The Dignity of the Human Person in the Face of Competing Interests: Prudent Use of Resources in the End-of-Life Care

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THE DIGNITY OF THE HUMAN PERSON IN THE FACE OF COMPETING INTERESTS: PRUDENT USE OF RESOURCES IN THE END-OF-LIFE CARE

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Introduction

Over the centuries, people were born, lived and died in a way that could be called a natural sequence of events. However, in modern times, the natural progression of life has been interrupted by developments in the legal systems and medical technology. These developments have dramatically affected the beginning and the end point of human life, particularly being applied to bring forward or to delay the point of death. This reality has even blurred the definition of death, which traditionally used to be the natural cessation of cardiac and respiratory activity. Some modern practices have made the sick people, particularly the people at the end of life, vulnerable to being abandoned, subjected to a premature death, or aggressively treated in unjustifiable ways. The treatment of patients has become a delicate balance between futile care on one extreme end, and medical negligence on the other extreme end. In the context of limited resources, this care for the dying patients has a direct impact on the care given to other sick people since the latter need to share the very same resources.

The continued emphasis on personal autonomy has influenced the process of caring for the sick and facing death when the inevitable death comes. Activities carried out in the name of autonomy and self-determination have somehow subdued the traditional way of practicing medicine in which the physician attended to a patient until the patient recovered or died naturally. Nowadays, the medical and legal changes have presented new ethical challenges. Subsequently, there is need to seek ways of handling the challenges and one of the viable options is the use of virtue ethics.

Human life is associated with a certain degree of dignity that is natural to humanity. The Catholic Church teaches that all human life is precious. Christianity promotes a morality that respects the dignity and sanctity of human life. The recognition of the value of human life places on the human family an obligation to defend human life, particularly offering protection and care to the people who are helpless and most vulnerable, for example, the unborn and the terminally ill. The practice of medicine and the development of new technologies are some of the areas of science that could be helpful in attaining the above goal. However, legal developments, medical knowledge and scientific research could also lead to abusing the dignity of human life, and to endangering the lives of the most helpless members of the human family. Some medical decisions make human beings vulnerable to harm or to avoidable prolonged suffering, e.g., in the context of medical futility.

Medical advances in the context of personal autonomy

Growth in technology regarding the severely sick persons has opened new possibilities of postponing the moment of death even when a patient is not expected to recover or improve. The possibility of cardiorespiratory support has enabled people to be kept alive as long as the body's metabolic functions are well supported by specialized equipment and provided with artificial nutrition and hydration. However, under such circumstances, the health condition of a dying patient does not improve. The progression of the patient's condition towards death is not halted but just slowed down. Ultimately, it becomes an expensive way of sustaining a life while the health is neither restored nor improved. Some people argue against the use of extraordinary means of treatment when death is imminent, considering that intensive care is financially, socially and emotionally expensive.

Good practice of medicine is important because of the way it affects everyone's life. According to the World Health Organization (WHO), health is defined as "a state of complete physical, mental, and social well being, not merely the absence of disease or infirmity."[1] However, there are times when patients and healthcare providers choose to promote one aspect of health without proper regard for the other aspects, for example, insisting on doing certain procedures that pursue physical health without seeking social wellbeing.

Newer medical technology and skills inspire health workers to try newer methods of treatment, particularly if a patient or a patient's healthcare proxy gives consent for that kind of treatment. The tendency for any doctor to undertake heroic procedures can be the result of the effort that the doctor has put in learning some specialized skills, added to the availability of an opportunity to apply those skills. In such a case, for Samuel Gorovitz, "Skills that have been acquired at substantial personal cost are skills that people like to use; people who can do sophisticated things like to do them."[2] For example, the doctor who trained in neonatology and the care of extremely premature neonates would be more inclined than other doctors to save an extremely premature neonate were the chance to appear. At the same time, a desperate patient would be more likely to seek heroic treatment than other patients.

Such conditions create the threat of utilitarianism in the delivery of healthcare, with the twofold aim of increasing pleasure and decreasing pain. Utilitarianism can be one way of looking at the needs of terminally sick or dying patients. The patient's desire for pleasure and happiness can be regarded as a guiding light to decide what could be done to the person or what ought not to be done. In the face of an impending death, a person could see the termination of suffering or pain as the most appropriate act of reducing pain and creating some pleasure. This opens the door to the possibility of euthanasia. On the other hand, when the death of a person is seen as the end of the possibility of future joy, since a person must be alive in order to enjoy any pleasure in

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[1] World Health Organization. "WHO Definition of Health." Accessed December 1, 2016.

[2] Samuel Gorovitz, *Doctor's Dilemmas: Moral Conflict and Medical Care* (New York: Oxford University Press, 1982), 21.

life, then the patient may demand that every possible medical effort be applied towards the prolongation of life.

Through the expression of autonomy, a patient is able to pursue the outcome that he/she desires. A patient's decision is influenced by multiple circumstances rather than just the diagnosis and prognosis regarding an illness. Whatever may appear to be the right decision from the medical point of view may not necessarily be the decision that a particular patient considers important, and hence a patient may express desires that are contrary to the wishes of the caregivers. Gorovitz affirms:

> The wrong decision from a purely medical point of view may thus not be the wrong decision from the broader perspective of the patient's life; the medical experts therefore have an important place in the decisions that must be made about treatment, but they have no basis for presuming to be able always to reach decisions about what, all things considered – medical and nonmedical alike – is best for the patient.[3]

Issues of morality often cause disagreements because of differing viewpoints. A study by Downing *et al*. found that most Kenyans, if they were told that they are about to die, would be more concerned for relatives and families than having their own pain and discomfort controlled, indicating a strong sense of community that makes people to place the needs of the family above those of the self and one's own medical care.[4] The study also showed that the majority of Kenyans would like to die at home, a desire that may sometimes conflict with medical opinions but also that highlights the need to develop more palliative care systems.

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[3] Ibid., 46.

[4] Julia Downing *et al*., "Public Preferences and Priorities for End-of-life Care in Kenya: A Population-Based Street Survey" in *BMC Palliative Care*, vol. 13: 4 (published online Feb. 15, 2014), accessed on September 27, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3936799/

Legal influence on healthcare delivery

The later half of the 20th century in America was marked by the discussion regarding the morality of foregoing medical treatment, eventually leading to a kind of American consensus in the 1990s.[5] This consensus recognizes that there is no absolute agreement on all medical issues but the consensus provides some guidelines. Kelly identifies three pillars to the consensus:

a) Recognition that not all treatments that prolong biological life are beneficial to patients.

b) Recognition that there is a moral difference between killing and letting die.

c) The legal system in the United States combines the two pillars named above to promote the legal concept of autonomy, privacy and liberty.[6]

Certain judgments of the American judiciary that involved highly publicized cases have influenced the processes of making medical decisions. In the Karen Quinlan case, parents demanded the removal of a ventilator, which they considered to be an extraordinary means of treatment, but allowed the use of artificial nutrition and antibiotics as "ordinary care" until Karen's death. In the case of Nancy Cruzan, the parents wanted the feeding tube removed as an expression of a "living will," of what Nancy would have wanted to be done in case she ever fell into a vegetative state. In the Terri Schiavo case, the court approved that the feeding tube could be removed as an expression of the right to die and of implementing a sort of a living will.

