The Catholic Lawyer

Volume 32
Number 1 *Volume 32, Number 1*

Article 4

October 2017

# Catholicism, Ethics and Health Care Policy

Lisa Sowle Cahill

Follow this and additional works at: https://scholarship.law.stjohns.edu/tcl

 Part of the Catholic Studies Commons, Ethics in Religion Commons, and the Health Law and Policy Commons

## Recommended Citation

Lisa Sowle Cahill (1988) "Catholicism, Ethics and Health Care Policy," *The Catholic Lawyer*: Vol. 32 : No. 1 , Article 4.
Available at: https://scholarship.law.stjohns.edu/tcl/vol32/iss1/4

This Article is brought to you for free and open access by the Journals at St. John's Law Scholarship Repository. It has been accepted for inclusion in The Catholic Lawyer by an authorized editor of St. John's Law Scholarship Repository. For more information, please contact selbyc@stjohns.edu.

# CATHOLICISM, ETHICS AND HEALTH CARE POLICY†

LISA SOWLE CAHILL*

*The Catholic Church's moral positions have the potential to shape public discussion and policy only to the extent that they can be put forward in terms which are accessible and convincing to citizens in general, including those who do not accept the specifically religious authority of Roman Catholicism.*

The interest of the Catholic Church in health care policy has been much in evidence in the past decade, not only through the activity of the Catholic laity in their capacity as American citizens, but also through the involvement of members of the Church hierarchy and even through that of ecclesial bodies such as the U.S. National Conference of Catholic Bishops and the Vatican's Congregation for the Doctrine of the Faith. A national event which raised pointedly the question of the extent and legitimacy of such involvement was the 1984 U.S. presidential campaign, which featured controversy over Catholic candidates' support of national abortion policy. Over the objections of New York Cardinal John J. O'Connor, Democratic Vice Presidential candidate Geraldine Ferraro and New York Governor Mario Cuomo insisted that they could not translate their religiously-based personal opposition to abortion into the public arena of law and law enforcement.

The reasons they gave for this conclusion were somewhat different. Ferraro tended to rely on the distinction between personal conviction and public policy in a pluralist society, concluding essentially that Catholics should not attempt to impose their moral commitments on others. Cuomo, on the other hand, did not resist as strongly the suggestions of O'Connor that Catholic views of the rights of the unborn have an appropriate role to play in changing national policy. Instead, he maintained

---

† This Article is taken from Thirty-First Annual Robert Cardinal Bellarmine Lecture, delivered at St. Louis University, October 28, 1987. It was previously published at 34 THEOLOGY DIG. 303 (1987).

* Bellarmine Lecturer 1987, Associate Professor of Theology, Boston College.

that there is at present in our society no consensus on the moral status of fetuses or on the exceptional justifying reasons for abortion, and that any just and enforceable law must be grounded in a consensus supporting it.

This debate between the Church and the Catholic politician exemplifies in quite a clear way two points of confusion regarding involvement of the Church in the public policy arena. The first is a confusion between morality and religion; the second is a confusion between morality and policy.

### *A. Morality and Religion*

Religion has to do with the relationship between humanity and God, while morality has to do with the relationships among human persons and among human communities. Thus, convictions about what it is right and wrong to do to or for other human beings are not as such to be classified as "religious" beliefs.

Ideas of morality can be grounded in or encouraged by religious beliefs; for instance, in biblical themes such as "image of God," "love of neighbor," "concern for the poor and oppressed," "self-sacrifice for others," and so on. In the category of religious grounding for moral ideas, we can also include the teachings of religious groups or traditions, such as papal addresses and encyclicals, Vatican declarations, or episcopal statements, such as those on contraception, euthanasia, abortion, or infertility therapies.

The first point of confusion, between morality and religion, is rooted in the idea that the influence of moral commitments which are religiously motivated is or should be limited to members of the religious group which supplies the motivation. There is no valid reason why this should be so as long as the moral commitments in question can be expressed and defended in terms which make sense to those outside the group. The real issue is not whether religious insights shape and guide moral commitments, but whether those commitments are also intelligible on broader grounds.

To put it another way, moral values and norms held by Catholics may be supported by reasons which go beyond their particular religious beliefs. In the case of abortion, Catholics may have a special commitment to defending the unborn because of the degree of emphasis which has been placed on this by the Church. But even so, this commitment is not a narrowly "religious" issue. Catholics and other religious persons have a right to become involved in the public debate to the extent that they can defend their position in a language which makes sense to persons from other religious and moral traditions. In other words, they must be able to discuss the status of the fetus, the moral significance of prenatal development, maternal welfare and rights, and social support systems for preg-

nant women and for children, in terms accessible and convincing to non-Catholics. If they enter public debate on these terms, then their moral arguments cannot be dismissed as attempts to "impose" *religious* beliefs on persons with different convictions.

