SUBJECTIVISM, VITALISM?
Catholic Teaching Avoids Extremes

By FR. GERALD D. COLEMAN, SS, M.Div., M.A., Ph.D., S.T.L.

Caring for people who are seriously ill and dying often means steering a course between two different approaches at odds with Catholic moral principles. One is subjectivism, the belief that one's primary responsibility is to oneself and one's particular values, an attitude that gives justification to physician-assisted suicide. The other inimical approach is vitalism, the belief that human life is absolute and must be preserved, at all cost.

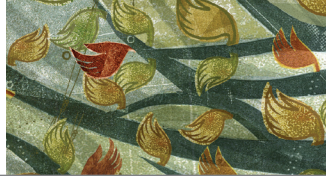
Two key ethical principles in medical ethics are critical in assessing subjectivism and vitalism. The first is beneficence (from *benefacere*, to do a kindness, provide a benefit). This principle has been valued from its early Hippocratic origins. It is the second part of the dictum, "first, do no harm, benefit only." Professionalism requires health care practitioners to put the patient's interests first.[1] Beneficence obliges a physician to treat a patient when there is hope of recovery, medical improvement and a stabilization of quality of life. In this light, a major task of medicine is to care while it attempts to cure.

Some of the specific norms that arise from this principle in the Catholic tradition are to never deliberately intend harm, seek the patient's good, use wisdom and prudence in all things. The second key principle is nonmaleficence, commonly translated as "first, do no harm."

These guiding principles urge physicians not to give up when someone is critically ill, injured or at the brink of death. Lifesaving is life respectfully honored. When an elderly man, riddled with cancer, but conversant and functioning, arrives at the ER with bowel obstruction that threatens his life, physicians will rightfully treat this patient when it is likely he will regain function and quality of life.

SUBJECTIVISM

While this article concentrates on medical vitalism (or life at all cost), its polar extreme needs some comment. Subjectivism, sometimes called ethical egoism, believes that one's primary obligation is to oneself. Selfishness



becomes a virtue. The legalization of physician-assisted death in Oregon, Vermont, Washington and Montana bolsters this attitude by advocating that the cessation of medical treatment is based solely on the personal choice of an individual. Those who advocate for physician-assisted suicide *de facto* reject beneficence in favor of maleficence.

The dignity of human life as fundamental is rejected by an insistence that life has worth only if an individual gives it value. Subjectivism does not necessarily deny that human life is created in God's image, but insists that when one's likeness to this image becomes diminished, for example, through a debilitating disease, life loses its inherent value and can be ended by personal choice. The Catholic tradition emphasizes the fundamental or intrinsic dignity of every human person. Subjectivism, on the other hand, opts toward an attitude of designated or accrued dignity: that is, when an individual no longer sees his or her life as valuable, then human dignity is lost.

The Catholic moral tradition rejects this perspective. The *Catechism of the Catholic Church* teaches, "Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for his honor and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of."[2] In his encyclical *Evangelium*

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Vitae, Pope John Paul II put it this way: "Life is entrusted to man as a treasure which must not be squandered, as a talent which must be used well."

VITALISM

In March 2013, Max (the name has been changed to protect privacy) was admitted to a Catholic hospital with severe lack of oxygen supply to the heart muscle due to coronary artery disease. The patient also suffered from chronic kidney disease. Before this admission, he had suffered cardiac arrest on two occasions but was successfully resuscitated. Now, suffering from confusion and lethargy, he became completely ventilator-dependent and was unable to tolerate any form of tube feeding. Extensive and intensive therapeutic efforts to improve his condition were unsuccessful, but they did sustain his life.