The above cases show two significant contributions that legal and medical developments have brought to the care of incompetent patients, namely:

a) Patient's autonomy, expressed either directly by the patient or through a health surrogate to determine what could be done or not done.

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[5] David F. Kelly, *Medical Care at the End of Life: A Catholic Perspective* (Washington D.C.: Georgetown University Press, 2006), 1.

[6] Ibid., 2.

b) The place of ordinary and extraordinary means of treatment in caring for patients, especially those whose religious affiliation provides them with an ethical position.

In making health interventions, the legal system in the United States has to strike a balance between two potentially conflicting approaches, which are: promoting the authoritative decisions of the judiciary or the autonomy of the patients. These decisions are made in the face of medical evaluation, and hence form a link between medical practices and legal developments.

Virtues: a helpful way to deal with ethical challenges

Virtues, particularly the cardinal virtues, are a helpful way to guide people in making difficult ethical decisions, especially when the concerns to be addressed are very personal. According to Nelson, "An ethics of virtue certainly has the resources for analyzing difficult situations and possesses the vocabulary for making fine but crucial distinctions between prohibited, permitted and required acts."[7] When a person chooses to pursue the development of a virtuous life, then the person develops a habit in which the decisions are made more easily and consistently, acknowledging the difficulties but desiring to maintain the dignity of being a member of the community of rational human beings.

In the modern times, it may be hard to apply the cardinal virtues how Thomas Aquinas did in the 13th century. Some of the understanding and application of virtues changed in practice, a reality that makes Nelson to write:

> Temperance has primarily come to mean restraint in the consumption of food and drink; the appropriateness of fearing real dangers has dropped out of our understanding of courage, which some see as a vice in the nuclear age; justice has

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[7] Daniel Mark Nelson, *The Priority of Prudence: Virtue and Natural Law in Thomas Aquinas and the Implications for Modern Ethics*, (University Park, PA: The Pennsylvania State University Press, 1992), 139.

> lost its connection to persons and is regarded almost exclusively as an attribute of legal systems and social structures; and prudence has become mere carefulness or even excessive concern for self-interest.[8]

In this way, Nelson laments the modern contraction of the classical meaning of the cardinal virtues. However, the cardinal virtues are still a respectable source of ethical behavior in our world today. Healthcare delivery is influenced not only by the medical and legal developments but also by the character of human beings as moral agents. The focus on virtues has the advantage of influencing not only the ethical decisions that need to be made but it touches on the people as moral agents. While being concerned with a person's character and one's actions, virtue theory is "more concerned with the kind of person one becomes than in judging particular actions, because the former largely determines the latter."[9] A virtuous person is expected to have a character that directs the development of good perceptions, choices and actions whenever different contexts arise. The virtuous person would be able to judge correctly and act appropriately.

Healthcare delivery would benefit well from virtuous activities. By balancing the needs of the dying patients with the needs and those who are expected to recover, health workers need to try to protect the welfare of all people. In the triage of patients, justification for determining who should have access to the limited resources could be made on the basis of relative probabilities for survival. However, such decisions must be made in good conscience. The subjective and intrinsic norm of human decision-making is the conscience, which could be defined as "the

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[8] Ibid., 149.

[9] Joseph J. Kotva, Jr. *The Christian Case for Virtue Ethics* (Washington D.C.: Georgetown University Press, 1996), 105-6.

practical judgment of reason upon an individual act as good and to be performed, or as evil and to be avoided."[10]

Following today's advanced medical practices, and being supported by prevailing legally protected privileges, one can mechanically prolong or shorten the process of dying through acts of commission or omission. Some people choose to undergo heroic treatment procedures that are hard to justify while some choose to have their lives ended as soon as their health condition starts to deteriorate so as to avoid a prolonged period of illness. Hence, end-of-life issues are potential points of ethical dilemmas. While virtue theory calls people to become good moral agents, Christian teaching invites people to look at God as the source and giver of human life, and to humbly acknowledge God's plan for humanity.

Christianity contributes to the understanding of morality concerning medical procedures, particularly in the light of technological and legal developments. For example, in the "Declaration on Euthanasia," the Congregation for the Doctrine of the Faith (CDF) stated, "In modern society, in which even the fundamental values of human life are often called into question, cultural change exercises an influence upon the way of looking at suffering and death; moreover, medicine has increased its capacity to cure and to prolong life in particular circumstances, which sometime give rise to moral problems."[11]

In this thesis, I am going to explore some of the significant legal and medical activities that have had a great influence on the healthcare delivery in the United States of America, focusing on the care of people that are severely sick or those whose death is imminent. Then I will discuss how the application of virtues, particularly the cardinal virtues, can inspire people not to neglect

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[10] John P. Kenny, *Principles of Medical Ethics*, 2nd ed. (Westminster, MD: The Newman Press, 1962), 12.

[11] Sacred Congregation for the Doctrine of Faith, "Declaration on Euthanasia" (May 5, 1980), iv, accessed on Oct 26, 2016, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

the needs of patients whenever some helpful procedures could be done, and also to enable people to desist from engaging in medical procedures that could be deemed futile. Patients and their caregivers can all benefit from cultivating virtue and hence create a way of life that respects the human dignity of patients and also uses the available resources prudently for the sake of the common good.

Ultimately, I hope to suggest some theologically sound proposals that are helpful to a patient, the patient's family and the rest of the country's health system, with a particular focus on an ethical way of delivering healthcare services. I will show how the developments in the Western world can be applied to develop some protocols of healthcare delivery that could be helpful to Kenya. It is my belief that the universal applicability of virtues can ensure that healthcare activities uphold the human dignity of patients, provide respect for healthcare work, and also use a country's limited resources prudently.

Chapter 1

Technological and legal developments influencing healthcare procedures

The growth in technology, alongside developments in legal systems, has affected humanity's view of health, healthcare and mortality. While this phenomenon is more developed and documented in the Western countries, there are signs of it getting established in other developing countries, for example, in Kenya. In this chapter, I will explore some of the significant events that have influenced healthcare delivery, particularly in the United States, so that I can use those ideas to develop a feasible and ethically appropriate plan that can be helpful to a country like Kenya.

