Quality-of-Life Judgments in Health Care Decisions

醫療倫理決定：生活品質的判斷

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摘要：在二十世紀九十年代，Kevin W. Wildes（韋氏）強調，在區分普通（相稱）的治療和特殊（不相稱）的治療時，有關生活品質的判斷有其重要性。Gilbert Meilaender（梅氏）卻質疑，生活品質的判斷，是否適用於沒有能力為自己作醫療決定的病人。本文旨在將他們的爭議，重新定位至醫療負擔的適合對象，並指出某些醫療倫理的用詞（包括生活品質、負擔、康復的希望）有其模糊性。考慮到韋氏和梅氏較近期的著作，以及天主教會醫療指引的更新版，本文指出梅氏對醫療決策的標準，進行了恰當的分析；而韋氏則在醫療倫理的領域中，提供了一個全面整體性的方法論：在尊重各持份者的主觀良心之同時，也能顧及天主教會客觀的倫理教導指引。

關鍵詞：醫療倫理、特殊（不相稱）的治療、普通（相稱）的治療、生活品質的判斷、Gilbert Meilaender, Kevin W. Wildes

Abstract: *In the 1990s, Kevin W. Wildes, S.J. emphasizes the importance of quality-of-life judgments in distinguishing between ordinary (proportionate) and extraordinary (disproportionate) means of treatments. Gilbert Meilaender questions the appropriateness of its application for incapacitated patients. This article reorients their discussion to the proper object of burden and highlights the ambiguity of various terms (including quality of life, burden, and hope of recovery). Taking into account their subsequent writings and recent Church guidelines, I contend that Meilaender aptly analyzes the criteria on making health care decisions, whereas Wildes have a prophetic voice on a holistic ethical approach in the realm of bioethics, giving due respect to both the subjective conscience of the individual making the decision and the objective moral teachings of the Catholic Church.*

Keywords: *Health care ethics, extraordinary (disproportionate) treatment, Gilbert Meilaender, Kevin W. Wildes, ordinary (proportionate) treatment, quality-of-life judgment.*

1. Introduction

Life is a gift from God. While we should preserve our life where possible, vitalism is to be avoided. The question is: How do we discern when the refusal or withdrawal of a medical treatment is morally justifiable? The Catholic tradition offers guidelines in the discernment process by distinguishing between ordinary and extraordinary means of treatment.

In 2016, the Pontifical Council for Pastoral Assistance to Health Care Workers issued the *New Charter for Health Care Workers. The New Charter* reiterates that we are morally obliged to use ordinary means of treatments but we may reject extraordinary means of treatments to preserve lives.[1]

While this principle appears to be relatively straightforward in itself, its application can be complicated. As Thomas O'Donnell says, one should not expect the Catholic principle to be a "moral

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[1] The Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers* (hereafter *The New Charter*) (2016), English ed., trans. The National Catholic Bioethics Center (Philadelphia: The National Catholic Bioethics Center, 2017), 86. The position of *The New Charter* on the distinction between ordinary and extraordinary means of treatments is in line with The *Ethical and Religious Directives for Catholic Health Care Services* issued by the United States Conference of Catholic Bishops (USCCB) in 2009 (subsequently revised in 2018). See USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (2009), 56-57; USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (hereafter *ERD6*) (2018), 56-57.

slide rule" which provides clear answers to cases.[2] In fact, different approaches have been adopted by moralists to interpret this principle.

This paper analyzes the following three articles with respect to the issue of quality-of-life judgments in health care decisions in the Catholic tradition:

- Kevin Wildes, S.J., "Ordinary and Extraordinary Means and the Quality of Life."[3]
- Response to Wildes's article: Gilbert Meilaender, "Quaestio Disputata: Ordinary and Extraordinary Treatments: When Does Quality of Life Count?"[4]
- Response to Meilaender's comments: Wildes, "Quaestio Disputata: When Does Quality of Life Count?"[5]

I proceed by first laying out the distinction between ordinary and extraordinary treatments, followed by a succinct summary of the different views of Wildes and Meilaender as well as the major issues in disagreement. Then, I identify what factors contribute to

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[2] Thomas J. O'Donnell, *Medicine and Christian Morality* (New York: Alba House, 1976), p. 63. See also John Berkman, "Medically Assisted Nutrition and Hydration in Medicine and Moral Theology: A Contextualization of Its Past and a Direction for Its Future," *The Thomist* 68 (January 2004): 80.

