

# RECLAIMING OUR MORAL TRADITION

## *Catholic Teaching Calls Us to Accept the Limits of Medical Technology*

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**A**lthough the U.S. Supreme Court handed down a decision last June that found no constitutional right to euthanasia and assisted suicide, it concluded its opinion with the following: "Throughout the nation, Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue."<sup>1</sup> As points of view in this debate become increasingly polarized, the Catholic moral tradition offers a middle position, well expressed in the introduction to the fifth section of the 1994 *Ethical and Religious Directives for Catholic Health Care Services*. Catholic moralists need to articulate this tradition more clearly.

### **MEDICAL TECHNOLOGY AND MEDICAL BRINKMANSHIP**

In 1995, the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) indicated that patients at the end of life are often given inappropriate treatment. Many patients included in the study spent their last days in an intensive care unit, on ventila-

tors, often comatose. Those able to communicate with the researchers expressed that they were in moderate to severe pain.<sup>2</sup> Attempts to ensure more appropriate care, including the Patient Self-Determination Act of 1990, seem to have failed, while initiatives to legalize euthanasia and assisted suicide have gained momentum, finding allies in the medical and legal communities and even within faith traditions.

Part of the explanation for this phenomenon lies in the success of science and medical technology, which has heightened the expectation that all that is needed to eradicate diseases is more knowledge and better technology. This belief can lead people to see sickness and death as factors they can, and ought to, control. Daniel Callahan explains:

The use of technology is ordinarily the way, in modern medicine, that action is carried out: to give a pill, to cut out a cancerous tumor, or to use a machine to support respiration. With an ethos of technological monism, all meaningful actions . . . are

### **Summary**

The success of science and medical technology has led to medical brinkmanship, pushing aggressive treatment as far as it can go. But medicine lacks the precision necessary for such brinkmanship to succeed, and the resulting cycle of expectation and disappointment in technology has, in part, led to an increasing acceptance of euthanasia and assisted suicide, linked closely with advocacy for patient autonomy.

At the opposite extreme lies medical vitalism, which refers to attempts to preserve the patient's life in and of itself without any significant hope for recovery.

The Catholic moral tradition offers a middle

ground, well expressed in the 1994 *Ethical and Religious Directives for Catholic Health Care Services*. The tradition does not deny the good of technology or state that some lives are not worth living. Rather, it calls us to accept the fact that medical technology has limits. In reclaiming this tradition, we reclaim the naturalness of death.

Reclaiming the tradition has practical consequences for the use of life-prolonging technology at the end of life and for end-of-life decision making. These can be placed in three broad categories: the Christian understanding of care, the ambiguity inherent in end-of-life decision making, and the task of Christian formation.

technological, whether technological acts or technological omissions. What nature does, its underlying natural causes and pathologies, becomes irrelevant. No death is "natural" any longer—the word becomes meaningless—no natural cause necessarily determinative, no pathology fatal unless failure to deploy a technology makes it so.<sup>3</sup>

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individual autonomy the "model of consumer choice in health-care."<sup>7</sup> This model presupposes that health-care consumers, as all consumers, should be able to choose the kinds of products they prefer. This model is supposed to enable "customers" to make successful choices in an efficient healthcare market. From this point of view, euthanasia becomes an option within a range of

Technological monism, this belief that all meaningful actions are technological, can in turn lead to what Callahan calls technological brinkmanship, "pushing aggressive treatment as far as it can go in the hope that it can be stopped at just the right moment if it turns out to be futile."<sup>4</sup>

Unfortunately, medicine lacks the precision necessary for such brinkmanship to succeed. Physicians pursue aggressive treatment for their patients beyond reasonable hope for success, because once they have begun a course of action, they do not know when or how to stop. Patients dread an impersonal death, surrounded by tubes, wires, and machines, but also are reluctant to refuse such treatments for fear of becoming "hopeless cases." They may be afraid that others will no longer respond to their medical and emotional needs and abandon them. Medical technology, with its promise of prolonged health and human flourishing, thus can become a threat to such flourishing.