The erroneous idea that Catholic moral values have no place in public debate because they are really matters of religious faith was accepted perhaps too easily by Geraldine Ferraro when she took the position that as a loyal Catholic she followed Church teaching on abortion, but could not force that teaching on her pluralist constituency. The real question should have been whether the Church's critique of national abortion policy has any cogent ethical merit to it, apart from its backing by religious authority.

### *B. Morality and Public Policy*

Not everything that falls in the category of morality—even publicly discussible morality—is a proper object of legislation or formal and enforced social policy.

First, there is a legitimate distinction to be made between private and public moral conduct. It is appropriate to regulate the latter, but probably in most cases not the former. In other words, law has to do with protecting the common good; behavior which concerns only private individuals who freely participate in it ("consenting adults") need not be prohibited by law even if it is immoral, or is considered to be so by some persons. Prohibition failed because it attempted to regulate private behavior in conformity with the moral ideas of a minority. However, we still prohibit and punish socially destructive behaviors related to the consumption of alcoholic beverages, such as drunken driving or "drunk and disorderly" conduct in public. Some persons consider contraception immoral, but legal interference is generally agreed to be inappropriate. Legal restriction of pornography and prostitution remains controversial precisely because there is lack of agreement on the degree to which these immoral activities, if undertaken by "consenting adults," really have an impact on the larger social good. In the case of abortion, the major controverted point is also whether the activity is indeed public or private. Does it harm the common good or the good of nonconsenting persons whom it affects? "Pro-choice" proponents do not see the fetus as an entity with protectable status, and thus tend to construe abortion as a private decision of the mother. "Pro-life" proponents do see the fetus as protectable, and thus want to restrict the decisions of those who would harm or destroy it, arguing that these decisions are a public danger. Religious belief is not the major issue here, but rather, whether arguments on either side can be made on good philosophical grounds. To take a recent example from Church teaching, the Vatican *Instruction* on reproductive

technologies holds the embryo to be inviolable because of its status as a "person." The document uses the terms "personal presence," "human life," "individual," and "person." It also says expressly that it is not taking a "philosophical" position on whether or not the embryo is a person. Nonetheless, the document does affirm that the magisterium has "constantly" taught that "the human being is to be respected and treated as a person from the moment of conception."[1] Needless to say, this is not an argument capable of moving protection of the embryo into the public policy arena as a matter of public, as distinct from religious, interest.

Moreover, on the question of viable public policy, we have to go still further than determining whether a moral activity has some public status. This brings me to my second point regarding the distinction between morality and public policy.

Even public moral conduct can be restricted or required by law only under certain conditions, conditions which ensure that legislation or policy will be just and effective. Otherwise the policy is worse than useless; it undermines respect for law and for the authority of government. This was a point which Governor Cuomo seemed to grasp in 1984, but which may have eluded Cardinal O'Connor. Cuomo resisted the efforts of the Church representative to influence Cuomo's cooperation with abortion policy, not because he saw such efforts as unwarranted religious intrusion, but because, even granting the *moral* arguments against abortion, there is not yet in our society a consensus on the immorality of abortion.[2] Cuomo may or may not have been right about the absence of consensus. At least one legislator, State Senator David Carlin of Rhode Island, disagreed, saying that there is more consensus than is usually supposed about the immorality of "abortion on demand," the use of abortion as a "back up" means of birth control, and abortions late in pregnancy.[3] The point, however, is that the presence or absence of consensus is a relevant consideration in formulating policy.

If consensus is lacking, it may be impossible to enforce the law justly and equitably, with the consequence that the law produces more injustice than it remedies.[4] The Church has an obligation to work toward public consensus on those issues in which it has a stake (a religiously-motivated

---

[1] *Vatican Doctrinal Statement, Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day, reprinted in* N.Y. Times, Mar. 11, 1987, at A-14, col. 5.

[2] *See* Remarks of Gov. Mario Cuomo at University of Notre Dame, *Religious Beliefs and Public Morality* (Sept. 13, 1984), *reprinted in* 14 ORIGINS 234 (1984); Remarks of Gov. Mario Cuomo at St. Francis College, Brooklyn, N.Y., *Abortion and the Law* (Oct. 3, 1984), *reprinted in* 14 ORIGINS 301 (1984).

[3] *See* Carlin, *Patchy Garment: How Many Votes Has Bernardin?*, COMMONWEAL, Aug. 10, 1984, at 422.

