Ethics for Health Care

Pádraig Corkery

Over the past number of years we have witnessed an increasing public interest in activities in the domain of health care. Countless documentaries, TV soap shows and news items focus in on the wonders and complexities of modern medicine: highlighting both the awesome advances which carry undoubted benefit for humankind and areas of ethical consensus, conflict and controversy.

The recent case in the Irish High Court is a good example of a dilemma that caught public interest and revealed the complexities of modern medical practice.[1] It involved a woman in her early 40s who has been unconscious for 20 years. She suffered very severe brain damage during a minor gynaecological operation carried out when she was 22. Since then she has been in a deep coma, heartbeating and breathing on her own, and sustained by the administration of hydration and nutrition through a tube.

The court proceedings and subsequent debate surrounded the removal of such feeding from the patient. Was such feeding obligatory treatment or could it be discontinued on the grounds of futility? The removal was sought by her family who argued that she should be allowed to die naturally. The nursing home in which she was cared for claimed that the removal of feeding would be contrary to their code of ethics and consequently opposed the move. The issues raised in this case will be discussed below.

Other examples of complexity and controversy come readily to mind: the extraordinary advances in the area of human reproduction, the care of persons who are HIV+ or who have AIDS, the use of fetal tissue in the treatment of Parkinsons sufferers, the anencephalic infant as an organ donor.[2] All of these issues have generated lengthy and illuminating debate amongst

1. *The Irish Times*, 6 May 1995, pp. 1, 4, 9.
2. Journals like the *Hastings Center Report* confront these issues regularly.

Pádraig Corkery is a priest of the diocese of Cork and Ross. He is Chaplain in University College, Cork. This article is the second in *The Furrow* (1995) series, 'Ethics for Professionals'.

medical associations, Government agencies and amongst professional ethicists.

The scope of this reflection is quite modest: to look at some of the ethical challenges facing health care institutions and health care professionals as we approach the twenty-first century. My reflections are based on my experience as a teacher of ethics to student doctors and nurses and as a member of the ethics boards of various health care institutions.

Health care in Ireland and worldwide has changed quite dramatically over the past thirty years. As outlined above, extraordinary advances have been made in all branches of medicine to restore health and to improve the quality of people's lives. During this time also medicine has become more dependent on sophisticated technology and more conscious of costs and limited resources.

WHY ETHICS?

A fundamental reason for such public, professional and media interest in health care is an abiding interest in ethics. Many of the new medical interventions raise questions for us that previous generations never had to confront: questions about human life, its origin and purpose, the scope and limits of personal autonomy, the very goals of medicine.

Most commentators are willing to concede that scientific and technological progress does not necessarily contribute to human flourishing. These advances must be evaluated by how they impact on human dignity and on the human family.

The scientific imperative – 'We can, therefore we must' – must be avoided if new scientific and medical advances are to serve the interests of humankind. It is also accepted by most that the ethical issues raised by contemporary health care are of concern to society in general and not just to the particular persons involved. Society, it is argued, has a legitimate and decisive role in legislating for such issues. This is reflected in the growing body of legislation governing *in vitro* fertilization, euthanasia, genetic engineering and so on.

Over the past number of years in Irish society, stock phrases such as 'business ethics', 'ethics in Government' have become part of our vocabulary. There is increased public demand for scrutiny of our institutions: Church, government, professional bodies and the business sector. This is a healthy development and should not be shied away from or resisted on grounds of a misplaced loyalty to persons or past performances.

Contemporary interest in health care is focused on two different levels: the macro and the micro. The former makes

enquiries about the underlying values and philosophies that inform health care institutions and their naming of priorities and policies. The latter looks at the ethics of particular medical interventions or omissions.

Of its very nature, ethics asks whether human actions and attitudes are 'appropriate', 'good', 'right', 'proper'. Though the questions are ones that are contemplated by most persons, the responses reveal a multiplicity of solutions and approaches.

The more fundamental questions of ethics: how one judges the godness or badness of actions, the weight given to consequences and intention, etc., are outside the scope of this article. I will look rather at some of the ethical challenges and tasks facing health care at the general and specific levels.

PATIENT RIGHTS

Over the past thirty years the question of rights has come centre stage at the national and international level. There is now a growing awareness of and a positive response to human rights, women's rights, consumer rights, gay rights, minority rights. This is reflected in a growing corpus of legislation, nationally and internationally, recognizing and promoting these rights.