#### **EUTHANASIA'S ATTRACTION**

The cycle of expectation and disappointment in technology has, in part, led to an increasing acceptance of euthanasia and assisted suicide, linked closely with advocacy for patient autonomy. Several writers have criticized what they consider an exaggeration of the value of autonomy.<sup>5</sup> Arthur Caplan, for example, has suggested that "the preeminence of autonomy reflects the fact that there is no broad consensus as to what constitutes good or bad with respect to the aims of health care."<sup>6</sup>

Carl Schneider has termed the emphasis on

choices, especially helpful when attempts at medical brinkmanship fail.

Roman Catholic ethics itself has not been immune to this mind-set. For example, Dick Westley, in his book-length treatise on euthanasia,<sup>8</sup> analyzes the traditional notion of "life as gift from God" in a way which leads to the conclusion that "our lives are our own and, hence, at our disposal."<sup>9</sup> He develops his understanding of autonomy through an analysis of the Prologue to the second part of Thomas Aquinas's *Summa Theologica*. He reads this text, however, with contemporary American eyes and concludes that "Aquinas clearly implies the affirmation of human autonomy."<sup>10</sup> Aquinas does indeed affirm human autonomy. But a notion of autonomy without a concomitant notion of the human good is antithetical to the philosophy and theology of Aquinas.

Recent Church teaching, from the 1980 "Declaration on Euthanasia" to Pope John Paul II's *Evangelium Vitae* (1995), has decried this understanding of choice. The latter document has termed it part of "the culture of death" (para. 12). More to the point, however, may be Callahan's criticism:

If the suffering of illness and death comes from the deep assault on our sense of integrity and self-direction, what is the best way we can—as those who want to do right by a person—honor that integrity? The claim of euthanasia proponents is that the assault of terminal illness upon the self is legitimately relieved by recognizing the right to self-determination, and that what the individual wants—a deliberately chosen death administered (or assisted) by another

er—is appropriate as a way of relieving suffering. Yet notice what we have accepted here. It is the idea that our integrity can *only* be served by the self-determination that brings death, by the direct implication of another in our death, and by the acceptance of the implicit assumption that the suffering is “unnecessary”—meaningless, avoidable. To accept that comes close to declaring that life can only have meaning if marked by self-determination.<sup>11</sup>

If no death is really natural and if all meaningful actions are technological, there then can be no distinction between refusing medical treatment and actively killing a patient. In the face of suffering, then, it seems more compassionate to accept a patient's choice to hasten death than to *cause* continued suffering. Ending such suffering lies within human control; therefore not to do so is immoral. This reaction avoids important questions regarding human nature, the meaning of life, and those goods which people ought to pursue. It offers no room for reverence for life or humility before God, which have long been guides for Christian ethics.

### MEDICAL VITALISM

A variety of Catholic moralists, alarmed by the growing trend toward the legalization of euthanasia and assisted suicide, have begun to defend an opposite extreme, medical vitalism. Medical vitalism refers to attempts to preserve the patient's physical life in and of itself without any significant hope for recovery.<sup>12</sup> Consider the following statement by Germain Grisez: “Acts which effect nothing more than keeping a person alive, no matter what that person's condition, do really benefit the person, even if only in a small way, and so, if not done for some ulterior reason, do express love toward the person.”<sup>13</sup> Grisez's language implies that any withdrawal of life-sustaining treatment is morally suspect.

Given the current social pressure to legalize euthanasia, it is not difficult to understand what motivates such a statement. But to use such language is to read our moral tradition through the lens of technological monism, *simplifying* rather than *clarifying* our tradition. It demands the acceptance of the same premises that euthanasia supporters articulate: It is not disease which causes death but rather the physician's or patient's refusal to use the means available to prolong life. No death is natural. Ironically, such reasoning increases the likelihood of technologi-

cal brinkmanship. Callahan expresses the dilemma in the following way:

Thus was created the perfect double bind: If you are serious about the value of life and the evil of death, you must not stand in the way of medical science, our best hope to eliminate it. If you hesitate to use that science to its fullest, to give it every benefit of doubt, you are convicted not only of failure of hope for the efficacy of science, but also of a lack of seriousness about the sanctity of life.<sup>14</sup>

### A MIDDLE GROUND

In an age of medical brinkmanship, we need to reclaim our moral tradition of “ordinary” and “extraordinary” (or “proportionate” and “disproportionate”<sup>15</sup>) means. The 1994 *Ethical and Religious Directives for Catholic Health Care Services* indicate how we might sensibly engage in such a task:

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering and death. Only in this way are two extremes avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forego it and, on the other hand, the withdrawal of technology with the intention of causing death.<sup>16</sup>

It is important to note the *Directives*' call that we avoid two *extremes*. It is only in terms of a middle ground that the Church's traditional teaching regarding the distinction between ordinary and extraordinary, or proportionate and disproportionate, means can be understandable today. The teaching does not prescribe a hard-and-fast rule regarding specific medical procedures, but rather urges a prudent decision regarding the benefits and burdens of a particular medical treatment for a particular patient.<sup>17</sup> It is important, therefore, to investigate what the tradition has meant by the term “benefit.” To suggest, as medical vitalism does, that every instance of artifi-

cially preserving the life of a patient is beneficial begs the question and would eviscerate the ordinary-extraordinary distinction.

Traditionally, "benefit" has not meant merely prolonging the patient's life but, rather, restoring the patient to relative health. In the sixteenth century, for example, the moral theologian Francisco di Vittoria acknowledged that "one is not held to protect his life as much as one can."<sup>18</sup> Tomas Sanchez and Alphonsus Liguori concurred, holding that no remedy is obligatory unless it offers a reasonable hope of checking or curing a disease.<sup>19</sup> This idea was echoed early in this century in manuals of moral theology; Hieronymus Noldin and Albert Schmitt maintained that ordinary means apply "where there is hope of recovery."<sup>20</sup> One of the great pioneers of Catholic medical ethics, Gerald Kelly, used two criteria to ascertain the obligation of using medical treatments. One was the difficulty of the remedy itself and the other was the "solid probability of success."<sup>21</sup> Kelly clearly explained what he meant by success:

Finally, there is the use of oxygen or intravenous feeding merely to sustain life in the so-called "hopeless" cases. If, in the circumstances, these things can be called remedies, it is only in the very wide sense that they delay the hour of death. It is true that they will sustain life, and in that sense they offer a hope of success; and it is also true that their use for a short time is not very expensive. Yet . . . it is difficult to see . . . how they really offer a reasonable hope of success.<sup>22</sup>

The distinction is part of the Thomistic-Aristotelian understanding of moral theology, which articulates that virtue is always in the middle, and vice at *either* extreme. In emphasizing that we are not obliged to use extraordinary or disproportionate means, the tradition does not deny the good of technology or state that some lives are not worth living. Rather, it calls us to accept the fact that medical technology has limits.

# Decision making in the Catholic tradition will not be exact.

In reclaiming this tradition, we reclaim the naturalness of death.

## PRACTICAL CONSIDERATIONS

Reclaiming the tradition has important practical consequences for the use of life-prolonging technology at the end of life and for end-of-life decision making. These practical considerations may be placed in three broad categories: the Christian understanding of

care, the ambiguity inherent in end-of-life decision making, and the task of Christian formation.

**The Christian Understanding of Care** The *Ethical and Religious Directives* state: "The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal." In all end-of-life decisions, especially when we are forced to decide for another, we must respect the dignity of the person and the preciousness of life. Such respect demands that we *care* for the patient. When patients are appropriately resisting the onslaught of disease, they must be able to depend on caregivers' support. True caregivers, however, will also be honest with patients and will acknowledge the time when aggressive treatment directed toward cure no longer constitutes *caring*.

**The Ambiguity Inherent in End-of-Life Decision Making** We must recognize that decision making within the Catholic tradition will not be exact. Caregivers may not agree on whether to stop or continue aggressive treatment. The middle position between euthanasia and medical vitalism is a dynamic, not static, one. Catholics will stand on a variety of sides at different times.

**Christian Formation** To engage in instructive debate, we must reclaim another element of our moral tradition, that of *phronesis*, or moral wisdom. In end-of-life decisions, recourse to principles is important. But in trying to answer the questions posed by contemporary medical technology, we cannot depend solely upon rules. We also need moral conviction and moral wisdom. It is the task of the Church to form people who are not only knowledgeable but also morally wise. □

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## NEW DOORS

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# Seton Resource Center has implemented child development services at Catholic elementary schools.

centers, and Catholic Charities offered the services of its health education department. DCS-NO contributed its healthcare expertise.

The NHP provides health screening, health risk appraisal, immunizations, health education and counseling, case management, and wellness programs for the neighborhood centers' 15,000 clients. We have expanded these outreach services to 10 other schools, churches, shelters, and social service centers near the archdiocese's centers. The annual budget is approximately \$500,000.

