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The Role of Morality in Health Care and Its Dilemmas

by

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Introduction: Health Care and Human Persons

Despite the ethical pluralism that exists in the modern health care setting and the "radical moral disagreement"¹ it often leads to, I think it is safe to assume that all health care professionals would agree that the chief goal of medicine is fulfilling the *health needs* of the human person.² To restore health and to help people maintain it is a matter of fulfilling human needs. Therefore, to think clearly about ethical dilemmas in modern medicine it is important to have an adequate conception of what it means to be a human person, because health care, in sustaining *health*, serves the *basic good of human life*, of which health is a vital dimension.³

I. Different Views of Personhood

Today there are many different notions of what it means to be a person.⁴ Some of these notions are *materialistic*, in the sense that they deny that human beings have a spirit or soul. According to this view, the human being is essentially reducible to his or her brain and central nervous system, since it is with these parts (and nothing more) of the human person that I think and communicate.⁵ Other views are radically *dualistic*, that is, they separate bodily life from personal life. Those who hold this view are fond of making a distinction between being *human* and being a *person*. In

this understanding, a "person" is one who is self-aware, able to communicate, and autonomous. If a member of the human family lacks these characteristics, we could call this individual human but we could not call him a person.⁶ There are also some anthropological views that would equate animal life with human life. This *equal species* anthropology maintains that it is wrong to discriminate on the basis of species, i.e., to treat human life as more valuable than nonhuman life.⁷

The view, I would argue, that has the most to say for itself is the one which understands the human person as *a bodily being with a difference*.⁸ Rather than separate human nature from personhood, this view rightly holds that one's body is an integral aspect of one's identity as a person. Moreover, against materialism, this view would affirm that man is capable of transcending his physicality because he is endowed with an immaterial intellect or soul. In this nondualistic view of the person both "body" and "soul" together form a unified whole. Those who follow this much older thinking about the nature of the human person, define personhood as *"embodied intelligent freedom."*⁹ This tradition also sees the human person as existing and finding fulfillment in a network of other human persons, i.e., as part of a *community of persons*.

Obviously, these various conceptions of the human person will have implications for how one evaluates moral dilemmas in health care. Indeed, our understanding of the person is, in many ways, more fundamental than the moral principles and norms that articulate for us morally upright courses of action. But why more fundamental?

II. Anthropological Starting Points for Ethics, Including Health Care Ethics

More fundamental because the starting point for ethics is two central features of human persons: their *intelligent freedom* and their *desire for happiness*.¹⁰ Morality, whether is it in the field of health care, politics, or law takes into account the fact that human persons are capable of making *free choices* which concern the kind of people they are going to be. That is, at the heart of every external deed resides a *choice* that forms and expresses one's moral identity or character.¹¹ For example, one's choice to become a doctor or a nurse was (is) a self-determining choice that influences one's life in a profound and perduring way.

Morality is also concerned with the achievement of true *happiness* for oneself and all human persons in community. Indeed, seeking lasting happiness for oneself is the overarching goal that structures all of one's choices and gives them meaning. Some philosophers describe this state of

personal completeness or harmonious wholeness as *integral human fulfillment*.¹²

The basic principles and norms of morality exist to serve the end of integral human fulfillment. Often, however, persons are in need of medical care because of a particular malady that threatens their health or even their life. If we understand health to be an essential need of the person, and its satisfaction a dimension of one's integral human fulfillment or happiness, restoring health is one of the ways – indeed, for health care workers it is the primary way – of contributing to the integral human fulfillment of persons.

III. Personhood and Health Care Ethics

In the context of health care, one's view of the human person will guide how one applies various principles of morality to difficult cases. For example, if one's understanding of personhood sharply distinguishes between being human and being a person, then, usually the very young (e.g., unborn children and infants – especially defective ones) and the very old (e.g., especially the severely incompetent) will not be viewed as persons in the proper sense. Therefore, one need not always treat them as beings who are the subjects of human rights and thus entitled to our full respect.

Similarly, if one views the human person dualistically, thus separating bodily life from the person as a conscious subject of itself, then, intentionally depriving the severely handicapped – whether young or old – and the irreversibly comatose – whether young or old – of their bodily life cannot be regarded as the intentional killing of a human person.¹³ Or, at least, if it is regarded as killing a person, it is justified on grounds of either “the lesser of two evils” or some “greater good” that one hopes to achieve.¹⁴ These two erroneous accounts of the human person are quite common in our culture today and they underlie the arguments advanced in support of abortion, euthanasia, physician-assisted suicide, and other immoral practices. They often are summarized in the expression “*quality of life ethic*.” In contrast, for those who view the human person nondualistically, the bodily component of the individual is also personal, that is, it too shares in the dignity of the person. Because the good of bodily life is an integral dimension of who one is, choices to terminate the lives of those who have irretrievably lost their capacity for conscious awareness and for communicating meaningfully to other conscious subjects, are immoral.¹⁵ They are choices to take the lives of human

persons, not "lumps of flesh." This view of the person is commonly referred to as the "*sanctity of human life ethic*."¹⁶