Prior to this hospitalization, the patient had clearly expressed his wishes to have maximal efforts used to preserve his life. His designated surrogate decision-maker held steadfast to the patient's wishes and demanded that all medical treatments be sustained, despite three physicians indicating that these efforts were futile, as all therapeutic options had been exhausted and the patient was continuing to deteriorate. The surrogate threatened legal action against the attending physician and the hospital in response to any deviation from medical management that was less than full support and aggressive therapeutic intervention. Max's surrogate remained steadfast: The patient's wishes were to "sustain life" for its own sake, independent of all circumstances. Even though Max's prognosis clearly demonstrated that he was dying, his biological life was being maintained at all cost.

Since medical vitalism affirms the value of human life as absolute, any cessation of efforts to prolong life is medically and morally unconscionable.

While the Hippocratic oath requires physicians to benefit their patients "according to their best judgment," this obligation ceases when medical treatment amounts to futile treatment.

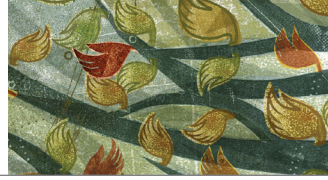
It is true that the Catholic moral tradition holds that a human person's first "inviolable right" is to life itself.[3] This is a foundational principle and is the condition for the exercise of all other human rights. In Catholic teaching, any discrimination against human individuals, or violation of this right on any grounds or in any stage of human growth or decline, constitutes a grave injustice and is prohibited.

However, while the right to life is absolute, the specific duty to preserve or protect life is not. Rather, as *Evangelium Vitae* (no. 65) points out, the means used to protect and preserve a particular life must take account of concrete circumstances and be "objectively proportionate to the prospect of improvement." When medical treatment no longer is proportionate to the "real situation of the patient," such treatment can be forgone or withdrawn because the treatment has become a burden to the patient and amounts to a nonacceptance of the actual "human condition" of the patient.

Biological life is not absolute and does not have to be preserved at all cost. The introduction to Part Five of the *Ethical and Religious Directives for Catholic Health Care Services* provides a critical guideline: "...two extremes are [to be] avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death." In the case of Max, the first extreme was transgressed, an unfortunate and troubling example of medical vitalism.

Since medical vitalism affirms the value of human life as absolute, it holds that any cessation of efforts to prolong life is medically and morally unconscionable.[4] Fr. Richard McCormick, SJ, S.T.D., classified this approach as "biologism."[5] He translated vitalism as a rigorist position that took into account only the biological or physiological aspect of a person and failed to see persons in their entirety.

Patients, families, physicians, clergy, church leaders and pro-life enthusiasts who uphold a vitalist mentality refuse to stop life-prolonging treatment; for example, the use of a ventilator to sustain respiration when cardiac arrest threatens death to a patient. Even in situations in which the patient can survive only temporarily, with treatment merely prolonging the suffering of the dying person, the vitalist will continue treatment.[6] This



approach denies the idea of "medical futility" and responds with available technology and pharmacology to what appears to be a patient's critical physiological need at the moment.[7] This approach has been labeled "unreflective activism": that is, it does not take into account the real-life situation of the patient being treated.

FAULTY RATIONALE

In assessing a doctor's duty, Fr. Gerald Kelly, SJ, classified vitalism as an "extreme attitude."[8] Fr. Kelly believed that vitalism led some physicians, patients and family members to always count on "the possibility of a miracle." This belief refuses to consider any case hopeless. To cease treatment amounts to defeatism, to give up on God who might step in and do something miraculous.

Other reasons ground a vitalist mentality. Physicians, for example, might experience feelings of failure or guilt if their patient dies. In an attempt to avoid these anxieties, medical treatment is prolonged until a patient dies naturally. Writing in 1939, Jesuit moralist Paul L. Blakeley offers a clear example of the vitalist mentality. He opined that in the hearts of all decent men and women, the sick must be cared for "at whatever inconvenience to themselves." Fr. Blakeley argued that since its beginning, the medical profession tells the physician that his "most solemn obligation is to fight death to the end, however hopeless the battle may seem. Giving in to death would outrage every instinct which has raised man above the savage who kills his old and his sick that they may no longer burden him."[9]