[4] *See* Carlin, *Abortion, Religion, and the Law*, 151 AM. 356 (1984).

stake), and arguments about what would constitute a morally respectable consensus in a humane society should be its major contribution to public policy debates.

An important note to add is that law can have an educative function as well as a representative one. This is especially true in our society, whose members often tend quite simplistically to equate the legal with the moral. Slavery was ended in our nation without the consensus of those who were most economically dependent on it; even the Civil Rights Act of 1964 was enacted without the backing of a full national consensus. This means that the notion of "consensus" required for defensible law should not be interpreted too strictly, and that, as a consequence, this notion may be difficult to define precisely. There must be consensus adequate to enforcement of the law; this will not necessarily mean that all American citizens agree with it.

The theologian Charles Curran, drawing on Catholic tradition, has outlined three criteria with which to assess the moral justifiability of public policy: (1) freedom is to be curtailed only when and to the extent necessary to protect the "public order;" (2) the "public order," which justifies intervention, includes social justice and human rights, the morality necessary for cooperative social existence, and the preservation of public peace; (3) a good law is one which is equitable and enforceable.[5] The issue of consensus is part of this final criterion, while the distinction between public and private morality is the basis of the first two.

## CATHOLIC TRADITION AND PUBLIC DISCOURSE

The distinctive contribution of Roman Catholic moral theology to public policy discourse has been to insist that it be open to conversation among partners representing quite diverse religious and philosophical traditions. In principle, Catholic tradition dissociates public moral discourse from specifically religious backing. The approach derives from the Christian philosophy of Thomas Aquinas, who in turn borrowed from the "natural law" theory of Aristotle. In the Aristotelian-Thomistic view, all persons share certain fundamental and culturally transcendent values, such as protection of human life, respect for truth, the importance of procreation and education of the young, and social cooperation. These values may be embodied or institutionalized differently in different cultures and eras, but at least their basic meaning is evident to all reasonable persons, who should freely seek to realize them in life. The Christian tradition explains the existence of the moral law based on these values by referring to a divine Creator of humanity, but does not limit knowledge of this law to religious persons.

---

[5] C. CURRAN, MORAL THEOLOGY: A CONTINUING JOURNEY 214-15 (1982).

The modern tradition of papal social encyclicals—from Leo XIII to John Paul II—has articulated this basic understanding of morality in terms of the "common good" as defining the normative nature of social life; "justice" as the standard of the common good; mutual "rights" and "duties" as the means by which justice is to be achieved; and "public authority" and "law" as the guarantors of rights, duties, and social justice. To use the framework "common good" is to claim both that there can be general consistency in formal definitions of what enhances human life in society and that it is necessary to pose continually the substantive question of which social arrangements enhance human dignity concretely.

This essential perspective on society, morality, and policy was masterfully translated into the American cultural setting by John Courtney Murray, S.J. In *We Hold These Truths*, Murray asserts that "the American Proposition" rests not on mere pragmatism, but on:

> the more traditional conviction that there are truths, that they can be known; that they must be held; for, if they are not held, assented to, consented to, worked into the texture of institutions, there can be no hope of founding a true City, in which men may dwell in dignity, peace, unity, justice, well-being, freedom.[6]

A similar commitment to objective moral truths which form the basis of a just, albeit religiously pluralist, society is at the heart of the recent NCCB economics pastoral, *Economic Justice for All.*[7] Cardinal Joseph Bernardin has urged Catholics to contribute to a new American consensus on a "consistent ethic of life" in many addresses, some of which are aimed specifically at the health care context.[8] When the Catholic bishops address policy questions, they may rely on their moral authority as Church leaders, but their public policy recommendations will only be as convincing to the American public as the arguments used to support them—arguments which will be concerned not with religious obligations, but with justice, duties, rights, and the nature of a society ruled by the common good of all.

A fact of which Catholics are only gradually becoming aware is that the guiding "natural law" ideal of a community of moral discourse in which participants share a common language of reason, justice, and fundamental "human" values can become a reality in only a modified sense. Murray, Bernardin, and the authors of the economics pastoral are successful and persuasive in their arguments partly because their audience

---

[6] J. MURRAY, WE HOLD THESE TRUTHS: CATHOLIC REFLECTION ON THE AMERICAN PROPOSITION 9 (1964).

[7] U.S. Bishop's pastoral letter and messages at U.S. Catholic Conference, *Economic Justice for All: Catholic Social Teaching and the U.S. Economy, reprinted in* 16 ORIGINS 34 (1986).