IV. Moral Truth, Moral Principles, and *Integral Human Fulfillment*

What now of morality? What is the role in health care, especially health care dilemmas? And how is it related to the fulfillment of persons? We have already spoken of three central anthropological features of human persons: (1) they are *bodily beings*; (2) they are able to make *free choices*; and (3) they seek *integral human fulfillment* or *happiness*. The task of morality is to provide objective norms or guidelines for directing our freedom so that our choices, including health care choices, are made in accord with *moral truth*. A choice that is made in accord with moral truth is one that respects the total well being, the happiness, the *integral human fulfillment* of the person. In fact, the "*first principle of morality*" itself can be stated as follows: *that in every act that carries out some choice one should respect integral human fulfillment*.¹⁷ That is, one should choose in such a way that one respects each and every basic good or value of human existence. Among these goods is *human life* itself, including health, bodily integrity, and the handing on and educating of new human life, *playful activities* and *skillful performances*, *knowledge*, *self-integration*, *practical reasonableness*, *friendship*, and *religion*.¹⁸ All of them are equally fundamental and intrinsically good. Fully realized and actualized in all human lives, they would constitute integral human fulfillment, total human happiness.

However, many different sorts of choices do not respect the first principle of morality, and hence, do not respect the person(s) in whom the basic goods are meant to exist. Among them would include alternatives of choice that *ignore*, *slight*, *neglect*, *arbitrarily limit*, *damage*, *destroy*, or *impede* some basic human good(s) in oneself or in another person(s).¹⁹ Each of these ways of choosing violates some aspect of the human person's dignity; each manifests a way of choosing that is incompatible with an openness and love for all goods of human persons. And, as we know, in the field of health care there are not only opportunities for doing good to patients, but also many opportunities for doing harm to them. For example, we can harm the good of truth by lying to our patients or by ignoring our patients' right to informed consent.

V. Health Care, Ethical Theory, and the "Four Principles of Bioethics"

Many bioethicists today are fond of an ethical system of "*common morality based on moral principles*." One such ethical system is based on

an ethical methodology which consists of "four principles": *beneficence, nonmaleficence, autonomy, and justice*.²⁰ While each of these principles is certainly important in any articulation of a bioethical theory, they are not sufficient by themselves, especially when divorced from the anthropological foundations of ethics and from the other principles of morality that were formulated above. Moreover, there are too many challenges that such a bioethical theory faces and is not able to withstand. One such challenge, among many others, is subjection to the "*technological imperative*." The "four principles" approach is not able to adequately respond to those who say, "if we *can* do something, then we *should* do something." Thus, in addition to the four principles, we need both a focus on the dignity of the human person and a wider set of moral principles in order to make good health care decisions²¹ – whether in difficult cases or in the simpler ones.

VI. Health Care Dilemmas: Care for the Dying at the End of Life

In this last section of my paper I shall treat some of the issues with respect to care for the dying patient at the end of life. For someone who adopts the anthropology and moral methodology that I articulated earlier, what might an approach to this matter look like? My specific focus here will be on the ethical problems that arise in the care of the dying (competent or incompetent) adult patient. What are the moral criteria and principles that are necessary to deal with various dilemmas that arise in the care of such patients? I will first articulate these general criteria/principles and then go on to apply them to the difficult case of *assisted nutrition and hydration* of the *permanently comatose/unconscious patient*.²²

Traditional ethics has tended to reject "*quality of life*" decisions in favor of a moral analysis that focuses on the obligatory or nonobligatory character of a particular medical *treatment*. In deciding whether to withhold or withdraw treatment from a sick patient, *two criteria* are necessary.²³ First, one must determine whether the continued use of a treatment is *futile*, i.e., of no therapeutic benefit. Second, the question must be asked whether the *treatment* (not the patient's life!) imposes an excessive *burden* (such as pain, indignity, risk, cost, etc.) which is not in proportion to the benefit gained or hoped for.

