# “Therapeutic Proportionality and Therapeutic Obstinacy”

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

It is noteworthy that so many of the very words used in our discussions of end of life questions betray the natural law tradition so characteristic of Catholic moral thought. “Proportionate”, “disproportionate”, “suitable”, “appropriate”, “ordinary”, “extra-ordinary” all speak to reasonableness and balance and order as these have been enshrined in Catholic moral thought. Long ago Plato asked in the *Euthyphro* whether certain actions were wrong because the gods had forbidden them or whether they were forbidden by the gods because they were wrong. There is no question that the Catholic tradition adopts the latter understanding of the role and place of the moral law. God has not *arbitrarily* forbidden certain actions but rather has prohibited those that are wrong, those that would, if you will, violate in some way human dignity.

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

St. Thomas refers to law as an *ordinatio rationis*, an ordinance of the reason directive of behavior toward some good end.[1] We cannot even speak of a directive being a law if it is unreasonable. Catholic moral reflection on decision-making at the end of life seeks to find and to choose moral actions that would be judged to be appropriate to the end desired by any reasonable person not simply by Cathoics.

To reflect on the concept of "therapeutic proportionality" in the texts of the recent magisterium one would of course begin with Pius XII and his address to physicians in 1957. Here the Pope uses the word "ordinary" to refer to those interventions to prolong life that one ought to consider morally obligatory. "But normally one is held to use only ordinary means – according to circumstances of persons, places, times, and culture – that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult."[2] That higher good is of

[1] *Summa theologica*, I-II, Q. 90.4.
[2] Pius XII, "The Prologation of Life" (November 24, 1957), quoted in Daniel A. Cronin et al., *Conserving Human Life* (Boston: The Pope John XXIII Center), 315.

course the attainment of eternal life with God, or as it is stated in the health care directives of the American bishops, "our common destiny to share a life with God beyond all corruption".[3]

Those means of prolonging life that one would consider to be not obligatory, that is, those that would be seen as morally optional, came to be known as extraordinary. "Ordinary" and "extraordinary" then came to be the standard terms used by Catholic ethicists to judge the morality of medical decisions with respect to prolonging life. "Ordinary" means of conserving life were morally obligatory, and "extra-ordinary" means were morally optional.

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

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

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[3] U.S Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, D.C.: USCCB, 2001).
[4] Maurizio Calipari, *Curarse y Hacerse Curar* (Buenos Aires: Editorial de la Pontificia Universidad Católica Argentina, 2007), 170.

“disproportionate” have come to be seen and understood by many as synonymous with the moral meaning of “ordinary” and “extraordinary”.

These terms “proportionate” and “disproportionate” first made their way into the formal teaching of the Church through the *Declaration on Euthanasia* (*Iura et Bona*) issued by the Congregation for the Doctrine of the Faith in 1980. The shift in terminology is addressed quite directly:

> In the past, moralists replied that one is never obliged to use "extraordinary" means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of "proportionate" and "disproportionate" means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.[5]

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

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

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

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

The year after *Iura et Bona* was issued, the Pontifical Council *Cor Unum* issued a document "Some Ethical Questions Related to the

Gravely Ill and the Dying".[6] Although the document was published after *Jura et Bona*, it had actually been prepared four years earlier as the result of a working group convened by *Cor Unum* to deal with ethical decision making at the end of life. It acknowledged that the terms "ordinary" and "extraordinary" "are becoming somewhat outmoded in scientific terminology and medical practice".[7] However, it does not want to discard the terms because in theology they are "indispensable". This judgment is probably made because of the long use of those terms in the Catholic tradition, particularly since the modern discussion of these questions begun by Pius XII. It does suggest equivalent terms such as "care suited to the real needs" of the patient. That phrase would assuredly be seen as addressing the judgment of therapeutic proportionality.

