast Catholic health care ministry in the United States. It should be noted in passing that this document issued by the United States Conference of Catholic Bishops has no magisterial weight itself. Nonetheless, it obviously intends to articulate and apply magisterial teaching and shows at least how the bishops in the United States read and understand the magisterial texts. Furthermore, the *Ethical and Religious Directives* were reviewed by the Congregation for the Doctrine of the Faith without any suggestion that the terminology was incorrectly used.

Part V of the *Ethical and Religious Directives* addresses "Issues in Care for the Dying". Within that section Directive 56 reads: "A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the communi-

ty."[9]

It is interesting to note that in the document of the U. S. bishops the emphasis is placed principally on the disposition and judgment of the patient rather than the medical judgment of the physician. In fact, in this Directive there is no reference at all to the judgment of medical personnel. Of course, the patient could not possibly make a judgment about whether the intervention in question posed a reasonable hope of benefit and did not entail an excessive burden without the expert medical advice of a physician. Furthermore, it is clear that the United States bishops see an equivalency between the terms "ordinary" and "proportionate" as well as between "extraordinary" and "disproportionate". Indeed, "proportionate means" are defined in terms of "a reasonable hope of benefit" (therapeutic proportionality) and their burdensomeness on the patient and the family.

The previous directive, *Directive 55,* speaks of the factors the patient needs to take into account in order to make an informed decision about his health care. It states, in part, "[Patients] should be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them." But again, the emphasis is placed more on the choices of the patient than the objective character of the prognosis and the evaluation of treatment from the physician's perspective. There appears to be more moral weight given to the decision of the patient as to what he can bear than to what might be seen, objectively, as a therapeutically proportionate intervention.

There is one *Directive* of the United States bishops that might be seen as containing an oblique reference

to the morally binding character of the objective judgment of the physician with respect to therapeutic proportionality. If the proposed therapy is indeed proportionate to the desired outcome in the judgment of the physician, taking due consideration of the subjective condition of the patient, then it may be morally obligatory *for the physician* to proceed with the treatment regardless of what the patient wants. *Directive 59* is concerned again with the one who receives medical care and addresses principally the importance of respecting the patient's judgment. Nonetheless the physician's judgment is taken into account. "The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching."

The emphasis is again placed on the patient until one encounters the subordinate clause that begins with "unless". The kinds of actions that would obviously be contrary to Catholic moral teaching would be, for example, a choice for euthanasia or physician assisted suicide. However, one would also have to conclude that a Catholic physician or health care institution could come to the conclusion, based on medical evidence and a certain prognosis, that the proposed medical intervention would provide the patient with a reasonable hope of benefit without an excessive burden and would therefore be morally obligatory in terms of being therapeutically proportionate.

Here the presumably more objective medical assessment and judgment of the physician could appear to be in conflict with the subjective judgment of the patient. In other words, the competent adult patient

might subjectively judge an intervention to be extraordinary and therefore morally optional while the physician may judge it, using the more objective criteria of therapeutic proportionality, as morally obligatory because the intervention holds out a reasonable hope of benefit without excessive burden. *Directive 59* suggests at least that the physician's scientific and medical judgment may trump or supersede that of the patient's more subjective assessment of the proposed treatment. The presumption is that the physician's assessment would be more objective because of his or her specific professional competencies. If such a conflict situation arose, the physician might be morally obliged to arrange for the transfer of the patient to another physician who could in conscience follow the direction of the patient.

The U. S. bishops place a greater emphasis on the subjective considerations of the patient than is seen in the documents of the Holy See and they appear to use the qualifiers "ordinary/extraordinary" and "proportionate/disproportionate" synonymously. We now return to the teaching of the papal magisterium.

John Paul II

In his encyclical *Evangelium vitae*, Pope John Paul II addresses the topic under consideration in section 65 and draws a clear distinction between what might be considered medically appropriate, for which he uses the term "proportionate", and what would be understood as more subjective in terms of an "excessive burden", even though he does not use the qualifier "extraordinary" with respect to the burden. He writes of "medical procedures which no longer correspond to

the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family."

The Pontiff goes on, "It needs to be determined whether the means of treatment available are proportionate to the prospects for improvement." This clearly speaks to the matter of "therapeutic proportionality". He concludes then, "To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather is the acceptance of the human condition in the face of death."

Here it is not clear if the qualifiers "extraordinary" and "disproportionate" were being used synonymously or whether John Paul II was saying that continued treatment could be curtailed *either* because it was burdensome to the patient *or* because it held out little or no hope for improvement of the patient's medical condition. An Attempt to Ascribe More Precise Meanings to Terms An awareness of both the *subjective* and *objective* elements in making a conscientious medical decision can certainly be found in the magisterial documents, but there have been attempts to address these element more directly than perhaps the magisterial documents themselves have. Some authors have attempted to appropriate the terms "ordinary" and "extra-ordinary" for the subjective dimension of a medical moral choice and have tried to appropriate the terms "proportionate" and "disproportionate" for the more objective, clinical dimension of the moral decision.[10]

While this appropriation and use of the terms might provide greater terminological consistency in moral analysis, there seems to be no explicit justification for such a designation in the magisterial documents

themselves. Without question, the terms proportionate and disproportionate do seem to be used more often with respect to the objective medical assessment of the treatment. However, in the magisterial documents one does not seem to find “ordinary” and “extraordinary” being used to refer more specifically to the subjective aspect of the dynamic process of medical moral decision-making.

Furthermore, such a use of the terms “ordinary/extraordinary” for the subjective aspect of making a medical moral decision and “proportionate/disproportionate” for the objective aspect seems to divide up the decision-making process too neatly into stages and into subjective and objective components. There is a very complex interplay between objective and subjective considerations on the part of both the physician and the patient as well as a dynamic back and forth of judgments and considerations without it settling into any kind of preordained chronology.

“Proportionate” has generally been applied to a medical intervention to designate it as morally obligatory after due reflection on both the therapeutic potential of the intervention as well as the resultant effects for the life of the patient showing that it holds out a reasonable hope of benefit without an excessive burden. Rather than stages, it would seem the “objective” aspect (therapeutic proportionality, if you will) and the “subjective” aspect (or “global efficacy” in the language of some authors) of the proposed medical intervention ought to be seen as two distinguishable but inseparable dimensions of the one decision taken. As the hylomorphic theory does not allow for a separation of form and matter but rather a distinguishing of the

two, so, too, must the objective and subjective aspects of the moral choice remain inseparable while to a certain degree distinguishable.

Although one seems to find no magisterial text explicitly ascribing the subjective dimension of the decision-making process to the terms “ordinary/extraordinary” and the ascribing the objective dimension to “proportionate/disproportionate”, one does certainly find evidence of the distinction. Although it is not explicit, the basis for the distinction might be found in the *Catechism of the Catholic Church* in No. 2278.

> “Discontinuing medical procedures that are burdensome, dangerous, extraordinary or disproportionate to the expected outcome can be legitimate; it is the refusal of ‘over-zealous’ treatment.”[11] One might interpret this brief passage from the *Catechism* as indicating a difference between the qualifiers “extraordinary” and “disproportionate” by virtue of the “or” which is placed between the two terms. “Disproportionate” would seem to refer to the more objective medical judgment with reference “to the expected outcome” of the medical procedure and “extraordinary” *might* be seen as referring to the more subjective element of the decision along with the qualifier “burdensome”.

Such a distinction might also be found in John Paul II’s famous address of April 2004 on the topic of the provision of hydration and nutrition to patients in a persistent vegetative state. He speaks of the provision of hydration and nutrition as “ordinary” *and* “proportionate” and therefore morally obligatory. “I . . . underline how the administration of water and food, even when provided by artificial means, always represents a *natu-*

ral means of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering."[12]

We also see this use of the terms in the most recent document of the magisterium on medical moral questions. On August 1, 2007, the Congregation for the Doctrine of the Faith responded to a *Dubium* submitted by the United States Conference of Catholic Bishops on the necessity of artificially administering hydration and nutrition to patients in a persistent vegetative state. Granted, this question raised by the *Dubium* deals more with the issue of care than of treatment. Nonetheless the terms carry the same meaning as they would if applied to treatment.

