ETHICS AND HEALTHCARE REFORM

HEALTHCARE REFORM AND CATHOLIC MORAL INTEGRITY

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Economic developments and the prospect of healthcare reform in the United States have raised challenges for the Roman Catholic healthcare ministry. Chief among these concerns is the prospect of being required, either by law or economics, to make provision for, and in some cases to provide, medical procedures currently prohibited by the moral tradition, such as sterilizations and abortions. A typical approach to resolve this tension between what may be required and what is permitted is to appeal to the principles of toleration and cooperation. Using these principles, it is possible to define the types of institutional relationships within which Catholic healthcare can comfortably exist.[1] It is our position that this response is too narrow, and will not allow Catholic healthcare to engage in a reformed healthcare system to the fullest extent possible. It is our belief that Catholic healthcare ought to see these developments as an opportunity to revisit and further develop the moral tradition.

That such an approach is possible is seen in the Vatican Council II text *Gaudium et Spes*. Paragraph 36 states "that created things and societies themselves enjoy their own laws and values which must be gradually deciphered, put to use, and regulated by man." Paragraph 59 specifically "affirms the legitimate autonomy of human culture and especially the sciences." Whether one sees these texts as affirming a continuity within the tradition,[2] or as signaling a profound methodological shift,[3] it is clear that science and theology must be in dialogue with each other in the pursuit of moral truth. Science does not merely offer technical competencies which theology then evaluates. The medical profession itself

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[1]Philip Keane, *Healthcare Reform: A Catholic View* (New York: Paulist Press, 1993).

[2]Alfons Auer and Robert Tucci in *Commentary on the Documents of Vatican II*, vol. 5, *Pastoral Constitution on the Church in the Modern World* (New York: Herder & Herder, 1969) 190-93, 268-70.

[3]David Hollenbach, *Claims in Conflict* (New York: Paulist Press, 1979) 118-33.

must be seen as a generator of moral meaning, offering a perspective different from the one presently informing moral thought.[4] One critical question we pose, therefore, to the institutional rearrangements of Catholic healthcare is this: are healthcare professionals genuine participants in the future moral guidance of this process?

Discussion of a Catholic response to healthcare reform, then, must begin with an appreciation of the medical perspective, rooted in the nature and goals of medicine. In lieu of a thorough discussion, it can be simply stated that the goal of medicine, understanding the person holistically, is not to keep physiological systems working to achieve their own biological ends, but to aid in the achievement and maintenance of the optimal health or well-being of the whole person. Medicine does not respond to kidney failure merely as a physiological event, but as an event affecting the whole person, requiring a response that is directed toward the good of the whole person, not merely renal function.

Further, medicine is, by its nature, interventitive. It seeks to assist the person by "coming between" the person and the threat or reality of some pathology or trauma. For example, palliative interventions come between the person and the symptoms brought on by illness or accident. Because it is interventitive, medicine necessarily entails the doing of some harm to the person in order to achieve its goal for the person. It is impossible for a surgeon to remove a pathological appendix without mutilating the body.

Medicine, then, will always entail the doing of some harm in order to achieve its goal. It is here that the medical perspective has historically challenged the tradition. Typically, moral theology is uncomfortable with any harm being associated with the doing of good. The doing of harm has been viewed by the tradition as entailing a disorder. As a general norm, one may not choose a disorder as the means to achieving a good end. In some cases, the Principle of Double Effect (PDE) has been useful to show that the disorder may flow from an otherwise good act as the reason "in spite of which" rather than "for which" an act is chosen.[5] An example is the respiratory depression that may result from the use of narcotics to manage pain.

Often, however, medicine requires that the harm or disorder be the reason "for which" an act is chosen. Examples include surgical mutilation.[6] Understand-

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[4]For a philosophical resource to support such a view, see Alasdair MacIntyre's discussion of practice and the tradition in *After Virtue* (Notre Dame IN: University of Notre Dame Press, 1981) as well as Michael Walzer's *Spheres of Justice* (New York: Basic Books, 1983).

[5]Joseph M. Boyle, "Toward Understanding the Principle of Double Effect," *Ethics* 90 (1980) 527-38.

