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Ending Renal Dialysis: Ethical Issues in Refusing Life-Sustaining Treatment

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INTRODUCTION: BACKGROUND AND ISSUES

As of 1991, approximately 230,000 people in the United States had end-stage renal disease (ESRD),¹ kidney disease that has irreversibly progressed to the point that there remains insufficient kidney function to sustain life. ESRD may result from a pathology affecting the kidneys alone, or it may be secondary to a systemic disorder, diabetes in the case of 35.8% of new U.S. ESRD patients in 1991.² For a multitude of reasons, many ESRD patients cannot receive transplants. For these patients, including 134,000 medicare recipients in the U.S. in 1991 (medicare recipients represented 93% of all U.S. ESRD patients), renal dialysis is the only option for sustaining life.³

While dialysis is no longer an experimental treatment, it uses complicated technology and is very expensive. The majority of U.S. dialysis patients receive hemodialysis, in which the patient's blood flows through a machine that filters out toxins (as opposed to peritoneal dialysis, in which fluid is infused into the abdomen and toxins filter from the blood into this fluid through the peritoneal membrane); the majority of these—58.8% of all U.S. medicare dialysis patients in 1991—receive it in a clinic on an outpatient basis (as opposed to at home).⁴ Such hemodialysis, on which I shall focus in this paper, cost approximately \$47,400 a year for each patient in 1991.⁵ Because the Federal government has covered the cost of dialysis for most ESRD patients since 1972,⁶ patients may not incur direct financial burden, but they do impose costs on society. Furthermore, when ESRD is consequent to a condition like diabetes, it will often be accompanied by other serious health problems that will sometimes impose more direct financial burdens on patients and their families.

Putting aside cost to patients and to society, dialysis is itself burdensome and its benefits may be limited. Most patients receive hemodialysis for three to four hours at a time, three times a week.⁷

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Patients may not only feel discomfort during dialysis, but may also begin to feel the effects of uremia, the buildup of toxins in their blood, before a dialysis session, and afterwards may feel tired or cramped.⁸ Dialysis therefore requires a significant time investment, or, put differently, may provide the patient with only several fully functional days each week. Dialysis patients must observe a strict diet, including limitations on fluid intake.⁹ Finally, dialysis cannot cure other complications of conditions like diabetes to which ESRD may be secondary. Therefore, the life that it sustains may be burdened by other such problems. Without denying that sustaining life can be a benefit even in such cases, one can still say that it is less of a benefit than it is when the life sustained is healthier.

For all of these reasons, patients may want to end dialysis, and the consensus among medical ethicists and health-care personnel is that ending dialysis can be acceptable in principle.¹⁰ There are protocols for helping patients through the decision to end dialysis and its aftermath,¹¹ and approximately eight percent of U.S. patients ended dialysis in 1987, resulting in death after a mean of eight days.¹²

To make the issue more concrete, one can consider an especially “hard case.” Last summer, in the Milwaukee area, an 85-year-old retired physician died after ending kidney dialysis after six years. The man’s kidney failure was secondary to diabetes. Due to circulatory complications of his diabetes, his legs had been amputated three years before. His daughter wrote of the “suffering” that dialysis had caused him. The man’s wife had been dying of cancer, and he decided that when she died and he was therefore no longer needed to support her, he would end dialysis. He did so with the support of his Catholic pastor, who, in his daughter’s words, “wrote specifically in the parish bulletin that according to the Catholic Church, discontinuation of dialysis is not suicide.” Reports of the case in the *Milwaukee Journal Sentinel* led to an exchange of letters to the editor concerning whether the man’s decision should be termed “suicide.”¹³

It is the purpose of this paper to consider the ethical issues raised by such cases. This is important not only because of the number of patients who might wish to end dialysis, but also because the use of life-sustaining treatment in general has, needless to say, led to many questions about what health-care personnel, families, and patients are ethically required, allowed, or forbidden to do, and what civil laws would be in keeping with ethical norms. In my discussion, I shall explain principles and draw conclusions that I hope will address some

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of these more general concerns as well as some of those peculiar to the use and ending of renal dialysis.

I shall argue that a patient's motives for ending life-sustaining treatment are of particular ethical importance. Great care must be taken to ensure that a patient is weighing the benefits of treatment against the burdens of that same treatment, rather than against the burdens of his medical condition that the treatment may not relieve. That is, patients must not end treatment in order to eliminate such burdens by means of the death that will result from ending treatment. This would be contrary to the spiritual meaning of human life. This same meaning of human life, however, also implies that, as the Catholic Church teaches, patients may forego treatment that does not offer benefits proportionate to the burdens it entails. This principle can be shown to be relevant for some dialysis patients. Furthermore, patients may take into account their underlying condition in assessing the total benefits to be weighed against the burdens of a treatment—a treatment that keeps a patient alive but in a condition like that of the Milwaukee-area dialysis patient I have mentioned offers fewer benefits than one that keeps a patient alive and generally well; therefore, in the former case, the benefits will not be proportionate to as great a burden as they would in the latter case.