Today's technology is very advanced

We live in an era that celebrates happiness, technological advances and the desire for autonomy and self-determination. However, we still encounter problems that are beyond human abilities, especially when we recognize our helplessness in the face of severe illness or imminent death. Modern technology has attempted to promote various avenues for adjusting the foreseeable time of natural death, either hastening it or delaying it. Legal systems have provided mechanisms that allow some people to enjoy certain privileges or to obtain medical decisions made in their favor, e.g., in the context of autonomy a patient can demand or refuse to have a certain procedure done even when the healthcare providers think otherwise.

The definition of death has traditionally been the cessation of breathing and respiration, functions that are controlled by the brain stem. However, with the development of technology that can test for electrical activity of the brain, today we can also define death according to the cessation of electrical activity in the brain stem. Cessation of brainstem functions would automatically lead to cessation of breathing and cardiac function, except that it is now possible to have mechanical support for the latter, a condition in which the machines would be sustaining the heart beat and respiration in a brain-dead person, or basically, in a corpse.

The person who is dependent on machines also requires very specialized skills provided by highly trained personnel. By receiving round-the-clock care that includes feeding, cleaning, regular turning, and regular observation and documentation of vital signs, every patient in intensive care consumes a lot of resources. Intensive care for the very sick patients is always expensive regardless of the age of the patient. In a policy statement released by the American Academy of Pediatrics, the pediatricians acknowledge that the advances in technology have not only brought improvement in the outcomes of high-risk newborn infants but also prolonged the lives of some terminally or severely ill or extremely preterm infants.[12] The use of modern technology has prolonged the process of dying for some infants or enabled some infants to survive with profound debilitating problems. Sometimes, these are the results of aggressive and expensive treatment procedures even when the prognosis is very poor. Hence, there are difficult decisions that have to be made by parents and healthcare professionals since the outcomes are not always predictable.

Technological dilemma: Doctors fear to tell a patient that "no more can be done"

One of the big problems of our time is the inability of many people, patients and doctors alike, to recognize that the developments in medicine cannot solve all the medical challenges that we face or do everything that we desire.

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[12] American Academy of Pediatrics. "Noninitiation or Withdrawal of Intensive Care for High-Risk Newborns." *Pediatrics*, Vol. 119, No. 2 (February 2007), 401.

Atul Gawande, in his book *Being Mortal*, highlights a big idea that concerns the last days of a person's life. Gawande points out critical issues that many people, health workers and patients alike, find hard to acknowledge or point out. This idea concerns the terminal point of earthly life, the moment when all the human effort aimed at bodily healing comes to an end and then death becomes imminent. That reality is hard to face, especially when a patient, and his/her family have not accepted the possibility of an imminent death, or when they have had a very optimistic expectation of a longer life and the success of treatment.

The pain associated with the death of a loved one, and the permanence associated with that parting, makes the encounter with death a profoundly painful experience. Many people expect the latest developments in medical care to enable humanity to overcome nearly all the threats of illnesses; however, the admission of helplessness by the medical practitioners, when communicated to the patients who have placed so much hope in medical care, shakes the very foundation of hope, and sometimes trust, in the healthcare system.

Sometimes the health workers find it hard to make direct references to the reality of bad news if the prognosis of a particular patient is poor. This is particularly difficult when the patient, or the family, is not open to acknowledge the imminent death. In his book, Gawande describes the story of Sara Thomas Monopoli, who is diagnosed with advanced lung cancer while 39 weeks pregnant with her first child. She and her immediate family, especially her husband and mother, are traumatized. They engage in different chemotherapy regimens, recognizing the failure of the various drugs and still moving on to new regimens with hope. For example, despite failing the first two regimens of chemotherapy, she is put on Pemetrexed, a drug that prolongs the average survival of patients by only two months (from 11 to 13 months), and that benefit is only for the people who have previously responded to the first-line chemotherapy.[13]

Terminal care is not only associated with the emotional challenge of having to face imminent death; it is also a big financial challenge for individuals and governments. According to Gawande, "Twenty-five percent of all Medicare spending is for the five percent of patients who are in their final year of life, and most of the money goes for care in their last couple of months which is of little apparent benefit."[14] Gawande goes on to underscore the financial burden that is associated with terminal care for cancer patients, saying, "Our medical system is excellent in trying to stave off death with $12,000-a-month chemotherapy, $4,000-a-day intensive care, $7,000-an-hour surgery. But ultimately, death comes, and few are good at knowing when to stop."[15]

While the doctors aim to cure the illness, comfort the patient and relieve the suffering, sometimes these goals may conflict with one another. The doctor and the patient (or the patient's surrogate) then have to decide which goal is to take priority. Eventually, some of the patients with incurable illnesses are made as comfortable as possible, particularly with regard to managing their pain, ensuring adequate nutrition, controlling infections and maintaining their social life with their loved ones. By recognizing an illness as terminal, the family and the healthcare workers have the opportunity to provide end-of-life care, although that is heavily dependent on the acknowledgement that death is imminent. When a patient's process of death extends over a long period of time, then the goals of care have to be reevaluated repeatedly. One

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[13] Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (New York: Henry Holt and Company, 2014), 152.

[14] Ibid., 153.

[15] Ibid., 153- 154.

condition that causes serious difficulties with regard to terminal care is when the patient enters into a vegetative state.

A common cause of moral dilemmas is when a patient becomes unconscious. Different conditions could account for a patient's unconsciousness and these different disorders of consciousness influence the type of care that a person could receive. A person is said to be in vegetative state when he or she has "lost the use of the cerebral cortex while the brain stem continues to function."[16] This is different from coma because patients in vegetative state have sleep-wake cycles unlike comatose patients who have no wakefulness states.

The term "persistent vegetative state" (PVS) is a diagnostic term that is used to indicate a state from which there is no reasonable hope of recovery to a state of even minimal awareness while the term "permanent vegetative state" is a prognostic term indicating that no recovery is likely.[17] The permanence of vegetative state depends on the cause of the cerebral injury. A proper diagnosis of the persistent or permanent vegetative state is possible when it is based on laboratory studies and clinical observations and supported by positron emission tomography.[18] The indiscriminate use of the acronym PVS and the interchangeable application to include both persistent and permanent states has led to some confusion. Hence it may be better to just use the term vegetative state.

Vegetative state (VS)

In the abstract to the article entitled, "Medical Aspects of the Persistent Vegetative State," published by *The New England Journal of Medicine* in 1994, the Multi-Society Task Force on

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[16] Kelly, *Medical Care at the End of Life*, 90.
[17] Ibid., 91.
[18] Ibid., 92.

