

Virtual Mentor

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Roman Catholic Medical Ethics: Beginning and End-of-Life Issues

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From the editor

“I was ill and you cared for me.” Matthew 25:30

These words are inscribed upon the wall of the medical school at Loyola University Chicago and are among the first things a newly matriculated student sees upon entering a career in medicine. To those of us who are part of the Christian tradition, it is a call, a charge we take up to continue Jesus’ ministry to care for the human person. For those of other faiths, it is a no less powerful reminder that we are trained as physicians with the foremost task of caring for those made vulnerable by illness. It is also a reminder that, from its earliest inception, the Christian faith has participated in the care of the sick. This may be no more apparent than in Catholic health care’s presence within the United States. The Catholic health system is second only to the VA (Veteran Affairs) hospital system in scope of services provided by a single organization, comprising some 16 percent of national health care, admitting nearly 5.4 million patients each year and attending to over 15.9 million emergency department visits and 88 million outpatient visits [1].

The Roman Catholic tradition has not only engaged the medical community as a source for health care, it has also occupied the intellectual acumen of philosophers, humanists and policymakers who have sought to define the goals and role of medicine in society. Drawing upon a rich tradition dating from the eras of philosopher-theologians Augustine (430 AD) and Thomas Aquinas (1274 AD), the Church has long reflected systematically on medico-moral dilemmas. While perhaps first formalized in the 15th and 16th centuries by theologians such as Banez, deLugo and deVictoria, theological reflection on medicine came to its most intense stage during the 20th century under Pope Pius XII. At that time the Church initiated a concerted effort to publish a number of statements regarding various topics in medicine in response to the rapid advance of such medical technology as mechanical ventilators. This effort catalyzed an expansive discussion among theologians that has continued to this day and has formed the backbone for theological reflection in which the Roman Catholic tradition participates.

In this issue of *Virtual Mentor*, we continue the church’s long and vibrant engagement with the medical community. Much of the issue focuses on the beginning and end of life, points in time that often serve as flashpoints for examination of moral values and beliefs. From there the issue explores the church’s contribution to medicine by concentrating not on a small number of prohibitions but rather on the true center of Catholic health care and its basic principles: a promotion of the goods within the profession of medicine that encourage, develop and lead to

the fruition of human well-being and flourishing and promotion of the common good.

Seven basic moral principles guide Catholic teaching about the role of medicine. First and foremost is the *principle of the intrinsic dignity* of each individual who has been created in the image and likeness of God (Genesis 1:26). This principle recognizes the worth of the individual patient who, because of illness or injury, seeks the help of the physician. Second, the *principle of solidarity* points to the common good of society. The common good principle is opposed to the radical individualism now so prevalent in the United States. Solidarity insists that there is a mutuality and an ongoing tension between the individual and society, and it points to the fact that each person's well-being is somehow connected to that of all others in society.

The need to expand access to basic medical services has become, in the last century, a dominant theme of Catholic health care reform. The third moral principle—the *principle of beneficence*—demands that we distribute health care resources equitably, not only within our society but also globally. Fourth is the *principle of due proportion*, which is applied at both the macroallocation and microallocation levels. Macroallocation strives to determine what proportion of community resources should be reasonably expended on health care relative to expenditures for other basic common goods. Microallocation, on the other hand, seeks to take the resources that have been set aside for health care at the macroallocation level and distribute them reasonably and justly. Fifth, Catholic health care employs the *principle of advocacy* for social change that looks beyond aid to individuals and focuses on the services and structures of society's health care practice. The *principle of subsidiarity* demands that *only* as much uniformity, centralization and regulation be institutionalized as is required to provide for the common good in society. Finally, there is the *principle of the preferential option for the marginalized*. Catholic ethical thought and teaching has given special attention to this principle since the last century when the widening gap between the haves and the have-nots became framed as a social justice issue [2].

It is my hope as editor of this issue of *Virtual Mentor* to provide an introduction to these principles and illustrate many of the contributions the Roman Catholic tradition has made to the profession of medicine, the richness of those contributions and the deep commitment the tradition places upon faith in action in the world.

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Ad Majorem Dei Gloriam.

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Clinical case

The question of uterine isolation in Catholic health care ethics

Commentary by Luke Dysinger, OSB, MD

“I guess it’s about that time again, Mrs. Northern. We should probably head over to pre-op and get this C-section started,” Dr. Jones said. “Before we go there are a few things I want to discuss with you. Given the fact that this will be your fifth C-section, during the operation I will be evaluating your uterus for stress and damage. It’s common that after repeat C-sections, scarring and potential weaknesses occur and can pose serious risks for future pregnancies. If we did identify any abnormalities, we would have a few options.” Dr. Jones and Mrs. Northern spoke at length regarding the alternatives. Given the potential risk for rupture and the danger it would pose for both the mother and fetus if another pregnancy were to occur, Mrs. Northern needed to consider her options carefully.

“So basically if everything is OK through this pregnancy,” she said, “I can choose to do nothing, take my chances with having another pregnancy, use some sort of birth control, or not have sex at all. The only other option would be for you to tie my tubes?”

Before Dr. Jones could answer, Mrs. Northern continued, “Honestly, Dr. Jones, I’m not sure what to do. I don’t know how I feel about taking hormones for the next 20 years, and condoms and the rhythm method can fail. As a Catholic, I don’t believe in abortion, so if I were to get pregnant, I would feel obligated to have the baby. Frankly, my husband and I have been having enough difficulties lately, and I’m not sure how he’s going to respond to all of this, especially with the possibility that we would need to abstain from sex.”

After much deliberation and discussion with Dr. Jones, Mrs. Northern decided that the only viable option would be to go ahead with the uterine isolation by means of tubal ligation if that were medically indicated. Dr. Jones felt as if he had been placed in a difficult situation, given that the delivery was taking place in a Catholic hospital. According to the ethical and religious directives that governed the hospital’s practices, Dr. Jones would not be allowed to perform uterine isolation because it would be a form of direct sterilization. On the other hand, Dr. Jones faced the prospect that, if Mrs. Northern got pregnant again, her uterus could rupture and pose a serious risk to her and her fetus if he did not perform the procedure. Then there were the difficulties that the Northern would face if nothing was done and they had to restrict their sexual relationship. Dr. Jones hoped for the best as the surgery began,

fearing the dilemmas that might ensue should his patient's uterus appear to be less than healthy.

As the surgery progressed and the newborn was delivered successfully, it became clear that Mrs. Northern's uterus had sustained significant stress and another pregnancy would put her at high risk. "Dr. Jones, are you ready to close?" asked the scrub nurse.

Commentary

The dilemma the surgeon in this case faces is that, although a future pregnancy in this patient could be life-threatening, Catholic moral teaching has repeatedly and consistently forbidden direct, intentional sterilization [1, 2]. The issue is rendered even more perplexing by the fact that, although direct, intentional sterilization is prohibited, Catholic teaching permits medical treatment that causes sterility as an unintended side effect. Thus oophorectomy, hysterectomy, and therapies such as radiation and chemotherapy are routinely provided in Catholic hospitals whenever they are necessary to preserve a woman's health, even when they impair fertility and result in sterility. The procedure Dr. Jones is considering, tubal ligation, is less traumatic and has fewer side effects than hysterectomy. Why, then, if the patient's future health may be at risk without this procedure, should the surgeon be prohibited from providing it?

At the root of this dilemma is the Catholic understanding of human sexuality. According to Catholic teaching, sexual intercourse is intended by God to have a twofold meaning and purpose: first, the intimate union of the couple, and, second, openness to the transmission of new life. Both these aspects of human sexuality (usually termed "unitive" and "procreative") must be preserved insofar as possible, and neither may be intentionally sacrificed for the sake of the other. Thus in vitro fertilization is prohibited because it eliminates conjugal intimacy in the name of achieving conception, while contraception and sterilization are considered immoral because their purpose is to facilitate sexual intimacy without the possibility of procreation. Since Catholic teaching also rejects the notion that "the end justifies the means," our surgeon's concern for the possibility of a future high-risk pregnancy would not render the means he contemplates—namely direct sterilization by tubal ligation—any less objectionable.

Some Catholic moralists have tried to find a way out of this impasse by describing the procedure Dr. Jones is considering not as direct sterilization, but rather as "uterine isolation." They point out that Catholics are not morally responsible for unintended temporary or even permanent infertility, as, for example, during the infertile phase of the menstrual cycle, in women after menopause or as the result of necessary medical treatment.

The principle of double effect

The classic moral justification for treatment that causes unintended sterility is the so-called principle of double effect, which acknowledges that every moral action has

not only one, but multiple effects. Although a person is obliged to anticipate and, as much as possible, assume responsibility for the full range of consequences of any action, he or she is morally responsible only for the intended effect. Provided that an objectionable side effect is truly unintended and unavoidable, it may be tolerated for a proportionately good reason. Using this rationale some Catholic moralists have argued that the surgeon's real intention, the principal and desired effect of tubal ligation in this case, is the isolation of a damaged uterus from foreseeable threats to the patient's future health. Thus they argue that the sterilization caused by tubal ligation constitutes a permissible secondary effect in this instance.

In 1993 the Congregation for the Doctrine of the Faith, the Vatican department responsible for legislation concerning Catholic Church teaching, published a document entitled, *Responses to Questions Proposed Concerning Uterine Isolation and Related Matters* [3]. This document invited those involved in the controversy to be honest and clear about their intentions. Applying the reasoning set out in this document to our case, the only foreseeable danger to the patient is pregnancy, and the only factor from which the surgeon intends to "isolate" the damaged uterus is a human zygote. In other words, the primary goal of tubal ligation in this case (and, indeed, the only medical indication for any tubal ligation), is the prevention of pregnancy by direct, intentional sterilization. The Vatican document restates the immorality of direct sterilization and recommends the use of morally licit means for avoiding pregnancy if pregnancy would constitute a serious threat to the mother's health.

This case illustrates the seriousness with which sterilization is regarded in the Catholic tradition. It is interesting to note that in recent decades state and federal guidelines have also come to acknowledge the gravity of this issue through increasingly restrictive legislation. Beginning with Medicaid Title 19 in 1978, federal regulations required that sterilization be accompanied by documentation of full informed consent and by a waiting period of 30 days between the time that the patient's consent was obtained and the surgery was performed, or at least 72 hours in the case of emergency surgery or premature delivery [4]. Since then most hospitals have implemented mandatory policies that mirror these regulations. As a result Dr. Jones could be both ethically and legally prevented from performing tubal ligation in this patient, regardless of whether the surgery took place in a Catholic hospital.

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Related article

[Principle of double effect and proportionate reasoning](#), May 2007

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Clinical case

Is artificial nutrition and hydration extraordinary care?

Commentary by Kenneth Craig Micetich, MD

Mrs. Henderson's eyes darted to the side of the bed as her nurse attempted to obtain an arterial blood gas. This response slightly startled John and made him consider whether or not he was causing her discomfort. John had often found it unsettling that she appeared awake, her eyes open, spontaneously moving her arm or leg, but it was a thought he repeatedly tried to dismiss.

Mrs. Henderson had been a resident in the ICU at Sacred Heart Hospital for seven months after a serious motor vehicle crash that claimed the lives of two of the four passengers. Her husband had been driving and had sustained only minor injuries. Mrs. Henderson, however, had suffered severe damage to her brain as a result of hypoxia secondary to cardiopulmonary arrest at the scene that ultimately caused her to lapse into a coma.

Her physician, Dr. Bernard, had informed Mr. Henderson after several months that, given his wife's MRI and physical exam, she most likely was no longer in a coma but in a persistent vegetative state (PVS). Dr. Bernard asked Mr. Henderson to consider goals for his wife's care.

"What do you mean...goals?" Mr. Henderson asked, slightly annoyed.

"I know this must be very difficult, Mr. Henderson. But now may be the time to consider what your wife would have wanted should she be in a position such as this. Did she ever discuss any of her wishes with you? Was your wife religious?"