It will as a matter of principle be impossible to specify in detail what sorts of benefits outweigh what sorts of burdens, and vice-versa. Much will depend on the individual patient. Each decision will therefore require prudence. However, since the possibility of burdens that are disproportionate to even the benefit of sustained life reflects the same spiritual meaning of human life that precludes choosing death as a means to relief from burdens, spiritual maturity will make a difference in patients' decisions, even though decisions reflecting spiritual imperfection are not necessarily blameworthy or unethical.

PRINCIPLES: THE MEANING OF LIFE, THE MEANING OF DEATH, AND

RESPECT FOR LIFE IN THE FACE OF DEATH

What do reason and, for those who are Christians, faith tell us about the meaning and value of life, and about how to view death in a way that is consistent with the value of life?¹⁴ To answer this question, it is necessary to consider first what kind of beings we are. We are material beings—our bodies are not extrinsic to our “selves,” like clothing—but we are at the same time more than material beings; we are spiritual beings because we have spiritual souls. What makes it possible for us to be simultaneously material and spiritual is the

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intimate relationship between our bodies and our souls: the human soul is the “form” of the body; it is what makes it to be a living, human body.¹⁵ Our body thus participates in the spiritual life of the soul.

Now the human soul is a spiritual soul because it is a rational soul; it is capable of knowing the true and loving the good. Yet it is really the person, body and soul, not only the soul, that knows and loves. This is what it means concretely to say that the body participates in the life of the soul.¹⁶ We can therefore say that in a certain sense the purpose of life, including bodily life, is a spiritual purpose: to know and to love. A Christian can add to this that our purpose is to know and love absolute Truth and Goodness: to know and love God in communion with God’s own knowledge and love of himself—that is, to participate by grace in the life of the Trinity.

At this point, we can see what it means to speak of the human body as having special value: the spiritual is more valuable than the material, and the human body shares in the value of the spiritual soul.¹⁷ We can also see what it means to treat the human body and human life—that is, bodily life—in accord with its value. The body must not be treated as though it were to be valued only for its material value, for its ability to experience such material realities as pleasure, in isolation from or opposition to its spiritual value, for its participation in knowledge and love.

First, then, we must not cease to respect its integrity and life, conferred upon it by its participation in the life of the soul, when pain or sickness causes the fact that there is not perfect harmony between body and soul, and that our person’s integrity is therefore not perfect, to intrude upon our consciousness.¹⁸ Above all, we must not think of even severe pain or grave illness as destroying the entire value of our bodily life.¹⁹ Pain and illness do not, after all, make it impossible to pursue spiritual goodness. To the extent that they make it difficult to do so, it is still incoherent to try more effectively to pursue such goodness by directly rejecting the body. For we come to pursue and live out spiritual goodness through our bodies—through our senses and through our bodily actions. Indeed, this is possible in the first place because of the intimate relationship between body and soul that I have described above. In other words, it is possible because the body shares in spiritual goodness. For these reasons, to reject the body as lacking in value is to reject spiritual goodness.

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In fact, on the Christian view, suffering can be an occasion for living out the spiritual value of human life. For we must remember that spiritual goods cannot be effectively pursued by attempting to grasp them. Rather, it is necessary to surrender to them. We do not so much make truth and goodness our own as allow them to possess and form us.²⁰ This is above all true when we are thinking of how we attain communion with Truth and Being in Person, namely, God. Our status as creatures precludes our ever grasping such communion. We can only receive it as a gift and then live in accordance with it. Indeed, to attempt to grasp it would be effectively to reject it, since it would be effectively an attempt at self-deification, that is, a denial of our need to receive it as a gift.

It was such an attempt on the part of our first parents that led to the estrangement of the human race from God, and to the disintegration of our humanity (and of all creation) when we thus lost communion with the one who is our integrating principle, and to death itself, the ultimate dis-integration.²¹ And while God has restored communion with the human race, he has done so in such a way that we now accept it and allow it to penetrate our being, including our bodies, and therefore definitively to relieve the burdens of our condition, only by surrendering ourselves to God precisely through death.²² Furthermore, if death can and must be such an act of self-surrender, so also must all the prefigurations of death we experience in illness and injury and pain. This is not to say that we may never try to relieve our own or others' suffering. The point concerns, rather, how we may do so. Actively to pursue death to escape the burdens of illness and injury and pain is the antithesis of suffering and dying in a spirit of self-surrender; as such, it actually subverts the communion with spiritual goods that is the meaning of our life.