[8] Cardinal Bernardin, *The Consistent Ethic of Life*, HEALTH PROGRESS, July-Aug. 1986, at 48.

shares some common fund of cultural values and experience. Indeed, several disagreements about their *interpretations* of what is "social justice" or "respect for life" have arisen because discussion partners do not always come from exactly the same social, economic, and political "place." I think it is illusory to speak of "natural law" morality as though the language of natural law guaranteed access to some realm of public discourse which completely transcends the moral and even religious commitments of our own traditions. At a recent conference at Georgetown University, Bryan Hehir remarked that even though the NCCB "peace pastoral" is directed at public discourse about defense policy, the bishops writing it were motivated to cling fiercely to noncombatant immunity by the Christian ideal of nonviolence and the Catholic commitment to protect innocent life no matter what the consequences.[9] Perhaps the realm of natural law discourse about public policy is best envisioned as a sphere into which one goes, not stripped naked of all particularistic commitments, but rather, in search of areas of overlap and agreement in the communities (religious, moral, political, philosophical) to which one's discussion partners belong. In the modern, first-world, Judeo-Christian, Western political and cultural community called the U.S.A., the language of rights, duties, justice, and common good expresses some fundamental agreements which might not be as clear as we move into conversation with more distant cultures. And even in the United States, comments Hehir, "religious differences will yield different conceptions of how to address medical ethics and standards of justice."[10] The point to keep in mind, however, is that religiously-grounded conceptions of social morality have the ability and right to survive in the arena of public policy to the extent that they can publicly *persuade*. When it seeks the end of public persuasion about important moral values, the Church is as legitimate a social actor as any other group bound by common interests, the merits of which it desires to bring to the attention of the social body.

I will now indicate some of the reasons why and the extent to which the Catholic Church should be interested in public policy, by considering four additional moral dilemmas in health care: artificial sustenance, health care for the elderly, reproductive techniques, and AIDS. On these, as on other policy issues, morality can be discussed in terms of justice, rights and duties, both of the individual and of the community. American notions of individual rights are particularly strong, can become distorted

---

[9] Conference at Georgetown University, Catholic Perspectives on Medical Morals: Foundational Issues (Oct. 13-16, 1986). Hehir's paper is entitled, "Religious Pluralism and Social Policy: The Case of Health Care." The proceedings of the conference are to be published in a volume edited by Tristram Englehardt and Stuart Spicker, for the Philosophy and Medicine Series of D. Reidel & Co.

[10] Hehir, *supra* note 9, at 24.

into individualism, and have deeply influenced these debates. With her equally strong commitment to place rights in the context of duties and of sociality, the Church as a *moral* teacher (not only a religious teacher) is justified in attempting to influence the way rights and duties are interpreted in this particular area of medical care.

### *A. Artificial Nutrition and Hydration*

Catholic tradition provides an approach to acceptance or refusal of medical treatment which is nuanced, flexible, and able to be expressed in terms of common moral values. The guiding principle in cases of life-prolonging treatment has been the distinction between ordinary and extraordinary means of life support. The Church has an interest not just in individual decision-making, but also in public policy, because social justice requires that practices be institutionalized in medical care which provide for the protection of individual rights and also for the support of the common good. To say that certain policies regarding treatment denigrate the value of human life is not to make any narrowly religious claim but to enter as a religiously motivated actor upon the scene of public discourse about the nature and structure of a just society. The questions of social morality at stake in the nutrition/hydration debate include at least the following.

Do debilitated members of a society retain the same right to share in social goods as actively contributing members? Is there a duty which corresponds to this right? Is it a duty of friends and family only, of the medical profession, of persons or groups who have previously contracted to be responsible for the sick, or of broader civic communities, and even of the society as a whole? Should the fulfillment of such duties be enforced by law? Should the definition of an appropriate share in social goods be tailored to the individual circumstances of each member of society? Is sickness a relevant circumstance? Can severe or terminal illness be an indicator in favor of reduced medical "therapy?" Is artificial nutrition more like a medical technology or more like natural eating and drinking? What implications will the resolution of this question in one direction or the other have for social attitudes towards illness, medical technology, and technology in general? At what point should individual preferences or even needs be limited by their effect on other persons or on social attitudes and future practices?

These are philosophical and social questions. They are important in the establishment of policy on the provision of artificial sustenance. Given the Catholic tradition of the value but nonabsoluteness of human life, and the importance of the dignity of the person, a credible argument can be made that artificial nutrition is to natural eating what respirator therapy is to natural breathing. Nourishment and air are both basic

human requirements. However, when these are technologically provided to an individual in an extremely debilitated physical state, from which there is no reasonable hope of recovery, the removal of these medical life supports may sometimes serve the best interests of the patient. Withholding or withdrawal of artificial nutrition is no more like "starving" the patient than withholding or removing a respirator is like "suffocating" him or her. Kevin O'Rourke, John Paris, and Richard McCormick are among the Catholic theologians who make this essential argument.[11] However, the key point to be stressed is not so much this particular conclusion, but that debates about artificial nutrition and hydration are not specifically *religious* matters. Church teaching may illumine relevant moral insights, but its persuasive power must rest on the cogency of its arguments about what constitutes an optional means of medical life support, given the human values of life, care for the sick, prudent social policy, and so on.