PVS gave a consensus statement that summarizes the medical aspects of the persistent vegetative state in adults and children. The Task Force said:

> The vegetative state is a clinical condition of complete unawareness of the self and the environment, accompanied by sleep-wake cycles, with either complete or partial preservation of hypothalamic and brain-stem autonomic functions. In addition, patients in a vegetative state show no evidence of sustained, reproducible, purposeful, or voluntary behavioral responses to visual, auditory, tactile, or noxious stimuli; show no evidence of language comprehension or expression; have bowel and bladder incontinence; and have variably preserved cranial-nerve and spinal reflexes. We define persistent vegetative state as a vegetative state present one month after acute traumatic or nontraumatic brain injury or lasting for at least one month in patients with degenerative or metabolic disorders or developmental malformations."[19]

The task force added that recovery from a nontraumatic persistent vegetative state after three months is exceedingly rare in both adults and children. Patients in PVS are incapable of awareness regarding pain, dehydration or starvation. Hence, some people hold that one could discontinue the provision of nutrition and hydration for such patients. For example, Cantor contends that the judicial approach that allows withdrawal of artificial nutrition is fully consistent with traditional medico-legal doctrines.[20] Clarke, Goldstein and Raffin also hold that nutrition and hydration can be withheld or withdrawn, particularly if the patient had given prior instructions for such a move (when he/she was competent) or if the health surrogate approves the

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[19] Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," *The New England Journal of Medicine* 330 (May 26, 1994): 1499- 1508.

[20] Cantor N. L. "The Permanently Unconscious Patient, Non-feeding and Euthanasia." *American Journal of Law and Medicine,* Vol. 15, No. 4 (1989): 381-437, accessed on Nov 12, 2016, https://www.ncbi.nlm.nih.gov/pubmed/2517381

decision for the patient.[21] Similarly, Hilde Buiting and others, following a study that compared certain medical practices in six European countries, concluded that decisions to forgo artificial nutrition and hydration "usually involve a limited degree of shortening of life and are not likely to involve extra suffering for dying patients."[22]

Death

There have been serious debates concerning the beginning and the end of human life, often associated with certain philosophical questions like the definition of personhood, human dignity, human rights, death, human freedom, autonomy, etc. In the context of the prolonged process of dying associated with chronic illnesses, different criteria have been developed to establish when death actually occurs. There are different ways of defining death and these ways influence the manner in which different people deal with the end-of-life issues. According to Munson, four concepts of death have emerged in the last two decades, and these are:

i) The traditional concept: death is marked by the permanent cessation of breathing and blood flow, which would also be called the cardiopulmonary notion of death. This concept has been easy to apply because it involves little technology to recognize.

ii) Whole-brain concept of death: death is marked by the irreversible cessation of all brain functions, meaning that there is no electrical activity that can be

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[21] D. E. Clarke, M. K. Goldstein, and T. A. Raffin. "Withholding and Withdrawing Nutrition and Hydration: Surrogates Can Make This Decision for Incompetent Patients," *Chest*, Vol. 104, No. 6, (December 1993), 1646-1647, accessed on Nov. 14, 2016, http://journal.publications.chestnet.org/article.aspx?articleid=1066738&resultClick=1

[22] Hilde M. Buiting, *et al*., "Forgoing Artificial Nutrition or Hydration in Patients Nearing Death in Six European Countries." *Journal of Pain and Symptom Management*, Vol. 34, Issue 3, (September 2007), 305–314, accessed on Nov 14, 2016, http://www.jpsmjournal.com/article/S0885-3924(07)00336-3/fulltext

recognized in the entire brain. This concept developed in the 1980's and has been the basis for the development of many state laws that relate to death.

iii) Higher-brain concept of death: death is marked by the permanent loss of consciousness; a person is declared dead if he or she is in an irreversible coma or a chronic vegetative state, conditions in which the brain stem continues to regulate breathing and cardiac function. This definition is considered very important because it enables the harvesting of organs from the dead person for transplant into other people who desperately need those organs. This concept has led to many challenges in its application, and some of the long-standing legal cases have involved this criterion, e.g., the Nancy Cruzan case.

iv) Personhood concept of death: death occurs when an individual ceases to be a person, that is, loses the features that are included in the criteria for personhood. These features are based on the functions of the individual rather than functions of the brain alone, and they include reasoning, remembering, feeling emotions, interacting with others, etc. The establishment of or cessation of personhood has been a difficult problem, with different philosophical positions being expressed, and hence is hard to secure an agreement based on this concept.[23]

Today's technological development has produced the necessary equipment to support a person's basic physiological and metabolic functions even when the person's vital organs have shut down, whether by death or severe illness. This involves using a variety of equipment, e.g., a ventilator to support the person's respiration, a dialysis machine to support renal functions,

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[23] Ronald Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*. 8th ed., (Belmont, CA: Thomson Wadsworth, 2008), 684-85.

artificial nutrition to support dietary needs, etc. The investment in such specialized equipment generally involves a lot of money to purchase the machines and a huge bill to maintain them.

In 1981, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, collaborated with other organizations to establish a uniform proposal that would significantly ease the enactment of good law on death throughout the United States. In its report entitled "Defining Death," the commission recommended that all states adopt the Uniform Determination of Death Act, in which we read, "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."[24]

According to Gorovitz, "The definition of death that we endorse reflects our reasons for valuing life."[25] In this case, if we hold that it is only experiences that are of intrinsic value, then life is precious because it is a precondition for experiences. Where there is no experience, or prospect of experience, then life loses its luster. Those who advocate the criterion of death based on neocortical function are led to conclude that any life devoid of experience is also without value and hence can be declared a form of death, and be discontinued with impunity. However, if we were to hold that human life has intrinsic value, entirely apart from experience, then the question of sentience would not arise, and even the irreversibly comatose patient would still be treated as a living person.

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[24] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "Defining Death: Medical, Legal and Ethical Issues in the Determination of Death." (July 1981): 73, accessed on Oct 27, 2016.
https://repository.library.georgetown.edu/bitstream/handle/10822/559345/defining_death.pdf?sequence=1&isAllowed=y

[25] Gorovitz, *Doctor's Dilemmas*, 156.

The issue of death, or the end-of-life, has attracted a lot of discussion over the years, particularly because of the complex issues associated with care, the emotions attached to the loss of life, and the pain and suffering associated with incurable illness. The Center for Bioethics of the University of Minnesota, in its 2005 document entitled "End of Life Care: An Ethical Overview," identified certain common elements that are associated with what would be called a good death. These include adequate pain and symptom management, avoiding a prolonged dying process, clear communication about decisions by patient, family and physician, finding a spiritual or emotional sense of completion, strengthening relationships with loved ones, and not being alone.[26]

The impact of legal developments

The developments in the legal system in the United States have provided patients with the opportunity to propose or oppose certain procedures in ways that have had a great impact on the delivery of healthcare services. A lot of these effects have been associated with the concept of autonomy. By extension, autonomy has influenced the pursuit of both medical futility and euthanasia. Many people pursue autonomy as an expression of freedom and an exercise of the rights of every individual to protection and to the available healthcare.