Secondly, however, we must not value bodily integrity in such a way that we guard it at the expense of spiritual goods. While it is, as I have explained, always futile to try to pursue spiritual goods by means that directly attack and therefore reject the value of the body, it is sometimes helpful or necessary in pursuit of spiritual goods to forego actions that would help to maintain our bodily integrity, and therefore indirectly to give up such integrity and even our lives.²³ Most clearly, love of God or neighbor can allow or compel us to give up our lives. But attempts to postpone as long as technology will allow the death toward which one is irreversibly moving, even in ways that are not directly incompatible with justice or charity, can

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still reflect an attitude of grasping of life, this time of bare material life, rather than a willingness to allow this life to attain its meaning by surrendering it to God.

Perhaps most relevant for the purposes of this paper, it must also be recognized that, while the pain and other burdens that accompany illness and injury can be the situations in which we learn to accept, live out, and return God's self-communication and grow in knowledge and love of him and thus prepare for a genuinely "good death," this can at some point require an especially difficult act of will, one greater than that of which many people will be capable. In short, persevering can at some point require "heroic virtue." While we must trust that God will give each person enough virtue to avoid doing anything that is immoral—to persevere in treatment that does not itself significantly increase spiritual burdens, even when the burdens of his condition seem extreme, rather than seeking to end those burdens by withdrawing from treatment—we must at the same time not foreclose the possibility that some people will not have the ability to allow the spiritual benefits of remaining alive to outweigh the sometimes-significant burdens of life-sustaining treatment itself, since accepting death (as opposed to choosing it) is clearly not intrinsically immoral.²⁴ In such cases—when the burden of a treatment is not proportionate to the benefit that someone can gain from life—the treatment can be ended (or one may refuse to initiate it on the basis of its predicted effects), even when this would entail accepting death.

Furthermore, when a patient's underlying condition is bad and cannot be relieved by life-sustaining treatment, the treatment's benefits are lessened and its burdens will more quickly become disproportionate to those benefits.²⁵ As I have indicated, even though suffering does not preclude and in fact can and sometimes must be an occasion for pursuit of spiritual goods through self-surrender, suffering can also make pursuit of those goods more difficult and can therefore make life less beneficial than life without suffering would be. The burdens imposed by treatment itself will therefore become more than a patient can spiritually bear sooner if the treatment does not relieve the burdens imposed by the patient's condition.

To summarize the principles whose derivation I have outlined in this section: Since life is never without value, a treatment is never without benefit when it sustains life; and one cannot in any case refuse life-sustaining treatment in order to end the burdens of one's condition by means of death. This would be to ignore and even act

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contrary to the spiritual meaning of life. On the other hand, one need not and indeed should not seek to preserve life at all costs. A treatment that imposes spiritual burdens greater than the spiritual benefits of remaining alive may be ended, even when this would entail death, and the judgment of when this is the case can take into account the fact that the benefits of remaining alive can be lessened by the effects of one's condition.

APPLICATIONS: JUST MOTIVES AND PROPORTIONATE ACTIONS

What can be concluded about concrete cases, for example, those of dialysis patients? First, a patient's motives for wanting to end dialysis are important in an ethical assessment of his decision. As I have indicated, ESRD is often consequent to diabetes, which also has other severe effects that result in suffering. It is not difficult to see how a diabetic ESRD patient could be tempted to end dialysis and die as a way to end the suffering imposed by other effects of diabetes. And there is reason to suspect that this is in fact at least part of the motivation for some patients to end dialysis, just as in general some patients are tempted to end their lives in order to end suffering.

The Milwaukee-area case illustrates the problem of possibly-mixed motives.²⁶ The patient's daughter wrote, "My father...chose to continue dialysis for six years in spite of the suffering it caused him. He chose to live confined to a wheelchair for three years after his legs were amputated—a very painful process with a long recovery period." Suffering caused specifically by dialysis could certainly be a reason to end dialysis. The condition in which dialysis keeps someone alive could be relevant in a judgment of how much suffering caused by dialysis needs to be accepted, as I have explained. It is possible, however, based on his daughter's explanation, that the Milwaukee-area patient also saw as a reason to end dialysis the cessation of the suffering imposed by his condition that would accompany the death that would follow an end to dialysis; note the daughter's statement that her father had "chose[n] to live," perhaps as if the opposite choice—"to die," as a means to ending suffering—would be equally warranted.

It seems that the ethical guidance that patients receive sometimes contributes to this problem. Such guidance is often at best ambiguous. The Milwaukee man's pastor's advice as reported by the man's daughter, quoted above ("discontinuation of dialysis is not suicide") does not take into account the issue of motivation. Discontinuation of

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dialysis in order to die and thereby to relieve suffering is suicide. The man's daughter also reported that his physician had told him that "no one can be forced to take dialysis." This is true enough: no competent adult can legally or ethically be "forced" to receive any treatment. But again, it is not clear that the man received fully accurate guidance concerning what constitute ethically appropriate reasons for ending dialysis. Articles for renal professionals and publications for patients will mention "burdens" and "benefits" of treatments²⁷ and will recommend assessment for stressors in the patient's life and for depression before a patient makes a final decision,²⁸ but at the same time will focus primarily on question-begging statements about "rights"²⁹ and will suggest that failure to maintain "quality of life" suffices to justify ending treatment,³⁰ which could lead a patient to believe that he may rightly judge his life to be without value and choose to end it; indeed one textbook refers (not disapprovingly) to the decision to end dialysis as a decision that "it is better to be dead."³¹