Mr. Henderson said, "Yes, my wife was very explicit about a situation like this. She had even written out a living will that specified that she never would want to be kept alive artificially with food and water. I will bring you the living will tomorrow when I come in."

Then Mr. Henderson remembered something about a speech that the pope had made not long ago, in which he seemed to say that artificial nutrition and hydration were mandatory for Catholic patients in PVS. Upon realizing this, Mr. Henderson turned to Dr. Bernard and said, "Doctor, my wife was a devout Catholic, and because the pope seemed to require all Catholics to be given artificial food and water, I think my wife would now want these measures given to her."

Dr. Bernard was now perplexed. It appeared to him that a patient's signed living will to forgo artificial nutrition and hydration would supersede the claim by Mrs. Henderson's husband that she would want these measures given to her. He was aware that the local bishop of the diocese had recently come out with a strong statement in support of the pope's speech, but Sacred Heart Hospital had not as yet officially reacted to the bishop. What was Dr. Bernard to do? Was he to follow the living will and discount the pope's and bishop's statements, or was he to follow Mr. Henderson's interpretation of what his wife would want in light of the recent ecclesial documents? Dr. Bernard wanted to accommodate his patient's request even if this might go against church and hospital policy. He decided to give himself a day to think about all the complexities of this case.

Commentary

Most people understand that patients with irreversible liver failure or with incurable metastatic cancer are terminally ill and that these patients will die despite sophisticated technological interventions. The right of these patients and their families to forgo life-prolonging treatments deemed burdensome and without reasonable hope of benefit is well-established. The treating doctor historically has been able to recommend limiting interventions when failure of the heart, liver or lungs leads to severe physiological derangements that are incompatible with life and cause the death of the patient.

On the other hand, society seems to find it difficult to address brain failure or dysfunction caused by severe primary central nervous system disease, trauma or anoxic insult. Such dysfunction may impair consciousness but does not directly produce the dire consequences associated with severe system breakdown seen in heart, liver or lung failure. Absent significant brain edema with herniation, one does not usually die directly of the brain trauma but of the consequences of loss of neurological function—hypoventilation, aspiration pneumonia, pulmonary emboli, and malnutrition and dehydration due to an inability to eat and drink. Thus supportive treatments such as airway protection, mechanical ventilation, and intravenous fluids and alimentation can prolong life in patients with severe neurological failure. But these supportive treatments will not restore brain function. It is the right of these patients and their families to choose to refuse life-prolonging treatments that are considered burdensome and without reasonable hope of benefit, but their decisions to do so can be met with requests for a third-party review or a legal challenge (e.g., Nancy Cruzan and Terry Schiavo cases), an outcome that demonstrates society's uncertainty in the face of severe primary brain dysfunction.

For some reason people tend to distinguish brain dysfunction from organ failure that produces severe physiological problems. The central nervous system serves as the basis for our consciousness, awareness of environment and self, and ability to interact with others. Functioning heart and lungs are a necessary but not sufficient condition to permit consciousness and awareness of self. It would seem logical that we would be most energetic in intervening when the heart and lungs fail because these organs support the activities of the primary central nervous system. Yet, when

the brain fails and we permanently lose self-awareness and consciousness, many are inclined to be quite aggressive in continuing interventions because the heart and lungs are still working. This paradox in our thinking has not been systematically explored but may reflect scientific knowledge of the central nervous system that is less well-developed than that of other organ systems and a recognition that brain failure is not “terminal” in the traditional meaning of the word.

The case at hand

Mrs. Henderson is in a persistent vegetative state. She is aware of neither herself nor her surroundings and cannot interact with others. She has sleep-wake cycles, and her eyes spontaneously open. Mrs. Henderson is not conscious and has no higher cortical function. Her movement is reflex-driven and not purposeful; speech is absent; her condition has remained unchanged for at least 7 months and is irreversible.

Dr. Bernard asks Mr. Henderson to consider “goals for his wife’s care.” Although the doctor may be criticized for not bringing this issue up earlier, he does have several motives for asking the question. First, the doctor and the hospital staff need to have a sense of how aggressive to be in the diagnosis and management of other medical problems that may arise. Second, the standard of care for the chronically ill requires that the patient’s clinical and lab reports be shared with the appropriate decision makers at periodic intervals, so options for future care along with its risks and benefits can be discussed. This requires an exploration of the patient’s values and those of the decision makers. Third, the doctor and staff may have a sense of being useless and providing futile care. Despite all of their knowledge and care, Mrs. Henderson’s neurological status is not going to improve, and perhaps their skills can better serve other patients. This consideration is not disrespectful but factual. Hospital resources and staff are not limitless. Patients in a persistent vegetative state can develop complications and comorbidities that consume staff time and energy at other patients’ expense. Lastly, continued care is expensive and may be financially burdensome to both society and family without a corresponding benefit.

Mr. Henderson is conflicted. Although his wife has a living will that could justify discontinuation of the food and fluid, he knows that she would want to be true to the principles of her Catholic faith. And Dr. Bernard is also conflicted. He must practice medicine within the structure of the hospital’s ethical and religious framework but, as a physician, desires to honor his patient’s legitimate wishes as noted in the advance directive.

The resolutions of these conflicts are beyond the expertise of the managing physician and require an ethics consultation. One would expect the ethics consultant to first ascertain the prognosis of the patient (not terminally ill but incurable and without decisional competence). Second, the ethics consultant would review the living will to understand its contents and instructions and to verify that it was properly executed. Third, the ethics consultant would decide whether withdrawal of food and hydration was an ethically acceptable option in the care of Mrs. Henderson. This determination would be based on the *Ethical and Religious Directives for Catholic Health Care*

Services [1]. The ERD, as it is called, is a well-reasoned and carefully written set of principles that guide Catholic health care facilities and policies. All Catholic health care institutions and physicians are required to follow these directives. Lastly, the ethics consultant would make certain that withdrawal of nutrition and hydration from a patient in a persistent vegetative state is not prohibited by state law [2]

The ERD states that 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” [3]. A patient’s advance directive can clearly indicate what his or her position would be if he or she were able to speak. Although we cannot determine the exact reasoning of the patient, the fact that the living will is executed is evidence that the means (artificial hydration and nutrition) are disproportionate. The ERD affirms the right of an individual to have an advance directive, but the institution is not obligated to follow the advance directive if its instructions conflict with Catholic teaching [4].

Does withdrawal of hydration and nutrition from patients in persistent vegetative states conflict with church teaching? The question arose because of a papal allocution in 2004 delivered by Pope John Paul II. The papal statement defined nutrition and hydration as ordinary means needed to provide comfort and seemed to indicate that food and fluid must always be provided. By contrast, the ethical and religious directives state that

...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 [5].

A critique of the papal allocution and the weight to be accorded it is the subject of analysis in another article in this journal issue as well as in other learned treatises [6]. At the present time, the papal statement has not led to a reconsideration of the statements contained in the ERD.

The ethics consultant in this case would find that the patient’s advance directive and her surrogate decision maker indicate that the patient determined that fluid and nutrition would be disproportionate means of maintaining life. Thus, withdrawal of hydration and nutrition would be an ethically acceptable option in her care, provided that state law allows withdrawal.

Keep in mind, however, that ethics consultations are rarely determinative. The consultant simply advises whether proposed care plans are ethically acceptable options. The case we have discussed could easily progress to a situation in which the husband wants to continue hydration and nutrition based on respect for his wife’s faith and the doctor thinks that it is futile and should be discontinued. In this

scenario, since Mrs. Henderson's advance directive was executed before the papal allocution, the ethics consultant could find that continued hydration and nutrition of the patient is an ethically acceptable option of care.

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Related articles

[The hard case of palliative sedation](#), May 2007

[Understanding the ethical framework for medical practice in Catholic health care](#), May 2007

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Clinical case

The hard case of palliative sedation

Commentary by Eran Klein, MD, PhD

Mr. Johnson had been battling cancer for as long as he could remember. At 65 years old, he still remembered the day when he was first told that he had prostate cancer at the age of 45. The past 20 years had been one struggle after another, each with its own twist. Most recently, Mr. Johnson had been diagnosed with metastatic cancer in his lungs, spine and brain. Years of illness had made his body fragile and frail. Even the smallest everyday tasks seemed nearly impossible. Pain seemed not to radiate from any single point but rather to encompass his entire body. The mere act of breathing now seemed an insurmountable task, one that caused excruciating pain and increased his hunger for oxygen. He had tried every analgesic that had been offered and seen palliative specialists from across the country. None had been able to offer him any real relief from his pain. Recently Mr. Johnson confided to Dr. Jackson that he was considering suicide as a way out of his pain, but Mr. Johnson was a religious man and was afraid of the consequences he might face in the afterlife.

Dr. Jackson, an anesthesiologist at St. Luke's, believed he might be able to help. "Mr. Johnson, none of the medications we have tried in the past has been able to alleviate your pain. What I suggest may be quite extreme, but it is most likely the only means that will give you any relief and put your conscience at ease. I believe that by placing you in a chemically induced state of unconsciousness, similar to that of a comatose individual, you will be free from your pain." Mr. Johnson was in so much pain that he was willing to try anything. After much deliberation and reflection, he agreed to the procedure. In Dr. Jackson's judgment, the patient possessed decision-making capacity sufficient to provide informed consent. Prior to undergoing the induction, Dr. Jackson broached the subject of what other care and life-sustaining measures Mr. Johnson wanted taken while he was sedated.

"Several options exist for your care while you are in this state," Dr. Jackson explained. "One of these is the means by which we may provide nutrition and hydration. Since you will be unable to eat normally, we can feed you through a surgically inserted tube. Would that be something that you would want?"

Mr. Johnson thought carefully about this offer. "Am I right in presuming that the last few weeks I have to live will be spent in this unconscious state and that I will not awaken?" Dr. Jackson replied affirmatively. "Then I don't see the point in prolonging the inevitable by having the artificial nutrition and hydration. I'm not going to feel anything, right? Let me go when the time comes."

The next day Mr. Johnson was sedated into unconsciousness. Several days passed, and Mr. Johnson's medical condition began to deteriorate due to dehydration. Eventually Mr. Johnson's body went into multi-organ failure. It was at this point that another member of the staff, concerned with the course of events, informed not only the hospital administration but also the local bishop, claiming that this act was directly contrary to the Catholic mission of St. Luke's Hospital. The local bishop responded promptly to the hospital administration, clearly stating his deep disapproval of recent events and demanding reconsideration of Mr. Johnson's care. The alternative, he claimed, was to institute a review process that could revoke St. Luke's Catholic identity and its ability to claim a religious affiliation. This seemed to the bishop to be a case of assisted suicide, if not out-and-out euthanasia.

Dr. Jackson had become dismayed at these turns of events. Suddenly, many serious thoughts began to bear down on him: the patient's proper care in a situation of true intractable pain, the patient's stated wishes, Dr. Jackson's own faith, the divided sentiment of the staff, and the identity and mission of St. Luke's Hospital. Knowing that events were only going to become more tense tomorrow, Dr. Jackson slept little that night as he considered his options.

Commentary

A good death is of great value, but defining a good death is, of course, no small task. Whatever else it involves, the absence or minimization of pain seems to be a part of it. The palliative care movement has been instrumental in bringing attention to the experience of pain at the end of life and developing tools to lessen it. For the most part, those within the Catholic moral tradition have welcomed this focus on pain relief. The practice of what is sometimes called "terminal sedation," however, represents the point where Catholic thought and palliative care may part ways. The clinical vignette presented here provides an opportunity to explore why.

The term "terminal sedation" lacks precision [1]. In a general sense, it involves producing sedation in a patient, typically with medications, that ultimately leads to death. Terminal sedation has a wide scope; it can run the gamut from treating intractable localized pain in the imminently dying with medications that happen to secondarily hasten death all the way to treating intractable suffering (broadly defined) in the nonimminently dying by inducing a state of decreased awareness in which patients, forgoing nutrition, ultimately die.