[3] Kevin W. Wildes, S.J., "Ordinary and Extraordinary Means and the Quality of Life," *Theological Studies* 57, no. 3 (1996): 500-512.

[4] Gilbert Meilaender, "Quaestio Disputata: Ordinary and Extraordinary Treatments: When Does Quality of Life Count?" *Theological Studies* 58, no. 3 (1997): 527-531.

[5] Kevin W. Wildes, "Quaestio Disputata: When Does Quality of Life Count?" *Theological Studies* 59, no. 3 (1998): 505-508.

their divergent views, with a focus on the different interpretations of Church guidelines. Taking into account their subsequent writings and recent Church teachings, Meilaender highlights the distinction between letting die and allowing to die; whereas Wildes points us to the direction of a holistic approach bearing in mind the particularity of each case without falling into the trap of secular moral relativism.

2. Distinction between Ordinary and Extraordinary Means of Treatments

On preservation of life, the Catholic Church offers teachings on how to make a decision on whether to accept or refuse medical treatments during vulnerable times such as at birth, in sickness, and in dying. By accepting God's gift of life, human beings are obliged to maintain life. We are called to preserve our life where possible under both approaches of morality — the morality of obligation and the morality of happiness. However, if we choose to isolate ourselves from this principle, we are prone to "meaninglessness and unhappiness," as *Evangelium Vitae* states.[6]

Although the life of a person is precious, there is no moral obligation to preserve life by all means and at all costs. Extraordinary treatments are to be distinguished from ordinary treatments.[7]

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[6] John Paul II, *Evangelium Vitae*, 48.

[7] Some Catholic moralists prefer to use the terms *proportionate* vs. *disproportionate* treatments instead of *ordinary* vs. *extraordinary* treatments. For them, the latter may imply making health-care decisions in the abstract manner, while the former highlights the "principle of the *proportionality of treatment*." For details of the principle, see *The New Charter*, 87. For a succinct

While a person is morally obliged to accept ordinary (or proportionate) treatments in health care decisions, one is at liberty to refuse or withdraw from extraordinary treatments.

Turning to the particular circumstances of the patient and his or her resources, treatments are extraordinary (disproportionate) when the treatments "*in the patient's judgment* [emphasis added] do not offer a reasonable hope of benefit,"[8] or when they "impose a heavy or excessive burden (whether material, physical, moral, or economic) on the patient, his [or her] family members, or the health care institution."[9] On the other hand, if the treatments are reasonably useful and not burdensome, they are ordinary and a patient is morally obliged to use them.[10]

However, what appears to be an ordinary treatment to a physician may be viewed as extraordinary by the patient. For example, while a treatment is ordinary for the doctor from the medical point of view because it is typical, accepted, and not experimental, a patient may judge that this same treatment is extraordinary with respect to the usefulness and burden of the treatment, taking into account his or her own situation.

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analysis of the distinction between the terminology, see Benedict M. Ashley, Jean K. deBlois, and Kevin D. O'Rourke, *Health Care Ethics: A Catholic Theological Analysis*, 5th ed. (Washington, DC: Georgetown University Press, 2006), p. 186. In this article, the terms *ordinary* and *extraordinary* are adopted in line with their usage (albeit not in an abstract sense) by Wildes and Meilaender.

[8] *ERD6*, 57.

[9] *The New Charter*, 86. This positon is in line with *ERD6*, 57, which states that treatments are extraordinary when they "entail an excessive burden, or impose excessive expense on the family or the community."