The Milwaukee-area patient's situation was also complicated by the terminal illness and death of his wife. It seems that this might have entered into his decision in a problematic way. The man said, "I just know I want to be with her in life and in death. That's the kind of companion she was." This suggests that he was, at least in part, choosing his own death as a means to end his separation from her after her death. He was also quoted by one of his daughters as having told her and his other children, "I really have been doing dialysis and staying alive so that I could be a support to your mother...and it doesn't make any sense to continue without her." This could mean that he saw life as simply unworthy of being lived once he was no longer needed by another.³²

It is, however, possible that someone could have a motive for ending dialysis that is at least formally good. Someone could, that is, judge that, taking into account his condition, dialysis is more of a burden than a benefit. The question then arises, when might this be true? Under what kinds of circumstances might continuing dialysis be contrary to the spiritual meaning and purpose of human life, as I have explained it? To answer, it is necessary to consider both what kinds of burdens of dialysis could become disproportionate, and what kinds of underlying conditions could render dialysis less beneficial.

Hemodialysis always imposes the burden mentioned above: it requires a significant portion of the patient's time, and patients must

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observe a strict diet. Suppose that a patient is generally in good condition and feels no significant burdens from dialysis apart from these. Would ending dialysis be an ethical option in such a case? It seems to me that it would not. As long as a patient does not need to invest the vast majority of his time in pursuing a course of treatment, it would seem that, objectively, the time he must invest is not disproportionate to the benefit that he receives: life and a still-reasonable amount of time really to live it. Dietary restrictions can be very unpleasant, but it is difficult to see how they could objectively be the sort of burden that outweighs preserving one's life. (Compare someone who must observe a special diet as the sole treatment for a condition and means of preserving his life, for example, some diabetics.³³) None of this is to say that no patients will experience these burdens as onerous. But I think it reasonable to expect that virtually anyone will be able to avoid being overwhelmed by them, with suitable support and counseling, both spiritual and psychological (the importance of which should not be minimized).

As has also been mentioned, however, dialysis can itself give rise to painful complications. When it does, it will impose a burden of a different kind, and perhaps one that would justify ending dialysis. Objectively, pain can be very difficult spiritually. This will be all the more the case when one has to prepare to face it on a regular basis, and for the rest of one's life (unlike in, for example, a chemotherapy regimen, which is usually of limited duration when successful). Subjectively, this is the sort of burden that it can sometimes require "heroic virtue" to face. Doing so will therefore be beyond the capacity of some patients.

A patient may wish to end dialysis in order to avoid being a burden to others, in this case to society as a whole, which will pay the costs of his treatment. Such a patient can have a good reason to end an expensive procedure. The primary concern would be to ensure that the patient's underlying motivation is really charity for others (perhaps especially for those who could use those resources to sustain their own lives) rather than a kind of pride that could make one unreasonably reluctant to accept others' acts of charity. In a certain sense, dependence on others can rightly be seen as a spiritual burden upon oneself—it prevents one from exercising a certain kind of charity toward those upon whom one is dependent. But it must not be seen as a burden upon oneself that is unmitigated or mitigated only extrinsically (that is, because it saves one's life). Dependence is

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certainly not intrinsically undignified.³⁴ Indeed, other's acts of charity are in a real sense the condition for one's own exercise of charity (above all, God's love precedes ours, and God's love comes to us through other human beings as well as directly). As long as this is recognized and one genuinely wishes to make one's own act of charity toward those in need of medical resources, one can in principle forego such expensive treatments as dialysis.

We must now consider what kinds of underlying conditions could render dialysis less beneficial, and whether in those cases it could be ended even if complications imposed no significant additional burden beyond time and dietary restrictions. Consider first a patient who is in severe pain. For such a patient, dialysis will be less beneficial: It will keep him alive but not relieve his pain. This could, I think, make even the burdens of uncomplicated dialysis disproportionate. While those burdens should not ordinarily be overwhelming in themselves, it is more easily conceivable that they could become so when added to the struggle that life with severe pain can become.³⁵

A patient who is really dying would certainly be justified in ending dialysis.³⁶ There is a difference in kind between prolonging life and prolonging the dying process. While each of us will eventually die, and while in certain imperceptible or minor ways we may already be undergoing the "disintegration" that will culminate in death, it is sensible to resist death before the beginning of the dying process in a way that it is usually not once that process has really begun.³⁷ In the former case, one preserves the conditions for coming to participate in spiritual goods; in the latter case, one would be refusing to surrender for the sake of those same goods. Therefore, when the dying process has begun, the burdens of such treatments as dialysis are usually disproportionate to their benefits.