The Congregation wrote, "The administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented."

It is difficult to know if the qualifiers "ordinary" and "proportionate" are used synonymously in the original address of John Paul II and subsequently in the Dubium as a way of indicating continuity between the teaching of Pius XII and the introduction of the qualifier "proportionate" in the Declaration on Euthanasia or whether "ordinary" was used to refer to the subjective element of burdensomeness and "proportionate" was

used to refer to the element of an objective judgment of the intervention achieving its desired therapeutic end.

In any case, it must be said that in the address of Pope John Paul II on April 2004, the decision for the continuation of hydration and nutrition is fundamentally based on a consideration of therapeutic proportionality. Here the patient is making no subjective judgment at all with regard to his overall wellbeing in light of his own choice of values. Instead the judgment is being made by the caregivers, by the medical professionals. "We know," they say, "using our best medical judgment, that this intervention with nutrients and fluids will preserve the life of this patient and is in his best interest and is therefore obligatory. It constitutes therapeutic proportionality. The intervention is proportionate to the desired outcome". If anything, the concurrence of the patient in receiving this intervention is merely presumed.

Concept of Therapeutic Proportionality Imbedded in Tradition

This language of the objectivity of therapeutic proportionality certainly reflects what has been contained in the ethical tradition of the Church for centuries. Although the moralists of the sixteenth and seventeenth centuries would refer to obligatory means of prolonging life as those that one can obtain and utilize with some ease,[13] they must also be means that would have an anticipated beneficial effect. The tradition applied this reasonableness not only to the effectiveness of the means employed (the more objective factors of therapeutic proportionality) but also to the disposition

and capacity of the patient. In other words, there was both an objective and a subjective component that went into the decision about what the morally obligatory course of action was. Food might indeed provide some nourishment but the consumption of that food might require heroic measures depending on the nature of the illness. Francisco de Vitoria, writing in the 16th century, addressed the physical impossibility of undertaking some treatments or even care: ". . . if the depression of the spirit is so low and there is present such consternation of spirit in the appetitive power that only with the greatest of effort and as though by means of a certain torture, can the sick man take food, right away that is reckoned a certain impossibility and therefore he is excused."[14]

The authors also spoke of a certain moral impossibility rendering a medical intervention optional or non-obligatory. Daniel A. Cronin did a thorough review of the tradition in terms of conditions that would render medical interventions not obligatory. Among those posing moral circumstances excusing one from the obligation of intervention even if the intervention might constitute what we have been calling therapeutic proportionality, Cronin lists harsh and severe remedies (*summus labor* and *media nimis dura*), such as an extraordinary effort even to get to a physician, extraordinary pain (*quidam cruciatus* and *ingens dolor*), such as the amputation of a limb in a day without anesthesia, great expense (*sumptus extraordinarius*, *media pretiosa* and *media exquisita*)and overwhelming repugnance or fear (*vehemens horror*).[15]

“Therapeutic Obstinacy”

The tradition held that not only these subjective factors may render certain interventions optional but also the anticipated medical effects of the interventions themselves. The moralists of the 16th and 17th centuries were clear about the unreasonableness of using medical interventions that held out little or no hope for the patient. Here one encounters the notion of “therapeutic obstinacy” or “accanimento terapeutico”.

It must be said that there are real difficulties with the translation of “accanimento terapeutico”. Frankly, the expression “therapeutic obstinacy” is almost never used in English. Indeed, the expression seems to be a contradiction in terms. If a medical intervention is truly obstinate, unreasonable, it cannot really be therapeutic.

Usually this term is translated in the English as “aggressive medical treatment”. However, even this term does not seem to do justice to the reality lying behind “accanimento terapeutico”, for there can be times when an aggressive medical treatment might actually be quite appropriate in one circumstance while not in another. An aggressive chemo-therapy regimen, for example, might be called for in the treatment of a 32 year old mother of four young children while it might not be appropriate for a frail 87 year old widow. Furthermore, the expression “therapeutic obstinacy” seems to imply that the actions of the physician would indeed go beyond even futile medical interventions.

First of all, futility is not a moral category but rather a medical one. It is simply a judgment about the suitability of the means employed for the attainment of the desired end. In this case, it is a judgment about the

suitability of medical interventions to restore health so far as possible or to provide comfort to those dying. One speaks of futility in the strict sense when the medical intervention is completely ineffective towards ameliorating the pathological condition of the patient.[16] There is no question of course that a judgment with respect to medical futility will be a significant factor in formulating a moral response to patient care. The moral agent must first assess the medical facts before being able to discern whether or not the intervention would constitute proportionate treatment, and therefore be obligatory, or a disproportionate intervention, and therefore be morally optional once the subjective factors of the patient are taken into account. However, one should consider that the medical intervention could be futile without necessarily being hurtful to the patient.

"Accanimento terapeutico" on the other hand seems to imply an intervention that is not only not obligatory but actually an intervention that one would even be obliged *not to undertake*. Therapeutic obstinacy would seem to imply almost a kind of battery, an assault upon the patient in the guise of medical treatment which is not only not therapeutic but actually harmful.

Another example of this concept can be found in the 1981 statement of the Pontifical Council *Cor Unum* discussed earlier. The document quotes a letter that Cardinal Villot had sent to the Congress of the International Federation of Catholic Medical Associations in which he refers to an abuse of the patient in the name of medicine: "A physician is [not] under obligation to use all and every one of the life-maintaining techniques offered him by the indefatigable creativity of science. Would it not be a useless torture, in many

cases, to impose vegetative reanimation during the last phase of an incurable disease?"[17]

"Useless torture" is very strong language and would seem to describe what is referred to by "accanimento terapeutico". Yet in other places, the term "accanimento terapeutico" almost seems to correspond to what has traditionally been termed extraordinary or disproportionate means of prolonging life and is therefore seen as morally optional.

In the Gospel of Life, 65, Pope John Paul II differentiates the refusal of "accanimento terapeutico", which is morally licit, from euthanasia which can never be licit. He writes, "Euthanasia must be distinguished from the decision to forego so-called 'aggressive medical treatment', in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family." In this context the pope quotes the 1980 *Declaration on Euthanasia* (*Bona et Jura*). The Supreme Pontiff continued: "In such situations, when death is clearly imminent and inevitable, one can in conscience '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'."[18]

Indeed, it seems that if an intervention would "only secure a precarious and burdensome prolongation of life", it would actually be harmful to the patient. If this is the case, it ought not truly to be referred to as a "treatment". A more neutral kind of word might be more appropriate, such as "medical intervention". The words of John Paul II in Evangelium vitae, before he

quotes the Declaration on Euthanasia, would seem to correspond to extraordinary means of prolonging life which are not obligatory but which may be chosen depending on the circumstances. For example, the patient might have a moral obligation to repay a debt or to receive the sacrament of reconciliation before death and would therefore be morally obliged "to secure a precarious and burdensome prolongation of life" in order to fulfill those other obligations.

However, the term "accanimento terapeutico" usually appears to have the connotation of actually being harmful to the patient. This connotation seems to be employed in an address by John Paul II to Members of the Pontifical Academy for Life on 27 February, 1999. He told them that they ought to reject "those forms of 'aggressive medical treatment' which do not really maintain the life and dignity of the dying person." (4) Now, if these interventions truly do not maintain the life of the dying person and constitute an assault upon his or her dignity they can hardly be referred to a "medical treatment", aggressive or otherwise. And the Pope does not refer to such "forms of 'aggressive medical treatment'" being used occasionally but insists that they are to be rejected.