The American legal system allows people to give some direction regarding the kind of care they would like to receive were they to lose their power of decision-making, i.e., by being mentally incapacitated, as occurs when a person falls into irreversible coma or into a vegetative state. There are two ways of giving such advance directives, that is, through proxy directives (appointing someone to make decisions when one is no longer able), or through treatment

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[26] The Center for Bioethics of the University of Minnesota, "End of Life Care: An Ethical Overview" (2005): 12, accessed on Oct 3, 2016, http://www.ahc.umn.edu/img/assets/26104/End_of_Life.pdf

directives (usually a written kind of living will in which a person gives instruction on the kind of care he/she would like to receive) and the two types of directives provide useful ideas to the caregivers.[27]

The legal system in America gives people freedom to choose certain options that tend to be controversial. For example, a person can challenge the decision of a physician who says that a particular patient is imminently dying (and thus certain treatment procedures should not be attempted) or when the doctor says that a certain life-saving procedure needs to be done to help a patient that has a good chance of improvement. Some people tend to hold extreme positions that are problematic whenever medical decisions need to be made; in particular, there are outstanding challenges associated with vitalism and subjectivism. Vitalism can be a big temptation for those who insist on preserving human life at all cost, including those who feel that they want to give God more time to work a miracle in the life of the patient.[28] Subjectivism is also bad because it leads people to abandon treatment or even to kill a patient based only on "the subjective choice of an individual."[29] This exaggerated use of autonomy or the overemphasis on individualism threatens the idea that human life has intrinsic value.

The American legal system can support medical futility. The system allows patients the opportunities to insist on receiving extraordinary life-sustaining healthcare regardless of the cost of the care to the healthcare system. This position may be held even against the advice of healthcare professionals who find a particular patient to be medically or legally dead. This situation not only puts pressure on the healthcare workers, who may have to serve a patient against their professional judgment, but it is also a strain on the limited resources of the healthcare system.

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[27] Kelly, *Medical Care at the End of Life*, 66.
[28] Ibid., 5.
[29] Ibid.

Norman G. Levinsky affirms that the ultimate master of the doctor is the patient as much as the doctor is under pressure to serve two masters, i.e., to consider the society's needs as well as the patient's needs in deciding what type and amount of medical care to deliver.[30] Levinsky holds that while the doctors do not have to do everything that is technologically possible for each patient, they "should decide how much to do according to what they believe best for that patient, without regard for what is best for society or what it costs."[31] Thus the doctor must not rely exclusively on costs or a patient's wish but must balance both, without being overwhelmed by the available technological advances.

The concept of medical futility requires that a person identify the criteria that can help to decide whether medical care to a particular patient is warranted or otherwise. According to Kelly, any treatment that is physiologically useless to the patient or that is irrelevant to the condition of a dying patient would be considered futile; however, any treatment that does not significantly improve a patient's quality of life (as happens when a patient is in vegetative state) or that has a low probability of success is not necessarily to be dismissed as medically futile care.[32] While a healthcare provider may consider some kind of treatment to be futile, the patient and/or the family should also have their opinion respected.

The legal system also supports vitalism and hence a family could oppose a declaration of death. A patient's family can refute the declaration of death regarding a patient (a decision made by healthcare professionals) and go to court to block the termination of medical care.

The story of Jahi McMath points to the exaggerated position that a family of a patient could take in the name of one's personal "right to healthcare." Jahi was 13-years old in December 2013 when she was operated for tonsillectomy at Children's Hospital Oakland. Jahi developed some

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[30] Norman G. Levinsky, "The Doctor's Master," *The New England Journal of Medicine* 311, No. 24 (1984), 1573.
[31] Ibid., 1574.
[32] Kelly, *Medical Care at the End of Life*, 142-45.

post-operative complications that led to cardiac arrest. Two pediatric neurologists, Dr. Robin Shanahan of Children's Hospital Oakland and Dr. Paul Fisher, who was appointed as an independent expert by the court, both examined Jahi and confirmed that she met all the criteria for brain death, and their reports led the Alameda County Superior Judge Evelio Grillo to declare that the hospital could take Jahi off the ventilator.[33]

The relatives objected to the discontinuation of respiratory support and made arrangements to transfer Jahi to a place where she could receive comprehensive care as they pursued legal redress for her predicament. In this case, the family disputed the conclusion of the doctors and the judge, insisted that Jahi was still alive, and continued to pray that God would restore her back to good health. Up to now, the family continues to sustain her on artificial nutrition and ventilation in a facility in New Jersey while they pursue in court a declaration that she is not dead.

Another case of medical futility involves Emilio Gonzalez, the eighteen-month-old child from Texas, who suffered from Leigh's disease, a progressive and fatal neurometabolic disorder. As the disease progressed, he was placed in the intensive care unit for several months. The Texas Advance Directives Act authorized the hospital to withdraw life support if the ethics committee had determined that further life support was medically inappropriate, and provided that the hospital had given the family a 10-days notice and attempted to transfer Emilio to an alternative provider.[34] However, Emilio's mother, with the support of various advocacy groups and lawyers went to court to ask for extension of the time during which the hospital was to continue offering

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[33] Rick Hurd and David Debolt. "Jahi McMath: Judge Denies Petition to Keep Girl on Ventilator Past Dec. 30," in *The Mercury News* (December 24, 2013), updated August 12, 2016, accessed October 3, 2016, http://www.mercurynews.com/2013/12/24/jahi-mcmath-judge-denies-petition-to-keep-girl-on-ventilator-past-dec-30/

[34] Robert D. Truog, "Tackling Medical Futility in Texas." *The New England Journal of Medicine* 357, no. 1 (5 July 2007), 1.

intensive care to Emilio. The case showed a conflict of opinions between the clinical team and the family, and the conflict was hard to reconcile. While Ms. Gonzalez wanted her son to continue to live until the point when he would die despite the treatment, the hospital staff wanted to discontinue the care that they considered to be futile.

In the context of such a conflict of opinions, and a breakdown of proper communication between families and clinicians on how to deal with a brain-dead patient and/or a terminally ill patient, "clinicians often justify their efforts to override the requests of family members by claiming that the continued use of life support is causing the patient unwarranted suffering or is contributing to an undignified death."[35] The clinicians also feel that they have some dignity to defend when they choose to act only according to what they consider to be morally acceptable. When called upon to offer what they consider to be futile care, "clinicians may justify their refusal to treat on the basis of their right to refuse to participate in medical interventions that they believe violate their moral integrity."[36]

A dying patient still has social relationships tied to him/her as well as to his or her family and that needs to be considered when decision is made on whether or not to terminate the treatment. For example, while the clinicians felt that the dignity of Emilio was lowered by his continued suffering, the mother and the other people who spent their time at his bedside felt that his life was still dignified even in his condition.[37] Some people advocate for the neglect of children that are born with congenital defects, arguing that such children cannot enjoy a good quality of life. On the contrary, John A. Robertson rejects the claim of some people that newborns are not persons, and also rejects the use of utilitarianism to claim that the cost of

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[35] Ibid.