The document from *Cor Unum* also seems to be the first one from the Holy See which makes an explicit distinction between the "subjective" and "objective" criteria that must be used in making a medical moral judgment. This document spoke to the legitimacy of trying to ascertain the concrete conditions of a person's health after undergoing a medical intervention. This, too, was regarded as appropriate matter to be subjected to the scientific judgment of health care professionals. However, the concrete conditions assessed by the physician included indeed the disposition and moral resources of the subject, the patient himself or herself. "The principle to follow is . . . that no moral obligation to have recourse to extraordinary measures

[6] Pontifical Council "Cor Unum," *Some Ethical Questions Related to the Gravely Ill and the Dying* (June 27, 1981) in *Enchiridion Vaticanum*, 7, *Documenti ufficiali della Santa Sede* 1980–1981.
[7] Ibid., 2.4.1.

exists; and that, incidentally, a doctor must follow the wishes of a sick person who refuses the measures."[8]

Maurizio Calipari draws attention to the fact that the *Cor Unum* document introduces the concept of "quality of life" into the objective criteria included in the judgment of whether an intervention would constitute therapeutic proportionality. Calipari thinks that "quality of life" must fall under the heading of objective criteria because the report of the Working Group differentiates it from subjective considerations. "But the criterion of the quality of life is not the only one to be taken into account . . . subjective considerations must enter into a properly cautious judgment as to what therapy to undertake and what therapy not."

**The Ethical and Religious Directives of the U. S. Bishops**

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

[8] Ibid., 2.4.3.

Part V of the *Ethical and Religious Directives* addresses "Issues in Care for the Dying". Within that section Directive 56 reads: "A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community."[9]

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

The previous directive, *Directive 55,* speaks of the factors the patient needs to take into account in order to make an informed decision about his health care. It states, in part, "[Patients] should be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them." But again, the emphasis is placed more on the choices of the patient

[9] USCCB, *Ethical and Religious Directives.*

than the objective character of the prognosis and the evaluation of treatment from the physician's perspective. There appears to be more moral weight given to the decision of the patient as to what he can bear than to what might be seen, objectively, as a therapeutically proportionate intervention.

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

The emphasis is again placed on the patient until one encounters the subordinate clause that begins with "unless". The kinds of actions that would obviously be contrary to Catholic moral teaching would be, for example, a choice for euthanasia or physician assisted suicide. However, one would also have to conclude that a Catholic physician or health care institution could come to the conclusion, based on medical evidence and a certain prognosis, that the proposed medical intervention would provide the patient with a reasonable hope of

benefit without an excessive burden and would therefore be morally obligatory in terms of being therapeutically proportionate.

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

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

**John Paul II**

In his encyclical *Evangelium vitae*, Pope John Paul II addresses the topic under consideration in section 65 and draws a clear distinction between what might be considered medically appropriate, for which he uses the term "proportionate", and what would be understood as more subjective in terms of an "excessive burden", even though he does

not use the qualifier "extraordinary" with respect to the burden. He writes of "medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family."

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

Here it is not clear if the qualifiers "extraordinary" and "disproportionate" were being used synonymously or whether John Paul II was saying that continued treatment could be curtailed *either* because it was burdensome to the patient *or* because it held out little or no hope for improvement of the patient's medical condition.

**An Attempt to Ascribe More Precise Meanings to Terms**

An awareness of both the *subjective* and *objective* elements in making a conscientious medical decision can certainly be found in the magisterial documents, but there have been attempts to address these element more directly than perhaps the magisterial documents themselves have. Some authors have attempted to appropriate the terms "ordinary" and "extra-ordinary" for the subjective dimension of a medical moral choice and have tried to appropriate the terms "proportionate" and

"disproportionate" for the more objective, clinical dimension of the moral decision.[10]

While this appropriation and use of the terms might provide greater terminological consistency in moral analysis, there seems to be no explicit justification for such a designation in the magisterial documents themselves. Without question, the terms proportionate and disproportionate do seem to be used more often with respect to the objective medical assessment of the treatment. However, in the magisterial documents one does not seem to find "ordinary" and "extraordinary" being used to refer more specifically to the subjective aspect of the dynamic process of medical moral decision-making. Furthermore, such a use of the terms "ordinary/extraordinary" for the subjective aspect of making a medical moral decision and "proportionate/disproportionate" for the objective aspect seems to divide up the decision-making process too neatly into stages and into subjective and objective components. There is a very complex interplay between objective and subjective considerations on the part of both the physician and the patient as well as a dynamic back and forth of judgments and considerations without it settling into any kind of pre-ordained chronology.