Patient rights have now also become a part of public consciousness. There is a growing demand that the rights of the person be respected and promoted in the domain of health care as they are in other domains of life. Though there is broad agreement on the substance of patients' rights there is less agreement on the resolution of conflicting rights and duties. It is against this background that ethics for doctors and the health care institutions must be discussed.

The Charter of Rights for Hospital Patients, published by Dr John O'Connell when Minister for Health, is to be found in all Irish hospitals.[3] It reflects and promotes this interest in the patient as a bearer of rights. Among the many rights enumerated are: a right to courtesy from all members of staff, a right to information concerning treatment, a right to respect for one's religious and philosophical beliefs, a right to have one's complaints investigated.

It is essential that the Charter and other similar documents be interpreted in a positive way rather than as part of an anti-establishment or anti-doctor agenda. They are a reflection of a contemporary expectation that we encounter and engage the patient as a whole person with physical, emotional, spiritual and psychological needs and rights.

3. *A Charter of Rights for Hospital Patients: Putting the Patient First.* Department of Health.

Given the complexity of a lot of modern health care, the right to information is a core right. Contemporary society has long recognized that knowledge empowers and enables us. It is essential for informed and adult decision-making. Knowledge restores choices and control back to the patient as person. Respect for this right involves the giving of information in language that is meaningful and within the grasp of the hearer. Undoubtedly this takes patience, time and courtesy but is essential if we are serious about respecting the patient as a person. It is not without significance that this right has long been honoured in other domains of life. The issue of consent is reduced to a meaningless legalism without a wholesome understanding and practice of information-giving.

A NEW MODEL

Probably one of the greatest challenges facing doctors now, particularly in the hospital context, is that of working as part of a team with other professionals: nurses, pastoral care workers, social workers, psychologists.

Successful teamwork involves the abandoning of a hierarchical model and the embracing of a model that encounters the other disciplines within health care as co-contributors to the overall task of patient well-being. The embracing of a model of interdisciplinary dialogue and co-operation has immediate and beneficial results for patient care and for the decision-making processes in hospitals, especially in cases of complexity and uncertainty. It is vital in today's world that complexity be acknowledged and decision-making be shared. Each of the disciplines within health care has its own vital contribution to make to the good of the patient.

Accountability and transparency, buzz words in today's political and business communities, also need to become part of the vocabulary and practice of health care. Silence and mystery were often the defining features of doctor-patient relationships in the past. This leads to fear, anxiety and a feeling of powerlessness that more often than not impeded the healing process.

Another significant challenge facing doctors and the health care professionals is that of resisting the movement that views health care as a lucrative business only. This development would see the replacement of the professional culture by the business ethos. This would be a radical assault on the values and philosophy that informed health care from its inception. This has already happened in other countries and has dramatically changed the face of medicine.[4]

4. See Richard A. McCormick, *Corrective Vision: Explorations in Moral Theology,* Sheed & Ward, 1994, pp. 149-164.

A similar diminishment could also occur in this country if we continue to develop a two-tiered system of medicine. Valuable elements of the traditional ethos of health care such as compassion, equality of persons, equal access to resources, care of the marginalized, can easily be lost if not owned and proclaimed by individuals and health care institutions.

CHRISTIAN ETHOS

From the perspective of the Christian tradition the latter development poses a challenge and an opportunity. This is particularly true of those health care institutions that were born out of a commitment to the person of Christ and the values of the Gospel. Such hospitals were established and run for a century by religious women and men as their response to the Gospel. They were particularly motivated and inspired by the Gospel's emphasis on compassion, care for the poor and the marginalized, respect for the equal dignity of persons, the values of justice and fair play, the reality of the person as a spiritual being. Until recently the majority of health institutions in this country were inspired by this Gospel vision. They generated a proud legacy of service and commitment.

Circumstances have changed dramatically since the founding of these hospitals. The State now plays an essential and welcome role in the provision of health care. Religious orders themselves have both experienced a diminishment of their numbers and have discovered new needs for this Gospel-inspired service.

But what of the hospitals and tradition they have left behind? It would be a tragedy if their values were lost in the changing world of health care. Even in those hospitals still bearing religious affiliation this witness will be lost unless it is owned by those who people them. And they cannot be owned unless they are explicitly named and reflected in the priorities and policies of the hospital. This is a vital task for the years ahead, that is to ensure that values like equality of care, attention to the needs of the marginalized and the recognition of the person as a spiritual entity find clear expression in the policies of hospitals.