[36] Ibid., 2.

[37] Ibid., 1.

treating defective newborns is too high compared to the benefits that are achieved because of medical treatments.[38]

Autonomy

Autonomy has become a significant source of authority because it is also backed by a number of judicial decisions that have been made by the United States Supreme Courts over the years. The decisions made by a competent patient, and even by the patient's health proxy when the patient is incapacitated, are considered to be the more weightier authority when challenged by a healthcare provider, however respected the healthcare provider is in the field of medicine.

John Stuart Mill has been instrumental in developing the theory of autonomy, describing autonomy as the significant way of expressing human freedom and choice. Mill's Principle of Liberty asserts, "The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."[39] Therefore, a person can legitimately be controlled so as not to harm others. Moreover, the person can be compelled to do good acts that protect one's community.

Autonomy is strongly emphasized in the context of delivering and receiving healthcare services. At the personal level, a patient's autonomy is a pivotal reference point in the determination of the course of action to follow in any medical case in the United States. Autonomy gives the patient a privileged position in decision making, even when other

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[38] John A. Robertson, "Examination of Arguments in Favor of Withholding Ordinary Medical Care from Defective Infants," in Ronald Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 639.

[39] David Lyons, "Liberty and Harm to Others," in *Mill's on Liberty: Critical Essays*, ed. Gerald Dworkin (Lanham, Maryland: Rowman & Littlefield Publishers, Inc, 1997), 116.

professionals think that the patient is wrong or when they disagree with the patient’s position. The right to determine what can be done to a person’s life or body is protected by the US Constitution and respected by both the legal system and the medical system.

Autonomy and the rejection of healthcare services

The exercise of autonomy allows a person to either accept or reject health care services. One way of expressing the acceptance or rejection of medical care is shown in a person’s understanding regarding euthanasia. Euthanasia involves the act of directly taking the life of a person, either one’s own or the life of another. There are multiple ways of describing euthanasia, either direct euthanasia (an act of commission) or indirect euthanasia (an act of omission). A dying person could also ask the help of another in ending one’s life, e.g., asking a physician to prescribe a lethal dose of medication (physician assisted suicide).

Sometimes the rejection of treatment by a patient may not be aimed at euthanasia but is based on the conviction that the particular means of care is unnecessary, or is done when the patient has no strength or will to pursue that kind of treatment. On May 5, 1980, the Sacred Congregation for the Doctrine of Faith (CDF) published the “Declaration on Euthanasia” that sheds light on the teaching of the Catholic Church regarding the means that can be used to care for patients whose death is imminent, giving patients and their caregivers an opportunity to determine remedies that are proportionate or disproportionate to the illness and the expected health outcomes. In the document, the CDF writes, “it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."[40]

Omission is more appealing to most people, compared to commission of an act, since people tend to feel more responsible for their own acts than they would feel for another person's disease if the disease ends up killing the patient. Along this line, many people would possibly find it harder to withdraw treatment procedures that are ongoing for a patient than they would feel in failing to initiate the very same treatment mechanisms. However, according to the report entitled "Deciding to Forego Life-Sustaining Treatment" written in 1983 by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, some people feel that withdrawing of treatment should require less justification than withholding treatment because a trial therapy could serve as part of the diagnosis, and thus a doctor would stop the treatment once he/she has established that it is not working.[41]

Treatment could be withheld or withdrawn for patients of any age. In this regard, the American legal system has contributed to the neglect of children born with congenital malformations, especially through the Baby Doe legislation and its aftermath. The Baby Doe case shows how events in hospitals with regard to newly born impaired children have influenced the legal system in the United States. A bad precedent was set by the kind of treatment that was meted on Baby Doe. In April 1982, Baby Doe was born in Bloomington Indiana with Down's syndrome and esophageal atresia. The parents and the physicians agreed that the baby should not

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[40] Sacred Congregation for the Doctrine of Faith, "Declaration on Euthanasia," iv.
[41] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "Deciding to Forego Life-sustaining Treatment" (1983): 76, accessed on 3 October 2016, https://repository.library.georgetown.edu/bitstream/handle/10822/559344/deciding_to_forego_tx.pdf?sequence=1

undergo the necessary surgery that would have allowed the child to survive and that decision was upheld by the courts, eventually allowing the child to die of starvation and dehydration.[42]

Later in May 1982, the Secretary of the Health and Human Services notified hospitals that any institution that received federal funds could not deny medical or surgical treatment, or nutritional sustenance to a handicapped child on the grounds of that handicap, starting the process of developing protocols that were eventually called “Baby Doe” regulations.[43] Different groups, including the American Academy of Pediatrics, opposed the regulations in different courts, until June 9, 1986, when the Supreme Court struck down the Baby Doe regulations. In this situation, the courts allowed the parents and the physicians to be making joint decisions on what ought to be done, without necessarily subjecting those decisions to legal endorsement. This opened the door for practical decisions to be made on a case-by-case basis.

The decision to continue or stop treatment for a severely sick child provides an example of how difficult it can be, when multiple opinions are held, to take appropriate action that is acceptable to all the different stakeholders. For example, a doctor may consider that the ventilator being used by a dying child could be used in a better way to help another child that has a better chance of survival, while a parent may choose to discontinue futile care and let a child die. The conflict of opinions arises because different people have different values affecting their decisions. A parent may feel that he/she has other responsibilities to other children and hence does not have to spend all the family’s resources on a dying child when the end is clear. A doctor may feel the obligation to offer services to other patients too, especially those that have a better chance of survival. In this case, people may be drawn to a similar course of action but for very different reasons, or be drawn to conflicting conclusions based on similar reasons.

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[42] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 636.
[43] Ibid.

There are also difficulties associated with making decisions for adults, especially when the adult is vulnerable and there are multiple opinions regarding the course of action to be pursued. The case of Sadie Nemser shows the difficulties associated with having to turn to the courts for a judicial opinion regarding her management.[44] As an eighty-year old woman with diabetes and gangrene of the foot, and also incompetent mental capacity to give consent for the amputation of the foot, disagreement among the doctors attending to her and further disagreements among her three sons regarding the necessity of the surgery presented Justice Jacob Markowitz with a difficult dilemma to solve.