It could also be mentioned, especially since this was a factor in the Milwaukee-area case, that some obligations, especially to family, could warrant preserving life or prolonging the dying process in ways that would be unnecessary or inappropriate absent such obligations. Thus, one's spouse's need for care could make it reasonable or perhaps even obligatory to accept what otherwise would be a disproportionately-burdensome treatment. Similarly, one should settle one's affairs and make peace with or express one's love for one's family before dying, and it would be right to prolong dying until one has had a reasonable chance to do so. Once one has fulfilled

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justice or charity in these matters, one could end the treatment that has kept one alive to do so. It must only be borne in mind that one can then end treatment only because the treatment would in the first place have been disproportionate had the patient had no special obligations. Thus, one cannot settle the issue of whether treatment is disproportionate by pointing to the lack of such obligations—one cannot, for example, end life-sustaining treatment simply because one's spouse has died.

It should be obvious that this analysis does not suffice to settle every practical question, to tell us in each case, in detail, what treatments would be disproportionately burdensome. Burdens such as pain will be experienced differently by different patients, and it is in part, even mostly, how they are experienced that will be ethically relevant.³⁸ There will be some grey area about the beginning of the dying process and therefore between “prolonging life” and “prolonging dying.” Therefore, while rules are necessary, prudence will also be necessary.³⁹ More or less detailed protocols for dealing with patients in general or dialysis patients in particular can be helpful in ensuring that patients' needs are met and even in ensuring that the guidance they receive is ethical, but they can only be seen as a help, not a substitute, for prudent health-care workers and indeed for prudent patients. And to develop prudence, one must develop an awareness and a right appreciation of the realities upon which one's actions bear,⁴⁰ including, importantly in matters of life and death (and in many other matters too), the spiritual realities of truth, goodness, and Truth and Goodness itself.

This is not only to say that one should be aware of the significance of how one happens to be able to cope with life, suffering, and death for one's participation in these realities. It is also to say that one should be open to growth in one's ability to appreciate them, growth that will transform one's attitude toward life, suffering, and death, making one more appreciative of the opportunities that life gives us to find fulfillment in these realities, of their power over suffering, and, at the same time, of their power over death. For someone who has matured spiritually in this way, life-sustaining treatments will more easily be seen as beneficial despite their burdens and despite the suffering they may not relieve—and will more easily be seen as burdens to be cast off when dying has really begun. Growth of this sort and the transformation of prudential judgment that it brings are important not because judgments and actions that reflect lack of

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full spiritual maturity are necessarily blameworthy, but because they are, in the long run, less conducive to human fulfillment and happiness; they are a holding-back of part of the self from participation in spiritual goods and, concretely, in the life of God that we receive when we have been crucified with him (Gal. 2:19–20).

Spiritual growth is also important for a more basic reason: To the extent that pain is experienced as an unmitigated burden, to that extent will one be tempted to end it even by death—tempted, that is, to the kinds of bad motives for ending treatment that I have discussed. This will be all the more a problem when one also has good reasons to end treatment, that is, when an action that could be described abstractly as “ending treatment” could be justified. For this will make the action seem more acceptable and will therefore make it more likely to be chosen, and therefore one’s bad motives as well as one’s good ones will more likely be chosen. In short, apart from spiritual growth, situations in which one is suffering and will die without treatment will more likely be near occasions of sin.

CONCLUSIONS

I have argued that patients may not end dialysis in order to bring about death and with it relief from the burdens of illness, but they may sometimes end dialysis because it imposes burdens disproportionate to the benefits it provides, even to the benefit of sustaining life. Both of these norms follow from an understanding of the meaning and value of human life: our bodies participate in the spiritual life of our souls and the spiritual goods to which our souls are open, so that (bodily) life may be treated neither as a mere means to the end of pleasure or the absence of pain, to be disposed of when these are not possible, nor as absolutely good, such that nothing could warrant giving up the measures that sustain it. One’s judgments about when life-sustaining treatments impose burdens disproportionate to their benefits must also be informed by an appreciation of the spiritual meaning and purpose of life if they are to be prudent. Prudence requires taking into account what might be called the subjective factor of how different patients will experience different burdensome conditions. However, people should strive for a deeper appreciation of spiritual goods in order to be prepared for such situations.