There is one element in the Catholic natural law tradition which perhaps should be emphasized more than it has been in regard to health care: the importance of seeing every individual as part of the social body. It is no longer sufficient to handle questions of medical morality in an individualistic manner. On the one hand, this means that we must be careful not to institutionalize practices in one area which will threaten respect for life in other areas. Some argue that withdrawing feeding, even if artificially provided, from very sick patients, will discourage basic care for others who seem to take from society more than they can contribute. On the other hand, respect for life does not end with prolonging biological existence. To focus on individual patients to the exclusion of their place within a larger context of health care is to ignore the sociality of the person, and to forget that the quality of life of all persons calls for social policy protection. One of the most difficult questions which our prosperous and technologically advanced society must face is that of distributive justice for all our citizens, including justice in health resource allocation. Both traditional moral analysis and recent court cases tend to address questions of medical crisis intervention and life-prolonging therapy for the hopelessly ill in isolation from broader considerations. Certainly the Church, its members, and its representatives, have a role to play here. One thinks appreciatively of the Catholic Health Association's task force report, *No Room in the Marketplace: The Health Care of the Poor*,[12] and also of Cardinal Bernardin's efforts to broaden our understanding of "re-

---

[11] *See* O'Rourke, *The A.M.A. Statement on Tube Feeding: An Ethical Analysis*, 155 AM. 351 (1986).

[12] Catholic Health Association's Task Force Report, *No Room in the Marketplace: The Health Care of the Poor, reprinted in abridged form*, HEALTH PROGRESS, July-Aug. 1986, at 87 [hereinafter *Health Care of the Poor*].

spect for life." He has pointed out repeatedly that there is moral inconsistency in the fact that a minority, including newborns and the dying, receive aggressive and often expensive crisis intervention, while others do not have basic and preventive care (for instance, before birth).[13] Government intervention through tax and welfare policy may be necessary. Bernardin does not speak out of narrow religious conviction, nor to Catholics only, when he urges:

> We must defend the right to life of the weakest among us; we must also be supportive of the quality of life of the powerless among us: the old and the young, the hungry and the homeless, the undocumented immigrant and the unemployed worker, the sick, the disabled and the dying.[14]

### *B. Health Care for the Elderly*

Cardinal Bernardin's words call to our attention the fact that even in a nation as prosperous as our own, social resources may not be distributed equitably. Of course, his exhortation to protect society's weak or powerless members throws into relief the fact that Americans in general enjoy a relatively high standard of living. We take it for granted not only that basic health needs should be met, but also that the costs of health care should be distributed so that those who are economically well-off or healthy will help bear the burden of health care for those who are poor or who are the victims of catastrophic illness. This distribution of burdens is accomplished both through private insurance programs and through tax-funded public programs. In a helpful summary of the state of the health care "safety net," the CHA task force report describes the coverage offered by the largest public insurance programs: Medicaid, Medicare, and tax benefits to employer-provided private health insurance.[15] The report reminds us that Medicaid covers only the poor in the welfare categories: aged, blind, disabled, or families with dependent children. One large "gap" in the net is by now familiar: middle-class persons who do not fit these categories and are unable to buy insurance must spend all their savings on medical care before they can rely on government funding.

For obvious reasons, the segment of the population most likely to experience high health costs is the elderly. Medicare is the federal program which targets the aged, who do not have to be poor to be eligible for its benefits. However, the fact that Medicare coverage is not complete coverage poses special burdens for the poor elderly. A particular problem is the fact that neither Medicare nor most private insurance programs pay for nursing home care:

---

[13] Cardinal Bernardin, *Health Care and the Consistent Ethic of Life*, 15 ORIGINS 36 (1985).
[14] *Id.* at 38.
[15] *Health Care of the Poor, supra* note 12, at 89.