It should be of no surprise then that the range of actions that fall under the terminal sedation umbrella engenders different levels of moral concern. Situations such as sedating a patient who is dying from graft-vs-host disease and has severe abdominal pain from intestinal ulcerations has become a relatively common and uncontroversial part of the practice of palliative care. Let's call this the "near" end of the spectrum. It is actions at the opposite, or far, end of the continuum that are the subject of intense controversy [2]. A patient with slowly progressing amyotrophic lateral sclerosis (ALS) who requests sedation rather than a PEG (feeding) tube and an assisted

breathing device is an example. Should the request be granted only if the patient is imminently dying? How is “imminently dying” defined? Is sedation an acceptable treatment for any kind of suffering? For all kinds? Does sedating someone who has refused nutrition and hydration merely ease the dying process or actually contribute to it?

Such concerns invite the following question: Does the far end of the terminal sedation spectrum represent the rational extension of uncontroversial practices at the near end (practices to which our intuitions just need to adjust), or does the far end represent instead a different kind of action which our intuitions rightly identify as problematic and which needs more thoughtful justification? One way to understand recent Catholic thought on this point is to think of it as motivated by a belief in the latter (that these actions *are* problematic) and by a desire to provide conceptual tools understandable outside the tradition for elucidating the needed justification.

The rule of double effect provides an example of just such an accessible tool. The rule of double effect originates in the Catholic theological tradition [3], but it has been applied in recent medical, philosophical and legal literature as well [4-7]. It is used to highlight the importance of intent when judging actions as either good or bad. According to the rule of double effect it may be impermissible to intentionally bring about a harm as a means to achieve some good end, but it may be permissible to bring about a harm as a mere foreseen but unintended consequence of pursuing that good end.

Put into the context of our case, it may be permissible to offer sedation that happens to speed the dying process if what one is aiming at is effective pain relief. It is not permissible, however, to offer sedation as a means of relief from the burden of consciousness. This would be to aim for, rather than merely to foresee, a hastened death. The application of the rule of double effect deserves much greater nuance than I have given it here [3, 8], as does criticism of it [9, 10]. My aim here is to show how the rule provides a relatively straightforward way of ethically parsing the practice of terminal sedation.

The case of Mr. Johnson unfortunately does not fit neatly into the spectrum of scenarios I have presented. Mr. Johnson seeks relief of intractable pain and presumably, were this to be available to him, would want to continue to live until he died of his underlying disease. He does not seem, for instance, to be motivated solely by a desire for control over the timing or manner of his death. He does not want to slip into an unconscious state because this is not the life (or death) he envisioned for himself but instead because his experience of pain has become overwhelming.

Dr. Jackson’s approach to Mr. Johnson’s condition, however, raises a question about whether pain relief is really all that is being sought. It seems that Dr. Jackson’s decision to forgo attempts to titrate sedation or anesthesia as a means of pain control that stops short of inducing unconsciousness at least raises the question of whether relief of Mr. Johnson’s current *pain* rather than relief of his current *situation* is really

what is being pursued. Thus, the approach jointly taken by Mr. Johnson and Dr. Jackson would seem to fall fairly close to the far end of the spectrum and, hence, to run afoul of the rule of double effect.

A controversial practice like terminal sedation creates unique problems for religious institutions involved in the provision of health care. Catholic institutions have been able to avoid, often by carefully created structural divisions and partnerships with other health care centers, participation in practices like abortion, contraception and assisted reproduction. End-of-life treatment, like terminal sedation or withdrawal of artificial nutrition and hydration, is in some ways more complicated for Catholic institutions, given that care of the dying is more intimately woven into the daily practice of acute medical care. While it may be acceptable to transfer patients pursuing elective abortions to other hospitals, transferring acutely ill patients to other facilities to receive their desired end-of-life care is less obviously so. Spelling out roles for those working in this field, like Dr. Jackson, is an ongoing challenge for Catholic hospitals.

Controlling pain at the end of life is essential to good medical care. Given the complex interplay of pain with other aspects of human life—suffering, values and faith—it is not surprising that medicine continues to struggle with finding its proper place in treating pain. The practice of terminal sedation in many ways represents the cusp of this struggle. Its definitional boundaries and acceptable practices are still in flux. The rule of double effect at least provides an accessible resource for conceptualizing this evolving practice.

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Virtual Mentor

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Medical education

Catholic medical education emphasizes service, human flourishing and personal growth

by Myles N. Sheehan, SJ, MD

I am a physician who specializes in internal medicine and geriatrics, and I am also a Roman Catholic priest and member of the Society of Jesus, better known as the Jesuits. As senior associate dean for education, under the direction of the dean and working collaboratively with the faculty who have the responsibility for the overall curriculum, I am in charge of managing the educational program of Loyola University Chicago's Stritch School of Medicine, a Catholic medical school.

At Loyola we have approximately 550 medical students from a variety of backgrounds, traditions and levels of commitment to religious belief. Less than half of the students are Roman Catholic and those who are Catholic come, like many American young people, with a diverse set of understandings about what it means to be Catholic, what the church teaches and whether being Catholic has relevance to their lives as people who are training to become physicians. Not all our students find church teaching congenial on matters like abortion, embryonal stem cell research, assisted suicide, or the role of medically assisted nutrition and hydration for persons in persistent vegetative states.

Is obtaining an education at a Catholic medical school like Loyola's or being part of a residency program at a Catholic hospital problematic? My contention is that a Catholic medical education provides possibilities for personal growth and excellent training that are not possible in secular environments. Let me suggest three arguments in support of this thesis.

First, there is a moral life beyond debate over difficult decisions at the beginning and end of life. By obsessively focusing on dilemmas, many miss the point that ethics is about developing and growing in ways that fully reveal what it means to be human. Catholicism has a rich ethical tradition based on its anthropology. What it means to be right or wrong based on Catholic ethics is not simply an abstract issue; it is about considering the challenges that face us, whether in medicine or in the rest of life, from a perspective that emphasizes human dignity and the notion that we are responsible for each other. Medical training at Loyola seeks to develop our students as professionals who are committed to service and aware that their actions have meaning and that their moral growth is connected to how they behave as persons and physicians.

Catholic teaching does not demand that individuals agree, but in a clinical setting that is sponsored by the church, there is a firm expectation that church teaching will be respected. For those who disagree as well as for those who agree with these teachings, learning at a Catholic institution is about developing as a person who is called to be a physician. This is a profoundly moral vocation. Many Catholics believe that a career in medicine is a calling from God and look to a tradition that describes Christ as the Divine Physician who came to heal a wounded humanity. Whether a medical student or resident accepts all church teachings or not, the opportunity to study, research, gain skill as a physician and work in a community that continues the healing ministry of Christ provides a rich background and setting not available in a secular environment.

One need not do abortions to become a superb obstetrician and gynecologist; advanced research is done at Loyola in applications of stem cells obtained from umbilical cord sampling. Students and resident physicians learn the latest treatments and techniques and are brought to a standard of care that is at the cutting edge of American medicine. There is no shortchanging of clinical training. Emphasizing that a moral life has meaning and that ethical commitments determine our growth as persons is a powerful advantage afforded to those who seek medical training in a Catholic setting.

Second, evidence suggests that Catholic health care and Catholic medical education, rather than creating problems, have been distinctive gifts to American medicine. The church's emphasis on service and care for the poor has resulted in Catholic institutions' providing a significant proportion of care for the marginalized, protecting the weak and disenfranchised, and bringing health care into underserved areas, whether rural or urban. Catholic health care institutions are responsible for approximately 16 percent of the hospital beds in the United States and manage large numbers of nursing homes and other facilities that provide housing and care for older persons.

For those who find church teaching obnoxious on some beginning and end-of-life matters, and who would find the idea of Catholic medical education somehow limiting, I suggest that the extraordinary commitment and service of the church to the poor and sick in this country is a strong counterargument. Catholic medical education obligates physicians to care for the least of our brothers and sisters. This distinctive religious voice provides a bulwark against other forces in society that would ignore the poor, the weak, the old, the immigrant and others who are frequently forgotten.

Third, education in a Catholic medical school or hospital witnesses to the view that human flourishing depends on scientific and material progress—and spiritual growth. What many have difficulty recognizing in a technological and secular environment is that there is a spiritual component to human life that is as real and perhaps more important than what can be measured, seen or manipulated. Catholic medical education testifies to the fallacy of biological determinism. We believe that

human beings are more than the sum of our biological processes. This understanding allows Catholic health care and those who train in Catholic settings to heal even in situations when cure is not possible. As human animals our lives are limited. There are things that hurt the spirit as much as illness can hurt the body. Learning the art of medicine that recognizes the spiritual depths of humanity and the limits of biological possibility is not an impoverished educational experience. It is an experience in what it means to care for others in a way that goes beyond the purely physical.

In short, Catholic medical education and residency training provide opportunities and serve populations that often are not well addressed in other settings. I believe *not* that Catholic medical education is deficient because of church teaching in some areas relating to medical practice, but rather that American medical education is enriched by diverse traditions such as that of the Catholic Church in health care and physician training.

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Medical education

The body and blood of medical school: one student's perspective on Jesuit education

by Jennifer K. Walter

I was not specifically looking for a Catholic institution when I applied to medical school. But after interviewing at Georgetown and meeting the ambassador of admissions, I realized that many of the characteristics I valued in a medical education were championed by the Jesuits. They advocate care of the whole person, recognizing that people are far more than just organ systems and that their religious beliefs are central to their decision making, particularly during illness. The Jesuits acknowledge that the professional role of physicians entails special responsibilities not demanded by other jobs. Not only does this role affect the individual relationship between physician and patient, it also imposes on physicians a responsibility to care for society's vulnerable and forgotten. As I come to the end of my medical training at Georgetown, I reflect on how these and other Catholic themes have been put into practice, both in the explicit curricula of the four years of training and in the informal, but probably more influential, interactions with physicians and residents in the classroom and at the bedside.

One of the most explicit ways Georgetown addresses the centrality of religion to patients' lives is in a second-year course entitled Religious Traditions in Health Care. The class provides students with basic information about the major religions we are likely to encounter and is taught mostly by physician-members of those faiths. The coursework emphasizes how these religious traditions intersect with health care, e.g., the religions' positions on organ donation, pain relief, end-of-life care and blood transfusions. In addition to this specific information, there is an overriding acknowledgement of the importance of religion in people's lives and a caution about the huge oversight we commit when we do not recognize the religious lives of patients and engage this aspect of their care. At Georgetown, time is dedicated specifically to learning how to take a spiritual history. We learned that, surprising as it may be to most medical students, many patients would not feel that their spiritual needs were sufficiently met simply by checking a box on the admissions documents that correctly identified their religious sects.

The extent to which this course affected classmates became apparent a few months later when we were introduced to the clinical world and began practicing how to take a social history from patients in the hospital. Divided into groups of 10 and led by a psychiatrist, we took turns interviewing patients who had agreed to see us. After we completed an interview with one older woman, we filed out of the room to discuss

the student's techniques. The patient had asked the last student in the room if we would stop to say a prayer with her. Because most of us had already left, the final student followed us down the hall and raised the idea to the group. There was a mixture of consternation and concern. Then a fellow student reminded all of us of the religious traditions class and the probable importance to this patient of our participation in her healing through respect for her religious beliefs. Several agnostic and atheist students were hesitant but, upon contemplating the benefit to the patient, agreed that not only was it acceptable to go back and pray with the woman, it was the right thing to do. The concept of caring for a patient as a whole person is not uniquely Catholic, but I believe that Georgetown's being a Catholic institution influenced the extent to which medical students understood the integral role faith plays in our patients' lives.

Respect for patients' and practitioners' religious beliefs was also modeled by several of the physicians with whom I worked. Dr. Edmund Pellegrino taught and practiced the tenet that a patient's spiritual beliefs trump all other values and should be acknowledged by the caregiver of every competent patient. One of the surgeons with whom I worked related the story of a patient who was a Jehovah's Witness and needed life-saving surgery that would most likely require blood transfusions. The surgeon proudly declared his Catholic faith and the fact that he had agreed to perform the risky surgery without using the blood transfusion and had preserved the patient's life while honoring her religious belief.