All of this implies that ethical guidance dispensed only at a time of medical crisis is unlikely to be of much help to patients. Growth in prudence is a lifelong process. It is a matter of learning not abstract

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norms but the meaning of life—indeed, of learning from God who we are as we develop in our relationship with him. Ethical norms will seem arbitrary and themselves burdensome apart from such a relationship.⁴¹ In general, no solutions to the myriad of problems that have arisen in our age of scientific medicine will be forthcoming unless people are formed as members of a “culture of life” that places technology at the service of the human person by placing the material at the service of the spiritual,⁴² allowing the material to be formed by the spiritual and thus receive value, treating the material—our bodies and the ways we have learned to help them heal—as neither irredeemable nor as an end in itself. This will in turn not be possible until we appreciate that we have been made as spiritual beings in order that we might be given a share in the life of God, since it is our openness to that share as our end that integrates and gives meaning to all that we are and do. In other words, we cannot live in the integrity and justice conferred upon us by God’s love until that love has been effectively revealed to us.⁴³ In short, preparing ourselves as a culture and as individuals to make appropriate use of the scientific and technological abilities God has given us, to share in God’s mastery over creation (Gen. 1:28), requires being formed by the Gospel of Life, with which “the Gospel of God’s love for man,” the love he revealed on the Cross, is “a single and indivisible Gospel.”⁴⁴

NOTES

¹Anne Marie Mills and Eli A. Friedman, “Center and Home Chronic Hemodialysis: Outcome and Complications” in *Diseases of the Kidney*, 6th ed., ed. Robert W. Schrier and Carl W. Gottschalk, vol. 3 (Boston: Little, Brown, 1997), p. 2807.

²Eli A. Friedman and Anne Marie Mills, “Dialytic Management of Diabetic Uremic Patients” in *Replacement of Renal Function by Dialysis*, 4th ed., ed. C. Jacobs, C. M. Kjellstrand, K. M. Koch, and J. F. Winchester (Dordrecht: Kluwer, 1996), p. 935.

³Mills and Friedman, “Center and Home Chronic Hemodialysis,” p. 2809.

⁴Mills and Friedman, “Center and Home Chronic Hemodialysis,” p. 2807.

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Mills and Friedman, "Center and Home Chronic Hemodialysis," p. 2807.

⁶Mills and Friedman, "Center and Home Chronic Hemodialysis," p. 2808.

⁷Mills and Friedman, "Center and Home Chronic Hemodialysis," p. 2810.

⁸Salim K. Mujais, Todd Ing, and Carl Kjellstrand, "Acute Complications of Hemodialysis and their Prevention and Treatment" in *Replacement*, p. 689; Mills and Friedman, "Center and Home Chronic Hemodialysis," p. 2831. Chronic complications also often arise; see *Replacement* and *Diseases*, *passim*, and esp. Peter G. Wilson, "Part A: Psychiatric Aspects of the Dialysis Patient" in *Replacement*, pp. 1455–65, and J. Ahlmén, "Part B: Quality of Life of the Dialysis Patient" in *Replacement*, pp. 1466–79.

⁹For some details, see Joel D. Kopple, "Dietary Considerations in Patients with Advanced Chronic Renal Failure, Acute Renal Failure, and Transplantation" in *Diseases*, pp. 2913–62.

¹⁰See, e.g., Carl M. Kjellstrand, Ronald Cranford, and Michael Kaye, "Stopping Dialysis: Practice and Cultural, Religious, and Legal Aspects," in *Replacement*, pp. 1480–82, 1498; Nancy Boucot Cummings, "Ethical and Legal Considerations in End Stage Renal Disease," in *Diseases*, pp. 2851–53, 2869–70.

¹¹E.g., Kjellstrand *et al.*, pp. 1482–84; in more detail, Ramiro Valdez and Alex Rosenblum, "Voluntary Termination of Dialysis: When Your Patient Says, 'Enough Is Enough!'" in *Dialysis and Transplantation* 23 (1994), 567–70.

¹²Kjellstrand *et al.*, p. 1482.

¹³See "Waukesha couple's decision to die together nears quiet end, as planned," *Milwaukee Journal Sentinel*, 8 August 1998 [newspaper on-line]; available from <http://www.jsonline.com/archive/aug98/news/wauk/980808waukeshacouplesdecisi.stm>; Internet; accessed 21 March 2000; "Waukesha man fulfills his wish to join his wife in death," *Milwaukee Journal Sentinel*, 14 August 1998 [newspaper on-line]; available from <http://www.jsonline.com/archive/aug98/news/wauk/980814waukeshamanfulfillshi.stm>; Internet; accessed 21 March 2000; "Suicide gets the spotlight," *Milwaukee Journal Sentinel*, 18 August 1998 [newspaper on-line], available from <http://www.jsonline.com/archive/aug98/news/editorials/0818letters.stm>; Internet; accessed 21 March 2000; "Suicide wasn't courageous," *Milwaukee Journal Sentinel*, 20 August 1998 [newspaper on-line]; available from <http://www.jsonline.com/archive/aug98/news/editorials/0820letters.stm>; Internet; accessed 21 March 2000; "Loving husband chose dialysis so he could be with his wife" and "Stories show endurance of their strong love,"

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Milwaukee Journal Sentinel, 25 August 1998 [newspaper on-line]; available from <http://www.jsonline.com/archive/aug98/news/editorials/0825letters.stm>; Internet; accessed 21 March 2000.