> Currently, Medicare payments account for less than half the total health care bill of the elderly. Of the direct out-of-pocket expenses incurred by the elderly in 1983—about $30 billion—42 percent was consumed by nursing home care, by far the largest component.[16]

Let us focus briefly on two interrelated aspects of this problematic picture. The first is the nature of "just" health care for the elderly. The second is the moral perspective which the Church can offer on the situation. First, as has been observed, a society which affirms the equal dignity of all members will not exclude any group from a share in the goods of that society simply because that group is more vulnerable or less able to assert its own claims than the dominant classes. However, the question of a just distribution of social goods must be answered with reference to two factors: the *availability* of resources, and the possibility that access to resources may vary legitimately according to *relevant differences* among potential beneficiaries. Race, sex, and age are examples of differences which do not reflect on the essential worth of persons, but which may or may not be relevant to the way they are treated. When the characteristic is irrelevant to the issue at hand, as it frequently is in education or employment, differential treatment is rightly called "discrimination." But in some cases, including areas of health care, differences can be pertinent. Some examples are special testing programs for persons who are susceptible to racially-linked diseases, preventive health care for youth, and maternity benefits for women. Can such differences be relevant to the limitation or denial of certain types of health care as well? One obvious limit can be set by considering the potential of a treatment to benefit the recipient, especially in the case of crisis care measures which are expensive, i.e., "scarce." An example of a current limiting policy of this sort is the requirement that an organ recipient must be a good tissue match and within certain age limits; otherwise a scarce resource may be "wasted."

Daniel Callahan, philosopher and director of the Hastings Center for bioethics, observes that:

> Currently, the provision of health care for the poor is set in the context of high-technology medicine, which continually strives to improve health and to extend life. This medical system, based on technological progress and constant improvement, does not readily admit that death might be acceptable, that old age and decline are a part of life, and that the good health of the poor has to be understood in relation to economics.[17]

At a meeting of a new CHA Task Force on Long-Term Care, Callahan and others pointed out that federal funds provide far more care to the

---

[16] Iglehart & White, *Catastrophic Health Insurance: Public/Private Role Debated*, HEALTH PROGRESS, Nov. 1986, at 10.

[17] Callahan, *A New Vision of Health*, HEALTH PROGRESS, Dec. 1986, at 85-86.

elderly than they do to children. A disproportionate share of Medicare funds (thirty to thirty-five percent) is spent on individuals in their last year of life, even though this group constitutes only five percent of Medicare enrollees. "'Don't use medicine to give a creeping immortality,' Callahan urged, pointing to the absurdity of giving artificial hearts to persons in their 70's, 80's, and 90's."[18] His remarks suggest that "catastrophic" illness should be defined somewhat differently for those in the beginning or prime of life, than for those near its natural end. It hardly would be "ageist" to limit access of the elderly to technologically sophisticated life-extending care if some of the resources saved were channeled into efforts to provide a higher quality of life—even if not a longer one—for the elderly themselves.[19]

The current medical care system, in other words, aims its high-tech strategies at those who can benefit from and pay for intensive interventions—whether or not long-term benefit is to be expected; whether or not a less technology-intensive measure would be adequate or better; whether or not others less able to pay could benefit equally or more; and whether or not such interventions in general draw resources away from more productive and ultimately more fair forms of medical care, both acute and preventive. Given the fact that medical resources are not infinite, it is simply not possible to extend indefinitely the life of every person. Pretending to do so by applying last-resort measures to any person immediately at hand in a hospital bed only disguises the fact that the system works against increasing the level of good health enjoyed by Americans generally, and against better health care for the poor in particular. Indeed, a technology-intensive, last-resort mentality actually militates against proper respect and humane care for gradually debilitated elderly persons for whom sensitive assistance in the necessities of daily living and considerate personal attention will be of most value in enriching their declining years. The implications hardly need to be spelled out in terms of the duties of respect for human dignity and of distributive justice both to give public financial support to forms of elderly care resembling the nursing home or home health aid, rather than the hospital; and to reconsider the values behind distribution of benefits within the health care establishment. Reconsideration of allocation of resources to health care in relation to expenditures for other social objectives, such as education and defense, looms as an important but virtually unapproachable further task.

How can or should the Church speak to these issues? The CHA's task force report reflects the NCCB economics pastoral in referring to an

---

[18] *CHA Task Force Probes Long Term Care of the Elderly*, 3 CATHOLIC HEALTH WORLD 1 (1987).

[19] Callahan, *Rethinking Health Care for the Aged*, N.Y. Times, Sept. 25, 1987, at A-39, col. 2.

evangelical "preferential option for the poor." I think such a preferential option has most usefulness in appealing to the Christian community, for instance, the Catholic medical center or the religious order engaged in care for the elderly. To argue that the poor should be "preferred" precisely and simply because they are suffering and in need, is to make an appeal to Jesus' command to love one's neighbor, and his illustration of neighbor-love with the parable of the Good Samaritan (Lk 10:29-37). Religious commitment can and should serve as a powerful motivator of morality. Some Christians would even argue that Christian discipleship entails some special moral obligations (such as loving one's enemy) which seem "foolish" to the unconverted but which are mandatory for the believer. However, neither any special duties that faith may entail, nor the reasons of faith for fulfilling universal human moral obligations, are appropriate subjects for public policy debate.