Respect for the moral boundaries of physicians was also modeled by some of the residents. A senior resident described the comfort he experienced from hearing Dr. Pellegrino's lecture that physicians were not required to perform procedures to which they were morally opposed. The Catholic Church's position regarding contraception and abortion was well known at Georgetown, yet students were exasperated at the unwavering way in which some physicians opposed contraception use, even when its purpose was to curb the HIV epidemic. Some students also argued that the obstetrics residents would not be adequately trained if they did not learn how to perform abortions. Many people in obstetrics distanced themselves from the Catholic position because they found that it constrained their practice, but they still accepted and respected those who chose to remain faithful to the Catholic doctrines. One of the residents, for example, was grateful that he was in a Catholic institution where he could educate his patients about all forms of contraception without being pressured to prescribe the drugs or place intrauterine devices himself.

The Catholic aspect of my medical education that resonated with me most was the commitment to social justice and responsibility to the poor and those with limited access to health care. While Georgetown's hospital is situated in an affluent part of Washington, D.C., and cares for many of the elite in the city, several programs offered by the medical school encourage work in underserved communities throughout the area. The medical school attempts to counteract the limitations of providing care largely for the privileged by training students at partnering hospitals which serve the city's poorest and clinics that accept the city's version of Medicaid.

A sense of responsibility to learn about what it means to be vulnerable and have limited access to care was emphasized throughout my time at Georgetown, from public health projects in my first year to study abroad opportunities in my final year. Several of the physicians I had an opportunity to work with in the public clinics had exceptional commitment to those without ready access to care, and, in addition to raising students' awareness about these issues, they demonstrated what it meant to assume professional responsibility for the entire community—not just the wealthy. The formal curriculum explicitly reinforced concern for the health care of the most vulnerable, e.g., the homeless, and the need to treat these patients no differently than we treat VIPs.

While no one would dispute the claim that there is room for improvement both structurally and individually in our efforts to live up to the promises of the Jesuit tradition, it is clear that many in the medical school believe in these values and attempt to instantiate them.

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Journal discussion

Reflections on Peter Clark's moral analysis of the use of methotrexate in ectopic pregnancies

by Thomas A. Shannon, PhD

Clark PA. Methotrexate and tubal pregnancies: direct or indirect abortion? *Linacre Q.* 2000;67:7-24.

Peter Clark is correct in identifying ectopic pregnancy as a serious medical and moral concern in his 2000 article "Methotrexate and Tubal Pregnancies: Direct or Indirect Abortion?" [1]. As a major cause for reduced childbearing potential and the leading cause of maternal morbidity and pregnancy-related deaths during the first trimester, ectopic pregnancy is an acute medical problem. For many it is an equally serious moral problem because resolving the medical crisis results in embryonic death. The moral concern is complicated by the fact that maternal morbidity and possible mortality from ectopic pregnancies are significant.

Clark's article provides a model for interdisciplinary analysis of complex clinical and ethical problems. First, Clark presents a detailed explanation of relevant medical information. Second, he applies a moral analysis to each of the possible medical scenarios. Third, he provides two traditional ethical models to help resolve the gap between the clinically and morally desirable outcomes. Fourth, he responds carefully and respectfully to opponents and critics of his position. Finally, he concludes thoughtfully, that methotrexate represents a complex challenge within Roman Catholic moral theology that requires further dialogue and debate.

Clark himself believes that the use of methotrexate is morally acceptable because it attacks the trophoblast, which is the set of embryonic cells that become the placenta. His argument is that, since the drug attacks these cells and not those that will become the embryo proper, it is attacking the source of pathology and not the new life [2]. Based on Clark's reasoning, the embryonic death is indirect and unintended (although foreseen) and thus permissible in Roman Catholic moral theology.

Clark applies the three-font principle and the principle of double effect, complemented by the use of proportionate reasoning, in his ethical analysis. I find the principle of double effect and especially its proportionate reasoning argument more convincing, primarily because of its broad appeal. Second, the reasoning is more straightforward, particularly in Clark's insistence that his resolution of the ectopic pregnancy crisis does not undermine the value of human life.

The method of proportionate reasoning as developed by Richard McCormick, SJ, has three elements that are less esoteric than many other ethical models, and the criteria can be applied relatively easily and debated without an in-depth understanding of major philosophical presuppositions and tenets. The criteria for moral justification of an act under proportional reasoning, as correctly noted by Clark, are that the means used will not cause more harm than necessary to achieve the value in question, no less harmful way exists to protect the value, and the means used to achieve the value will not undermine it [3]. In the case of an ectopic pregnancy the use of methotrexate preserves a woman's fallopian tubes so she remains fertile, methotrexate is overall the least harmful treatment because it is less invasive and less costly than the alternatives, and, finally, because its use directly affects the trophoblastic cells, methotrexate does not undermine the value of human life.

But there is another side to this discussion that is not highlighted in any of Clark's arguments. In the case that Clark describes, as in many others, the ectopic pregnancy occurs in the context of a desired pregnancy; that is, a couple is seeking to have a child, to establish a family. This is the assumed overarching intention that should be kept in mind as one thinks this case through. This couple wants a child. The methotrexate solution honors this intention by preserving the integrity of the fallopian tube and making future pregnancies possible. The current pregnancy would be lost, indirectly as Clark argues, but the more critical issue is that the methotrexate solution is the one that is most life-affirming and life-enhancing and that it makes possible future pregnancies.

I offer this, not as a criticism of Clark's analysis, but as a complement to it; a highlighting of a circumstance that often gets overlooked in our zeal to give equal protection to all pregnancies. By noting the importance of the intention to create a family, moral analysis can incorporate another significant, if not controlling, element in the moral evaluation of this critical problem.

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Clinical pearl

Diagnostic criteria for persistent vegetative state

by Daniel Dilling, MD

A 40-year-old carpenter, husband and father of four teenage children, falls from a ladder at work and sustains severe head injury. Treatment during his hospitalization includes intubation and mechanical ventilation for airway protection and surgery to relieve pressure on his brain that formed as a result of a subdural hematoma. Doctors also insert a gastric tube for artificial nutrition. As he recovers in a rehabilitation facility, he is able to breathe again without the need for a ventilator. He opens his eyes and looks around the room. He assumes a near-normal sleep and wake cycle and occasionally makes some vocal sounds that do not seem to be meaningful. He is not able to eat by himself and aspirates food if it is put into his mouth. After six months of this marginal recovery, he is declared by a neurologist to be in a persistent vegetative state (PVS), and the family begins to wonder about his future. They reluctantly ponder the idea of withholding artificial nutrition, stating that he would not want to live this way.

The story of Terri Schiavo and her husband's pursuit of the right to remove her feeding tube sparked public debate and much individual introspection on the subject of withholding artificial nutrition in patients with PVS. Then U.S. Senate majority leader and renowned heart surgeon William Frist went on record questioning the opinion of several neurologists who had declared that Mrs. Schiavo was in a PVS "based on a review of the video footage which I spent an hour or so looking at last night in my office" [1]. A clearer understanding of the diagnostic criteria for PVS is needed, for both the medical community and the lay public, as we ponder this issue. The open eyes and presence of autonomic function can be both confusing and bothersome for families and health care personnel and can lead to false expectations and flawed decisions.

The term PVS was introduced in 1972 by Scottish neurosurgeon Bryan Jennett and American neurologist Fred Plum [2]. The choice of the word "vegetative" was purposeful and meant to emphasize the fact that such a person is organically alive but lacking in intellectual activity or sensation. Secondly, it was chosen because it is a term that families of those stricken with the condition can understand. The unfortunate use of the term "vegetable" when referring to such patients has called into question the appropriateness of the designation PVS when describing this condition.

PVS results from injury to the brain after interruption of the blood supply (anoxic brain injury), with infection to the central nervous system (as in encephalitis) or after severe head trauma. The patient retains autonomic and brainstem function but lacks the ability to receive sensory input or to communicate. Sleep and wake patterns often return to normal; eyes are usually open, and a patient may make grimacing movements or grunting noises. A diagnosis of PVS is appropriately withheld until at least one month after the impairment of consciousness.

In 1994 the *New England Journal of Medicine* published the consensus reports of a task force that had been charged with determining the clinical criteria for diagnosing PVS [3, 4]. The clinical criteria are:

1. No evidence of awareness of self or environment; no interaction with others.
2. No evidence of sustained, reproducible, purposeful or voluntary behavioral responses to visual, auditory, tactile or noxious stimuli.
3. No evidence of language comprehension or expression.
4. Return of sleep-wake cycles, arousal, even smiling, frowning, yawning.
5. Sufficient hypothalamic and brainstem autonomic functions to survive if given medical or nursing care.
6. Bowel and bladder incontinence.
7. Variably preserved cranial nerve and spinal reflexes.

PVS must be differentiated from other disorders of prolonged impairment of consciousness, such as minimally conscious state, akinetic mutism, locked-in syndrome and brain death. The usual investigations done during an evaluation of PVS are an electroencephalogram (EEG), brain imaging such as MRI or CT, and perhaps PET scanning. Most important, however, in the evaluation is the patient's history—including as clear an understanding as possible of the initial insult—and a physical exam by a neurologist.

Management of patients with PVS usually includes temporary tracheostomy and percutaneous feeding tube placement, since patients are unable to eat normally. Decisions by families to consider withholding or withdrawing care often come months or even years after the trauma. By that time, since autonomic function is relatively normal and there is no longer a need for artificial respiration, artificial nutrition and hydration are all that are left to withhold. At that point, families who have accepted that the condition is indeed irreversible generally rely on moral and religious authorities and known patient preferences to guide their decisions.

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Health law

Duty to treat: conscience and pluralism

by Kayhan Parsi, JD, PhD

It's a shibboleth in Anglo-American jurisprudence that one has no duty to rescue. This may seem callous or even immoral, but, indeed, absent a fiduciary relationship, individuals typically have no legal duty to help others [1]. This was the holding in the early 20th-century case *Hurley v. Eddingfield* which wound its way to the Indiana Supreme Court [2]. In this case a pregnant woman, Mrs. Hurley, sought the services of her family physician, Dr. Eddingfield. Although no other physician was available, Dr. Eddingfield refused to see Mrs. Hurley and she eventually died. Did the court find that, because of Dr. Eddingfield's commitment to a Hippocratic ethic, he had an affirmative legal duty to treat this patient? Hardly. Rather, the Indiana Supreme Court stated that, "The [state licensure] act is a preventive, not a compulsive, measure. In obtaining [a medical license] the state does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept" [2]. The Supreme Court of Indiana was merely following the prevailing norms of the day—that a licensed physician had no legal duty to treat a patient who requested his or her services.

If we survey the development of 20th-century health law, we observe certain challenges to this laissez-faire approach to the practice of medicine. As legal scholar Sara Rosenbaum has noted, there have been significant challenges to the historical no-duty-to-treat rule, principally in the form of EMTALA (Emergency Medical Treatment and Active Labor Act) and various civil rights laws (notably the ADA [Americans with Disabilities Act]) [3]. Yet the AMA's *Code of Medical Ethics* states in principle VI that "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care" [4]. Physicians, then, in nonurgent settings, have the freedom to choose whom they wish to treat and the environment in which they provide medical treatment. What does this mean for the issue of conscience, something that has recently received great attention from the media as well as from various academics and bioethicists?

A 2007 article by Farr Curlin and colleagues, in the *New England Journal of Medicine* reported physicians' attitudes on this question [5]. The authors mention the flurry of legislative activity, especially the Illinois Health Care Right of Conscience Act, which protects health care professionals who exercise their moral convictions in the practice of medicine—even when doing so conflicts with their professional duties. Moreover, their study findings suggest that about 40 million Americans are

treated by physicians who believe they are not obligated to discuss treatment options they find morally objectionable, and nearly 100 million Americans are treated by physicians who do not believe they have an obligation to refer patients to physicians who may be able to accommodate their requests.

