

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

**MAURIZIO CALIPARI**

*Pontifical Academy for Life, Via della Conciliazione 1, 00193 Rome*

## ***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 well-grounded 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.<sup>1</sup>

### ***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.<sup>2</sup>

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<sup>1</sup> 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.

<sup>2</sup> Cf. CONGREGATION FOR THE DOCTRINE OF THE FAITH, Instruction *Donum Vitae*, n. 4; SGRECCIA E., *Manuale di Bioetica*, vol. I, 3<sup>rd</sup> ed., Milano: Vita e Pensiero, 1999: 122.

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*<sup>3</sup> 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”<sup>4</sup>. 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.<sup>5</sup>

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

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<sup>3</sup> 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 Mondadori, 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.

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

<sup>5</sup> Cf. GIOVANNI PAOLO II, *Lett. Enc. Evangelium Vitae*, n. 38.

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<sup>6</sup>, 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.<sup>7</sup> 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.

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<sup>6</sup> 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.

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

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<sup>8</sup>, 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. Naturally 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

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<sup>8</sup> 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-ISBN, 1994: 3-6; ENGELHARDT H.T. JR., *Manuale di bioetica*, Milano: Il Saggiatore, 1999: 286-293.

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.<sup>9</sup>

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.<sup>10</sup>

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

<sup>10</sup> 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 origins, 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.,

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 *équipe* 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

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*L'etica alla frontiera 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.

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<sup>11</sup>, 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

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<sup>11</sup> 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.

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 therapeutic 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<sup>12</sup>. 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

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<sup>12</sup> 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.

considerations 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 “extraordinary” 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 indispensable 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 patient. 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 re-established 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 consider 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*<sup>13</sup> 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

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<sup>13</sup> Cf. KELLY G., *The Duty of Using Artificial Means of Preserving Life*, in *Theological Studies*, XI (1950): 206; see also CALIPARI M., *La proporzionalità delle cure negli scritti di Gerald A. Kelly*, *SJ*, in *Medicina e Morale*, 2006/2: 238.

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*”<sup>14</sup>, 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

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<sup>14</sup> 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.

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 explanatory 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<sup>15</sup>, 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

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<sup>15</sup> 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), 3<sup>rd</sup> ed., Roma: Paoline, 1963: 89-124.

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.<sup>16</sup>

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

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

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 “categorical” 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.