A perhaps more persuasive *public* argument can be made by using the terms of *justice*, including the delineation of "rights" and "duties" so close to the heart of the North American political tradition. Catholic discussion participants may have reference to those concepts as they have been framed by the modern social encyclical tradition. On the one hand, this tradition avoids the tendency of United States individualism to stress rights to the neglect of duties and of social cooperation. On the other hand, it need not rely on specifically Christian (biblical) imagery, especially variations on gospel rhetoric that draw on the "liberation theologies" of the economically disadvantaged third world nations. Emerging from that context, a keynote such as "preferential option for the poor" may well be a valid and vital interpretation of the gospel message and even of social justice. However, it may go against the grain of the North American traditions and vocabulary of independent individualism. The "preferential option" language may thus suffer a diminishment of persuasive power in the process of translation to the North American context, whatever its real merits in its indigenous setting, or its continuing merit for those committed to the evangelical ideals of Jesus. The social encyclicals offer a language which may provide more ready access to United States policy debates, informed as those debates are by a commitment to "equal access" and a resistance to "preferential treatment."

In *Pacem in Terris (Peace on Earth)*, for instance, John XXIII speaks of the responsibility of governmental authority to secure both the rights and the duties of every individual and group. Every person has:

> the right to life, to bodily integrity, and to the means which are necessary and suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and finally the necessary social

services.[20]

Nonetheless, "all members of the political community" are "entitled" to "share in" the "common good." Since this share will vary "in different ways according to each one's tasks, merits, and circumstances," the "civil authority must take pains to promote the common good of all, without preference for any single citizen or civic group." Still, it may sometimes serve justice and equity if the government gives "more attention to the less fortunate members of the community, since they are less able to defend their rights and to assert their legitimate claims."[21] To sum it up, the encyclical uses the framework of the common good to assert that all persons should be considered equally, and enjoy both a right to life's basic physical and spiritual necessities, and a duty to use them well. The manner in which one shares in the common good may be defined in light of one's special circumstances without undermining basic equality. It may be the duty of government, as it coordinates competing needs, to give special attention to those less able to assert their claim to just treatment. The language of justice goes beyond that of charity in opening Catholic Christian moral values out onto the horizon of public policy, allowing church leaders to make their case in defense of social justice, while escaping any accusation that they put forward only a narrowly "religious" posture.

### *C. A Note on AIDS*

Without going into any great detail, it is possible to indicate how such a framework also would apply to a difficult social and medical problem such as the AIDS epidemic. We are all aware that AIDS may be acquired through activities to which Church leaders and others raise moral objections—though those who engage in such activities are not the only ones afflicted with AIDS. We also know that AIDS carriers present a risk of fatal infection to those with whom they come into contact—though evidence indicates strongly that the contact which transmits AIDS must be very close contact of a few narrowly specified kinds.

The AIDS patient, like any other patient, must be approached in terms of justice. Beyond the fact that many AIDS sufferers, especially children, contract this terrible disease through no fault of their own, it must be insisted that moral culpability should not be a factor in determining treatment of the AIDS patient unless we are willing to apply that standard uniformly. Are we willing to apply it to patients dying from lung cancer, cirrhosis of the liver, heart disease, high blood pressure, or obesity because they persisted in unhealthy habits? To women suffering a hemor-

---

[20] John XXIII, *Pacem in Terris*, in SEVEN GREAT ENCYCLICALS 291 (W. Gibbons ed. 1963).
[21] *Id.* at 301-02.

rhage after an abortion? To men with gonorrhea or syphilis? To alcoholics, drug addicts, or sex abusers seeking rehabilitation? To accident victims who were careless or did not wear protective clothing? Certainly the lines of causation in all these cases are many and pluriform, and the task of judgment correspondingly complex and presumptuous. To single out the suspected homosexual as a non-candidate for medical care would give reason for an accusation of "homophobia"—that is, singling out homosexuality as an object of particular fear and loathing among all the other forms of human activity to which moral and prudential objections reasonably could be made. Care of AIDS victims is certainly one area in which public policy should not attempt to "legislate" sexual morality or the morality of drug use. It would be virtually impossible to use such policy to enact sanctions fairly and without causing greater social evils. This is especially true in view of the fact that there is no clear consensus in our society about the limits of acceptable adult sexual behavior.