Recall that the AMA's principle VI states that a physician may choose whom he or she wishes to treat. Opinion 9.12 of the *Code*, however, states that "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination" [6]. Legally, physicians have no general duty to treat. Yet, it's clear that civil rights laws have made discrimination based on factors such as race or national origin invidious.

How do we balance a physician's sincere commitment to a certain moral belief with a patient's right to receive legal procedures or therapy (say, oral contraception) to which the physician is opposed? Should a pluralistic society allow individuals the freedom to express their conscience when doing their work? Consider the research scientist engaged in developing weapons. Can that research scientist opt out of weapons research based on his moral convictions? Or, can members of religious organizations (say, Jehovah's Witness or Quakers) be excused from military service if their conscience or religious tradition forbids it?

When one is working in health care, a number of professional, personal, religious and cultural norms come into play. When do we decide that one's moral convictions may excuse him or her from professional obligations? Although this may seem to call for ad hoc decision making, it does require a more systematic approach. Is one's objection based on well-recognized values in that religious tradition? Or should this even matter? Can one develop a sincere objection based on conscience that has no rooting in any religious values at all? We might expect that a pluralistic culture such as ours would tolerate and respect a wide range of views regarding specific kinds of health care procedures. Yet such tolerance must be balanced with patients' access to legally sanctioned procedures. The approach taken by some professional organizations seeks to strike a balance—allowing health care professionals to opt out of specific procedures but also requiring that they refer patients to another health care professional [7], thereby accommodating the conscience of individual health care professionals while allowing patients access to health care procedures that are legally available.

One last point deserves mentioning. It is possible that some professional roles may demand engagement in behavior that one believes is unethical. Take the example of the lawyer who works with criminal defendants. Would it be a valid exercise of conscience for a lawyer to habitually state that he or she did not wish to work with certain kind of defendants (sex offenders, say) on the basis of moral convictions? Or can an emergency physician consistently decline to treat patients who engage in sexual practices he or she find morally objectionable? We would be loathe to open the floodgates for professionals to opt out of their work roles whenever they had to

do something distasteful or even offensive to them. Rather, it's important for students considering professional careers to reflect upon the nature of their work. Can they, in good conscience, do the work required of their profession? If the answer is that the work itself creates such an internal conflict, perhaps the student should consider another specialty where such conflict does not readily arise.

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Policy forum

Understanding the ethical framework for Catholic health care

by John O'Callaghan, SJ, STD

The first time I got involved in preparing the ethics section of the documentation required for my institution's JCAHO (Joint Commission on the Accreditation of Healthcare Organizations) accreditation visit, I was surprised at the variety of meanings given to "ethics." As someone trained in moral theology, I thought what we meant by the ethical aspect of life—including health care—was obvious. After devoting some time to responding to JCAHO's concerns, I became convinced that Catholic health care must carefully understand ethics in its most fundamental meaning.

Some in the health profession think of ethics as synonymous with the regulations of HIPAA (Health Insurance Portability and Accountability Act). That's not surprising, since HIPAA deals with concrete applications of such deep ethical principles as privacy and confidentiality which ground Catholic health care. But clearly, HIPAA does not exhaust, or even adequately describe these principles. Other people seem, when citing "ethical" concerns, to be speaking about risk management. In the litigious culture in which we have to operate, risk management, too, is important—but cannot simply be equated with what the Catholic tradition calls ethics.

In the Catholic tradition ethical principles stem, fundamentally, from a view of "the truly human"—what it means to be a human person, how being human *affects what we do* to ourselves, to others, to society, to our physical world. That's the basis for two questions that have become watchwords for medical students at my institution: "Am I becoming the person I want to be?" "Am I becoming the physician I want to be?"

To answer these questions we must reflect on our actions and pose the deeper question that is at the heart of all ethical reflection: "Does what I am doing reflect and express my very best self, the deepest truth of my own humanity?"

Of course, as human beings we can't always be sure that we are answering that question with truth and objectivity. In practice, how do people involved in Catholic health care decide among competing answers to that question when caring for patients, for colleagues and for themselves? What basis do they have to make such determinations?

In general, Catholic health care officials look to the church's centuries-old ethical tradition, unsurpassed in depth and breadth by any body of ethical wisdom in the world. In its medical aspects, it is not a collection of prohibitions—not a long list of no-no's. Rather Catholic ethics is generally positive; it grounds the respect, concern, care and cooperation on which so many Catholic health care facilities pride themselves. It expresses itself in medical care that treats the whole person—body, mind and spirit.

In particular, Catholic institutions look to a document that the Catholic Bishops of the United States first published in 1971 and have updated several times, most recently in 2001. This document encapsulates our ethical tradition as it regards proper health care; its title is *Ethical and Religious Directives for Catholic Health Care Services*.

The ERD, as it is known in the community, is a “metadocument” that provides the ethical framework within which we practice our healing art. It is the basis for all further ethical regulations that govern our practice: it validates and grounds everything that HIPAA prescribes; it is the foundation for all correct, honest risk management; once in a great while it requires that we ask for an exemption from certain prescriptions by regulatory bodies whose job it is to ensure what *they*, but not we, judge to be the correct practice of medicine [1]. In a few areas it differentiates our practice from that of other health care facilities [2].

Continually revised in consultation with theologians, administrators and physicians, the bishops' document intends to provide standards and guidance, not to cover in detail all the complex issues that confront Catholic health care today. The ERD begins by stating as the theological basis for our ministry a continuation of the healing ministry of Jesus, who “touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing. He ‘came so that they might have life and have it more abundantly’” [3]. Each of the document's six parts covers a different aspect of ethical concern: social, pastoral and spiritual responsibility; the patient-professional relationship; challenges in care at the beginning and end of life; and collaboration with other organizations and providers.

Each section begins by establishing the biblical foundation for discussion, and only after that are specific directives for Catholic practice given. There are 72 directives in all, and they take up less than 15 pages of the 46-page document; the other text examines the attitudes, spirit and concern of the church's rich ethical tradition. Though a small number of the directives are prohibitions [4], the majority deal with what Catholic health care ought to do, not avoid.

Pope Benedict XVI said in 2006, “Christianity, Catholicism, isn't a collection of prohibitions. It's a positive option.... We've heard so much about what is not allowed that now it's time to say, ‘We have a positive idea to offer’” [5]. The *Ethical and Religious Directives* are filled with the kind of positive ideas that appeal immediately to anyone wishing to provide health care that goes beyond cataloguing

and treating *disease* and seeks to treat *the sick person*—body, mind and spirit. Far from imposing a largely restrictive framework that impedes doing what is needed for the good of our sick, the document provides a resource for guidance to heal people in total accord with their true nature and its moral exigencies—the way Jesus did.

Notes and references

1. For example, the exemption from training in performing abortions which has been granted to medical programs or residents “with a religious or moral objection” (*ACGME Program Requirements for Residency Education in Obstetrics and Gynecology*) and the expansion of the Residency Review Committee categories to include “induced abortions, surgical and medical, and missed abortions” as procedures counting for *abortion* in residency training (*RRC for Obstetrics-Gynecology*, June 2005 Newsletter, “Resident Case Logs.”
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Policy forum

The principle of double effect and proportionate reason

by Nicholas J. Kockler, MS, PhD

Mrs. Wilson recently discovered that she had an ectopic pregnancy—the embryo was implanted in her fallopian tube. Her physician admitted her to a Catholic medical center for treatment and scheduled a salpingostomy (a surgery that makes an incision in the fallopian tube through which the embryo is removed). But an ethics-savvy surgery center nurse questioned whether that procedure was morally permissible given the Catholic identity of the hospital. The nurse called the bioethics committee to inquire whether the doctor should perform a salpingectomy (surgical removal of the fallopian tube) instead, fearing that the Catholic Church considers a salpingostomy to be a direct abortion.

Mr. Jones has advanced metastatic liver cancer with neoplasms in his bones that cause excruciating pain. He has built up tolerance for virtually all pain medications; his doctors believe that one of the few remaining ways to alleviate his pain is to sedate him. Mr. Jones has said that he no longer wants any curative treatments. The Catholic hospital in which Mr. Jones is receiving care has a strong stance against euthanasia and physician-assisted suicide. Members of Mr. Jones's family approach his doctors and unanimously request, "Please end his life so he can stop suffering."

How does one begin to make sense of these cases? What morally viable options are available for the patients and health care professionals? The principle of double effect enables bioethicists and Catholic moralists to navigate various actions that may or may not be morally justifiable in some circumstances. The questions in this essay are the following: What are the principle of double effect and its proportionate reason condition? How do they function in clinical situations—at both the beginning of life and at the end of life? Despite historical and contemporary debates on the interpretation and application of these concepts, the principle of double effect developed within the long history of Catholic moral theology as a conceptual tool for determining the moral permissibility or justification of actions that have both good and bad (evil) effects. Proportionate reason is one of four conditions of the principle of double effect. In various ways, the principle of double effect and proportionate reason assist decision makers in moral analysis in both Catholic and non-Catholic health care settings.

The principle of double effect

The history of the principle of double effect dates at least as far back as the work of St. Thomas Aquinas. Although St. Thomas did not use the term "double effect" or

refer to the principle, he used the concept in justifying killing in self-defense [1]. In so doing, he recognized the bad effect (death of the assailant) and the good effect (preservation of the victim's life). Can one justifiably kill an attacker to save his or her life? St. Thomas answered in the affirmative. Likewise those who use the principle of double effect today attempt to discern the rightness or wrongness of actions that will have both good and bad (evil) effects.

To make such a determination, one must analyze an action on the basis of four conditions; all of which must be met for the action to be morally justifiable. The conditions of the principle of double effect are the following [2]:

1. The act-in-itself cannot be morally wrong or intrinsically evil [3].
2. The bad effect cannot cause the good effect.
3. The agent cannot intend the bad effect.
4. The bad effect cannot outweigh the good effect; there is a proportionate reason to tolerate the bad effect.

In analyzing acts within the framework of the four conditions, one considers that, if the act satisfies the four conditions, then the act is *indirect* and, therefore, morally licit. If, however, the act does not fulfill these four conditions (or, according to some interpretations, just the first two conditions) the act is *direct* and, therefore, the act is not morally licit [4]. Some theologians argue that application of the four conditions depends on several factors, not the least of which are how one formulates the conditions and how one describes the act. In fact, some argue that the first three conditions are three statements of the same moral proposition: the act cannot be intrinsically evil.

By analyzing our example cases we can appreciate why certain acts are permissible and others are not. In Mrs. Wilson's case, a traditional application of the principle indicates that salpingostomies are *direct* abortions whereas salpingectomies are *indirect* abortions. This conclusion is not without controversy, especially given the development of salpingostomy as the standard of care for ectopic pregnancy [5]. Salpingostomy "directly" attacks the developing embryo, so it does not satisfy the first condition. A surgeon performing a salpingectomy, however, removes the *pathological* tissue (fallopian tube), which does fulfill the first condition. The death of the embryo does not cause, in and of itself, the good effect—preservation of the mother's life; it is the removal of the pathological tissue that causes the good effect, thus fulfilling condition 2. The agent (physician or mother who consents to the procedure) does not intend the death of the embryo, but rather intends the cure of the ailment, thus fulfilling condition 3. The last condition, whether there is a proportionate reason to tolerate the unintended bad effect, asks if the good effect (preserving the life of the mother) outweighs the bad effects—death of the embryo, and, incidentally with salpingectomy, reduction or elimination of the mother's fertility. I will examine proportionate reason more closely below.