Vitalists affirm that our medical system was built to treat anything that might be treatable, at any stage of life, "even near the end, when there is no hope of a cure, and when the patient ... might prefer quality time and relative normalcy to all-out intervention."[10] Viewed this way, vitalism is not a product of malevolence, but a by-product of two strengths of American medical culture: the system's determination to save lives, and its technological virtuosity to do so. However, this type of technological superiority can amount to a "form of abuse."[11]

Other vitalists hold that we are always obliged to ward off death because the imminence of death can never be determined with sufficient accuracy. Still other vitalists claim that since there is no real difference between forgoing treatment (allowing to die) and killing or self-killing, neither should be permitted.[12]

An extreme overinterpretation of the sacredness of human life roots certain vitalist mentalities. The *Catechism of the Catholic Church* affirms that "Human life is sacred because from its beginning it involves the creative action of God and it remains for ever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can under any circumstance claim for himself the right directly to destroy an innocent human being."[13] Some characterize this teaching as the "Sanctity of Life Ideal,"[14] which insists that human life is absolute, irrespective of its quality. This "ideal" imposes on vitalist physicians and others the duty to always preserve the lives of their patients and family members. Doctors not only have the obligation to refrain from killing, but also an obligation to prevent death. This interpretation of the sanctity of life implies inviolability as physical human life is a value of the highest order.[15] Contrary to this position, Pope Pius XII taught that "it is precisely this supernatural calling which highlights the relative character of each individual's earthly life. After all, life on earth is not 'ultimate' but a 'penultimate' reality."

THE FOOD AND WATER DEBATE

In December 1983, Nancy Cruzan, a 25-year-old woman in Missouri, was in a serious car accident, pronounced dead by the police, and then resuscitated by paramedics. Years later, her parents wanted to withdraw medical nutrition and hydration that kept Nancy alive in a persistent vegetative state. The facility caring for her insisted on a court order before following the parents' instructions. The case then entered the legal system. In 1990, the U.S. Supreme Court affirmed the right of the State of Missouri to demand clear and convincing evidence of a person's expressed wishes made when competent. New witnesses eventually came forward, testifying that Nancy had said she never wanted to be fed by force or kept alive by machines. Authorization was then given to remove assisted nutrition and hydration, and she

died shortly thereafter (December 1990).

In his reflection on this case, Fr. McCormick discussed the use of medical nutrition and hydration for permanently vegetative patients. He cites William May's opinion as an example of vitalism. May wrote that "feeding such patients and providing them with fluids by means of tubes is *not* useless in the strict sense because it does bring to these patients a great benefit, namely, the preservation of their lives."[16]

The Catholic tradition teaches that one does not need to conserve one's life through gravely inconvenient means.

The discussion about nutrition and hydration for persons in a vegetative state received wide attention when John Paul II addressed the issue in 2004. He said that "in principle," medically assisted nutrition and hydration are ordinary means of care. In 2007, the Congregation for the Doctrine of the Faith clarified the pope's teaching by adding that the "artificial" administration of food and water is ordinary and obligatory "to the extent in which, and as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient."

In 2009, the *Ethical and Religious Directives* were rewritten in order to incorporate this teaching. Directive 58 states that "in principle," patients in "chronic and presumably irreversible conditions" must receive medically assisted nutrition and hydration since these patients "can reasonably be expected to live indefinitely if given such care." The intent of the directive is to protect the human dignity of persons in a vegetative state.