On 2 Feb 2003 Pope John Paul II addressed the participants in the World Day of the Sick and reiterated established Catholic teaching. "And while palliative treatment in the final stage of life can be encouraged, avoiding 'accanimento terapeutico', it will never be permissible to resort to actions or omissions which by their nature or in the intention of the person acting are designed to bring about death."[19] This was translated in English as "a treatment at all costs mentality" but it is the same concept of therapeutic obstinancy. A year

earlier Pope John Paul II addressed the World Organization of Gastro-Enterology in 2002 and employed again the term "accanimento terapeutico". It is interesting to look through the various translations of this text provided by the Vatican. It seems to me that the only one which most accurately speaks to the reality under consideration is the German. The passage reads:

> The complexity of the human being requires that, in providing him with the necessary treatment, the spirit as well as the body be taken into account. It would therefore be foolhardy to count on technology alone. From this point of view, an exasperated and overzealous treatment [esasperato accanimento terapeutico] [ensañamiento terapéutico exasperado][übertriebene lebensverlängernde Maßnahmen][acharnement thérapeutique exagéré], even if done with the best of intentions, would definitely be shown to be, not just useless, but lacking in respect for the sick person who is already in a terminal condition. (23 March 2002)

Here one sees the term referring to an intervention which is not simply disproportionate or extraordinary or even futile or useless. In this passage the term "accanimento terapeutico" clearly refers to an intervention which is actually lacking in respect for the sick or dying person. Therefore, it would seem that one ought never to undertake, under any circumstances, "accanimento terapeutico" in the sense in which it is used in this context. This would have "accanimento terapeutico" differing in kind from "disproportionate treatment" and one might even ask if therapeutic obstinacy is not a misnomer in terms of the reality to which it refers.

Again, if it is obstinate it cannot be truly therapeutic.

As the Catholic moral tradition continues to develop in its reflection on end of life decisions there must be continued refinement of the terms used to allow a greater precision in ethical judgment. Even though ordinary/extraordinary and proportionate/disproportionate are often used synonymously in official church teaching, the terms proportionate/disproportionate do seem to be applied more directly to the assessment of medical interventions and the judgment as to whether or not they will achieve their desired objectives. The terms "ordinary/extraordinary" seem generally to have a more broad and hence less clear application. Finally, it seems that the reality which is often addressed by the terms "accanimento terapeutico" or "therapeutic obstinancy" might more accurately be referred to as excessive measures to prolong life or even abusive measures to prolong life rather than aggressive medical treatment or therapeutic obstinacy. Again, this is because the interventions cannot be "therapeutic" if they are excessive or tyrannical and actually militate against the good of the patient.

NOTES

1 *Summa theologica*, I-II, Q. 90.4.

2 Pius XII, "The Prologation of Life" (November 24, 1957), quoted in Daniel A. Cronin et al., *Conserving Human Life* (Boston: The Pope John XXIII Center), 315.

3 U.S Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, D.C.: USCCB, 2001).

4 Maurizio Calipari, *Curarse y Hacerse Curar* (Buenos Aires: Editorial de la Pontificia Universidad Católica Argentina, 2007), 170.

5 Congregation for the Doctrine of the Faith*, Declaration on Euthanasia* (May 5, 1980), Part IV.

6 Pontifical Council "Cor Unum," *Some Ethical Questions Related to the Gravely Ill and the Dying* (June 27, 1981) in *Enchiridion Vaticanum*, 7, *Documenti ufficiali della Santa Sede* 1980–1981.

7 Ibid., 2.4.1.

8 Ibid., 2.4.3.

9 USCCB, *Ethical and Religious Directives*.

10 M. Calipari, "The Principle of Proportionality in Therapy: Foundations and Applications Criteria," *NeuroRehabilitation* 19.4 (2004): 391–397.

11 *Catechism of the Catholic Church*, 2nd ed. (United States Catholic Conference/Libreria Editrice Vaticana,1997).

12 John Paul II, "On Life-Sustaining Treatments and the Vegetative State," *National Catholic Bioethics Quarterly* 4.3 (Autumn 2004): 573–576.

13 Cronin et al., *Conserving Human Life*, 78–145.

14 Francisco de Vitoria, *Reletio de Temperantia*, I, quoted in Cronin et al., *Conserving Human Life*, 35.

15 Cronin et al., *Conserving Human Life*, 99–111.

16 Edmund D. Pellegrino, M.D., "Decisions at the End of Life: The Use and Abuse of the Concept of Futility," in *The Dignity of the Dying Person*: *Proceedings of the Fifth Assembly of the Pontifical Academy for Life* (February 24–27, 2007), eds. Juan de Dios Vial Correa and Elio Sgreccia (Vatican City: Libreria Editrice Vaticano, 2000), 219–241. Also, "Futility in Medical Decisions: The Word and the Concept," *HEC Forum* 17.4 (December 2005): 308–318.

17 Pontifical Council "Cor Unum," *Some Ethical Questions*. 2.4.3. See *Documentation Catholique*, 1970, p. 963 for the Cardinal's letter.

18 Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," *Iura et Bona* (May 5, 1980), II: *AAS* 72 (1980): 551.

19 John Paul II, *Message of His Holiness for the Eleventh World Day of the Sick* (February 2, 2003).

THE PRINCIPLE OF ETHICAL ADEQUACY IN THE USE OF MEANS OF PRESERVING LIFE: BETWEEN THERAPEUTIC EXCESS AND ABANDONMENT OF THE PATIENT

MAURIZIO CALIPARI

Introduction

Reports in our day continually recount, at times dramatically at the center of attention and as much by individuals as in the forum of public opinion, the problem of administering therapeutic interventions and life support in relation to the dignity of the patient and with respect to authentically human values. The new and ever-growing technical possibilities of medical intervention that in fact go beyond ensuring the maximum number of *chances* for life and/or the best conditions of health for the greatest number of people, at times may involve a further burden of personal suffering for the same patient, without which burden, on the other hand, there might be real opportunity for benefit. What is to be done in these cases? Which criteria should be adopted in order to be able to express an ethical and operative judgment that is wellgrounded and justifiable concerning the use of means of preserving life?

The present text represents an attempt to find a concrete response to these questions by way of proposing a new plan of valuational dynamism, to be able to help medical praxis, whether on the part of health care

workers or that of the patient, to make operative decisions that are at times difficult and controversial but always oriented toward ensuring the integral good of the suffering person in need of care.[1]

1. Anthropological-Theological Premises

At the beginning of my itinerary, I consider it necessary to recall some essential premises of an anthropological and theological nature, without then allowing myself then in this venue to justify them; given the global context of the proposal of this Congress, I believe that one in fact may agree to adopting an anthropological formulation of a personalistic nature (with an ontological foundation), from which derive the axiological criteria of each ethical evaluation.

In this point of view, individual physical life -- among the relative goods *of* the person (and not only *for* the person) – without a doubt represents what precedes and grounds all other goods as the first condition of possibility for their subsistence and development.[2]

As part of the effort to evaluate ethical correctness concerning the use of means of preserving life, fundamental and irremissable reference always must be made to the recognition of the inalienable *dignity* – that is, the *value* – of the *person* [3] that each human being possesses from the first instant of his existence. Such dignity belongs to each man *by nature* and has its ultimate foundation within the free and personal act of love with which God creates each human being "in His image and likeness"[4]. For this reason, this dignity is not susceptible to any *quantitative* or *qualitative* variations, and it cannot depend neither upon different existential circumstances nor upon the personal

recognition or concession of other people. Our personal dignity begins with us and is implied until the moment of our death.

During the earthly phase of life, the distinctive dignity of each human being manifests and expresses itself first and foremost in the *primary good* of physical life, that is, through the fact of existing as “living” beings, called to give glory to God with our existence, in view of the completion of our journey that is fulfilled in eternal life.[5] Remaining on the horizon of the argument that serves as the object of our reflection, consequently the problem to confront – in the eyes of the moralist, and likewise of each person entitled to undertake responsibility for concrete choices – is not, in the first instance, that of establishing the *obligatoriness* or not of a determined means of preserving life, but rather that of *recognizing* and *respecting* the dignity of the person in need of care and/or life support, trying to characterize *hic et nunc*, that is, within the given situation, the best manner by which to promote his *integral good* (which includes also the good of physical life) by way of the decision to employ or not a particular means of preserving life.