"Proportionate" has generally been applied to a medical intervention to designate it as morally obligatory after due reflection on both the therapeutic potential of the intervention as well as the resultant effects for the life of the patient showing that it holds out a reasonable hope of benefit without an excessive burden. Rather than stages, it would seem the "objective" aspect (therapeutic proportionality, if you will) and the "subjective" aspect (or "global

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

efficacy" in the language of some authors) of the proposed medical intervention ought to be seen as two distinguishable but inseparable dimensions of the one decision taken. As the hylomorphic theory does not allow for a separation of form and matter but rather a distinguishing of the two, so, too, must the objective and subjective aspects of the moral choice remain inseparable while to a certain degree distinguishable.

Although one seems to find no magisterial text explicitly ascribing the subjective dimension of the decision-making process to the terms "ordinary/extraordinary" and the ascribing the objective dimension to "proportionate/disproportionate", one does certainly find evidence of the distinction.

Although it is not explicit, the basis for the distinction might be found in the *Catechism of the Catholic Church* in No. 2278. "Discontinuing medical procedures that are burdensome, dangerous, extraordinary or disproportionate to the expected outcome can be legitimate; it is the refusal of 'over-zealous' treatment."[11] One might interpret this brief passage from the *Catechism* as indicating a difference between the qualifiers "extraordinary" and "disproportionate" by virtue of the "or" which is placed between the two terms. "Disproportionate" would seem to refer to the more objective medical judgment with reference "to the expected outcome" of the medical procedure and "extraordinary" *might* be seen as referring to the more subjective element of the decision along with the qualifier "burdensome".

Such a distinction might also be found in John Paul II's famous address of April 2004 on the topic of the provision of hydration and

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

nutrition to patients in a persistent vegetative state. He speaks of the provision of hydration and nutrition as "ordinary" *and* "proportionate" and therefore morally obligatory. "I . . . underline how the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering."[12]

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

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

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

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

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

**Concept of Therapeutic Proportionality Imbedded in Tradition**

This language of the objectivity of therapeutic proportionality certainly reflects what has been contained in the ethical tradition of the Church for centuries. Although the moralists of the sixteenth and seventeenth centuries would refer to obligatory means of prolonging

life as those that one can obtain and utilize with some ease,[13] they must also be means that would have an anticipated beneficial effect.

The tradition applied this reasonableness not only to the effectiveness of the means employed (the more objective factors of therapeutic proportionality) but also to the disposition and capacity of the patient. In other words, there was both an objective and a subjective component that went into the decision about what the morally obligatory course of action was. Food might indeed provide some nourishment but the consumption of that food might require heroic measures depending on the nature of the illness. Francisco de Vitoria, writing in the 16th century, addressed the physical impossibility of undertaking some treatments or even care: ". . . if the depression of the spirit is so low and there is present such consternation of spirit in the appetitive power that only with the greatest of effort and as though by means of a certain torture, can the sick man take food, right away that is reckoned a certain impossibility and therefore he is excused."[14]

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

[13] Cronin et al., *Conserving Human Life*, 78–145.
[14] Francisco de Vitoria, *Reletio de Temperantia*, I, quoted in Cronin et al., *Conserving Human Life*, 35.

anesthesia, great expense (*sumptus extraordinarius*, *media pretiosa* and *media exquisita*)and overwhelming repugnance or fear (*vehemens horror*).[15]

**"Therapeutic Obstinacy"**

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

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

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

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

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

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

Another example of this concept can be found in the 1981 statement of the Pontifical Council *Cor Unum* discussed earlier. The

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

document quotes a letter that Cardinal Villot had sent to the Congress of the International Federation of Catholic Medical Associations in which he refers to an abuse of the patient in the name of medicine: "A physician is [not] under obligation to use all and every one of the life-maintaining techniques offered him by the indefatigable creativity of science. Would it not be a useless torture, in many cases, to impose vegetative reanimation during the last phase of an incurable disease?"[17]

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

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

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

prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted'."[18]

Indeed, it seems that if an intervention would "only secure a precarious and burdensome prolongation of life", it would actually be harmful to the patient. If this is the case, it ought not truly to be referred to as a "treatment". A more neutral kind of word might be more appropriate, such as "medical intervention". The words of John Paul II in Evangelium vitae, before he quotes the Declaration on Euthanasia, would seem to correspond to extraordinary means of prolonging life which are not obligatory but which may be chosen depending on the circumstances. For example, the patient might have a moral obligation to repay a debt or to receive the sacrament of reconciliation before death and would therefore be morally obliged "to secure a precarious and burdensome prolongation of life" in order to fulfill those other obligations.

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

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

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

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

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

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

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

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