

Bioethics for clinicians: 27. Catholic bioethics

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Abstract

THERE IS A LONG TRADITION OF BIOETHICAL REASONING within the Roman Catholic faith, a tradition expressed in scripture, the writings of the Doctors of the Church, papal encyclical documents and reflections by contemporary Catholic theologians. Catholic bioethics is concerned with a broad range of issues, including social justice and the right to health care, the duty to preserve life and the limits of that duty, the ethics of human reproduction and end-of-life decisions. Fundamental to Catholic bioethics is a belief in the sanctity of life and a metaphysical conception of the person as a composite of body and soul. Although there is considerable consensus among Catholic thinkers, differences in philosophical approach have given rise to some diversity of opinion with respect to specific issues. Given the influential history of Catholic reflection on ethical matters, the number of people in Canada who profess to be Catholic, and the continuing presence of Catholic health care institutions, it is helpful for clinicians to be familiar with the central tenets of this tradition while respecting the differing perspectives of patients who identify themselves as Catholic.

[Although far from typical, the following is an actual case. All of the details included in this discussion are taken from the public record.^{1,2}]

Mrs. P is 25 years old and is about 10 weeks pregnant. She has tuberculous meningitis. Her disease was in an advanced stage when she was admitted to hospital and underwent surgery to relieve the pressure on her brain. She is now clinically brain dead. Her husband — like the patient, a devout Catholic — requests that her body be maintained on life support in the intensive care unit to save her fetus. Other family members concur that she is “pro-life” and would want to carry the fetus to term if possible.

What is Catholic bioethics?

There is a long tradition of bioethical reasoning within the Roman Catholic faith, a tradition that extends from Augustine’s writings on suicide in the early Middle Ages to recent papal teachings on euthanasia and reproductive technologies. Roman Catholic bioethics (which we refer to in this article simply as Catholic bioethics) comprises a complex set of positions that have their origins in scripture, the writings of the Doctors of the Church, papal encyclicals, and reflections by contemporary Catholic theologians and philosophers. Informed by scriptural exegesis and by philosophical argument, Catholic bioethics is rooted in both faith and in reason. During Vatican II (a reformational council held in the early 1960s) Catholics were directed to read the “signs of the times” in applying the teachings of the Church to the contemporary situation³ — in other words, to remain attuned to the progressive revelation of Christ through history.

Fundamental to Catholic bioethics is a belief in the sanctity of life: the value of a human life, as a creation of God and a gift in trust, is beyond human evaluation and authority. God maintains dominion over it. In this view, we are stewards, not owners, of our own bodies and are accountable to God for the life that has been given to us.⁴ Life, however, is not an absolute value, for the Catholic understanding of its meaning and purpose is founded in a belief in the resurrection of Christ and the hope of an afterlife.

The doctrine of natural law, as articulated by Thomas Aquinas in the 13th century, views human life as a basic good that cannot be made subject to utilitarian estimation. Life is the basis and necessary condition of other goods, and human beings

Review

Synthèse

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have an innate desire to seek these goods, such as sexual reproduction, social life and knowledge. Our inborn human tendencies provide the basis for our moral obligations and for fundamental human rights. The Catholic tradition also holds that human life and personhood begin prenatally. Therefore, although the Canadian Criminal Code takes birth as the point at which a legal person comes into existence, Catholic ethics presumes a human fetus to be, at every stage, a person possessing a right to life.

Contemporary Catholic bioethics is concerned with a broad range of issues, including sexuality, marriage, reproduction, birth control, sterilization and abortion. In recent years, Catholic bioethicists have registered opposition to some emerging reproductive technologies, including artificial donor insemination, in-vitro fertilization, surrogacy and cloning. Also of concern are end-of-life issues, including advance directives, palliative care and pain control, suicide, euthanasia and the refusal or cessation of futile treatments, organ donation and the definition of death. Catholic bioethicists have contributed to the debate on the right to health care, conceived as a community and governmental responsibility. In general, they have applied principles of social justice to this debate.

Why is Catholic bioethics important?

Patients and their families expect that their religious beliefs and values will be respected whatever the faith of the health care professionals responsible for their care. A large number of Canadians profess to be Catholic: there were 12.2 million Roman Catholics in Canada at the time of the 1991 census.⁵ Many hospitals and institutions in this country have a Catholic orientation and mission statement. It is important for clinicians who work in such settings to be aware of the policies that flow from such a mission. Clinicians should be aware of the religious convictions of their patients and the possibility that some procedures they might suggest could seriously violate the patient's beliefs and lead to problems of conscience. So too, patients should not expect physicians to engage in practices that they consider to be morally unacceptable.

How should I approach Catholic bioethics in practice?