Personally, I think that such a difference in perspective in confronting the moral problem at hand may not represent purely a question of “words”, but on the contrary, a matter totally substantial, so that only by turning attention to the person of the patient in its *objective* and *integral* truth (which includes also his *subjectivity*), he will be able to find the response that is most adequate to his real and current needs, whether he finds himself in conditions of good health or experiences the difficulty of illness or of nearing death.

Naturally, the underscoring of such a perspective of

ethical approach certainly does not mean denying the just requirement concerning the fact that moral reflection, in order to be able to work out concretely a judgment of ethical evaluation on the use of a particular medical procedure, or more generally the use of a means of preserving life, it is necessary to identify the most objective and clear criteria possible.

2. A valuational dynamism in three "phases"

Looking through the various texts of the moral Tradition and of the Magisterium concerning the use of means of preserving life[6], one may notice the prevalent use of two terminological dyads, in order to connote them from the point of view of the probable moral obligation to have recourse to them: traditionally, the "ordinary/extraordinary" dyad, and of more recent use, the "proportionate/disproportionate" dyad. At times, these terminological pairs are utilized as simple synonyms, while at other times they seem to be used with different meanings between them.[7] Therefore, I put forward this question: Is it possible to arrive at a conceptual clarification that might take into account the specificity of each of these two expressions, without necessarily having to consider them in terms simply of "equivalence" or "alternative"?

Personally, after long study and repeated reflection, I gradually have arrived at the firm conviction that the response should be in the affirmative, and from this my point of view, I thus set about to offer an argued justification.

In discussing the formulation of an ethical judgment concerning the use of means of preserving life, I necessarily consider first and foremost to underscore the

fact that the "ethical evaluation" in question comes to be referred more strictly to *the use in situation* of the means, and not to the means in itself as such. In fact, the "things", or the material objects, if considered in themselves do not possess ethical quality; rather, only free and knowledgeable human actions can have it.

Such an *evaluation*, then, will have to be worked out in light of many factors[8], some of which being of prevalently *objective* character, and others of a nature more distinctly *subjective*.

Generally for this reason, in a given clinical situation, the formulation of such a moral judgment should be a gradual process that depicts the result of a progressive and attentive evaluation of numerous elements, in an atmosphere of sincere and constant dialogue between the patient (or his legitimate representatives) and those who assist him. In this continued confrontation, it is necessary on the part of doctors that every care be taken to avoid the risk of falling into a kind of excessive and arrogant medical paternalism, in which they regard the patient as a "minor", to manage to leave out the patient's personal participation. On the other side, the patient has the duty to shun any form of misunderstood "autonomism" in confrontations with the doctor, that is to say, an attitude that tends to consider the same doctor by the same standard to be a mere "instrument" to use, in the name of one's own autonomy, in order to fulfill his own desires regarding the care of health or life.

In any case, it is necessary to recognize that the first and final responsibility for the ethical judgment to be formulated belongs in the final analysis to the patient (or who legitimately represents him), as far as he is the first proprietor of the personal good of life. Natu-

rally then, even the doctor must obey the dictates of his own moral and professional conscience without ever violating that of the patient. In the case, therefore, of an onset of unhealthy conflict between the conscience of the patient and that of the doctor, as to the ethical evaluation of carrying out a particular intervention of life support, the best solution is without a doubt the interruption of the established *therapeutic covenant* between the two at the initial moment of the care relationship. Returning back to our argument, what I definitively would like to propose is a dynamic valuational process that may be described through the articulation of *three phases*. By logic, this process initially must examine elements of a medical-technical scope or, more generally, all those factors that lend themselves to a predominantly objective evaluation (*first phase*); successively, it must take into consideration those factors more strictly connected to the subjectivity of the patient (*second phase*); and finally, it must yield a conclusive ethical judgment that takes well into account the previous phases of evaluation and expresses itself in a morally adequate operative decision (*third phase*).

2.1 First phase: Evaluation of "Proportionality"

My proposal is that of reserving the qualification of "proportionate" or "disproportionate" to the use of a means of preserving life (it matters not whether it is diagnostic, therapeutic, palliative, assisting, natural, artificial, etc.) considered in the *first phase* of this valuational dynamism, during which what must be analyzed prevalently are elements of a technical-medical character, among which the majority lend themselves to an *objective* evaluation substantially independent

from the subjectivity of the patient.

In this point of view, the *proportionality* or *disproportionality* of a means of preserving life will indicate the "medical-technical" adequacy or inadequacy of its use, in relation to the attainment of a particular objective concerning health or life support for the patient.

Let us consider, for example, the use of a *natural* means for preservation of life, that being the consumption (or the provision) of food and liquids. We may declare that, in a given clinical situation and for a determined subject, it always will be retained to be "proportionate" to the degree (and up to the moment) in which it preserves the actual ability to achieve its *specific* finality, that being to nourish the person, providing the substances necessary for life maintenance.

The same reasoning, also with an *technically* more complex evaluation, counts in the case of a medical intervention (diagnostic, therapeutic, or of life support). In order to clarify the application of the concept of "proportionality" to medical acts in general, it seems useful to me to state beforehand the reference to some foundational principles held in common between moral theology and medical deontology.

In the choice of means of intervention, each conscientious doctor has the duty to follow several fundamental criteria. He must always use those means that, within the limits of their actual availability and according to the most up-to-date scientific acquisitions, prove to be: the most efficacious for the pathology to be diagnosed or treated, the most suited to the particular physio-pathological conditions of the patient in question, the least risky for his health/life, and the

most free from grave or damaging collateral effects.[9]

With regard to the parameter "efficacy", I would like moreover to state precisely that its evaluation may be carried out only in relation to achieving a definite diagnostic or therapeutic objective (healing, prevention of relapses, prolonging of life, alleviation of suffering, physical rehabilitation, etc.). Such an objective, within the given clinical situation, comes to be characterized beforehand by way of a dialogic confrontation between doctor and patient, as a synthesis of the "technical" objectives of the first (doctor) and of the legitimate and reasonable expectations of the second (patient), based upon the value recognized by the latter concerning the anticipated benefits of the proposed treatment.

In this sense, I propose to utilize the term "medical efficacy" in order to point out the objective health effects that the use of a means of preserving life yields, in relation to a precise medical objective, and the term "global efficacy" in reference to the attainment of health effects that may prove to be truly significant for the life of the patient, according to his personal evaluation, within the complex context of his existence and on the basis of the axiological scale he has adopted.[10]

Within clinical practice, therefore, a situation may come to pass in which a given remedy may promise or may show to have a certain "medical efficacy", technically speaking, but not a "global efficacy" for the patient. On the basis of his personal judgment, in fact, the true results obtainable (or obtained) by way of a certain medical intervention might not hold vital significance so as to render it obligatory, or merely to justify the use of such means. Obviously, the minimal presupposition such that a patient might experience the

global efficacy of a therapeutic intervention is to show it to have a sufficient medical efficacy in relation to his actual health conditions. In the ethical assessment of a therapeutic intervention, medical efficacy definitively is a necessary but not always sufficient element to guarantee global efficacy for the person who is subjected to it.