[10] *The New Charter*, 86; *ERD6*, 56.

The Church also indicates that we are always bound to use certain life-sustaining measures which provide the basic necessities of life including food, water, and air. For sick persons in a vegetative state, medically assisted nutrition and hydration (henceforth MANH) represents a natural means of preserving life and should be considered ordinary.[11] This principle extends to those patients who cannot take food orally.[12] However, MANH becomes morally optional when it cannot reasonably be expected to prolong life, or when it is significantly burdensome for the patient, or gives rise to intolerable physical discomfort.[13]

3. Views of Wildes and Meilaender

In his 1996 article, Wildes states that according to the Catholic tradition, two factors are important in deciding whether a medical treatment is ordinary or extraordinary. First, for the treatment to be ordinary and therefore morally obligatory for the patient, the treatment itself "must offer some hope of benefit (*spes salutis*)."[14] Secondly, even if there is such a hope, the treatment is considered extraordinary and could be refused by the patient if it is burdensome to the patient.

For Wildes, the impact on the patient's quality of life is important in deciding whether that treatment is burdensome and

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[11] John Paul II, *Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas*, 4.

[12] *ERD6*, 58.

[13] *Ibid.*

[14] Wildes, "Ordinary and Extraordinary Means," p. 505.

therefore extraordinary. Since "the assessment of the burdensome nature of a treatment is a quality-of-life judgment," there does not exist a definite rule for making such judgments in a universal manner without due consideration of the different situations of patients.[15]

Wildes observes that as a result of technological advances in MANH procedure, there are confusions on the moral obligation to use MANH for sustaining the lives of patients who are in a vegetative state. In response to these uncertainties, some groups of bishops have issued guidelines which state that MANH should be administered provided that it is useful in the sense that the patient can assimilate the nutrition. Wildes opines that these statements have indeed misrepresented the traditional teaching by reducing the patient's subjective quality-of-life judgment to some form of objectified codes. Furthermore, while these guidelines largely focus on patients with terminal illnesses, he believes that they contradict with the Catholic tradition which holds that the decision on ordinary and extraordinary treatments is not limited to those who are dying.[16]

In 1997, Meilaender publishes a response to the article of Wildes. Meilaender agrees with Wildes's distinction between ordinary and extraordinary treatments as well as the importance of quality-of-life judgments in making a medical decision. In line with Wildes's views, Meilaender also emphasizes that a patient may refuse useless or burdensome treatments, and that the assessment is specific to the health situation of the patient. Furthermore, taking

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[15] Wildes, "Ordinary and Extraordinary Means," p. 507.

[16] *Ibid.*, pp. 508-511.

into account the change in the patient's condition, a treatment which may be considered ordinary to a patient in the past may become extraordinary in some future point of time.[17]

However, Meilaender disagrees with Wildes's negative comments on the objective guidelines issued by some groups of bishops. For Meilaender, Wildes has ignored the situation when other people need to make decisions on behalf of incapacitated patients. Here, Meilaender quotes the example of an unconscious patient in a vegetative state. When MANH is useful in sustaining the life of this patient who does not experience any burden, this feeding method should be continued. However, if the patient's surrogates are allowed to make the medical decision based on the quality-of-life judgments on patients and families, there is a possibility that they might decide to withdraw MANH "*so that* [the patients] will die," because "it is a burden to the rest of us to feed them."[18] In order to ensure that due respect is given to preserve the life and dignity of the patient taking into account his / her patient's own circumstances, it is appropriate to objectify decisions in these cases. He points out that Wildes "consistently blurs the important distinction between refusing treatment for oneself and refusing it for another."[19]

In 1998, Wildes responded to Meilaender's comments. He admits that in his 1996 article, distinction is not made between the case of a patient who decides for himself / herself and the

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[17] Meilaender, "Quaestio Disputata," pp. 527-528.

[18] *Ibid.*, p. 530.