A basic understanding of Catholic bioethics can help physicians to understand the needs and aspirations of their Catholic patients. It is also helpful to appreciate that some issues, such as matters concerning reproduction, are controversial even within Catholic bioethics. For example, certain actions that, from a natural-law perspective, would be viewed as intrinsically evil might be regarded from a "proportionalist" perspective⁶ as justifiable if they bring about a good that is proportionate to or greater than the associated evil. (Proportionalism has been a point of some contention in recent Catholic bioethical debate.⁷)

Underlying the Catholic stance on specific bioethical questions is a metaphysical conception of the person as a

composite of body and soul. As long as there is a living body, even if mental capacities are reduced or absent, there is still a person present. A human being is considered to be a person from conception to the death of the whole. In contrast, modern society sometimes tends to take a developmental or "gradualist" view, such that personhood begins some time later than conception and can be lost (for example, in the extreme stages of dementia or in a persistent vegetative state) well before the physical death of the individual. The difference between these stances is of profound ethical significance for both beginning-of-life and end-of-life decisions.

Although the principles of beneficence, nonmaleficence, autonomy and justice are compatible with Catholic beliefs, some patients will be guided by the theological requirements of faith, hope, love and fidelity and by more specific religious requirements that are not completely captured in the principles of secular bioethics. Catholic patients may appreciate various kinds of spiritual aid and support at the end of life, be it psychological support or the offering of Holy Communion, the Sacrament of Reconciliation, or the Sacrament of the Sick (last rites). It is appropriate to call a priest on behalf of Catholic patients when death is imminent.

Specific issues

Reproduction

Catholic teaching on birth control and abortion derives from a view of marital sexuality and responsible parenthood in which the sexual expression of love between the spouses is integrated with the procreative implications of that union. By this standard, contraception and contraceptive sterilization are not permissible, although some dissent on these matters has been expressed by those who take a proportionalist approach.

The Catholic tradition rejects "direct" abortion on the grounds that it takes an innocent human life. Although there is some discussion as to what counts as a direct abortion, the generally accepted view is that any intentional termination of a pregnancy is a direct abortion, whereas an "indirect" abortion occurs when a tubal pregnancy or a cancerous uterus is removed. In such a case, the death of the fetus would be viewed as the unintended consequence of an action intended to save the mother's life.

The Catholic position on new reproductive technologies has been generally cautious. The use of in-vitro fertilization that does not preserve the integrity of the unitive and procreative aspects of marital sex puts a couple at odds with the official position of the Church, which asserts the right of the child to be born to parents united in the exclusive commitment that is marriage. The same is true of any procedure involving donated gametes or embryos.

Genetic testing

To the extent that genetic screening and counselling, as well as prenatal genetic diagnosis, may precipitate delibera-

tion about birth control and abortion, an effort should be made to explore the convictions of the parties involved before genetic tests are carried out. Some Catholic couples may seek prenatal diagnosis solely for the sake of knowing the results and being prepared. Open access to genetic testing and nondirective counselling respect this purpose.

Organ donation

The Catholic Church has no objection to cadaveric organ donation and transplantation; indeed, it views such gifts as a demonstration of Christian love. Some Catholics, however, may have folk beliefs that make them disinclined to donate organs; that is, they may think that a lack of bodily integrity postmortem may preclude the resurrection of the body after death. Church doctrine does not support these beliefs.

Proposals to change the criterion of death from whole brain death to persistent vegetative state^{8,9} will meet with much resistance from the Catholic community, which sees the body as an essential aspect of the human person. Catholics also share in the general reluctance to offer payment of any kind for organ donations on the grounds that it runs contrary to the idea of the “gift of life” and treats human remains as a commodity.

Hospitalization for episodes of acute mental illness

Although the duty to preserve one’s health extends to all types of illness, in cases of mental illness a clash between the principles of autonomy and of beneficence can become sharply evident. The Catholic position on a person’s right to refuse treatment unless he or she is a potential harm to oneself or others is less liberal than prevailing Canadian law. Within Catholicism, the individual has a duty to promote his or her own health, and thus may be seen as having a moral obligation to seek treatment even if he or she does not meet legal criteria for involuntary commitment and treatment.

Research involving human subjects

Given the Catholic view that a person does not have the moral right to take serious risks to health, the likelihood of harm will set limits to participation in clinical trials. The deliberate use of deception in psychological or behavioural experiments is also problematic for those who take the view that deception is inherently wrong and cannot be justified by the beneficial results of a study. With respect to genetic research, the generally accepted principles that protect confidentiality, privacy, self-determination, justice and, ultimately, the dignity of the human person are compatible with Catholic health care ethics.

Life support

The monotheistic religions of Judaism, Islam and Christianity maintain that we have a duty to protect the life given

to us by God; accordingly, these faiths have always rejected suicide. Early authorities in the Catholic Church, including Augustine and Aquinas, condemned rational suicide, holding it to be outside the authority of the individual to take his or her own life. Failure to use ordinary measures to preserve life is regarded as morally equivalent to suicide within the Catholic tradition. What is less clear is whether this position commits the Church to an absolute duty to prolong life in all circumstances, regardless of the condition of the patient.