Therefore, it may be stated that a medical intervention is considered "proportionate" to the degree (and up to the moment) in which it demonstrates itself as *adequate*, within the given clinical situation, toward the achievement of a precise preordained medical objective, with respect to the fundamental criteria recalled above. Such a judgment of proportionality, being of a predominantly medical-technical nature, is the concern of the caring doctor and of the é*quipe* that eventually collaborates with him; it must spring from the evaluation likened to various aspects bound to the medical intervention in question:

> a) *The concrete or plausible availability of the means*: The first and obviously necessary condition such that a diagnostic, therapeutic, or life support means might prove proportionate is that it be, *hic et nunc*, concretely available for use or "reasonably" available. The *reasonableness* of its availability must be assessed on the basis of the efforts (distance, facilities, time, etc.) necessary to obtain it, in relation to the gravity and/or urgency of the clinical situation to be confronted. For this reason, a medical means that, in the absolute, prove to be the best and most recommended in addressing a certain clinical condition within the given situation, also could prove to be disproportionate to

the degree that such a means is *available* or *reasonably available.*

b) The actual technical possibility of using the means adequately: Beyond the concrete availability of the means, it is necessary that there also be someone who may utilize it with sufficient skillfulness and competency, at the most opportune moment. To use a remedy or medical instrument in an inadequate way, in fact, may cause a significant lessening of its efficacy, but above all a notable increase of risks for the patient, rendering the use of this same means disproportionate.

c) The reasonable expectations of real "medical efficacy" of the means: Beyond examining the two aforementioned elements, which represent nearly a prior condition for the use of a particular means of preserving life, one of the principal factors for determining its proportionality is the reasonable prediction of beneficial effects that it can procure *for a particular patient, within the specific clinical situation* and in rapport with a preordered medical objective. Such measurement comes to be verified constantly throughout the duration of the medical intervention, where the concrete conditions of the patient may vary in time. Let us remember also that the element of *medical efficacy* comes to be composed by that of *global efficacy*, which we will examine further on among factors of a "subjective" kind.

d) The eventual damaging collateral effects upon the patient that the use of the means bears: Nearly all medical interventions, along with the

researched beneficial effects, also bear collateral effects that are more or less negative for the patient. Sometimes, they may cause significant damage to the health of the person. For this reason, in parity with medical efficacy, it will be necessary to consider as the more proportionate use that therapeutic means which, in the given clinical situation, involves fewer damaging collateral effects for the patient.

e) Foreseeable risks to the health/life of the patient, eventually involved in the use of the means: Many medical interventions involve a certain percentage of risk to the health of the patient. The greater the degree (in terms of *probability* or *gravity*) of such risks[11], the greater the percentage of expected *medical efficacy* must be concerning the use of the means in question so that it might be considered proportionate. The importance of such risks also is related to the degree of severity of the pathology to be ascertained or treated as well as to the urgency of the requested intervention within the clinical situation to examine. The more the patient slips into critical conditions, so much higher will be the threshold of acceptable risk. In any case, the quantification of the threshold of acceptable risk in the use of a means of preserving life, in relation to a particular pathology, should be established according to clinical *standards* that are shared extensively within the medical community.

f) The actual possibility of recourse to therapeutic alternatives of equal or greater efficacy: The possibility of finding recourse to valid therapeu-

tic alternatives, with respect to the hypothesized means in confronting a certain clinical situation, constitutes a further element for the doctor to take in consideration in the assessment of therapeutic proportionality. Obviously, the *condition sine qua non* for such a comparison is that the possible alternatives of intervention offer a foreseeably equal or greater medical efficacy to that means being evaluated.

g) The quantification of health resources (technical, economic, etc.) necessary for the utilization of the means: This assessment factor concerning the proportionality of means of preserving life always acquires increasing weight, above all in the management of present models concerning the public allocation of present health services in the majority of Western countries.

The often very elevated costs of modern medicine and of sophisticated technologies that support it point out, in fact, the crucial problem within the correct administration of available health resources that obviously are not unlimited. Within a social scheme of public administration of health resources, therefore, it is necessary to bear well in mind the fact that, having a limited quantity of available resources, it is necessary to rationalize their use as best as possible in order to avoid harmful waste or injustices that would penalize other needy subjects[12]. Therefore, the costs – technical, economic, etc. – required for the utilization of a means of preserving life must be evaluated in relation to the gravity of the pathology to be treated, to the urgency of the intervention, and to real possibilities for therapeutic success. One derives from these consider-

ations that, in parity with efficacy, connected risks, and damaging collateral effects, it is only right and fair to orient oneself toward the use of that means of preserving life which bears the least social cost, based on the principles of distributive justice and solidarity.

In order to avoid equivocal interpretations, therefore, it is reconfirmed strongly here that the fundamental good of human life is not disposed to be quantified merely in economic terms, neither can it be measured in relation to other goods that are either inferior or lacking in homogeneity. In the same manner, no person may decide without committing a grave act of arbitrary arrogance that the life of a person may be worth, based on the quality of his health, the utilization of a certain quantity of health resources and nothing more.

Consequently, one may conclude that when recourse to a given medical intervention may be the only way to save a human life, if it demonstrates that it verifies all of the criteria of proportionality previously indicated, its use will prove to be "proportionate", independent of its cost.

2.2 Second phase: Evaluation of "Ordinariness"

During the first phase of the predominantly technical-medical evaluation of a means of preserving life, one that yields a judgment of *proportionality* or *disproportionality* concerning its use within a given clinical situation, a second phase should follow that takes into consideration much more *subjective* aspects of the medical intervention, those that are more strictly dependent upon the subjectivity of the patient. I propose to reserve the qualification of "ordinary" or "extraordi-

nary" to the use of a means of preserving life (it matters not whether it be diagnostic, therapeutic, palliative, assisting, etc.) considered in this *second phase* of the dynamism of its assessment, whose formulation pertains principally to the patient.

Which will be, therefore, the objective criteria that the interested person is obliged to adopt in order to yield such a judgment? What are the elements to consider, in order to evaluate the *ordinariness* or *extraordinariness* of the use of a means of preserving life in an ethically correct manner?

I am convinced of the fact that, on this point in particular, moral Tradition may have developed an ethical analysis that is truly profound, one which today represents a point of comparison that is absolutely indispensible for any further reflection. For this reason, I draw upon several useful elements from the patrimony of the classical authors to integrate within the present proposal -- modifying them wherever necessary – on the basis of the global context of what I will be saying.

Toward such a purpose, I prefer to focus attention upon the indication of those factors that may connote, for the patient, the "extraordinariness" of the use of certain means of preserving life, and in absence of which one might presuppose the "ordinariness" of the same means. In fact, given the importance of the value at stake, that being the primary good of physical human life, it seems justified to me to employ a conceptual formulation that departs from the presumption of *ordinariness* of the means used with the aim of saving the same life, up to the eventual moment in which its concrete use within the given clinical situation may not demonstrate the involvement of aspects that may involve a real factor of *extraordinariness* for the pa-

tient. In such a manner, one then may confirm that a means of preserving life always must be considered *ordinary*, or at least that its *situational* use may not bear for the patient at least a significant element connoting its extraordinariness, according to that patient's prudent judgment.

What, then, are the factors that may render the use of a means of preserving life *extraordinary*?