[19] *Ibid.*, pp. 528-529.

situation where a surrogate has to make a medical decision for an incompetent patient. However, he opines that this distinction is indeed not necessary because it is not relevant for his discussion of ordinary and extraordinary treatments. Further along Meilaender's line of argument, Wildes criticizes that Meilaender has failed to identity the different types of incompetent patients: "those who have never been competent and those who are no longer competent." He continues to state that in discussing the situation of incompetent patients, Meilaender "confuses the issues at hand by implicitly equating treatments that are 'useless' and treatments that are burdensome."[20]

4. Why Different Opinions?

While the above articles appear to have various points of disagreement, the salient issues in dispute are: How do quality-of-life judgments relate to the distinction of ordinary and extraordinary treatments? How does one's understanding of personhood / personal identity affect the decision about the usefulness and burden of a treatment?

While Meilaender focuses on the distinction between the different situations of competent and incompetent patients in decision-making, I propose to re-orient the discussion to the meaning and the proper object of *quality-of-life judgment* and *burden*. The different views of Wildes and Meilaender could have been caused by the ambiguity and different interpretations of these terms.

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[20] Wildes, "Quaestio Disputata," p. 506.

Although both Wildes and Meilaender use these terms, their meanings and applications as understood by moralists can be radically different. Indeed, Wildes also emphasizes that language and terminologies in the field of bioethics can sometimes be oversimplified.[21] This observation is also echoed by Benedict Ashley, Jean deBlois, and Kevin O'Rourke, who remind their readers "to realize that quality of life is an ambiguous term."[22]

Wildes in his 1996 article points out that the term "quality of life" is frequently employed by secular political and social parties to promote their support in euthanasia and abortion. Therefore, Catholic theologians have become reluctant to use it when they discuss the distinction of ordinary and extraordinary treatments.[23]

Although Wildes recognizes the ambiguity of this term, he occasionally blurs the ordinary and extraordinary treatment distinction on the interpretation of quality-of-life judgments as corresponding to (i) the quality of life as affected by the treatment, or (ii) the quality of life as a result of the illness even with treatment.

The traditional Catholic teaching is that treatments are extraordinary when they are unable to provide a reasonable hope of benefit or when they give rise to an excessive burden. In other words, with respect to burden, the proper object of assessment is the *burden as a result of the treatment*. In his

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[21] Wildes, "Ordinary and Extraordinary Means," p. 500.

[22] Ashley, deBlois, and O'Rourke, *Health Care Ethics*, p. 189. See also Berkman, "Medically Assisted Nutrition and Hydration," p. 89.

[23] Wildes, "Ordinary and Extraordinary Means," p. 500.

1996 article, Wildes disagrees with the 1992 statement of the U.S. Bishops' Pro-Life Committee which reiterates the distinction between "a repugnance to a particular procedure and repugnance to life itself."[24]

While Wildes aptly highlights that the benefit of a treatment "does not mean simply the prolongation of life," his challenge on why certain treatments "cannot be refused because the life effected will be burdensome"[25] may be subject to abuse.

In his response to Meilaender, Wildes explicitly clarifies that a patient is morally right to refuse a treatment on the basis that "I do not want to live like that" after considering the quality of life "that will result from a treatment."[26] The question therefore hinges on whether the discernment is based on assessing the burden on the patient because of the treatment itself, or assessing the *burden of illness* on the patient's quality of life. If one takes the latter interpretation and confuses (i) the usefulness of a treatment in providing remedy to the illness itself, and (ii) the usefulness of a treatment to achieve full recovery of health, it signifies a deviation from the Catholic tradition. With this deviated understanding of the deficient quality of life (as a result of the illness rather than because of the treatment), one could indeed be advocating the patient's right to die as he/she so wishes.

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[24] U.S. Bishops' Pro-Life Committee, "Nutrition and Hydration, Moral and Pastoral Reflections," *Origins* 21 (1992), p. 708, as quoted in Wildes, "Ordinary and Extraordinary Means," p. 510.