By using these two criteria, the health care worker, in the words of the moral philosophers John Finnis and Anthony Fisher, O.P., "does not indulge in arbitrary 'quality of life' decision-making, but rather makes a (sometimes difficult) therapeutic judgment about the helpfulness or not of the proposed medical treatment in dealing with the patient's illness. On this basis some treatments will be medically indicated and morally required

('ordinary'); others will be optional ('extraordinary'); and still others will be contraindicated (and immoral)."²⁴

With regard to the difficult moral problems of whether to artificially feed and hydrate the irreversibly comatose, there are, admittedly, divergent opinions, even among conservative Roman Catholic and Protestant ethicists and bishops.²⁵ However, given the nondualistic anthropology that we have argued in favor of, even the very reduced and deficient life of the irreversibly comatose remains intrinsically good; it is the very existence of an *irreplaceable* and *nonsubstitutable* body-person who can still be harmed, e.g., by being subjected to indignities. Thus, I would argue, that unless these patients are immanently dying or unable to assimilate the nourishment and fluids provided, then feeding and hydrating them remains morally required because it is a *benefit* to them, namely, *it sustains their lives* – lives which, despite their debilitated condition, remain instances of a basic human good.²⁶

This moral stance is not, however, to be identified with "vitalism," that is, the view that we are obligated to maintain human life, especially so-called mere "biological life," at all cost even if the burdens outweigh the benefits. On the contrary, as already noted, we are not obligated to use "extraordinary" means of treatment; but generally, in these cases, I do believe feeding and hydrating provide the patient with a benefit and are not overly burdensome. Moreover, recalling our nondualistic anthropology, we must affirm that the bodily lives of those who have permanently lost consciousness are still personal. We cannot divide the person in two and say that the unconscious body that lies before us is no longer the person that we knew and loved. The life of this individual remains *inherently the very life of a human person*. In other words, human life, however burdened, is always a good of the human person, and not merely a good for the person. Thus, to quote William E. May, et al., "remaining alive is never rightly regarded as rendering a benefit."²⁷

In treating the permanently unconscious or those in severe pain or with an incurable sickness, the *standard of care* that all health care professionals must aim for is a *compassion* which forswears not only "direct" killing, but one which promotes and protects their well-being, alleviates their pain, and assists them in their bodily, emotional, and spiritual needs. It is only this kind of care that will ensure "*dignity in dying*," rather than "*death with dignity*."

Conclusion: Why Morality in Health Care?

Why should we be concerned with *morality* in the field of health care? As human persons, one of our greatest needs is our need for *moral*

truth.²⁸ Morality guides us to the satisfaction of that need. And we satisfy it by choosing *well*, that is, in accord with the integral human fulfillment of persons. We might look at the matter this way: the fundamental principles and norms of morality direct us to the basic goods which fulfill us as persons and they also show us the way to choose these goods in morally upright ways, so that we might more fully participate in them. It is only by participating in these goods, including the goods of life and health, that we *perfect* ourselves and become the "complete", i.e., *happy* beings we are called to be by our Creator.²⁹

References

1. I borrow the expression from Joseph Boyle, "Radical Moral Disagreement in Contemporary Health Care: A Roman Catholic Perspective," *The Journal of Medicine and Philosophy* 19 (1994): 183-200.
2. Cf. Benedict Ashley, O.P. and Kevin O'Rourke, O.P., *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, D.C.: Georgetown University Press, 1997), chapter 1.
3. Cf. John Finnis and Anthony Fisher, O.P., "Theology and the Four Principles: A Roman Catholic View I," in (Ed.) Raanon Gillon, *Principles of Health Care Ethics* (West Sussex, England: John Wiley & Sons, 1994), p. 37.
4. See the following informative articles on personhood: Patrick Derr, "The Historical Development of the Various Concepts of Personhood," and Benedict Ashley, O.P., "Contemporary Understandings of Personhood," in (Ed.) Russell E. Smith, *The Twenty-Fifth Anniversary of Vatican II: A Look Back and a Look Ahead* (Braintree, MA: Pope John Center, 1990), pp. 17-34 and pp. 35-48, respectively.
5. Cf. Francis Crick, *The Astonishing Hypothesis: The Scientific Search for the Soul* (Old Tappan, NJ: MacMillan, 1995). Another good description of the materialist view, by a neuroscientist who disagrees with it, is found in the late Sir John C. Eccles, *How the Self Controls Its Brain* (Berlin and Heidelberg: Springer-Verlag, 1994), chapter 3. Some philosophers will also use the term "physicalism" to describe this view of the human person, especially the relationship between mind and body.
6. This anthropology is expressed well in the thought of the philosopher John Harris, "The Philosophical Case Against the Philosophical Case Against Euthanasia: A reply to John Finnis": "[A] person is a unified complex being, but

that complexity is part of what it is to possess the radical capacities of intelligence and autonomy – in short, the capacity to value existence. *When these are lacking the person has ceased to exist (or has not yet come into being),*” in (Ed.) John Keown, *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press, 1997, revised paperback ed.; originally 1995), p. 41, emphasis added.