Referring ourselves to what for centuries has been reflected by the Moralists of the Tradition, we may confirm that one of the principal elements, connoting the eventual *extraordinariness* of a means, is represented by the fact that the patient experiences, subjectively and within the concrete situation, a *certain impossibility* ("*quaedam impossibilitas*"), physical or moral, concerning its use. Naturally, this *impossibility* must assume such an extent so as to constitute an excessive burden for the same patient with respect to his actual human resources. Which factors may cause a similar *impossibility*? It appears to me that, in substantial terms, they might be reestablished into the following traditional categories:

> *a) An excessive effort to procure and/or use the means*: This eventual effort may be requested of the patient in relation to places, procedures, times, etc. demanded in order for the means to come to fruition. It is well also to underscore how such an effort, because it might constitute a real factor of extraordinariness, must come to represent a *particularly grave* obstacle for the person according to his subjective evaluation. It is reasonable to presuppose, in fact, that the procurement and use of a means of preserving life always demand some form of "strain" on the

patient. Nevertheless, such strain frequently presents itself to an acceptable and well-manageable degree to the interested subject, representing only an *ordinary* burden in such a case;

b) Experiencing, in connection to the use of the means, enormous or unbearable physical pain that cannot be soothed sufficiently: Despite the enormous progress that analgesia has achieved during the last decades, it is always possible that the use of a certain means of preserving life might bring at times a high degree of physical pain to the patient. It is well-known to all how the threshold of enduring pain may be a strongly subjective element, and variable for another person in relation to other factors (biological, psychological, environmental, etc.), even within the same individual. Only the subject, therefore, can assess if the eventual physical pain, experienced as a consequence of the use of a certain means, may reach such a degree as to condition heavily his global personal equilibrium. In such a case, the use of that means for him surely will be extraordinary.

c) Economic costs, connected to the use of the means, that may be very grave for the patient or for his relatives: We already have considered, with regard to the factors of *proportionality* of a means of preserving life, the question of economic costs necessary for the procurement and use of the same means for the purpose of correctly managing health resources in a government of public health assistance, in light of the principle of distributive justice. Here, let us con-

sider this factor from the point of view of the subjective burden (personal or familial) that it eventually may involve for the patient, in relation to his actual economic *status*. If the costs involved in the procurement and/or use of a certain means prove untenable or heavily conditioned for the patient and/or his family, also in relation to their future sustenance, the utilization of such means acquires a characteristic of extraordinariness. I hold that even for this element of ethical assessment, even if the application be suitable concerning the *relative*[13] norm -- which allows the subject to calibrate his own judgment in a realistic and circumstantial way based on his own conditions of life – on the contrary, it does not seem morally sustainable to establish a "maximum ceiling" for expenses (who would decide and with which criteria?) above which, for whichever person and in whatever economic *status* he may find himself, the use of a certain means of preserving life then would prove to be extraordinary.

d) Experiencing a tremendous fear or a strong repugnance in relation to the use of the means: Concerning the determination of a similar eventuality, diverse subjective factors of a psychological, emotive, cultural, environmental, etc. type may converge. When the mechanisms of the subject's self-dominion are not sufficient to handle and compensate for the emotions of fear and/or repugnance eventually stirred up by the use of a means of preserving life, these mechanisms may reach such a degree as to cause a *certain impossibility* for the person to resort to the use of that means, which for the subject will

prove then to be extraordinary.

Near to these factors that potentially trigger a *certain subjective impossibility* concerning the use of a particular means of preserving life, three other important elements also may be listed that may weigh substantially on the judgment of the eventual *extraordinariness* of the means, though not necessarily representing a cause of "*quaedam impossibilitas*" for the patient concerning its use:

> *e) A reasonably high probability of grave risks to the patient's life or health, connected to the use of the means, evaluated by himself in relation to the gravity of his actual clinical condition*: Even this element already had been confronted, in treating the criteria of proportionality. We want here to consider among them the genuinely subjective dimension. There exists in fact a technical evaluation, of an objective nature, concerning the eventual risks connected to a medical intervention, based upon statistics provided by the medical literature on the *standards* adopted by the scientific community and verified in clinical experience. Nevertheless, once the doctor has evaluated the acceptability of reasonably foreseeable risks, from the technical point of view, that a certain means bears for the patient in relation to his clinical condition, it still remains to be verified whether or not the patient, who may have received from the doctor the information necessary for him to work out a worthwhile choice, might hold it subjectively to be acceptable to subject himself to the rate of predicted risk in relation to the benefits reasonably expected within the concrete

clinical situation. A level of risk to the life or health of the patient, reasonably assessed by him to be excessive (in terms of probability and/or importance), would render the utilization of such means to be extraordinary.

f) A low rate of "global efficacy", in relation to the benefits reasonably expected by the patient, according to the axiological scale adopted by him: After having listed medical efficacy among the criteria of proportionality, let us refer ourselves here to the already cited "global efficacy" as an important factor of possible extraordinariness. We have, in fact, already underscored how the importance of an objective health benefit, obtainable by way of recourse to a means of preserving life, arrives *de facto* at representing such an advantage for the patient that it justifies the utilization of the same means, taking also into account what it eventually brings with it in terms of a burden for him and/or for his family. This criterion brings to mind the classical moral adage of "*moraliter parum pro nihilo reputatur*"[14], in reference to those benefits that are truly obtainable but of such little importance as to be nearly tantamount in fact to nothing. In this sense, the use of a means of preserving life that were to offer similar benefits would prove to be *extraordinary* for the patient. Naturally, such an assessment can be executed only by the same patient, in light of the real significance that the obtainable benefits cover in the field of his global value outline and within his actual clinical conditions.

g) The permanence, consequent to use of the

means, of such clinical conditions so as to impede the patient's fulfillment of his gravest and most non-deferrable moral duties: This final important factor of possible extraordinariness concerning the use of a means of preserving life, makes reference to cases in which the mechanism of action, or the consequences of the means to utilize, place the patient within a clinical condition that, in the given situation, may be an obstacle or impediment to the fulfillment of grave moral duties (of love or of justice) that cannot be put off without serious negative consequences for himself or for others. In this category of means also may be numbered, in certain circumstances, even the induction within the patient of a state of total or partial unconsciousness (anaesthesia, pharmacologically induced coma, analgesia, etc.) for medical reasons.

Among the factors that have the greatest influence in the subjective evaluation of this element of extraordinariness, there is surely the "duration of time" of the unfavorable clinical condition connected to the use of the means, placed in rapport with the gravity and urgency of the duties to be fulfilled, that it impedes.

2.3 Third phase: Classifying Synthesis

Having clarified the principle points that characterize the second phase of the valuational dynamism we are proposing, one whose end is that of determining the ordinariness/extraordinariness of the use of a certain means of preserving life from the point of view of the subjectivity of the patient, it remains to be delineated

briefly the third and final phase of this process.

In reality, this phase shows itself to be more simple and immediate with respect to the first two, anticipating the formulation of a synthetic judgment that may connote the use of a given means, based upon its *proportionality/ disproportionality* and its *ordinariness/extraordinariness*, as we previously have defined and described them as such.

Crossing together these descriptive variables, we may deduce the following theoretical classification of means of preserving life:

a) Proportionate and ordinary means;

b) Proportionate and extraordinary means;

c) Disproportionate and ordinary means;

d) Disproportionate and extraordinary means.

In each clinical situation, therefore, by way of the valuational dynamism that I have sought to delineate, the utilization of a certain means of preserving life may be ascribed to one of the four categories just recalled.

For each of these *descriptive* categories, then, it is necessary to characterize in a foundational and consequential manner, the corresponding levels of moral dutifulness that may guide the adoption of concrete operative decisions, with regard to the use or not of the hypothesized means in a given clinical situation. I would like to dedicate the following paragraph to this consideration.

First, then, it seems important to me to make a final observation concerning the first two phases of the valuational process just described. For the greatest ex-

planatory efficacy and systematic clarity, I have spoken of these phases as two wholly distinct and temporally successive stages of judgment. In actuality, within the concreteness of clinical practice, daily experience demonstrates how these two phases often intersect and superimpose themselves in their implementation, above all when the dialogue of confrontation between patient and health care personnel reaches a good level. This "mixing" of valuational moments, above all justified and acceptable, usually does not invalidate the judgment process in its totality, provided that they respect the proper criteria and competencies examined above.

3. The Judgment of "Ethical Adequacy" concerning the Use of a Means of Preserving Life

In order to complete my proposal of reviewing moral doctrine concerning the use of means of preserving life, it is necessary to concentrate our attention on one specific aspect of the problem: that of *moral dutifulness*. Until now, in fact, we have sought to examine the valuational dynamisms of a "descriptive" type, in order to connote the use of a given means, situationally, from the point of view of its proportionality and its ordinariness. It then remains for the crucial question to be addressed concerning ethical duties within the order of action (to utilize the proposed means or not) corresponding to each of the categories of classification indicated above. The *moral dutifulness* of the use of whatever means of preserving life may be implied on the basis of three classical moral paradigms: *obligatoriness, optionality,* and *illicity*. Each of these paradigms, obviously, makes an interior appeal to the person (patient, doctor, relatives, etc.) so that he may

respond in an adequate manner according to the responsibility that is proper to him, to the grave moral duty of preserving the fundamental good of life.