¹⁴For fuller treatments of what follows, see Kevin E. Miller, “The Incompatibility of Contraception with Respect for Life” in *Life and Learning VII*, ed. Joseph W. Koterski (Washington, D.C.: University Faculty for Life, 1998), pp. 80–126, and for the role of faith specifically in anthropology and ethics, idem, “The Role of Mercy in a Culture of Life: John Paul II on Capital Punishment” in *Life and Learning VIII*, ed. Joseph W. Koterski (Washington, D.C.: University Faculty for Life, 1999), pp. 405–42.

¹⁵See St. Thomas Aquinas, *Summa Theologiae*, I, q. 76, aa. 1, 3, 4, 5; *Catechism of the Catholic Church*, no. 365.

¹⁶One can, in fact, see indications of the body’s “form” (the rational soul) in its form or appearance. For an insightful discussion, see Leon R. Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: Free Press, 1985), pp. 276–98.

¹⁷For the hierarchy of goods and its ethical relevance, see Karol Wojtyła, “On the Metaphysical and Phenomenological Basis of the Moral Norm,” in *Person and Community: Selected Essays*, trans. Theresa Sandok, Catholic Thought from Lublin, vol. 4 (New York: Peter Lang, 1993), pp. 78–79. This view that I have adopted and defended elsewhere (see Miller, “The Incompatibility of Contraception with Respect for Life”), that the value of the body and bodily life and the ethical implications of this value follow from an account of the body-soul relationship, stands in contrast with the view of Germain Grisez that life is one of a number of “basic human goods” that are self-evident, irreducible, and incommensurable; see, e.g., Grisez, *Christian Moral Principles*, vol. 1 of *The Way of the Lord Jesus* (Quincy: Franciscan Press, 1983), pp. 115–228.

¹⁸On the effects of sickness on the body and the body-soul relationship, see Kass, *Toward a More Natural Science*, p. 220.

¹⁹Thus, while I deny that life is irreducibly or incommensurably good, I affirm on the basis of the body-soul relationship—an intrinsic relationship, not an extrinsic one as in dualism—that life is intrinsically good. Hence my view also stands in contrast to that implicit in the discussion of end-of-life issues in Benedict M. Ashley and Kevin D. O’Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, D.C.: Georgetown Univ. Press, 1997), pp. 421–28; cf. especially their criticism (p. 423) of the view “that patients can so deteriorate as to be beyond the possibility of benefit,”

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even when they can be kept alive, and their contention (p. 426) that “when consciousness and freedom have been lost ... the artificial prolongation of life ... ceases to be of any real benefit.” In the end, then, my practical conclusions concerning end-of-life treatment will be consistent with Grisez’s (see, e.g., *Difficult Moral Questions*, vol. 3 of *The Way of the Lord Jesus* [Quincy: Franciscan Press, 1997], pp. 214–25), but for different reasons. The significance of these distinctions will become clear as the argument develops.

²⁰This is true notwithstanding the reality of self-determination (for discussion of which, see Wojtyła, “The Personal Structure of Self-Determination” in *Person and Community*, esp. p. 191). In fact, it is because our willing of a good is really an opening of self up to the good—an allowing of self to be possessed by the good—that it makes us good.

²¹For this account of original sin and its consequences, see the *Catechism of the Catholic Church*, nos. 374–79, 397–400. It is rooted in the theological anthropology retrieved in this century by Henri de Lubac; see esp. *The Mystery of the Supernatural*, trans. Rosemary Sheed (New York: Crossroad, 1998), and my discussion of its ethical implications in Miller, “The Role of Mercy in a Culture of Life.”

²²In brief, Christ turned the suffering and death that are the consequences of humanity’s estrangement from God into an act of love for the Father, in which we can participate (in the Holy Spirit). See, e.g., John Paul II, *Salvifici Doloris* (1984), nos. 14–18.

²³Cf. Pius XII’s statement in his 24 Nov. 1957 Address to an International Congress of Anesthesiologists (in *Conserving Human Life*, ed. Russell E. Smith [Braintree: Pope John XXIII Medical-Moral Research Center, 1989], p. 315): “But normally one is held to use only ordinary means [of treatment]. ... A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.” See also the references to the distinction between “proportionate” and “disproportionate” means of treatment in the Congregation for the Doctrine of the Faith’s *Declaration on Euthanasia* (1980), chap. IV. My contention is that Pius XII really does mean that spiritual goods are “higher” than material ones, which presupposes that neither are incommensurable, and that the CDF really does mean that one can determine whether the benefits of a treatment are “proportionate” to its burdens, which again presupposes that the goods at issue, including the good of human life, are not incommensurable—and that this presupposition is philosophically cogent and ethically significant, for the reasons I am indicating in the text. This is in contrast with Grisez’s position, as I have noted, that the goods at issue in decisions about end-of-life treatments are incommensurable. Grisez