[25] Wildes, "Ordinary and Extraordinary Means," p. 510.

[26] Wildes, "Quaestio Disputata," p. 507.

One may refer to the view of Gerald Kelly, whose position is that unless the patient objects, one should continue with MANH although this kind of prolongation of life is "relatively useless."[27] However, if the patient is incapacitated and is racked with pain in such a state that he does not profit spiritually, health-care professionals and the family may assume that the patient does not want MANH. Nonetheless, as John Berkman aptly analyzes, Kelly hesitates to propose this because others may regard him as "Catholic euthanasia." Therefore, he proposes the alternative of "better pain management."[28]

This is precisely the reason why Meilaender defends that Church teachings are necessary to counteract the "choice of death" preferred by some patients and their surrogates in view of their illnesses.[29]

Indeed, there have been two approaches among moralists to distinguish between ordinary and extraordinary treatments. One approach is to merely assess the burden of the treatment itself. The other approach, which is widely used, is to assess both the burden and benefits of the treatment. This second approach resonates with Church teaching.

Meilaender articulates that the assessment between ordinary and extraordinary treatment should be made with reference to the patient's life as burdened by treatments. He states that patients

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[27] Gerard Kelly, *Medico-Moral Problems* (St Louis: Catholic Health Association of the United States and Canada, 1958), pp. 128-141, as quoted in Berkman, "Medically Assisted Nutrition and Hydration," p. 82.

[28] Berkman, "Medically Assisted Nutrition and Hydration," p. 82.

[29] Meilaender, "Quaestio Disputata," p. 529.

"may choose a life that is shorter but relatively *less burdened by treatments* [emphasis added]."[30] In other words, in line with Catholic teaching, a patient is morally right to choose a shorter life which is free of painful treatments.

David Kelly, Gerard Magill, and Henk ten Have in their *Contemporary Catholic Health Care Ethics* also indicate that there may come a point in time when a patient lacks "the ability to carry out humanly meaningful purposes," and therefore suffers from a "lack of quality of life." When the "benefits of continued living" are "outweighed by *the burdens of the kind of life that is likely to result from life-sustaining treatment* [emphasis added] or by the burdens of the treatment itself, the treatment may be forgone."[31] As Berkman observes, this type of "insufficient 'quality' in life itself" argument has become a choice about life in itself, and is not merely a choice about a medical treatment.[32]

Furthermore, the term "hope of recovery" in itself could be ambiguous. If a treatment is not useful in eliminating a disease but is successful in abating the effects of the illness,[33] would this count as having some hope of recovery? In this regard, Wildes's proposal to consider "the human being as a whole" and the importance of discernment is helpful for the patients to consider her own situation.[34]

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[30] Meilaender, "Quaestio Disputata," p. 528.

[31] David F. Kelly, Gerard Magill, and Henk ten Have, *Contemporary Catholic Health Care Ethics* (Washington, DC: Georgetown University Press, 2013), p. 128.

[32] Berkman, "Medically Assisted Nutrition and Hydration," p. 95.

[33] Ashley, deBlois, and O'Rourke, *Health Care Ethics*, p. 186.

[34] Wildes, "Quaestio Disputata," p. 508.

However, in his response to Meilaender's article, Wildes in 1998 comments that when the patient's "body is so broken that it loses its potential for anything other than existing," there is no obligation to continue treatment.[35] Here, Wildes's view of personhood gravitates towards the prevailing "Promethean" anthropology—human beings earn their own dignity through their own works.[36] This deviates from the Catholic principle of the sanctity of human life—every human being, no matter in what stage of life or health, has the same dignity and is properly speaking a person. This is because we are all created in the image of God and God loves each one of us.[37] Having said this, human life is not to be preserved at all costs since death is inevitable. This is why we need the principle of ordinary and extraordinary treatments to discern when to accept and when to refuse a treatment.

5. Different Interpretations of Church Guidelines

Wildes and Meilaender differ in their interpretation of Church guidelines with respect to health care decisions.