What balance might we characterize among the four descriptive categories first listed as these three moral paradigms?

First of all, let us examine the case of utilizing a means of preserving life that, in following the assessment performed during the first phase of the dynamism that we described before, may prove to be "proportionate", that is, medically adequate (according to the criteria previously indicated) in the clinical situation to be confronted for a particular patient. There is no doubt that the use of such a means will never be able to be considered *illicit* (if not for extrinsic reasons) when it represents a therapeutic means adequate for the realization of a good end, being that of sustaining life or health; consequently, it will prove to be ethically obligatory or optional for the patient. That which will determine the circumstance of one or the other degree of moral dutifulness is, fundamentally, the emerging judgment from the second valuational phase, that being characterized by an examination of more subjective elements (and these already have been indicated) and, for this reason, of pertinence to the same patient. Whenever the utilization of a certain means of preserving life, appraised as proportionate, may prove to be "ordinary" for the patient, recourse to such a means is to be held as *obligatory* for him. Whenever the same means proves instead to be "extraordinary" for the patient, recourse to it will be *optional* for him, at least in principle. Particular circumstances, in fact, may come to pass in which, in order to be able to fulfill more grave duties (of love or of

justice, towards God or towards neighbor), even the use of a proportionate and extraordinary means could prove to be *obligatory* for the patient.

What should be said, instead, of the employment of a means of preserving life that were to prove "disproportionate", that being not adequate from the medical point of view (always according to the previously indicated criteria), based upon the judgment having surfaced from the first phase of the valuational dynamism?

It seems to me to have to conclude that the choice of seeking recourse to the use of such a means should be considered, in principle, as a morally *illicit* act whose gravity takes on different degrees according to the real effects that the utilization of the means causes in the patient. When, in fact, we assess as "disproportionate" (that being medically not adequate) a means of preserving life, we may refer ourselves to three diverse eventualities (3 types) in relation to the effects that it causes on the patient's health: 1) It may concern an intervention that procures a certain benefit for the patient, but to a degree that is insufficient to surpass the eventual harmful collateral effects connected to it; 2) it may concern a means not capable of procuring any benefit for the patient; and 3) it may concern a means in which its concrete use demonstrates itself only as harmful to the patient's health.

It is clear, therefore, that the moral illicity of the use of a disproportionate means will result in increasing gravity from the first to the third type.

Such illicity, in my opinion, would not cease to subsist even when the utilization of a similar means were to have to prove itself to be "ordinary" for the patient (in

reference to the *second valuational phase*), in the sense of not bearing any particular element of extraordinariness for him.

Nevertheless, I retain at least in theory that only one exception to this evaluation may be foreseen: It concerns the case in which the use of a disproportionate means of the *first type* (objectively beneficial, but in an insufficient way) may represent, *hic et nunc*, the only manner that the patient has at his disposal in order to be able to fulfill the most grave and indeferrable moral duties (of love or of justice). Only in this eventuality, in my way of seeing it, recourse to a means of preserving life assessed as "disproportionate" (but only if of the *first type*) may be considered morally licit for the patient, according to the twofold possibility already described concerning the use of proportionate means: ethical *obligation* to seek recourse whenever the means were to prove also "ordinary", based upon assessment by the same patient; *optionality* of its use whenever, instead, its use were to bear elements of extraordinariness. Naturally, concerning disproportionate means, two elements come to be verified in any case: The prior condition of their effective availability and the acquisition of reasonable certainty that their use may not constitute, within the given situation, a serious violation of the principle of distributive justice, taking away from other more needy patients a good part of the health resources actually available, in terms of gravity and urgency of treatment,.

4. Ethical Dutifulness on the Part of the Doctor

The perspective adopted by the moralists of the Tradition in treating the moral question of the use of means

of preserving life has been, in wide preponderance, that of duties on the part of the patient; it is necessary to wait several centuries, within the studies of some modern moralists[15], for a progressive expansion of the perspective to be noticed, up to including even a more thorough analysis of the moral duties on the part of the doctor.

Within the area of my newly synthetic proposal on the subject of the use of means of preserving life, I already have underscored the importance and the specificity of the general role of doctors and health care personnel in the assessment of the *first phase* of the valuational dynamism we have delineated. It now remains for us to characterize with greater precision what the moral duties may be that correspond to the doctor, and to whomever eventually collaborates with his professional work, with regard to the utilization of a particular means of preserving life within a given clinical situation.

The respond appears consequential with respect to the premises that I have posed until now: The doctor who freely accepts the burden of a patient's care, establishing in this way that which often comes to be defined as "therapeutic covenant", has the duty first and foremost to fulfill the same moral obligations of the patient in order to preserve his life and to care for his health.

This fact signifies that the doctor has the ethical duty to ensure first and foremost the fruition of "proportionate" and "ordinary" means for the patient, those so assessed according to the criteria previously indicated, in the measure of their real availability within a given clinical situation.

Additionally, then, the doctor also has the obligation of securing for the patient, within the limits of possibility, the fruition of "proportionate" and "extraordinary" means of what he eventually were to choose to make recourse, in a licit and reasonable manner.

Based on the same ethical logic, the doctor has the precise duty to seek no recourse to the use of means of preserving life that would prove to be "disproportionate" (with the exception of the case already described regarding disproportionate means of the *first type*), not even after the explicit request of the patient.[16]

Obviously, within the assessment and election of means of intervention, the doctor has the right/duty to preserve full autonomy of conscience, be it at the ethical level or that of the professional, as how he has the duty fully to respect the moral conscience of the person entrusted to his care. I already have pointed out earlier how substantial and unhealthy discord of conscience between patient and doctor eventually may transpire concerning the election of a given means, and it may constitute a valid reason to break off that *medical covenant* previously established between them.

Conclusion

I have reached the conclusion of my journey. Introducing this work, I had declared the principal objective that would pre-establish it: To arrive at proposing a new synthesis of moral doctrine concerning the use of means of preserving life, in continuity with the teachings of centuries of Tradition, but also setting our attention upon the new ethical demands placed by the

incessant development of the medical sciences and of technologies applied to it.

Believing, then, that we must not lose the richness contained within the materials of the moral reflection of the past, nor lose the more recent intuitions of moral thought stimulated by continual medical progress, I have attempted to delineate a new systematic outline of assessment that dynamically would join together both conceptual pairs of "proportionality/disproportionality" (chronologically more recent) and "ordinariness/extraordinariness" (more traditional), without depriving them all the same of their differences and specificity.

From this valuational dynamism, I finally have tried to derive a corresponding normative schema that may represent a precise reference point for concrete choices concerning the election and recourse to various means of preserving life. The result of my effort of new systematization, in its entirety, could be named the "principle of ethical adequacy concerning the use of means of preserving life".

I am well aware of the fact that the proposal emerging from this study, although it seems to me to be well founded and coherently developed, represents only "one" route – certainly not the only possible one – in addressing in a systematic manner the moral question concerning the use of means of preserving life. The same observation counts also for the terminology that I conventionally have chosen to adopt in the present proposal, having thus taken care to remain most faithful to the concepts and perspectives already developed by the centuries-old way of moral Tradition.

Still, it seems important to me to underscore how the

perspective chosen in formulating the new proposal may have been eminently of a theoretical nature. The "principle of ethical adequacy concerning the use of means of preserving life" that I have designed limits itself to providing general norms that intentionally, along the route of these pages, have not been applied in a systematic manner to particular clinical cases. This "categorial" development, so to say, certainly represents a final task to unfold in other successive studies that I sincerely wish may be stimulated by the present work.