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therefore claims that in general, “[w]hen the classical moralists required a ‘proportionate reason’ for freely accepting bad side effects [as when one accepts death as a side effect of rejecting burdensome treatment], they implied that the good sought and the evil accepted could be rendered commensurate. ... But the commensuration they required can be explained without admitting the commensuration of premoral goods and bads the proportionalist requires. For one can say that the reason for not accepting bad side effects is ‘proportionate’ if their acceptance does not violate any of the modes of responsibility [which govern pursuit of goods]. For example, by this criterion one who risked the death of healthy children in medical experiments would lack a proportionate reason, for to take such a risk would be unfair” (*Christian Moral Principles*, p. 300). More specifically, he holds that “when it is not wrong in itself either to accept some form of health care or forgo it, the benefits and burdens must be evaluated. Unless these are measured by moral standards [such as “fairness,]” however, there is no rational way to commensurate them, since they are diverse instances of values. Therefore, relevant moral standards must be employed” (*Living a Christian Life*, vol. 2 of *The Way of the Lord Jesus* [Quincy: Franciscan Press, 1993], p. 527). Accordingly, Pius XII’s “teaching does not imply that there is a hierarchy of value among the basic goods considered in themselves, but that priorities among them are established by unfettered practical reason and reflected by the commitments which shape an upright person’s life” (*Living a Christian Life*, p. 529, n. 119). It seems to me that these claims are gratuitous both exegetically, and, for the reasons I indicate in my argument, philosophically.

²⁴On the genuine spiritual difficulties that suffering can impose, see John Paul II, *Salvifici Doloris*, no. 26.

²⁵This is consistent with the CDF’s teaching that judgments concerning means of treatment must be made “taking into account the state of the sick person and his or her physical and moral resources” (*Declaration on Euthanasia*, chap. IV).

²⁶For the record, my use of this case to illustrate the issues requiring analysis does not mean that I am questioning the motives of the man or his family. I am in no position to do this, since I cannot know these motives. Nor do I mean to question whether ending dialysis was objectively justified; I lack access to sufficient information to make this judgment. I mean only to analyze the ethical significance of what the newspaper accounts suggest as possible motives and as relevant factors—without passing judgment as to whether these motives were really operative or whether these factors would be dispositive.

²⁷*Cf.* Valdez and Rosenblum, “Voluntary Termination,” p. 566.

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²⁸Valdez and Rosenblum, “Voluntary Termination,” pp. 567–68.

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Valdez and Rosenblum, “Voluntary Termination,” p. 567; National Kidney Foundation, *When Stopping Dialysis Treatment Is Your Choice* (New York: National Kidney Foundation, 1996), p. 1.

³⁰National Kidney Foundation, *When Stopping Dialysis Treatment Is Your Choice*, pp. 1, 3.

³¹Kjellstrand *et al.*, p. 1480.

³²“Waukesha couple’s decision.”

³³On the centrality of dietetic measures in medicine, see Kass, *Toward a More Natural Science*, 232–33.

³⁴Here I disagree with Ashley and O’Rourke, *Health Care Ethics*, p. 427.

³⁵*A fortiori* this will be true when a patient is unconscious; hence in such cases a given burden will more likely be disproportionate. But contrary to Ashley and O’Rourke (*Health Care Ethics*, p. 426), to be disproportionate, the burden will still have to be significant; hence I agree with Grisez (*Difficult Moral Questions*, pp. 218–25) that nutrition and hydration in particular should be continued in such cases.

³⁶On the meaning of “dying” or “terminal,” see Grisez, *Difficult Moral Questions*, p. 221, in contrast to Ashley and O’Rourke, *Health Care Ethics*, p. 423. Grisez’s position is consistent with that of the Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, chap. IV (“When inevitable death is imminent in spite of the means used ...”).

³⁷On this in relation to the purpose of medicine, see Kass, *Toward a More Natural Science*, pp. 203–9.

³⁸Classical criteria for distinguishing extraordinary means of treatment acknowledge this; see Daniel A. Cronin, “The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Human Life” in *Conserving Human Life*, pp. 103–04.

³⁹On the need for prudence in medical practice, see Kass, *Toward a More Natural Science*, pp. 209–10. On the meaning of prudence in relation to moral virtue, see Josef Pieper, “Prudence,” trans. Richard and Clara Winston, in *The Four Cardinal Virtues* (Notre Dame: Univ. of Notre Dame Press, 1966), pp. 3–9, 32–36.

⁴⁰On this as of the essence of prudence, see Pieper, “Prudence,” pp. 10–17.

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⁴¹Cf. John Paul II, *Evangelium Vitae* (1995), nos. 48–49.

⁴²

Cf. John Paul II, *Redemptor Hominis* (1979), no. 16.

⁴³Cf. John Paul II, *Redemptor Hominis*, no. 10.

⁴⁴John Paul II, *Evangelium Vitae*, no. 2.