In his 1996 article, Wildes criticizes that the guidelines issued by certain groups of bishops on MANH neglect the importance of quality-of-life judgments. In response, Meilaender stresses that these guidelines are useful for surrogates who have to make

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[35] *Ibid.*

[36] Kelly S. Johnson, "Catholic Social Teaching," in *Gathered for the Journey: Moral Theology in Catholic Perspective*, ed. David Matzko McCarthy and M. Therese Lysaught (Grand Rapids, MI: Eerdmans, 2007), p. 228.

[37] Ashley, deBlois, and O'Rourke, *Health Care Ethics*, p. 189.

medical decisions for incapacitated patients. In these particular cases, Meilaender argues that quality-of-life judgments should not be taken into consideration.[38] In objectifying treatment decisions, Meilaender opines that the patient's situation is well respected since the surrogates' own quality-of-life judgments are "not to be imposed on subjects who cannot speak for themselves."[39]

While Meilaender's comments are helpful in protecting the interests of incapacitated patients, the guidelines of the Church apply to everyone—not just the surrogates but also patients who understand their own situation and who can speak for themselves.

In Wildes's article, he identifies two types of bishops' statements. The Pennsylvania Bishops' statement on MANH "illustrates the tendency both to objectify the judgment about ordinary and extraordinary means and to misrepresent traditional teaching."[40] On the other hand, Wildes commends that the Texas Bishops have made excellent statements to preserve the core of the traditional teaching.[41]

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[38] Wildes, "Ordinary and Extraordinary Means," p. 508; Meilaender, "Quaestio Disputata," p. 529. See also Nicanor Pier Giorgio Austriaco, *Biomedicine and Beatitude: An Introduction to Catholic Bioethics* (Washington, DC: The Catholic University of America, 2011), p. 142.

[39] Meilaender, "Quaestio Disputata," p. 529.

[40] Wildes, "Ordinary and Extraordinary Means," pp. 508-509, with reference to Pennsylvania Bishops, "Nutrition and Hydration: Moral Considerations," *Origins* 21 (1992): 541-553.

[41] Wildes, "Ordinary and Extraordinary Means," p. 508, with reference to Texas Bishops, "On Withdrawing Artificial Nutrition and Hydration," *Origins* 20 (1990): 53-55. For a detailed analysis of the different views of the Pennsylvania and Texas Bishops, see Berkman, "Medically Assisted Nutrition and Hydration," pp. 84-95.

To analyze the comments of Wildes, reference is made to the *Declaration on Euthanasia* issued by Congregation for the Doctrine of the Faith in 1980. The Declaration, which is usually regarded as the source of teaching for the 1995 encyclical *Evangelium Vitae*, states that,

> 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* [emphasis added].[42]

I now turn to the Pennsylvania Bishops' statement on MANH, which is criticized by Wildes. In this statement, the Pennsylvania Bishops accept that for situations where a family "may have reached the moral limits of its abilities or its resources," they are "not morally obliged to do more."[43] Taking into consideration the particular situation of each case, the Church teachings are not merely objectifications.

With respect to the application of the principle of ordinary and extraordinary treatments, Wildes appropriately points out that it entails a decision after weighing the benefits and burdens of a treatment, and that it is not only limited to decision made for patients who are close to death. While Pope John Paul II

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[42] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, IV. See also *The New Charter*, 86.

[43] Pennsylvania Bishops, "Nutrition and Hydration: Moral Considerations," p. 549, as quoted in Berkman, "Medically Assisted Nutrition and Hydration," p. 88.