There is the added challenge of resisting forces of depersonalization. The growth of technology in health care is both inevitable and beneficial. Today, everything from diagnosis through acute care to appointments is done by computer. Though this lends itself to greater efficiency it also increases the possibility of health care being depersonalized to an unacceptable level.

THE PERMANENTLY UNCONSCIOUS

At the micro level contemporary health care continues to throw up new and complex issues. One of those issues was addressed recently by the Irish High Court. The essential details of the case are as outlined above: a petition from a family to discontinue the feeding administered to their permanently unconscious daughter over the past 20 years, in order to facilitate her natural death. The High Court granted the request but allowed for the possibility of an appeal.* In the light of that possibility, I will deal with the substantive issues surfaced by the facts, rather than with the facts *per se.*

It is important to acknowledge that the Irish case is not without precedent elsewhere. Similar cases have been the subject of court proceedings in the United States and in England. In both jurisdictions the cases generated lively debate amongst both professional groups and the general public. Within the Catholic community there was also considerable debate and disagreement as to the appropriate action. The range of approaches and conclusions can be seen both in statements of Bishops' Conferences and individual Catholic theologians.

In the international debate five areas of disagreement can be readily identified:

1. What status should be given to artificially administered nutrition and hydration? Is it a medical intervention or a basic first-order human response? Does the means of administering the nutrition and hydration change its moral status?

2. How to classify the consequences of withdrawing the nutrition/hydration. Are we allowing a fatal pathology to take its natural course i.e. enabling the person to die naturally and with dignity? Or do we intentionally introduce a new set of physical conditions that kills the patient? If the latter is the case, are we responsible for intentionally and directly killing the patient?

3. Is there a *benefit* for the patient in continued feeding? Does continued life/existence count as a benefit or should benefit be measured by appeal to some understanding of life's goals/purposes?

4. When dealing with incompetent patients, who should be involved in decision-making with regard to their future treatment? Because of conflict in this area, an increasing number of Americans and Canadians write a Living Will in which they clearly outline their medical preferences or appoint someone to make those decisions for them. Living Will proponents argue that this restores decision-making to the patient as person.[5]

**Editor's Note.* The case has been appealed and is now being heard in the Supreme Court.

5. D. V. Molloy, *Let Me Decide*, 1990.

5. How to classify patients in a permanently unconscious state. Are they dying patients or seriously ill patients?

Among Catholic Bishops' Conferences who studied cases similar to this one there is a presumption in favour of feeding permanently unconscious patients unless such feeding has 'no medically reasonable hope of sustaining life or poses excessive risks or burdens.[6] The Bishops of Florida[7] argued that as a general rule artificial sustenance should not be withheld or withdrawn from these patients. The Texan Bishops[8] viewed such withdrawal as morally appropriate in certain circumstances. However the Bishops of Pennsylvania[9] adopted a much more restrictive approach. They approved of withdrawal in two circumstances only: when death is imminent or when the patient is unable to assimilate what is being supplied. Outside of these exceptions they argued that the withdrawal of nutrition/hydration is euthanasia by omission.

The Catholic community in England in response to the Tony Bland case allowed for the possibility of the moral withdrawal of nutrition/hydration in certain circumstances, yet rejected the reasoning of the Law Lords.[10]

These statements indicate the existence of pluralism within the Catholic tradition on this issue. They clearly indicate the difficulty of going with certitude from agreed principles to their application in complex cases. Catholic writers are equally divided on the issue. Those opposed to the withdrawal of nutrition/hydration have argued that such food is a basic requirement of human care and belongs to the same category of obligation as the duty to keep patients warm and clean. Further, they would argue that the withdrawal of such feeding is the direct and intended cause of the patient's death. For these writers the benefits of continued treatment are clear: continued living while

6. National Conference of Catholic Bishops' Committee on Pro-Life Activities. 'Nutrition and Hydration: Moral and Pastoral Reflections', *Origins* 21:705 (19 April 1992).

7. Catholic Bishops of Florida. 'Treatment of Dying Patients', *Origins* 19:47-8 (1989).

8. Texan Catholic Bishops 'On Withdrawing Artificial Nutrition and Hydration', *Origins* 20:53-55 (7 June 1990).

9. Catholic Bishops of Pennsylvania 'Nutrition and Hydration: Moral Considerations', *Origins* 21:541, 543-553 (30 January 1992).