Recently the NHP was named a corecipient of a \$450,000 grant for an integrated mobile assessment and treatment team to serve homeless individuals. The partnership is a participant in the CHA and Catholic Charities USA Neighborhood-Based Senior Care National Initiative, funded by the Retirement Research Foundation (see *Health Progress*, July-August 1997). The NHP was also included in the U.S. Public Health Services' 1996 compendium, *Models That Work*.

### SCHOOL-LINKED HEALTH SERVICES

Seton Resource Center has implemented child development services at Catholic elementary schools. The program is cosponsored by the Sisters of Mercy Health System-St. Louis, the Sisters of Charity Health System-Houston, the Vincentian Fathers, DCNHS-WC, and the Archdiocese School System.

This behavioral health program includes behavioral screening, individual and group counseling, personal safety training, and self-esteem and leader-

ship skills development. The Seton Resource Center administers the program in four Catholic schools, while Mercy Family Center administers it in four others. Three schools of social work place their students at the schools, and graduate students extend the capabilities of full-time staff.

Another school-linked service was originally funded by Hotel Dieu Hospital, which awarded the Louisiana State University School of Nursing a grant to implement a pilot employee health program at a Catholic elementary school. The District Nurses Association also provided funds. Nursing students and faculty members at the school conducted health risk assessments, health screenings, health education programs, school safety inspections, and wellness classes. The YWCA conducted exercise classes as part of a weight-control program.

The Daughters of Charity Foundation has renewed this grant, and DCS-NO is working with LSU to expand these preventive health services to three of the schools where Seton Resource Center has implemented its behavioral health program. Hotel Dieu Hospital also awarded a grant to the Redemptorist Fathers to expand their peer mentoring program to two high schools in New Orleans.

### A PROMISING BEGINNING

The sale of a hospital does not have to mean the death of a ministry—it can be the moment of its rebirth. Urged by the charity of Christ, the Daughters of Charity and their collaborators will continue to work to meet the needs of the poor. □

## TRADITION

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### NOTES

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2. SUPPORT Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients," *Journal of the American Medical Association*, November 22, 1995, p. 1595.
3. Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death*, Simon and Schuster, New York City, 1993, p. 68.
4. Callahan, p. 192; see also pp. 40-42.
5. See Willard Gaylin and Bruce Jennings, *The Perversion of Autonomy*, The Free Press, New York City, 1996.
6. Arthur L. Caplan, *If I Were a Rich Man Could I Buy a Pancreas?* Indiana University Press, Bloomington, IN, 1992, p. 256.
7. Carl E. Schneider, "From Consumer Choice to Consumer Welfare," *Hastings Center Report*, November-December 1995, p. S25.
8. Dick Westley, *When It's Right to Die: Conflicting Voices, Difficult Choices*, Twenty-Third Publications, Mystic, CT, 1995.
9. Westley, p. 77.
10. Westley, p. 77.
11. Callahan, p. 98.
12. See Richard A. McCormick, *Health and Medicine in the Catholic Tradition*, Crossroad Publishing Co., New York City, 1984, p. 54.
13. Germain Grisez, "Should Nutrition and Hydration Be Provided to Permanently Comatose and Other Mentally Disabled Persons?" *Linacre Quarterly*, May 1990, p. 38.
14. Callahan, p. 86.
15. Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," *Origins*, August 14, 1980, p. 156.
16. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, U.S. Catholic Conference, Washington, DC, 1995, p. 21.
17. See Gerald Kelly, *Medico-Moral Problems*, Catholic Hospital Association, St. Louis, 1958, p. 135.
18. Francisco di Vittoria, "Relectio IX, de Temperentia," *Relectiones Theologicae*, 1587. Quoted in Kevin D. O'Rourke, "On Prolonging Life," *Doctrine and Life*, September 1989, p. 354.
19. See Gerald Kelly, "The Duty of Using Artificial Means of Preserving Life," *Theological Studies*, June 1950, p. 207.
20. Hieronymus Noldin and Albert Schmitt, *Summa Theologiae Moralis*, vol. 2, F. Rauch, Oeniponte, 1939, p. 308.
21. Kelly, "The Duty of Using Artificial Means," pp. 214-215.
22. Kelly, p. 215.