Like any other carrier of infectious disease, however, the AIDS patient should be handled in a manner which minimizes risk to health care workers. Defining proper guidelines for treatment will, of necessity, involve compromise between sensitive patient-care routines and protection of the care-giver. Health care facilities can do much to reduce risk of AIDS infection by adhering strictly to guidelines already published by the Public Health Service, the American Hospital Association, and the Occupational Safety and Health Administration. Additional measures, such as testing for the virus upon admittance to the hospital, or to the surgical unit, may be justified. The right to privacy of the AIDS victim must be respected, but this right is not an absolute in relation to the right of medical personnel to be protected from fatal disease. Finally, the question of wise and humane use of medical resources arises in the case of AIDS, as it does in that of artificial nutrition and of care of the elderly in general. AIDS victims are in desperate need of group living facilities and hospice arrangements in which they can be afforded compassionate medical, social, psychological, and spiritual assistance from professionals trained to manage the disease. Such special arrangements would help limit the economic drain caused by overuse of hospitalization, and would help limit risk of infection by concentrating AIDS care in the hands of a few who would be prepared to handle it expertly.

### *D. Infertility Therapies*

The Congregation for the Doctrine of the Faith's *Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day* is an example of an attempt to influence social attitudes and public policy with essentially philosophical

arguments about "the dignity of the person."[22] The document makes frequent reference to religious themes and to past Church teaching. However, the extent of its influence beyond the Catholic community will depend on whether or not its analysis of common human values is rigorous and convincing. The strongest part of the Vatican's case against technical substitutes for natural intercourse rests in its objections to donor or surrogate therapies which involve "outsiders" in the procreative efforts of spouses. Given the moral and legal difficulties presented by the much-publicized surrogate mother cases in the United States, it is reasonable to assume that there exists in our culture a certain receptiveness to a critical moral analysis of third-party infertility therapies. The document's argument that substitutes for natural intercourse within marriage also contradict the intrinsic meanings of marriage and parenthood, and thus are also morally "illicit," may turn out to be less persuasive. It may be less clear experientially and philosophically that the "dignity" of sexuality and marriage demand that the physical integrity of the act of sexual intercourse be observed in each and every case. If public policy is the end in view, it is not enough to appeal to the tradition of the Church, or to previous pronouncements of the magisterium. In the section on "Moral and Civil Law," the document claims that:

> the rights of the family and of the institution of marriage constitute fundamental moral values, because they concern the natural condition and integral vocation of the human person: at the same time they are constitutive elements of civil society and its order.

The legislator is urged properly to take care for the "public order" and "the common good," on the basis of "rational principles." Not incidentally, this section focuses on respectful treatment of existing embryos and on legal restriction of infertility therapies which reach beyond marriage, rather than on intra-marital technologies. The effectiveness of these exhortations will depend on the logical force and cultural sensitivity of the arguments put forward in favor of regarding the embryo as having "from conception" the full rights of a human person; and in favor of the moral unity of marital commitment, sexual expression, and parenthood. The Church's moral positions have the potential to shape public discussion and policy only to the extent that they can be put forward in terms which are accessible and convincing to citizens in general, including those who do not accept the specifically religious authority of Roman Catholicism.

## SUMMARY

Catholic experience with the abortion debate has taught us, first, that

---

[22] *See supra* note 1 and accompanying text.

the moral commitments of religious persons and groups cannot be dismissed as "personal" and "private" if they can be argued on public grounds. Second, it has shown that more than moral defensibility is required for a viable public policy. The Catholic contribution to public policy discourse has been the tradition's commitment to an objective moral order, in principle knowable by all reasonable persons. It is best, however, to picture the language of "natural law" as giving access to a sphere of dialogue, rather than to a mythical trans-cultural realm. On questions such as abortion, artificially administered nutrients, and reproductive technologies, it is important to avoid the individualism of both the right ("duty to treat every person equally") and the left ("right to privacy"), and to try to make sense of human dignity within the context of interdependence and sociality. This project becomes especially important when we consider the allocation of health care resources among groups, and set allocation questions within a vision of the meaning and importance of life, health, other life-enhancing goods, and death. A duty of mutual support includes attention to society's most vulnerable, but it also presses the question of a just distribution of community resources. Finally, the moral authority of the Church in the public forum will be only as good as the cogency, logic, and cultural nuance of its arguments. A lesson to be drawn from the recent U.S. episcopal pastoral letters is that a broadly consultative process is helpful in achieving a consensus within the Church which is in touch with the values of the culture in which it is situated, and which can as a result speak effectively to that culture. Another lesson is that it is indeed appropriate for Catholic leaders to address specific points of social policy, in a manner exhibiting equally the virtues of reasonableness, courage, and modesty.