10. Joint Committee on Bio-Ethical Issues of the Catholic Bishops of England, Ireland, Scotland, and Wales. 'The Ethics of Withdrawing Nutrition and Hydration from a Patient in a Persistent Vegetative State', *Doctrine & Life* 43:492-3 (October 1993). See also the contribution of the Christian Churches in Britain to the Euthanasia debate, 'Euthanasia and the Law', *Doctrine & Life* 43:493-496 (October 1993).

the burden imposed by continued treatment is slight.[11] Finally, many make use of the 'slippery slope' argument: if the giving of nutrition and hydration is judged to be optional for one category of patient then the danger exists of such feeding becoming optional for other patients who have a poor quality of life and are vulnerable. They would be particularly conscious of the needs of the severely handicapped newborn or the semiconscious, senile old person.[12] In brief, they argue that the giving of nutrition/hydration must remain an absolute; to allow exceptions would result in the erosion of care for the vulnerable.

Those Catholic writers who see the withdrawal of nutrition and hydration from such patients as a moral act would contest each of the above points.[13] They would see the withdrawing of such feeding as being in keeping with Roman Catholic medical ethics and its clear distinction between ordinary/obligatory care and extraordinary/optional care. In their judgment, the burdens of continued feeding outweigh the benefits and therefore such feeding is not morally mandated.

I find these latter arguments most persuasive. They reflect a keen sense of the naturalness of death, and of the possibility that human dignity can be as abused through over-treatment as it is through neglect. Though life is always to be treasured and respected the obligation to preserve life is not an absolute.[14]

CONCLUSION

The years ahead carry undoubted challenges for health care institutions and professionals. At an organizational level, the whole infrastructure of health care must become more responsive to the rights of the patient. Old attitudes of paternalism and hierarchy must yield to those of inclusion, dialogue and interdisciplinary co-operation. Relationships based on power and privilege must be replaced by ones founded on equality and solidarity.

11. Robert Barry O.P. 'Feeding the Comatose and the Common Good in the Catholic Tradition' *Thomist* 53:1-30 (January 1989), John M. Grondelski 'Removal of Artificially Supplied Nutrition and Hydration: A Moral Analysis' *Irish Theological Quarterly* 55:291-302 (1989).
12. William May et al. 'Feeding and Hydrating the Permanently Unconscious and other Vulnerable Persons', *Issues in Law and Medicine* 3:203-217 (Winter 1987).
13. Kevin Kelly, 'A Medical and Moral Dilemma', *The Month* 26:138-144 (April 1993); John J. Paris & Richard A. McCormick, 'The Catholic Tradition on the use of Nutrition and Fluids', *America* 156:356-61 (1987).
14. Pius XII, *Acta Apostolicae Sedis*, 24 November 1957, pp. 1031-2. 'But normally one is held to use only ordinary means – means that do not involve any grave burden for oneself or another. . . . Life, health, all temporal activities are in fact subordinated to spiritual ends.'

The years ahead will also yield cases of increasing complexity. Ethical complexity must first of all be acknowledged and then debated in a patient, courteous and moderate manner. Pluralism must be facilitated when it is not self-evident what the appropriate course of action is. For those who engage life from the perspective of the Christian tradition all the above are clearly important. What is probably more important is that the principles of equal access to medical resources, justice and care for the marginalized be established as priorities in health-care policies.

Where were we? In facing this radical interrruption of evil into our history we are forced to face the darkness in ourselves. It is a much more painful step to see ourselves in the faces of the torturers than to find ourselves with the victims. When one of my daughters asked 'What were they like – the concentration camp guards?' I hesitated for a moment before answering 'They were like us – they were men and women like us.' So the struggle to deal with evil and with suffering reaches down into the very depths of what it means to be human. We are all called into question. We seek out 'the perpetrators' to put them on trial, yet our daily silence in the face of suffering which has not ceased implicates all of us. Where were we when there was 'ethnic cleansing' in the former Yugoslavia, in Rwanda, in East Timor? Where were we when the innocent were shot on the streets of Belfast? Where were our voices raised in anger, protest? Men and women made in the image of God are daily involved in causing unspeakable pain to men and women made in the image of God.

—ANNE THURSTON, *Because of her Testimony* (Dublin: Gill and Macmillan) p. 72.