7. Cf. Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (New York: St. Martin's Press) pp. 165-183; 201-206, for his case against what he calls “speciesism,” i.e., the denial of rights to nonhuman beings simply because they are not members of the human species. I have responded to Professor Singer in “The Gospel of Life vs. The Culture of Death,” *Homiletic & Pastoral Review* (April 1997): 20-28.

8. On the nature of this difference, see Mortimer Adler, *The Difference of Man and the Difference it Makes* (New York: Fordham University Press, 1993; originally 1967), especially chapters 7 through 14; David Braine, *The Human Person: Animal and Spirit* (Notre Dame, IN: University of Notre Dame Press, 1992); and Benedict Ashley, O.P., *Theologies of the Body: Humanist and Christian* (Braintree, MA: Pope John Center, 1995, originally 1985), pp. 307-332. In the Preface to the 1993 edition of his book, Adler writes: “[M]an differs radically in kind [not merely superficially and not merely in degree] by virtue of an intellectual power possessed by no other animal and not seated in the human brain” (ix.) According to Adler, while animals possess merely *perceptual thought*, man, because of this immaterial power, is equipped with *conceptual thought*.

9. Ashley and O'Rourke, *Health Care Ethics*, p. 5; see also pp. 3-7.

10. Cf. Finnis and Fisher, “Theology and the Four Principles,” p. 32.

11. Cf. Germain Grisez, *The Way of the Lord Jesus, Vol. 1: Christian Moral Principles* (Chicago: Franciscan Herald Press, 1983), chapter 2. See also Pope John Paul II, *Veritatis Splendor* (The Splendor of Truth), #71 on the self-determining dimension of free choice.

12. Cf. Germain Grisez, Joseph Boyle, and John Finnis, “Practical Principles, Moral Truth, and Ultimate Ends,” *American Journal of Jurisprudence* 32 (1987), pp. 131-133.

13. Cf. William E. May, “Bioethics and Human Life,” in (Ed.) David Forte, *Natural Law and Contemporary Public Policy* (Washington, D.C.: Georgetown University Press, 1998), pp. 7-9.

14. As an example of this kind of moral reasoning, *The Detroit News* reported that a presidential panel is going to recommend that the federal government fund research on human embryos because, according to the panel, “the moral cost of destroying

embryos in research is outweighed by the social good that would come from the work," (Federal Embryo Research Endorsed," May 23, 1999, 5A).

15. Cf. May, "Bioethics and Human Life," pp. 7-9.

16. An insightful discussion of these two "ethics" – the "quality of life" versus the "sanctity of life" – is found in (Ed.) Luke Gormally, *Euthanasia, Clinical Practice and the Law* (London: The Linacre Center for Health Care Ethics, 1994), pp. 118-126.

17. Cf. Grisez, Boyle, and Finnis, "Practical Principles, Moral Truth, and Ultimate Ends," pp. 127-128. Using religious language, the Bible expresses this most fundamental moral principle by saying that you ought to "love God and your neighbor as yourself" (see Deuteronomy 6.5, Leviticus 19.18, Matthew 22.37, Mark 12.30-31, and Luke 10.27).

18. Cf. *ibid.*, pp. 106-108.

19. Cf. William E. May, *An Introduction to Moral Theology*, revised edition (Huntington, IN: Our Sunday Visitor Press, 1994), p. 78.

20. Cf. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York and Oxford: Oxford University Press, 1994). See also chapters 2-6.

21. Cf. Finnis and Fisher, "Theology and the Four Principles," p. 31, see also pp. 35-42.

22. The literature on this issue is voluminous. See the interesting exchange in *Ethics & Medics* between William E. May ("Tube Feeding and the 'Vegetative' State," December 1998 and January 1999) and Kevin O'Rourke, O.P. ("On the Care of 'Vegetative' Patients," April and May 1999).

23. Cf. Finnis and Fisher, "Theology and the Four Principles," pp. 38-39. See also (Ed.) Gormally, *Euthanasia, Clinical Practice, and the Law*, chapters 5 and 6.

24. Cf. Finnis and Fisher, "Theology and the Four Principles," p. 39.

25. See William E. May's helpful overview of the different positions taken on this issue by Roman Catholic bishops, theologians, and philosophers, "Caring for Persons in the 'Persistent Vegetative State'," *Anthropotes* 13 (1997): 317-331.

26. Cf. May, et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," *Issues in Law and Medicine* 3 (1987): 203-217.

27. Ibid., p. 205.

28. Cf. William E. May, "People's Needs, Moral Truths and Priests," in *The Catholic Priest as Moral teacher and Guide (A Symposium)* (San Francisco: Ignatius Press, 1990), pp. 71-90.

29. On the importance (and neglect) of happiness as a fundamental principle in (contemporary) Christian ethics, see Servais Pinckaers, *The Sources of Christian Ethics* (Washington, D.C.: The Catholic University of America Press, 1993), pp. 17-22.