Since at least the 16th century¹⁰ Catholic theologians have made a distinction between ordinary and extraordinary measures, holding that a person is obligated to use ordinary measures but has the choice whether to accept extraordinary measures. Gerald Kelly’s definition of these terms was used for many years in Catholic hospitals in the United States and Canada:

Ordinary means of preserving life are all medicines, treatments, and operations which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain or other inconvenience *Extraordinary* means of preserving life ... mean all medicines, treatments, and operations, which cannot be obtained without excessive expense, pain or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.¹¹

It seems that these terms were originally used within a commonsensical understanding of what is medically customary. The issue was primarily the patient’s obligations, and only secondarily the physician’s duties. Patients were obligated to use measures within their financial means; they were not obligated to reduce their family to poverty in an effort to stay alive. The level of pain that patients could endure, and the distances they would have to travel to obtain care were relevant. Some authorities stressed the aspect of burden; others, including Kelly, included the notion of medical futility in the calculation.

Two points are in order here. First, in recent medical practice, many extreme measures to preserve life have become customary. It is now necessary to ask which means of preserving life *should* be medically routine and which should be a matter of choice. Use of a procedure should be determined not by whether or not it is routine but by factors such as financial burden to the family and to society, pain, disfigurement and, perhaps most significant, medical futility.

It is also clear that one cannot think in terms of an A list of ordinary procedures and a B list of extraordinary ones.¹² The use of a ventilator, for example, may be ordinary or extraordinary, depending on the condition of the patient, his or her prognosis, the stage of the illness and so forth. Although the physician has the right and the duty to inform the patient about treatment possibilities and their potential benefits and risks, it is primarily the patient and his or her family who have the right to determine what is ordinary or extraordinary from an ethical point of view.

Resolution of the case

Because Mrs. P has suffered whole brain death, the complete death of the person has occurred even though respiration and pulse are being artificially maintained. Although we may speak loosely of “sustaining her life for the sake of her child,” it is really a matter of sustaining vital functions in a deceased person for the same purpose.

The first question, then, concerns medical capability. Is it medically possible to carry her 10-week pregnancy to term? If not, the question is moot. If it *is* possible, then the question for Catholic ethics is twofold. First, is it obligatory to sustain her body to save the fetus? Second, if it is not obligatory, is it nevertheless morally permissible?

There have been a handful of cases world wide in which an early pregnancy in a woman who had suffered brain death was carried close to term or to the point of viability.¹³ Given these cases, there appears to be at least a possibility that the fetus would survive. However, given the necessity of using large doses of drugs to control the tuberculous meningitis and to sustain vital functions, and the lack of a healthy nutritional environment for the fetus, the process could impose an excessive burden on the unborn child. Because of the very early stage of development of the fetus, the likelihood of sustaining the mother’s body long enough to bring the child to the point of viability is slight. It seems that there is both excessive burden and only a tenuous hope of benefit. The process thus constitutes extraordinary means, and therefore there is no moral obligation to sustain Mrs. P’s body for the sake of her unborn child.

It is a different story when we ask what is *permissible*. The issues that determine permissibility are threefold. First can we justify the use of medical resources from a financial perspective? Second, what would Mrs. P have wanted? Third, are we harming the fetus?

With regard to the financial question, it could be argued that a decision to designate a procedure as extraordinary on financial grounds implies that there is no entitlement to costly treatment in the context of a publicly funded health care system. But, unless and until society identifies certain procedures as being too expensive to be supported, we cannot make a financial case to deny this family the opportunity to try to bring the baby to term.

The second question relates to protecting the autonomy of the patient after death. Is this what Mrs. P would have wanted? Does her “pro-life” stance allow us to assume that she would wish to be used as a human incubator? Such an assumption may be an illogical leap and an affront to the dignity of the human person.¹⁴ However, Mrs. P’s family feels that she would want the fetus to live and therefore would want her body to be used in this way. Although it is difficult to make this assumption, it is perhaps more problematic to assume that we *cannot* make this particular leap in this *particular* case. From the perspective of preserving the patient’s autonomy after death, it seems that it is permissible to provide the care that the family is requesting.

Third, can we justify the possibility of causing harm to the fetus? The physicians have a Hippocratic duty to “do no harm.” However, we must be careful to draw a distinction between causing disability and causing harm. One’s humanity does not depend on freedom from disability; therefore, the possibility of disability should not be decisive. Whether the drugs to which the fetus is exposed will have harmful effects is highly uncertain; it is possible that the fetus will not be harmed by the drugs. From this perspective, it is morally permissible to provide the care requested.

In conclusion, although not obligatory, it is morally permissible to maintain Mrs. P’s body in order to attempt to preserve the life of her fetus. As a result, her husband, in consultation with the physicians, may make this decision.

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Related Web sites

- National Catholic Bioethics Center (formerly the Pope John Center): www.ncbcenter.org/home.html
- Guild of Catholic Doctors (and related links): www.catholicdoctors.org.uk
- Catholic Resources for Medical Ethics: www.usc.edu/hsc/info/newman/resources/ethics.html
- Linacre Centre for Healthcare Ethics (United Kingdom): www.linacre.org

Related texts

- Ashley B, O’Rourke K. *Health care ethics: a theological analysis*. 4th ed. Washington: Georgetown University Press; 1997.
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