As much as Mrs. Nemser wanted to live (despite the gangrene and infection threatening to cause her death), she did not notice the conflict between her desire to live and her other desire to keep her foot rather than have it amputated. Ultimately, it was notable that she did not understand the full impact of her illness. However, she was aware of her bodily integrity and hence did not want any amputation. While some of her physicians indicated that she would benefit from surgery to amputate her foot, her own son, who was himself a physician, was opposed to the surgery, basing his decisions on his medical assessment that the surgery would not have feasible benefits that would outweigh the risks involved. In his judgment, Justice Markowitz refused to grant the petitioners authority to consent to the amputation of the woman's foot. This shows that the judicial system is also limited in offering solutions to dilemmas, and hence the judge referred the case back to the medical personnel.

By returning the case to the family and the doctors, Judge Markowitz exposed a weakness that occurs in negotiations whenever many people's opinions must be sought; however, the judge also showed that any complicated case presents a greater need for consultation among the

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[44] Supreme Court, New York, "Petition of Norman S. Nemser and Stanley Nemser for an Order Pertaining a Surgical Operation to be Performed on Sadie Nemser." 20 September 1966, 51 Misc.2d 616, 273 N.Y.S.2d 624.

stakeholders, for humility to acknowledge other peoples' opinions, and for the desire to be open to change when other people's opinions are contrary to ours.

Another case that has helped to promote the importance of a patient's autonomy is the *Schloendorff v. Society of New York hospital case* of 1914. In that case, Justice Cardozo of the New York Court of Appeal determined that every person has autonomy over what happens to his/her body; without consent, any treatment would amount to trespass or medical battery except when the treatment procedure is an emergency and the patient is unconscious - a situation in which the patient cannot give consent.[45] In that particular case, Justice Cardozo acknowledged that Mary Schloendorff had given consent only for examination under ether of an abdominal lump and not for the removal of the fibroid and yet the surgeons removed the tumor. In the context of autonomy, the patient could be wrong as far as medical knowledge is concerned; however, without the informed consent of the patient, the doctors cannot legally enforce any treatment procedure, except in the case of an emergency in a life-threatening situation.

Autonomy and the expression of advanced directives

Different states in America have developed laws that allow a person to make a "living will," that is, to give directives as to how he or she should be treated should the person become unconscious and unable to give opinions to healthcare providers. That practice was implemented by a piece of legislation called the "Natural Death Act," which was passed in California in 1977, and now the practice is recognized in all fifty states.[46] Such legislation allows a person to authorize a physician to withhold or discontinue the use of any artificial life-support mechanism when death is imminent. The practice is supported further by the legal instrument called the

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[45] Justice Cardozo, Court of Appeals of New York, 1914. *Schloendorff v. Society of New York Hospital*. 211 N.Y. 125, 105 N.E. 92.

[46] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 686.

durable power of attorney, through which an individual can name someone else to act on his/her behalf should the person become legally incompetent to act for himself/herself. In expressing their autonomy, capable patients may legally refuse almost all kinds of medical treatment although their freedom does not extend entirely to a health surrogate. As Kelly affirms, "Surrogates may refuse only those treatments that are of little benefit or of great burden (best interests standard) or treatments that the patient, while capable of choosing, decided against (substituted judgment standard)."[47]

The widespread use of legal means to control one's end-of-life care is reflected in a federal law that took effect in 1991, the Patient Self-Determination Act.[48] This progressive change in laws has not only affected individuals in their actions but also involved professional bodies. For example, the American Medical Association has a policy that holds that it may be morally appropriate to withhold all means of life-prolonging treatment, including artificial feeding, when a patient is in irreversible coma.[49]

The patient's desire to discontinue treatment in certain states of illness runs the risk of leading the patient to euthanasia. Discontinuation of care is thus a sensitive issue, especially when a person has to decide on behalf of another. Some ethical theories have been proposed to deal with such dilemmas, e.g., utilitarianism, virtues, the Catholic moral tradition, etc. In this paper, I focus primarily on the cardinal virtues as significant guides in dealing with dilemmas. In some cases, the principle of the double effect makes it morally acceptable for a patient to be given pain medicine for the sake of stopping the pain even when the medicine could shorten the life of the patient, considering that the shortening of life is a secondary and unintended

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[47] Kelly, *Medical Care at the End of Life*, 86.
[48] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 687.
[49] Ibid., 687.

consequence of the pain relief. The principle of double effect is based on the teaching of Thomas Aquinas in the *Summa Theologica*, in which Aquinas says that an act of self-defense can have two results, one of which is intended (a good outcome) and one that is unintended (a bad outcome).[50] Based on this understanding, an act is considered morally acceptable when it fulfills the four conditions of the principle of the double effect: (i) that the intended act is good in itself, (ii) that the good effect is directly intended by the one who acts while the bad effect is foreseen but not intended by the moral agent, (iii) that the good effect is not brought about by using the bad effect as a means, and (iv) that the good effect is of equal or greater proportion than the evil effect.[51]

Some prominent legal battles in America have demonstrated that advanced directives given by competent persons can guide the decisions involving end-of-life care but those very directives can also be the basis of protracted legal processes. The Karen Quinlan and the Nancy Cruzan cases stress the expression of autonomy that a person can manifest through his/her health surrogate.

Autonomy and opposition to extraordinary means of treatment: Karen Quinlan

In April 1975, 21-year old Karen fell into coma after taking several drinks at a party. Blood and urine tests showed that she had taken some alcohol, Aspirin and Valium but in small quantities. After about one week of being in coma, neurological tests showed extensive brain damage. Then she progressed into a rigid fetal position, associated with weight loss, and need for respiratory support.[52]

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[50] Thomas Aquinas, *Summa Theologica*, II-II, q. 64, a. 7, in vol. 3, trans. Fathers of the English Dominican Province (New York: Benziger Bros., 1948), 1465-1466.

[51] James F. Keenan. “The Function of the Principle of Double Effect,” *Theological Studies*, 54 (1993), 300.

[52] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 689.

The Quinlan family held that in her earlier days, Karen had said that she would not want to be maintained in a respiratory support system in case she were too sick to need such care. Hence the father, Joseph Quinlan, requested the hospital to discontinue the treatment. However, since Karen was already twenty-one years old, the parents could not make decisions for her unless they were appointed legal guardians by the court. In seeking the guardianship, the father argued his case on three constitutional grounds:

> a) That there is a right to privacy that allows individuals, or others acting on their behalf, to terminate the use of extraordinary methods of treatment even when death may result.
>
> b) That the Catholic Church, to which the Quinlans belonged, does not support the continued use of extraordinary means to support a life. Thus the father said that the family's religious liberty (guaranteed by First Amendment) should not be infringed upon and they should be allowed to act according to the teaching of their faith.
>
> c) That since Karen, in her condition, had lost the dignity of earthly life, keeping her alive was an act of cruel and unusual punishment (against the guarantee offered by the Eight Amendment) and hence her life should be allowed to end.[53]

In the face of a medical report that showed that Karen still had some electrical brain activity and her pulse was still palpable, meaning that she was still legally and medically alive, Judge Robert Munir of the New Jersey Superior Court declined to authorize the termination of the treatment, claiming that that would be homicide and act of euthanasia.[54] The Supreme Court of New Jersey, in 1976, eventually ruled that on the grounds of privacy, Karen could have the respirator disconnected according to the decision expressed for her by her guardians, the parents.