[6]Austin O'Malley, *The Ethics of Medical Homicide and Mutilation* (New York: Devin-Adair, 1919) 26-27; Patrick A. Finney, *Moral Problems in Hospital Practice: A Practical Handbook* (St. Louis MO: B. Herder, 1956) 146-48.

ing the person as an integrated whole of various parts, medicine challenged theology to look at the doing of harm from a different perspective, and to discern if it were possible, in some medical circumstances, to chose a disorder as the means to achieve an end. The result of this investigation was the Principle of Totality (PT), rooted in Thomas[7] and later expanded by Pius XII,[8] which holds that one may choose the disorder of *physical* mutilation for the sake of the *physical* good of the whole person. Later, the possibility of organ transplants from living donors challenged theology to once again examine the disorder of physical mutilation from yet another perspective. Again, moral theology discovered that, contrary to what had been widely held, one could choose to harm the self for the good of another.

Brief reference to the development of these principles illustrates what *Gaudium et Spes* means when it refers to the legitimate autonomy of the sciences. By recognizing the nature and goals of medicine, moral theology has been able to accept a different perspective on the role a disorder may play as a means to a good end, and therefore has been able to find within the tradition insights that have allowed certain practices which initially were thought to be prohibited. It is our contention that this same recognition can be used to offer new a perspective on reproduction, leading to the allowance of interventions presently thought to be prohibited.

Based initially on the notion that the reproductive faculty exists for the common rather than individual good,[9] reproduction has been understood by the tradition to lie outside the sphere of the PT. It may not be mutilated even for the sake of the physical well-being of the woman because the faculty, unlike the other tissues, organs and systems, does not exist for the health of the woman. Rather than being in service to the woman, the sexual faculty is viewed as having procreation as its own biological end. As a result, when pregnancy is a health risk to a woman, a resolution must be found within the sphere of sexual ethics, rather than medical ethics.

Medicine offers a different perspective. By viewing the person as a whole, medical science understands that the reproductive organs do not exist as a discrete system having its own ends that must be viewed independently from the woman's overall health. While it may be true that the sexual faculty does not itself directly promote the health of the woman, it is wrong to suggest that the faculty does not directly impact on it. This can be best illustrated in the fact that pregnancy is the cause of 9.1 maternal deaths per 100,000 live births in the United States.[10] The leading cause of death in these cases are pulmonary

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[7]*ST* II-II, q.65, a.1.

[8]*AAS* 45:674-75.

[9]*Summa Contra Gentiles* 3.2.123.

[10]L. M. Koonin et al., "Maternal Mortality Surveillance, United States, 1979–1986," *Morbidity and Mortality Weekly Report* 40 (1991) SS-2, 1-13.

embolism, pregnancy-induced hypertension complications, hemorrhage, and infection. Pregnancy constitutes a health issue for the whole person. It should, therefore, be understood as a medical reality not unlike other medical realities.

From a medical perspective, issues related to reproduction cannot be addressed solely as sexual issues. Respecting the autonomy of medicine means today, as it has in the past, recognizing that moral theology must attend to this perspective in its moral evaluations. Rather than engaging in discussions of the toleration of or cooperation with evil, medicine can, as it has in the past, offer the tradition a different perspective to understand the evil involved.

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FEMINIST THEOLOGY

THE CONCRETE FOUNDATIONS OF EXPERIENCE: PSYCHOLOGY, WOMEN'S EXPERIENCE, AND CHRISTIAN SYMBOLS

Two papers were presented in this workshop that explored how feminist psychology can inform feminist theological reflection. In her paper "Mothers and Other Strangers: Psychoanalysis and Feminist Sacramental Theology," Susan Ross used feminist psychoanalytic insights to rethink the relationship of women to the sacraments. Ross turned to the works of Margaret Homans and Jane Flax for an understanding of the subject. Both theorists accept Lacan's view that full subjectivity comes when the child represses his presymbolic physical attachment to the mother and enters into the symbolic order of linguistic and cultural exchange. On this view, the symbolic comes to be associated with the father and so with the masculine while the presymbolic is associated with the feminine. Both Homans and Flax supplement Lacan's theory with nuanced accounts of the position of women with respect to the symbolic. In particular, Homans notes that separation from the presymbolic is less definitive for girls because it in some sense calls for a repression of their own femininity. This ambiguous subject position forces women to be "bilingual." That is, they are conversant in the language of the symbolic but have not fully lost their embodied, presymbolic awareness. Ross drew on the writings of Nancy Jay and William Beers for an understanding of the relation between sacrifice and gender. Jay argues that rituals