Kelly, Magill and Ten Have and others believe that the prior, 1981, edition of the *Directives* more accurately represents the "centuries-old Catholic teaching that allowed for the withdrawing and withholding of morally extraordinary treatment, based on the balancing of human burdens and benefits."[17] They propose that Directive 58 in the 2009 edition tends toward medical vitalism in that the primary goal is to preserve life and is not "patient specific." While the means might become "optional" if there are other medical complications or if they become "excessively burdensome," there is a tendency to treat this patient abstractly and not consider other important factors such as the patient's expressed wishes about tube feeding. They cite Daniel Sulmasy, MD, "To say that the value of something is immeasurable ... does not mean that its value is indefinite."[18]

The Catholic tradition teaches that one does not need to conserve one's life through gravely inconvenient means. One may have an intense fear and strong repugnance toward tube feeding, for instance. Catholic moralists have readily categorized such a case as extraordinary by the criterion that a particular procedure can be so feared or subjectively repulsive that it constitutes a moral impossibility.[19]

GUIDELINES FOR DISCERNMENT

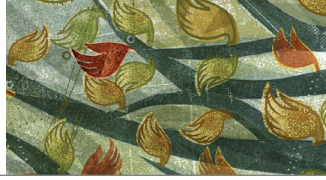
The Introduction to Part Five of the *Ethical and Religious Directives* presents a critical guideline for properly critiquing medical vitalism:

"We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome... The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of 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."[20]

This teaching is a *de facto* repudiation of medical vitalism as it reiterates the Catholic tradition that human life is not absolute, and treatment may be declined when it is nonbeneficial or excessively burdensome. While Directive 56 explains ordinary and extraordinary means of preserving one's life, Directive 57 is explicit:

"A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community."

These same principles are found in the 1980 *Declaration on Euthanasia* from the Congregation for the Doctrine of the Faith: "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." In his 1995 encyclical *Evangelium Vitae*, John Paul II affirmed this tradition: "To forgo extraordinary or disproportionate means is not the equivalent of suicide or death."[21]

The Catholic moral tradition rejects medical vitalism, as this approach places technological means over the moral and spiritual importance of facing death truthfully and considerately.[22] The *Catechism* is clear: "Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the *refusal of 'overzealous' treatment*" (no. 2278, italics added).

Vitalism absolutizes life, feeds into the technological imperative, denies human finitude, does not express a belief in the Resurrection and does not allow space for the work of dying to occur. Cumulatively, vitalism is a form of idolatry.

CONCLUSION

Both vitalism and subjectivism are rejected by the Catholic moral tradition. While it upholds the sanctity of human life, the tradition recognizes that human life is not absolute. Human life does not need to be prolonged under all circumstances, nor can it ever lose its intrinsic dignity even if an individual rejects its value. Life can be let go, not because a person's life ever loses its worth or fundamental dignity, but in an individual case the benefits of continued living are outweighed by the burdens "of the kind of life that is likely to result from life-sustaining treatment or by the burden of the treatment itself."[23]

Catholic moral theology urges a very different way of thinking than vitalism or subjectivism: Human life has its limits, death is a normal human event, mere biological survival in given circumstances is not the highest good and cure-oriented treatment may be disproportionate and unreasonable.

Vitalism absolutizes life, feeds into the technological imperative, denies human finitude, does not express a belief in the Resurrection and does not allow space for the work of dying to occur.

The church honors the reasonable judgments of dying persons about the proportionality of benefits and burdens of treatment,[24] and acts in accordance with its long ethical tradition that supports the moral acceptability of using adequate analgesics to relieve pain even though they may accelerate the dying process.[25]

There are spiritual goals that can be seriously obstructed by attempting to prolong life unnecessarily. These spiritual purposes can be thwarted by medical interventions that undermine a dying person's capacity for consciously expressing love for others and love and thanksgiving to God. These spiritual purposes should be facilitated by emphasizing palliative care and de-emphasizing cure-oriented treatment when such treatment has become an obstacle to living out one's spiritual ideals: "this is the fundamental meaning of the judgment that particular interventions have become 'excessively burdensome,' 'disproportionate,' 'unreasonable,' or in the older ... terminology 'extraordinary.'"[26] Medical vitalism and subjectivism are incompatible with these spiritual aims and the current policy of informed consent governing medical decision-making in end-of-life care.[27]

FR. GERALD D. COLEMAN, SS, is vice president, corporate ethics, Daughters of Charity Health System, Los Altos Hills, Calif.