"seems to limit" the distinction of ordinary and extraordinary for those who are dying, the Church is indeed not restricting the withdrawal of medical treatment on those who are terminally ill, Wildes observes.[44]

By quoting the example of Church teachings in feeding patients who are in a vegetative state through MANH for years, Meilaender also recognizes that Church guidelines are applicable to those patients who are not dying. As he rightly points out, even if Church guidelines in the administration of MANH (in particular the guidelines in the document of the Pennsylvania Bishops) are a departure from the traditional distinction of the ordinary and extraordinary treatments, "they are wise to do so."[45] What needs to be defended is not the history or the absolute traditional principle of ordinary / extraordinary treatments. Rather, we need to hold fast to the intention of the principle—the distinction is developed as a means for us to achieve the goal of making moral medical decisions of not preserving life at all costs ("the duty to do positive good") and at the same time, not to take innocent life intentionally (with the absolute "duty to avoid doing evil").[46] In our contemporary age, new questions and issues arise. Within this new context, the Church who reads the signs of the times acts rightly to issue teachings in order to guide Christians on moral and faith issues.

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[44] Wildes, "Ordinary and Extraordinary Means," p. 509.

[45] Meilaender, "Quaestio Disputata," p. 530.

[46] Berkman, "Medically Assisted Nutrition and Hydration," p. 81.

6. Subsequent Developments and Way Forward

The articles of Wildes and Meilaender under review were written in the 1990s. In line with the position of the previous *Charter for Health Care Workers* issued in 1995,[47] *The New Charter* issued in 2016 continues to disapprove of artificial prolongation of life which does not confer any "real benefit" on the patient.[48]

In the fourth edition of *Bioethics: A Primer for Christians* published in 2020, Meilaender highlights the distinction between letting die and allowing to die. Succinctly stated, if one refuses a medical treatment "*so that* [italics in original]" the patient will die, it is not the same as "allowing to die."[49] Citing the example of deciding on whether to perform an ordinary surgery on a child with Down syndrome, if the parents choose to refuse treatment for the child because they regard the life of the infant as unworthy of living because of his / her disabilities, this is not allowing to die, but letting the infant die.

In the Catholic tradition, the above scenario of letting die (which could be a result of tiredness of life or perceived lack of quality of life because of sickness; or a seemingly unworthy life to live as judged by human standard) is not endorsed because it aims at the death of a patient.

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[47] The Pontifical Council for Pastoral Assistance to Health Care Workers, *The Charter for Health Care Workers* (Vatican City, 1995), 119.

[48] *The New Charter*, 86.

[49] Gilbert Meilaender, *Bioethics: A Primer for Christians*, 4th ed. (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2020), pp. 86-87.

On the other hand, if a treatment is refused or withdrawn because it is excessively burdensome to the patient, the family, and the health care institution, it does not constitute letting die. The decision of allowing to die is in agreement with Catholic teaching — it is morally acceptable to refuse extraordinary treatments which only prolong the patient's life without any real advantage to him / her.

In Wildes's subsequent work *Moral Acquaintances: Methodology in Bioethics* (2000), he highlights that there does not exist a set of universal moral reasoning that can be applied to everyone. His comment provides a significant clarification on his previous negative comments on the objectification of Church teachings by the Pennsylvania Bishops, who according to Wildes "portrays life as an absolute good" and therefore blurs the traditional Church teachings on the distinction between ordinary and extraordinary treatments.[50]

Wildes in this recent work categorically states that bearing in mind the contemporary context of "multiculturalism" and "moral pluralism," it is a false presumption that there is one universal set of "moral reason" which functions in an identical manner for everyone.[51] Turning to the particularity of each case without falling into the trap of secular moral relativism, Wildes proposes that

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[50] Wildes, "Ordinary and Extraordinary Means," pp. 508-509.