In Mr. Jones's case, a traditional application of the principle of double effect indicates that one can administer pain medicine *even if the patient's death is a foreseen, unintended consequence*. How is this justifiable? Is this not euthanasia? The key for Catholic moralists in distinguishing palliative sedation (or allowing to die) from euthanasia (or killing) is the way in which the Catholic tradition understands intentionality. Here, the administration of pain or sedative medicine is not, in and of itself, morally wrong (fulfilling condition 1). The death of Mr. Jones, were it to happen, does not cause his relief of pain (fulfilling condition 2)—the sedative medicine accomplishes this. The agent, the physician or Mr. Jones's surrogate decision maker, does not intend on the death of Mr. Jones (fulfilling condition 3). This last statement may seem to contradict the statement provided by the patient's family. Nevertheless, a close examination of the intent behind their statement is his relief from suffering caused by his pain. Arguably, Mr. Jones's family sees his death as the only means to achieve this end or is unable to distinguish between pain relief and death. Again, is there a proportionate reason for tolerating the bad outcome that would permit sedating Mr. Jones? I now turn to that question.

Proportionate reason

As mentioned above, proportionate reason grounds the fourth condition of the principle of double effect. How does one determine whether the good effect outweighs the bad effect? The phrasing of this question is immediately problematic. One of the main critiques of proportionate reason is its mathematical connotation: how can a good effect *outweigh* a bad effect, especially in end-of-life decisions where the bad effect is often death? Proportionate reason is a moral principle that one may employ to determine objectively and concretely the rightness or wrongness of actions [6]. Given the other conceptual problems with the principle of double effect, many Catholic theologians and moralists have appealed to proportionate reason in an attempt to delineate a more useful interpretation of the principle or to replace it entirely [7]. Thus, proportionalism developed in response to the more problematic approaches to the principle. One should note, however, that even in the traditional formulations of the principle, proportionate reason is a central feature of the four conditions, so traditional interpretations require a concept of proportionality [8].

One should not understand proportionate reason in purely mathematical terms, but rather as a balance between values and disvalues in determining whether the means (an act) is *proportionate* to the intended end or *reason*. The "reason" (*ratio*) here is not "some serious reason" that an agent identifies to justify the evil effect of the act; alternatively, what many commentators "mean by 'reason' [is] a concrete value which is at stake in the act of an agent" [9]. The term "proportionate" means a formal relation between the reason for the act and the premoral values and disvalues in the act [10]. "More specifically, the term signifies a proper structural relation (*debita proportio*) of the means to the end or of the end to further ends" [11]. Thus, the proper understanding of proportionate reason contains these two dimensions: the reason (*ratio*) and the proper structural relation (*debita proportio*) of the premoral values and disvalues involved in the action. Proportionalism is the general analytic

structure for determining the rightness or wrongness of actions within which one appeals to proportionate reason [12]. Scholarship on the principle of double effect, proportionalism and proportionate reason is immense and complex. Unfortunately, I can only treat it cursorily here.

One can easily imagine the problems that emerge in the analysis of moral dilemmas using proportionate reason. Nevertheless, several thinkers have offered criteria for whether proportionate reason obtains. Walter describes some candidates:

- (1) a non-contradiction between the means and the end or between the end and further ends, (2) the means do not undermine the end, (3) the means do not cause more harm than is necessary, (4) in the action as a whole the good outweighs the evil, (5) the means are in a necessary causal relation to the ends, and (6) the means possess the inherent ability to effect the end [13].

Considering first the definition of proportionate reason and second the criteria that establish it, one should recognize that there are various ways of knowing whether proportionate reason obtains. Walter suggests that there are two general ways of knowing: pre-discursive and discursive knowing. His discussion relates to moral epistemology (i.e., the study of moral knowledge), which need not be discussed in detail here. It suffices to say that several modes of knowing exist, from the intuitivist modes to those of discursive reasoning (i.e., analysis and argument) [14], all of which give one insight as to whether the criteria for proportionate reason have been fulfilled.

Pope John Paul II's encyclical, *Veritatis Splendor*, explicitly condemned proportionalism as a normative ethical theory [15]. But some Catholic theologians suggest that the pope's understanding of proportionalism may not have been entirely accurate [16]. The pope categorized proportionalism as a species of consequentialism, which the church condemns because, using consequentialist reasoning, a desirable end can justify any means. No Catholic moralist or theologian would agree with this extreme position. Like consequentialism, proportionalism is teleological, but one can distinguish it from consequentialism precisely because proportionalism accounts for both *means* (the *debita proportio*) and *ends* (the *ratio*). Moreover, proponents of proportionalism, so-called proportionalists, did not develop proportionalism explicitly as a normative ethical theory. Rather, it was an attempt to expand the fourth condition of the principle of double effect. Whether proportionalism evolved into a normative ethical theory is subject to further theological and philosophical inquiry beyond the scope of this essay.

In terms of our cases, one sees that proportionate reason exists in both. In Mrs. Wilson's case, one may claim that a salpingectomy fulfills the fourth condition because the good effect (preservation of her life) outweighs the bad effect (death of the embryo). Because the means (removal of pathological tissue) is indirectly ending the early life of the embryo, such means are proportionate to the intended end; there is a non-contradiction between the means and the end. What about a salpingostomy?

Or administering methotrexate? The permissibility of salpingostomy requires a re-interpretation of the act in question and a determination of whether it passes the first two conditions. Is a salpingostomy a *direct* abortion?

In Mr. Jones's case, one may argue that terminal sedation fulfills the fourth condition because the good effect (relief of pain) outweighs the bad effect (death of Mr. Jones). Here, the means (palliative sedation) is proportionate to the end (relief from pain) insofar as it is the last remaining option. The question of alternatives can help physicians and surrogate decision makers discern what the true intentions behind certain requests are. Thus, a physician might ask Mr. Jones's decision maker, "If there were any other way to relieve Mr. Jones of his pain, would you want to pursue that option?" If he or she answers yes, then one can claim that his or her intent is not in the death of Mr. Jones, but relief of Mr. Jones's pain. The agent cannot intend both to cause the patient's death and relieve his pain. In this hypothetical case, if there are no alternatives to relieving his pain except for sedating him, there is a proportionate reason to do so, and such an act is not euthanasia (*direct* killing of Mr. Jones).

Conclusion

In both example cases, one finds justification for certain actions by applying the principle of double effect, which relies upon specific criteria to establish proportionate reason. Though controversial and subject to various interpretations, the principle of double effect and proportionate reason allow sensitivity to various moral issues in health care, especially from a Catholic perspective; they inform the moral reasoning behind several moral norms in Catholic teaching (e.g., in the *Ethical and Religious Directives for Catholic Health Care Services*); and they represent useful analytical tools for resolving complex moral dilemmas confronted by providers in a variety of health care contexts, Catholic or non-Catholic.

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Medicine and society

Medical futility: legal and ethical analysis

by Peter A. Clark, SJ, PhD

For the past decade a debate has been raging within the medical, ethical and legal communities on the concept of medical futility. Despite its emergence as a dominant topic of discussion, especially as it applies to end-of-life care, the concept of medical futility is not new. Physicians at the time of Hippocrates recognized some medical conditions as impossible to cure and recommended no further treatment for those patients [1]. What has fueled the fires of the current multifaceted debate is the patients' rights movement and the perception that the right of self-determination extends not only to the refusal of medical treatments but to demands for overtreatment [2].

The patients' rights movement began as a reaction to the paternalism of physicians who unilaterally overtreated patients and prolonged their lives against their wishes or the wishes of their surrogate decision makers and family members. The perception of physician-driven overtreatment resulted in a series of legal cases ranging from the Quinlan case in 1976 to the Cruzan case in 1990, which gave patients or their appropriate surrogates the legal right to refuse medical treatment, even if doing so resulted in the patient's death. Despite physician or hospital administration arguments that treatment was appropriate, the courts ruled in favor of the patient's right to refuse treatment and the patient's surrogate's right to withhold treatment, generally on the condition that there was clear and convincing evidence that the patient would refuse life-sustaining treatment if he or she were conscious and able to do so.

In the 1990s, patients and patient surrogates began demanding treatments that physicians believed were *not* in the best interest of the patient because they were medically futile and represented an irresponsible stewardship of health care resources. In legal cases such as Wanglie in 1991 and Baby K in 1994, the courts ruled in favor of the right of patients or their surrogates to request even those medical treatments from which physicians believed they would receive no medical benefit [3]. What has been problematic for the judges in these cases has been the lack of professional or institutional policies on medical futility against which they could judge physician and hospital compliance or noncompliance [4]. These complex cases have set the stage for the present debate over medical futility, which pits patient autonomy against physician beneficence and the allocation of social resources.

Patients and surrogates make the ethical argument that, if they have the right to refuse or discontinue certain medical treatments on the basis of their best interest, they have the right to request certain medical treatments on that same basis. Physicians argue that many of the requested interventions are both burdensome for the patient and medically inappropriate because they fail to achieve the desired physiological effect and result in a misallocation of medical resources. Although providing these treatments can compromise physicians' professional integrity, many feel compelled to comply with the patient's or surrogate's wishes because they believe that society has mandated the provision of such interventions unless there is an agreement to withhold them [5]. The ever-present fear of litigation has not only fueled this debate, it has placed the very foundation of the patient-physician relationship in jeopardy.

The position of absolute patient autonomy ignores the fact that a well-established "best interest" standard assumes both a connectedness of the patient to family and physician and a communication process that allows surrogates to take into account objective, community-based best interest standards [6]. A resolution of these concerns will have to avoid both the traditional physician-driven overtreatment and recent patient- and patient surrogate-driven overtreatment by balancing patient/surrogate rights with physician/societal rights [7]. From an ethical and a legal perspective, one way to foster this balance is to apply a process-based approach to futility determinations on a case-by-case basis. The goal of a process-based approach would be a medical futility policy that protects the patient's right to self-determination, the physician's right of professional integrity and society's concern for the just allocation of medical resources and is securely rooted in the moral tradition of promoting and defending human dignity.

Legal implications

Perhaps one of the biggest challenges in implementing a futility policy is recognition by physicians and health care institutions that adopting such a policy carries with it the threat of litigation. Texas took the lead in addressing the issue of medical futility from both a medical and legal perspective.

In 1999, Texas legislation combined three preexisting laws regulating end-of-life treatment into a single law, the Texas 'Advance Directives Act.' This law established a legally sanctioned extrajudicial process for resolving disputes about end-of-life decisions. This mechanism for dispute resolution may be used in response to a surrogate, living will, or medical power of attorney request to either "do everything" or "stop all treatment" if the physician feels ethically unable to agree to either request [8].

The Texas law became a model for other states and for individual hospitals seeking to make changes in statutory regulations and institutional policies regarding end-of-life treatment decisions. Futility policies are a relatively new initiative in health care, and there was uncertainty as to how the courts would respond when confronted with a "futile treatment" case.

The Texas law was tested in March 2005 when Sun Hudson, born with thanatophoric dysplasia, a typically fatal form of congenital dwarfism, was removed from a breathing tube against the wishes of his mother, Wanda Hudson. The breathing tube was removed pursuant to Chapter 166 of the Texas Health and Safety Code, the Advance Directive Act [9]. Under this act, the doctor's recommendation to withdraw support was confirmed by the Texas Children's Hospital ethics committee. Although it is not required under the act, Texas Children's Hospital took the extra step of getting a judge to rule on its decision. The judge found that the act authorized the hospital to withdraw life support over the objection of the baby's mother.

Wanda Hudson was given 10 days from receipt of written notice to find a new facility to accommodate Sun if she disagreed with the hospital decision, but she was unable to find another facility. Texas Children's Hospital stated that it attempted to contact 40 facilities, but it, too, was unable to find one willing to accept the boy.

On March 15, 2005, physicians at Texas Children's Hospital sedated Sun for palliation purposes and removed the breathing tube; he died within a minute [10]. This was the first time a hospital in the United States had allowed removal of life-sustaining support against the wishes of the legal guardian, and it became a precedent-setting case that should help relieve some of the anxiety of physicians and hospital administrators about invoking a medical futility policy in future cases. It appears that the court acted in the best interest of the patient—who doctors said was certain to die and most likely to suffer before doing so—using a process-based approach.

One of the goals in implementing a futility policy is to facilitate communication between the patient or surrogate and the health care staff so that all parties can come to an acceptable agreement regarding the proposed treatment. If agreement is not reached between the physician or hospital and the patient or surrogate, either party may seek injunctive relief from the courts, or the patient/surrogate may file medical malpractice action.