NOTES

1. Jim Summers, "Theory of Healthcare Ethics" in Eileen E. Morrison, *Health Care Ethics*, 2nd ed. (Boston: Jones and Bartlett, 2009), 3-40, specifically 11. See also Albert R. Jonsen, Robert M. Veatch and LeRoy Walters, eds., *Sourcebook in Bioethics*, (Washington, D.C.: Georgetown University Press, 1998), 23-24.
2. *Catechism of the Catholic Church*, (Washington, D.C.: United States Catholic Conference, 1994), no. 2280.
3. *Catechism of the Catholic Church*, no. 2270.
4. David Kelly, Gerard Magill and Henk ten Have, *Contemporary Catholic Health Care Ethics*, 2nd ed. (Washington, D.C.: Georgetown University Press, 2013), 127.
5. Richard A. McCormick, *Corrective Vision* (Lanham, Md.: Rowman & Littlefield, 1994), 212.
6. James F. Bresnahan, "Observations on the Rejection of Physician-Assisted Suicide: A Roman Catholic Perspective," *Christian Bioethics* 1, no. 3 (1995): 256-284.
7. Bresnahan, 258.
8. Gerald Kelly, "The Duty to Preserve Life," *Theological Studies* 11 (1950): 550-556.
9. Paul L. Blakely, "Mercy Killing Turns Back the Clock," *America*, 62, no. 4 (Nov. 4, 1939): 90.

10. Jonathan Rauch, "How Not to Die," *The Atlantic* (May 2013): 64-69.
11. Rauch, 66.
12. John Robinson, "*Baxter* and the Return of Physician-Assisted Suicide," *Hastings Center Report* 40, no. 6 (2010): 15-17.
13. *Catechism of the Catholic Church*, no. 2258. The *Catechism* is citing *Donum Vitae*, intro. 5, the 1987 document from the Congregation for the Doctrine of the Faith.
14. Helga Kuhse, "A Modern Myth: That Letting Die Is Not the Intentional Causation of Death," in Helga Kuhse and Peter Singer, eds., *Bioethics: An Anthology*, 2nd ed. (Oxford, U.K.: Blackwell, 2006), 315-328.
15. See James F. Keenan, "The Concept of the Sanctity of Life and Its Use in Contemporary Bioethical Discussion" in *Sanctity of Life and Human Dignity*, ed. Kurt Bayertz (Boston: Kluwer Academic, 1996), 1-18.
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17. Kelly, Magill and Ten Have, 198.
18. Daniel P. Sulmasy, "Speaking of the Value of Life," *Kennedy Institute of Ethics Journal* 21, no. 2 (June 2011): 181-199.
19. See Scott M. Sullivan, "A History of Extraordinary Means," three-part historical survey in *Ethics and Medics* vol. 31, nos. 9, 10 and 11, (2006).
20. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, D.C.: USCCB, 2009), 25-26.
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22. See Thomas A. Nairn, "Reclaiming Our Moral Tradition," *Health Progress* 76, no. 6 (1997): 36-8, 42.
23. Kelly, Magill and Ten Have, 128.
24. *Ethical and Religious Directives*, nos. 25-28.
25. Bresnahan, 258-259. See Ronald Hamel and Michael Panicola, "Must We Preserve Life?" *America* 190, no. 14 (2004): 6-13. See *Ethical and Religious Directives*, no. 61.
26. Bresnahan, 259.
27. David J. Mayo and Martin Gunderson, "Vitalism Revitalized," *Hastings Center Report* 32, no. 4 (2002): 14-21. See Ronald Rolheiser, "Insane for the Light: The Final Stage of Human Maturity and Christian Discipleship," *Chicago Studies* 52, no. 1 (2013): 10-31.

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