[51] Kevin W. Wildes, *Moral Acquaintances: Methodology in Bioethics* (Notre Dame, IN: University of Notre Dame Press, 2000), pp. 5-6.

various parties (including the patients, their families, physicians and health care workers, organizations, institutions, and society) act together as moral "acquaintances," i.e. "moral friends."[52] While issues on bioethics primarily concern individuals, as demonstrated in the question of what I should do in this particular situation, Wildes reorients our attention to the intricate networks of relationships that patients have with professionals and institutions. As with the development of moral conscience on the individual level, he highlights the importance of education for forming the "moral identity" of institutions.[53]

The significance of Wildes's discussion is the direction he points towards a holistic ethical approach for the field of bioethics. In the covenantal relationship between health-care professionals and patients, both parties participate in the healing process.[54] When patients or their surrogates make a medical decision, Christians do not merely rely on the secular right of autonomy and the secular view on quality of life. Instead, the source of a free and informed consent of personal judgment is derived from the "'sacred and inviolable' character of the human person."[55] One essential element of this principle of informed consent is the health-care professionals' provision of important information

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[52] Wildes, *Moral Acquaintances*, p. 162.

[53] *Ibid.*, p. 175.

[54] *ERD6*, 23-37.

[55] Ashley, deBlois, and O'Rourke, *Health Care Ethics*, p. 192. See also *ERD6*, 26.

about the nature, the effect, and the risk of the treatment.[56] Useless treatments should not be continued. The Church, in issuing her teachings on moral issues, helps Christians to form their conscience which is indispensable for making an informed consent to decide what is right and good in this particular situation.

Applying Wildes's proposed acquaintanceship among parties to the quality-of-life judgment in health care decisions, it brings to the fore the importance of informed discernment on a holistic approach—with an emphasis on the human being (bodily life, personal life, and soul) as a whole bearing in mind the situation of the patients, and as guided by the teachings of the Catholic Church. The emphasis of Wildes on the uniqueness of each case resonates with *The New Charter* and the *Declaration on Euthanasia* which states that in making a healthcare decision, one needs to bear in mind the unique circumstances faced by the patient and his / her resources (physical and moral).[57]

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[56] In Hong Kong SAR, *The Code of Professional Conduct* issued by The Medical Council of Hong Kong stipulates that before the administration of invasive and major procedures, explicit and voluntary consent from the informed patient is required, after the physician's explanation to the patient regarding the nature and risk of the treatment concerned. The Medical Council of Hong Kong, *The Code of Professional Conduct* (October 2022), pp. 14-17, https://www.mchk.org.hk/english/code/files/Code_of_Professional_Conduct_(English_Version)_(Revised_in_October_2022).pdf [accessed 24 September, 2024]. See also 陳浩文、區結成編著，《如何走下去：倫理與醫療》(*Towards Sustainability: Medical Ethics and Professionalism*)（香港：香港城市大學出版社，2018），頁87-88。

[57] *The New Charter*, 86; *Declaration on Euthanasia*, IV.

7. Conclusion

In the Catholic tradition, ordinary and extraordinary means of health care treatments are distinguished. Patients are at liberty to refuse extraordinary treatments. With respect to those treatments which offer a reasonable hope of recovery and do not entail excessive burden on the patient (as well as his or her family and the society), these treatments should not be refused.

In this decision making process, the particular situation of the patient, including quality-of-life judgments and the effect of the treatment on the patient, are crucial for assessing the benefits and burdens of the treatment. Although the principle of distinction in itself is clear and straightforward, the application can be complicated.

While decision making on health care treatments are patient-specific and time-specific, it is apt for the Church to issue guidelines to inform Christians how to make these decisions. However, different interpretations of Church statements give rise to contrary opinions on the appropriateness and usefulness of these guidelines. The ambiguity of terms such as quality of life and burden as well as different opinions on the proper object of assessment all contribute to diverse views of how this principle should be implemented.

Bringing Wildes and Meilaender together into dialogue, we have seen how different views of ethicists could highlight the way forward—the indispensable role of objective guidelines as appropriated by the educated subjective conscience in an informed context. This calls for a collaboration among the patient, his/her surogates, the physicians, the healthcare workers, as well as the insitutions and organizations. All parties (Christians and secular) are “moral acquaintances” as Wildes puts it. As “moral friends,” we work together to understand the guidelines of the Church to make informed and morally acceptable medical decisions at the vulnerable times of life.