Physicians are particularly adverse to litigation. The physician who loses a malpractice claim risks damage to his or her professional reputation and the possibility of an increase in malpractice payment premiums. Perhaps even more dreaded though, is the report that will be filed with the National Practitioner Data Bank confirming that the physician lost a medical malpractice suit [11]. A data bank report will follow the physician for the remainder of his or her career, since all hospitals are mandated to query the data bank on a regular basis. Even the physician who prevails in a professional malpractice action expends substantial time defending himself by meeting with attorneys, answering interrogatories, appearing for deposition and testifying at trial. Obviously then, the threat of litigation alone will deter some physicians from ever invoking a futility policy.

For those physicians who are willing to risk litigation for the sake of preserving their professional integrity, a futility policy offers legal benefits. Although a futility policy will not insulate a physician from litigation, it should enable him or her to fashion a strong defense in a medical malpractice claim. As a general rule, to prevail in a professional malpractice action the plaintiff must establish that the harm he or she suffered resulted from the physician's having breached the standard of care. Implementing a futility policy requires consensus from other physicians and other interdisciplinary committees within the institution that the proposed treatment is not beneficial to the patient. Such a consensus among physicians can then be submitted as evidence in legal proceedings to demonstrate that the standard of care was not breached.

Implementation of a futility policy may also give rise to claims for injunctive relief. The patient or surrogate may file an action asking a court to order that the "futile" treatment be administered. Likewise, a physician or institution may petition the court for an order that futile treatment not be initiated or, if already initiated, be discontinued, as in the Wanglie case [12]. If the physician has withheld or discontinued treatment in accordance with the institution's futility policy, the court may be more inclined to conclude that the treatment is, indeed, inappropriate.

Ethical implications

Futility is defined as "inadequacy to produce a result or bring about a required end; ineffectiveness" [13]. Medically, the concept of "futility," according to the American Medical Association, "cannot be meaningfully defined" [14]. Essentially, futility is a subjective judgment, but one that is realistically indispensable [15]. There is consensus within the medical community that at specific times during the course of an illness some treatments are medically futile; consensus ends however, when attempts are made to formulate a fully objective and concrete definition. As a result, futility has been confused with interventions that are harmful, impossible and ineffective. Distinguishing futility from the concept of harmful and ineffective interventions has led to some clarity. In general, a medically futile treatment is

an action, intervention, or procedure that might be physiologically effective in a given case, but cannot benefit the patient, no matter how often it is repeated. A futile treatment is not necessarily ineffective, but it is worthless, either because the medical action itself is futile (no matter what the patient's condition) or the condition of the patient makes it futile [16].

But until we have a more clear understanding of what medical futility means at the bedside, there will not be widespread agreement on definitions and implications of futility in general [17].

Ethicists Baruch Brody and Amir Halevy have distinguished four categories of medical futility that set the parameters for this debate. First, physiological futility, also known as quantitative futility, applies to treatments that fail to achieve their intended physiological effect. These determinations are based not on vague clinical

impressions but on substantial information about the outcomes of specific interventions for different categories of illness states. The second category, imminent-demise futility, refers to those instances in which, despite the proposed intervention, the patient will die in the very near future. (This is sometimes expressed as “the patient will not survive to discharge,” although that is not really equivalent to dying in the very near future.)

Brody and Halevy use the third term, lethal-condition futility, to describe those cases in which the patient has a terminal illness that the intervention does not affect and that will result in death in the not-too-distant future (weeks, perhaps months, but not years) even if the intervention is employed. The fourth category, qualitative futility, refers to instances in which an intervention fails to lead to an acceptable quality of life for the patient [18]. When a treatment is judged to be qualitatively futile, the claim being made is that, although the treatment may succeed in achieving an effect, the effect is not worth achieving from the patient’s perspective [19].

Medically, a consensus concerning the clinical features of medical futility remains elusive. Ronald Cranford’s conclusion is representative: “Whatever futility means, it seems obvious that this is not a discrete clinical concept with a sharp demarcation between futile and non-futile treatment” [20]. Brody and Halevy’s four categories emphasize that decisions on medical futility must be made on a case-by-case basis and must include both a substantive component and a role for patient and surrogate input. Determining whether a medical treatment is futile basically comes down to deciding whether it passes the test of beneficence; that is, will this treatment be in the patient’s “best interest”? The test of beneficence is complex because determining whether a medical treatment is beneficial or burdensome, proportionate or disproportionate, appropriate or inappropriate, involves value judgments by both the patient and the physician.

The Catholic perspective

The medical futility debate is, at bottom, a conflict between respect for patient autonomy, on one hand, and physician beneficence and distributive justice, on the other. In seeking a balance between the values and goals of the patient and the values and goals of medicine, individual autonomy cannot be so inflated in importance as to destroy the principle of beneficence and overlook the equitable distribution of medical resources in society. To find the balance, physicians must reach a consensus on what constitutes a reasonable medical treatment, and patients and surrogates must restrict their self-advocacy to what is fair and equitable for all [21]. The reasonable treatment decision must center on the best interest of the patient, without failing to recognize that every individual is also a member of society. If a physician believes, after carefully considering the patient’s medical status, values and goals, that a particular medical treatment is futile because it violates the principles of beneficence and justice, then the physician is ethically and professionally obligated to resist administering this treatment. The justification of medical treatments on the basis of weighing the benefits and burdens and the appropriate use of medical resources is

firmly rooted in the Catholic moral tradition of the ordinary versus extraordinary means distinction.

Various church documents from *Veritatis Splendor*, to the Pontifical Academy of Life's *Respect for the Dignity of the Dying* to *Evangelium Vitae* make it quite clear that individual autonomy is not an absolute. Pope John Paul II applied this principle to medical treatments in *Evangelium Vitae* when he stated: "Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects of improvement" [22].

The Catholic tradition maintains that if a medical intervention is judged to be ordinary it is viewed as morally mandatory. If extraordinary, it is morally optional. It is said to be ordinary if it offers a reasonable hope of benefit for the patient and could be used without excessive inconvenience, which includes risk, pain and expense. If it offers no reasonable hope or benefit or is excessively burdensome, it is extraordinary [23].

Pius XII further clarified the ordinary versus extraordinary means distinction when he declared that "we are morally obliged to use only ordinary means to preserve life and health—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" [24]. Pius XII bases the distinction between ordinary and extraordinary means on the idea that human life is a basic good, but a good to be preserved precisely as a necessary condition for existence of other values. One must examine the circumstances of a particular situation, which include cost factors and allocation of resources, because these circumstances dictate the balance to be considered between life and these other values. Due to the imprecision of the terms ordinary and extraordinary and the rapid advances in medicine and technology, the Catholic Church now speaks of proportionate and disproportionate means. In determining whether a medical treatment is beneficial and proportionate, the Congregation for the Doctrine of the Faith in *The Declaration on Euthanasia* concludes that,

...it will be possible to make a correct judgment as to the means [proportionate or disproportionate] by studying the type of treatment being used, its degree of complexity or risk, its cost and 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 [25].

This statement, which is rooted in the Catholic tradition, gives physicians the ethical justification to refuse medical treatments if they are either gravely burdensome or medically futile for the patient.

Catholic hospitals are called to embrace Christ's healing mission, which means they must offer patients those treatments that will be beneficial to them. These treatments should restore their health, cure them when possible, relieve pain and suffering, provide comfort care, and improve quality of life. The test of beneficence is whether or not physicians can achieve these goals, not just any goals or any interests [26]. A process-based futility policy will assist physicians in providing patients with medical treatments that are in their best interest, will foster a responsible stewardship of health care resources, and will provide the courts with a fair standard to be used in adjudicating these cases.

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Medicine and society

Roman Catholic ethics and the preferential option for the poor

by Thomas A. Nairn, OFM, PhD

Roman Catholic health care facilities follow a set of guidelines that are compiled in a publication entitled *The Ethical and Religious Directives for Catholic Health Care Services*. Developed in 1949 by what was then known as the Catholic Hospital Association, these directives were published by the United States Conference of Catholic Bishops in 1971 and most recently updated in 2001. Whereas the early versions of the directives almost exclusively concerned specific procedures that were either allowed or not allowed in Catholic hospitals, especially those procedures that occur at the beginning or at the end of life, the 1994 and 2001 versions begin with a section entitled, “The social responsibility of Catholic health care” [1].

Each of the six sections of the ERD, as the document is known, begins with an introductory narrative. As part of the introduction to the chapter on social responsibility, the bishops state:

...the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country’s health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured and the underinsured [2].

Preferential option for the poor

The bishops speak of the care for the poor—or the preferential option for the poor—as a biblical mandate. The gospel narratives often link this option to the early proclamation of Jesus in the synagogue where, quoting Isaiah, he notes that his mission is to “bring glad tidings to the poor, proclaim liberty to captives, recovery of sight to the blind, to let the oppressed go free, and to proclaim a year acceptable to the Lord” (Luke 18-19). Other pertinent texts refer either to the beatitudes, which declared the poor to be blessed (Matthew 5:3-12; Luke 6:20-23), or to Matthew’s account of the last judgment scene, in which the poor are seen to represent Christ (Matthew 25:31-46).

The language of preferential option for the poor in the body of the ERD, however, is of more recent origin, coming from the Latin American Bishops’ Conferences that met in Medellin, Colombia, in 1968 and in Puebla, Mexico, in 1979. The Medellin Conference called upon the Catholic Church in Latin America to become a church of

the poor: “to be the evangelizer of the poor and one with them, a witness to the value of the riches of the Kingdom, and the humble servant of all our people” [3]. During the Puebla Conference, the term “preferential option for the poor” was coined. In their description of the term, the bishops stated that “this option does not imply exclusion of anyone, but it does imply a preference for the poor and a drawing closer to them” [4].

In 1986, the United States Catholic bishops continued discussion of this theme. They explained, “As followers of Christ, we are challenged to make a fundamental ‘option for the poor’—to speak for the voiceless, to defend the defenseless, to assess lifestyles, policies and social institutions in terms of their impact on the poor” [5]. A year later, Pope John Paul II also addressed this theme in an encyclical:

The preferential option or love of preference for the poor...is an option, a special form of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness. It affects the life of each Christian inasmuch as he or she seeks to imitate the life of Christ, but it applies equally to our social responsibilities and hence to our manner of living, and to the logical decisions to be made concerning our ownership and the use of goods [6].

Health care and the option for the poor

To understand how the Catholic preferential option for the poor affects health care, one must explore the nature of health care itself. According to Catholic social teaching, health care is not a commodity best regulated by a free market economy. Rather it is a social good that is considered to be a basic right. If health care is a basic right, then the fact that tens of millions in this country and billions around the world lack access to it must be viewed as a grave injustice. The Catholic social tradition stresses that the antidote to this injustice is solidarity and dedication to the common good.

This notion of a preferential option for the poor involves a self-conscious move from a passive understanding that the work of Christians is to provide charity to the poor to an active position that demands justice for the poor. The latter stance raises questions regarding the causes of injustice, which are often linked to what Pope John Paul II called the social structures of sin. The preferential option demands solidarity with the poor, defined not as some “feeling of vague compassion” but “a firm and persevering determination to commit oneself to the common good” [7]. What do such responsibilities encompass? The Jesuit theologian Thomas Massaro puts it succinctly, “The entire tradition of Catholic social teaching...can be interpreted as a unified effort on the part of church leaders to encourage a more humane society where the most vulnerable members are better protected from harm” [8].