Finally, I would like to recall how what has constantly kept my attention, during all of the reflection on the theme under study, may have been the trouble of maintaining in evidence the "centrality" of the human person, of his authentic good and of his particular dignity, considered within their integral truth – according to the anthropological and theological vision here adopted – as a first and ultimate reference point for every moral reasoning on the theme of preserving life and caring for health.

NOTES

1 The content of this lecture represents a synthesis of more extensive explanatory and argumentative materials found in the fifth chapter of my book: CALIPARI M., *Curarsi e farsi curare. Tra abbandono del paziente e accanimento terapeutico*, Cinisello Balsamo (MI): San Paolo, 2006.

2 Cf. CONGREGATION FOR THE DOCTRINE OF THE FAITH, Instruction *Donum Vitae*, n. 4; SGRECCIA

E., *Manuale di Bioetica*, vol. I, 3rd ed., Milano: Vita e Pensiero, 1999: 122.

3 For an approach concerning the long and complex history of the philosophical concept of "person," we refer to the following texts: AA.VV., *Persona e personalismo. Aspetti filosofici e teologici,* Padova: Gregoriana, 1992; ABBAGNANO N., *Persona*, in Dizionario di Filosofia, Torino: UTET, 1984; 665-667; BERTI E., *Genesi e sviluppo del concetto di persona nella storia del pensiero occidentale*, in CASTELLANO D. (ed.), *Persona e Diritto*, Udine: Missio, 1990: 17-34; DANTO A.C., *Persons*, in EDWARDS P. (ed.), *Encyclopedia of Philosophy*, vol. VI, New York: MacMillan, 1972: 110-114; DONATI P. (ed.), *La cultura della vita,* Milano: Franco Angeli, 1989; LOMASKY L., *Person, concept of*, in BECKER L.C., BECKER C.B. (ed.), *Encyclopedia of Ethics*, vol. II, New York: Garland, 1992: 950-956; MAZZONI A. (ed.), *A sua immagine e somiglianza?*, Bologna: Città Nuova, 1997; Entry "persona" in MONDIN B., *Dizionario enciclopedico del pensiero di S. Tommaso d'Aquino*, Bologna: Studio Domenicano, 2000: 516-521; MOUNIER E., *Il personalismo*, Roma: A.V.E., 1999; PALAZZANI L., *Il concetto di persona tra bioetica e diritto*, Torino: G. Giappichelli, 1996; PAVAN A., MILANO A. (ed.), *Persona e personalismi,* Napoli: Dehoniane, 1987; PESSINA A., *Bioetica. L'uomo sperimentale*, Milano: Bruno Mondatori, 1999: 76-93; SGRECCIA E., *Manuale di...*, pp. 105-137; THOMASMA D., WEISSTUB D., HERVÉ C. (ed.), *Personhood and Health Care*, Dordrecht (NL): Kluwer Academic Publishers, 2001; WOJTYŁA K., *Metafisica della persona*, Milano: Bompiani Il

Pensiero Occidentale, 2003; ID., *Persona e atto*, Città del Vaticano: Libreria Editrice Vaticana, 1982.

4 Cf. TETTAMANZI D., *Nuova bioetica cristiana*, Casale Monferrato (AL): Piemme, 2000: 38-41.

5 Cf. GIOVANNI PAOLO II, Lett. Enc. *Evangelium Vitae*, n. 38.

6 The texts to which I refer are not reported here since they constitute the specific object of other presentations of this Congress, to which we refer for appropriate synthesis.

7 Cf. LEONE S., *La prospettiva teologica in Bioetica*, Acireale: Istituto Siciliano di Bioetica, 2002: 467-470.

8 I consider wholly insufficient the attempt made by several authors to schematize the process of evaluating the proportionality of treatments through the formulation of a kind of algorithm. See, for example, ABEL F., entry *Accanimento Terapeutico*, in PRIVITERA S., LEONE S. (ed.), *Dizionario di Bioetica*, Bologna-Acireale: EDB-ISB, 1994: 3-6; ENGELHARDT H.T. JR., *Manuale di bioetica*, Milano: Il Saggiatore, 1999: 286-293.

9 Cf. ROMANO M.L., entry *Proporzionalità delle cure*, in PRIVITERA S., LEONE S. (ed.), *Dizionario di Bioetica*, Bologna-Acireale: EBD-ISB, 1994, 769-770.

10 Within contemporary bioethical debate, and in particular in the cultural zone of the United States, a concept very near to that of "efficacy" is spreading, that dealing with the concept of *futility*. This term, whose medical acceptance has ancient ori-

gins, today at times comes to be reinterpreted by several authors in an ambiguous and deceptive manner. Nevertheless, not holding it necessary to our ends to linger over a deeper study of this argument, we refer the reader who might be interested to a valuable explanatory contribution, whose contents seem to us wholly able to be shared: PELLEGRINO E., *Decision at the End of Life: The Use and Abuse of the Concept of Futility*, in PONTIFICIA ACADEMIA PRO VITA, *The Dignity of the Dying Person*, Città del Vaticano: Libreria Editrice Vaticana, 2000: 219-241. Cf. also LAMB D.,*L'etica alla frontiere della vita. Eutanasia e accanimento terapeutico*, Bologna: Il Mulino, 1998: 115-137; SUAUDEAU J., *La futilità delle terapie: aspetti scientifici, questioni etiche e giuridiche*, in Medicina e Morale, 2005/6: 1149-1197.

11 For a deeper understanding of the ethics of health risk, see: SCHÖNE-SEIFERT B., *Risk*, in Reich T.W. (ed.), *Encyclopedia of Bioethics*, vol. 4, New York: MacMillan, 1995: 2316-2321; PONTIFICIA ACADEMIA PRO VITA, *La prospettiva degli xenotrapianti, Città del Vaticano: Libreria Editrice Vaticana*, 2001: 41-43.

12 The bibliography concerning this argument is now quite vast. For an introductory panorama to the problem, see: FRANCE G., ATTANASIO E., *Economia sanitaria, linee e tendenze di ricerca in Italia*, Milano: Giuffrè, 1993; HUMPHREY, C., EHRICH K., KELLY B., *Human Resources Policies and Continuity of Care*, in Jour Health Organ Manag., 2003, 17(2): 102-121; INSTITUTE OF MEDICINE (USA), *Assessing Medical Technology,*

Washington DC: National Academy Press, 1985; MENEGUZZO M., *La programmazione ed il controllo delle strutture sanitarie*, Milano: McGraw Hill Libri Italia, 1988; MOSKOP J., KOPELMAN L. (ed.), *Ethics and Critical Care Medicine*, Dordrecht: D. Reidel Publishing Company, 1985: 147-161; PERRIN J., *Resource Management in NHS* (National Health Service), London: Chapman & Hall, 1985; SGRECCIA E., SPAGNOLO A.G. (a cura di), *Etica e allocazione della risorse nella sanità*, Milano: Vita e Pensiero, 1996.

13 Cf. KELLY G., *The Duty of Using Artificial Means of Preserving Life*, in *Theological Studies*, XI

(1950): 206; see also CALIPARI M., *La proportionalità delle cure negli scritti di Gerald A. Kelly, SJ,* in Medicina e Morale, 2006/2: 238.

14 Cf. DE LUGO J., *Disputationes Scholasticae et Morales*, ed. Nova, Parisiis Vivès, 1868-69, VI, *De Iustitia et Iure*, disp. 10, sect. 1, n. 30.

15 Cf. KELLY G., *The Duty of Using Artificial Means of Preserving Life*, in Theological Studies, XI (1950): 203-220; *The Duty to Preserve Life*, in Theological Studies, XII (1951): 550-556; *Medico-Moral Problems*, Part V, St. Louis Missouri: The Catholic Hospital Association of the United States and Canada, 1954; HEALY E.F., *Medicina e Morale* (trans. Eng. by V. Cusumano), 3rd ed., Roma: Paoline, 1963: 89-124.

16 Cf. D'AGOSTINO F., *Bioetica*, Torino: Giappichelli Editore, 1998: 216.