Cardinal Joseph Bernardin, the late archbishop of Chicago, was a prelate who took the preferential option for the poor seriously. His book, *Consistent Ethic of Life* was an attempt, as he repeated in many of his talks dedicated to this topic, “to defend the

right to life of the weakest among us and to be visible in the support of the quality of life of the powerless among us” [9]. In a 1986 address at the Catholic Medical Center in Jamaica, New York, he articulated the contours of the sorts of challenges that must be faced by those in health care who take seriously the mandate of a preferential option for the poor. As one reads his words, one could simply substitute “preferential option for the poor” for “consistent ethic”:

If Catholic hospitals and other institutions take the consistent ethic seriously, then a number of responses follow. All Catholic hospitals will have outpatient programs to serve the needs of the poor. Catholic hospitals and other Church institutions will document the need for comprehensive prenatal programs and lead legislative efforts to get them enacted by state and national government. Catholic medical schools will teach students that medical ethics includes care for the poor—not merely an occasional charity case, but a commitment to see that adequate care is available. If they take the consistent ethic seriously, Catholic institutions will lead efforts for adequate Medicaid coverage and reimbursement policies. They will lobby for preventive health programs for the poor [10].

Cardinal Bernardin continued:

My point in raising these issues is not to suggest simplistic answers to complex and difficult questions. I am a realist, and I know the difficulties faced by our Catholic institutions. Nonetheless, the consistent ethic does raise these questions which present serious challenges to health care in this nation—and specifically to Catholic health care systems [10].

At the present time, the preferential option for the poor in health care is more of an ideal than reality. It calls for what Catholics describe as a conversion of heart. Yet, it also offers hope to more than just the poor. Thomas Massaro suggests:

To adopt the principles of Catholic social thought is to agree that we all need to work hard so that full participation is extended to all, without favoritism or discrimination. We all have something to contribute to the common good, and all may benefit from the gifts we bring to the common table of human community and solidarity [11].

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Op-ed

The Catholic Health Association's response to the papal allocation on artificial nutrition and hydration

by Ron Hamel, PhD

Pope John Paul II's allocution on "Care for Patients in a 'Permanent' Vegetative State" sent shock waves through the Catholic health care system in the United States when it was released on March 20, 2004. It was probably not the practical import of the pope's comments that created such consternation, for persistent vegetative state (PVS) is not a common condition, and most patients in PVS are probably not in Catholic health care facilities. What was most disturbing was that the allocution seemed to reflect a change in church teaching about ordinary and extraordinary means of caring for the dying (now commonly referred to as proportionate and disproportionate means), which had remained consistent for over 500 years. The logic of the pope's statements could be applied beyond patients in PVS to all patients as, in fact, several bishops and others have proposed since the allocution. Such a development could have a devastating effect on end-of-life care in Catholic health care facilities.

The Catholic Health Association of the United States (CHA) has no jurisdiction over Catholic health care organizations; membership in the organization is voluntary. It is, however, looked to by system and facility members for guidance, and that was surely the case after the papal speech. After a group of theologians and ethicists completed a thorough analysis of the allocution, its possible meanings and its potential implications, the CHA issued a brief statement to its members indicating that there was a lack of clarity in the allocution, that it required further study, and that, in the meantime, Catholic health care facilities should continue to follow Directives 56, 57 and 58 of the *Ethical and Religious Directives for Catholic Health Care Services* (a document first issued in 1971 by the United States Conference of Catholic Bishops [USCCB] and approved by the Vatican's Congregation for the Doctrine of the Faith [CDF] for guiding the practice of Catholic health care facilities) [1].

Directives 56 and 57 define ordinary (or proportionate) and extraordinary (or disproportionate) care for the dying and clearly reflect the long-standing tradition and teaching on this subject. Directive 58 applies the definitions from Directives 56 and 57 to artificial nutrition and hydration (ANH). In brief, Directive 58 says that there should be a presumption in favor of providing nutrition and hydration as long as "this is of sufficient benefit to outweigh the burdens involved to the patient" [2]. By contrast, the pope's allocution claimed that ANH was "normal care" and hence not subject to the weighing of benefits and burdens.

On what grounds could the CHA take the position of deferring to the directives rather than encouraging its members to immediately adhere to the stipulations of the 2004 allocution? The allocution was, after all, papal teaching. While all papal teaching is important, it does not all have the same weight. The pope makes dozens of speeches per week, virtually all of them expressing views and sentiments on particular issues, but they are not intended as infallible or definitive teachings. In fact, allocutions are among the least authoritative of papal statements. Other statements have more authority, with the culmination of authority coming in papal encyclicals and infallible pronouncements (which are few). Within the church, teachings with different levels of authority require different types of responses. What kind of response is due by Catholics to a papal allocution?

In ecclesiastical language, a papal allocution requires “religious submission of will and mind” [3]. What this means is that one must give very serious attention to the teaching and must receive the teaching with an openness that is ready and willing to make the teaching one’s own. Essentially, this means having a presumption in favor of the teaching, rather than in favor of other positions. Therefore the burden of proof is on the person who would challenge the presumption, and the presumption holds unless there are substantial reasons to override it.

What were the “substantial reasons” that overrode the presumption in favor of this 2004 allocution on care of patients in PVS? First, the allocution did not have the weight or authority of other types of teaching. In 1980, the Congregation for the Doctrine of the Faith (CDF) issued the *Declaration on Euthanasia* in which it affirmed the principle of proportionate/disproportionate means as it had been traditionally understood. A declaration from the CDF has more authority than an allocution. The *Declaration on Euthanasia* was not rescinded before, during or after the papal allocution. It continued to be normative for the church. Although they had less authority than the Declaration on Euthanasia, the *Ethical and Religious Directives* (approved by the CDF) were not rescinded or altered. So traditional church teaching on proportionate and disproportionate care for the dying remained normative, even after the allocution.

Second, the papal allocution seemed to alter the traditional teaching of the church by stipulating that a particular means, i.e., artificial nutrition and hydration, was “normal care” and “a natural means of preserving life, not a medical act,” and, therefore, morally obligatory, independent of an assessment of benefits and burdens to the patient, the patient’s family and the community. In the Catholic tradition, no means was said to be ordinary or extraordinary in the abstract, apart from a consideration of the benefits and burdens of the means upon the patient as judged by the patient or the patient’s surrogate [4]. If Pope John Paul II was intending to alter or revise 500 years of teaching on such a significant matter, it seemed odd to CHA staff that he would choose to do so in an ordinary speech to a group of conference participants and not acknowledge that this was a revision or a development of church teaching.

Third, and related to the above, the position which the pope articulated not only seemed to alter longstanding church teaching, it also reflected a minority position within the Catholic theological community, one which seemed to be at variance with traditional teaching. The allocution was not the first time that the pope had stated that position—he had done so in remarks during one of his visits to the United States. Nor was he the first to express the position. It was articulated by several Vatican advisory bodies in 1981, 1985 and 1995 [5]. In 1992, the Committee on Pro-Life Activities of the United States Conference of Catholic Bishops issued a document called “Nutrition and Hydration: Moral and Pastoral Reflections” in which the position was advocated [6]. It was also espoused by a few State Catholic Conferences over the years [7]. Nonetheless, it has been and continues to be a minority position. This is not to say that the majority rules or that the position is wrong, but in this case the majority position has 500 years of tradition behind it and, if a change is warranted because of technological and social developments, it needs to be carefully debated and argued. To date, this has not occurred.

Fourth, the circumstances surrounding the allocution raised some doubts about the degree to which the position reflected the pope’s own thinking. The pope’s speech came at the end of a conference entitled “Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,” sponsored by the World Federation of Catholic Medical Associations and the Pontifical Academy for Life. The leaders of these organizations and a vast majority of conference speakers and participants reflected prolife views to the far right of center. One viewpoint dominated the conference, and there was little opportunity for the expression of alternative views or for honest dialogue and debate. The conclusions and recommendations were announced to the press the day before the conference began [7]. At the time (one year before his death) the pope was suffering from end-stage Parkinson’s and was extremely frail. These circumstances made it difficult to feel confident that this papal speech came out of a long and careful study and consultation process.

Finally, and surely no less important, many of the more scientific claims within the allocution fly in the face of medical and scientific literature and the current consensus among clinicians regarding persistent vegetative state. Furthermore, these claims were not substantiated by references to the literature.

In light of these considerations, it seemed reasonable to encourage Catholic health care organizations to continue as they had been until there was clarification by appropriate authorities, while taking very seriously the many positive aspects of the allocution. To date, there has been no clarification of the allocution by the CDF or the USCCB, nor did Pope John Paul II repeat the content of the allocution. Neither has the current pope, Benedict XVI, made any statements on the topic despite opportunities to do so. The concerns behind the papal allocution were and remain legitimate. Altering church teaching, however, may not be the best means to address them and may well have many harmful unintended consequences. Perhaps the lack

of clarification over these three years indicates that the church's position is being re-evaluated and that approaches to the challenges the allocution sought to address are being explored.

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Related articles

[Understanding the ethical framework for medical practice in Catholic health care,](#)
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[Is artificial nutrition and hydration extraordinary care?](#) May 2007

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Response to [“In search of obscure diagnoses: *House*”](#)

I enjoyed reading the articles about medical shows on television in the March 2007 issue of *Virtual Mentor*. I am a pre-medical student at the University of Michigan and have watched some of these shows, with *House* being my favorite.

I was especially interested in the article discussing the obscure conditions portrayed in *House*, which the author appropriately calls “a show about zebras”[1]. The article focuses on the clinical aspects of a few rare diseases diagnosed by Dr. Gregory House, the show’s brilliant medical detective. I was surprised that the article, which appears in a journal about medical ethics, gave no more than a fleeting reference to the astonishingly unethical behavior that this doctor displays in each episode of the show. House’s unique diagnostic approach includes avoiding his patients, treating before testing, manipulating families, playing video games in his office, watching *General Hospital* in comatose patients’ rooms while hiding from his boss, and—my personal favorite—having his fellows break into patients’ homes to look for diagnostic clues.

One of the diseases discussed in the article is primary amoebic meningoencephalitis, which is caused by the waterborne amoeba *Naegleria fowleri* [1]. This disease affects a patient portrayed in the two-part episode “Euphoria”—named for the first symptom experienced by the patient in the episode. The illness occurs in a crooked, “euphoric” police officer who is shot and left with bullet fragments in his head, but presents with other symptoms. Dr. House—the Jack Bauer of medicine—sends his fellow, Dr. Foreman, to break into the police officer’s home to check for bacteria, toxins, etc. While there, Foreman comes across a greenhouse where the officer was growing marijuana with stolen water and fertilizer. Foreman later contracts the same condition.

As the officer’s condition worsens, House wants to see if he can do an MRI on a patient with bullet fragments in his head. So he buys a gun and bullets of the same type as those in the officer’s head, goes to the morgue, shoots a corpse in the head, and throws it into the MRI machine. The machine breaks and the body is a mess. To treat the officer’s latest symptom—unbearable pain—House puts him in a coma to control the pain and stop his screaming, but soon thereafter, the patient dies.

Desperate to save Foreman, House deliberately infects him with Legionella bacteria, because the police officer had legionellosis, which slowed the original infection for some reason. Later House heads back to the officer’s flat, where he discovers the stolen drainage water used by the officer for his marijuana, riddled with *Naegleria*.

After House cures Foreman of his amoebic infection, he delivers his moral message: “Don’t cut corners when growing your pot.”

Obviously it is House’s ridiculous methods and countless acts of malpractice that make the show amusing. As a medical student’s essay explained, “To build and maintain story-line intrigue, medical dramas almost always develop a tangled web of personal romances and professional rivalries that frequently violate the ethical and professional codes by which the overwhelming majority of physicians operate”[2]. But I worry that this show and other medical programs on television give the audience a warped view of medicine, because, as noted in another essay in *Virtual Mentor*, “society’s image of medicine is probably most defined by medical dramas”[3].

To discuss the lack of ethics in *House* would be like discussing the lack of realism in *Star Wars*; it would span 100 pages or more. House’s misbehavior would, in real life, lead to newspaper headlines, multimillion-dollar lawsuits and severe (and probably career-ending) disciplinary action against him, but that misbehavior is most likely the key reason for the show’s popularity. People enjoy powerful figures in movies and TV shows and watching House allows viewers to vicariously feel his power as a physician—power that is immeasurably amplified by reckless and repeated violations of the mores of medicine.

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Suggested Readings and Resources

May 2007

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