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[53] Ibid., 690.

[54] Ibid.

The parents had argued that the respirator could not cure or improve her condition but at best could only prolong her inevitable slow deterioration and death.[55]

Eventually, following the judgment of the New Jersey Supreme Court, where the Quinlans appealed, Karen was weaned off the respirator and she continued to breath on her own. She was supported only with high nutrient feeding and regular antibiotics until her death in 1985. This outcome shows that the ventilator was actually a form of extraordinary means of treatment. The parents could justify their actions because "treatments are morally extraordinary when their burdens outweigh their benefits, and this does not necessarily require that the treatment itself cause actual harm or that the patient's death be imminent."[56]

Autonomy and a person's right to die: The Nancy Cruzan case

In January 1983, twenty-five-year-old Nancy Cruzan was involved in a road accident after the car she was driving crashed. She suffered irreversible brain damage, losing all the higher brain functions. She was sustained by artificial feeding while admitted at the Missouri Rehabilitation Center, with her care costing US$ 130,000 per year, and paid for by the state because she was a legal adult by the time of her accident.[57]

Nancy's family claimed that she had said that she would never have wanted to be kept in such a state, and hence the hospital should discontinue the life-prolonging procedures that were actually only prolonging death. The family went to court and appealed for disconnecting of the feeding tube.[58] While the Missouri Supreme Court overruled the decision of a lower court, and refused to allow Nancy's parents to disconnect the feeding tube, the United States Supreme

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[55] Ibid., 734

[56] Kelly, *Medical Care at the End of Life*, 103.

[57] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 691.

[58] Ibid., 692.

Court recognized a strong constitutional basis for living wills and the designation of another person to act as a surrogate in making decisions on behalf of another.[59] In that case, the US Supreme court held that the US Constitution permits states to decide on the standard that must be met in determining the wishes of a comatose patient.

In that ruling, one significant omission by the US Supreme Court is that the court did not make any distinction between providing nutrition and hydration and other forms of medical treatment, although the Missouri living-will statute explicitly forbids the withdrawal of food and water.[60] The Supreme Court's decision allowed the parents of Nancy to successfully ask for the removal of the feeding tube, particularly after they argued that Nancy's condition made the regulation of her feeding to be a medically complex procedure that would resemble intravenous drips rather than simply giving someone food and water.[61] Following the Supreme Court's decision, the local court in Missouri accepted the subsequent request by Nancy's parents to have the feeding tube removed, particularly after some more friends of Nancy testified that she would not have wanted such kind of treatment.[62] Nancy Cruzan eventually died on December 26, 1990, at a time when some people were protesting the discontinuation of her care.

Nancy Cruzan's case points out not only the challenges involved in making decisions for an incompetent person, but also the challenges faced in letting die when a person's process of death has irreversibly commenced. The case also points out the great financial cost associated with terminal care for a person whose death is imminent. Ultimately, the case points out the threat of euthanasia, a goal that can be pursued in the name of expressing one's right to die.

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[59] Ibid.
[60] Ibid., 693.
[61] Ibid.
[62] Kelly, *Medical Care at the End of Life*, 52.

Autonomy expressed in conflicting voices: The Terri Schiavo case

Terri Schiavo's case presents an example of a difficult end-of-life situation in which the various possible decisions appear controversial. Because of a cardiac arrest, Terri collapsed on the morning of February 26, 1990, in the house where she lived with her husband Michael Schiavo. Subsequent neurological tests showed that the disruption of oxygen supply to the brain during the moment of collapsing led to severe and irreversible damage to her brain, and she was diagnosed to be in a vegetative state.[63]

The treatment that was accorded to Terri Schiavo, and the legal battles that ensued regarding her care, expose various social, financial, political, legal, and religious difficulties that are associated with care for the severely sick persons. Terri's case was a platform for the expression of multiple vested interests that included: the desire of Terri's parents (Robert and Mary Schindler) to take the control of Terri's life from the husband; the political establishment and the legislature in Florida that wanted to promote a pro-life agenda; the pro-life groups that wanted to keep Terri on a feeding tube indefinitely; the judicial system that wanted to defend its independence from the legislative arm of the government; and the religious leaders that invoked the power of prayer as a form of divine intervention for the welfare of Terri.

The prolonged case stretched the emotions and the patience of the people concerned. For four years, Michael cared for Terri while she was in a vegetative state. The four years of agony had their toll on Michael and thus could have contributed to his desire to know the long-term prognosis of Terri. Hence in 1994, when the doctors that were attending to Terri confirmed that it was unlikely that she would ever regain consciousness, he told the long-term facility that was caring for Terri that he did not want her to be resuscitated if she suffered a heart attack or if some

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[63] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 676.

other life-threatening event occurred to her, that is, he signed the "do not resuscitate" (DNR) order.[64]

Financial matters associated with Terri's healthcare became a source of conflict between her two families. Michael Schiavo and the parents of Terri had had good relations before Terri's illness and also for the first two years of Terri's illness. However, starting in 1993, the two parties started to disagree. While Terri's parents accused Michael of not giving good care to Terri, Michael on the other hand claimed that the disagreement was really about the money he had received from a malpractice suit (Michael had sued Terri's gynecologist in 1992 and won the suit). He had been awarded US$ 750,000 earmarked for Terri's extended care and US$ 300,000 to compensate him for his loss and suffering.[65] Michael claimed that the Schindlers wanted to force him to give them a part of the compensation that he had received. When the parents filed a suit to ask the court to transfer Terri's care to them, the court dismissed the suit, claiming that the court did not find Michael's care inadequate.

Prolonged court cases sometimes create a platform for various interested groups that have "hidden agendas" to intrude into the case and pursue their own goals. Some of these groups can distort the facts, e.g., some disability advocacy groups showed up in Terri Schiavo's case. There were groups that were openly religious in their views while some protesters compared Terri's treatment to the actions of the Nazis, as they condemned the decisions of the courts.[66] Ultimately, Terri's case shows the numerous ways in which a legal system can influence medical care.

The judicial system through the different law courts, alongside the legislature in Florida and Congress, played significant roles in the Schiavo case and guided the kind of care that Terri received. The decisions of the courts regarding the case partly relied on the testimonies of the

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[64] Ibid., 678.
[65] Ibid.
[66] Ibid., 681.

members of Terri's family to decide what she would have chosen for herself were she able to decide. This use of best interests standard was helpful because there were no advance directives from Terri and no clear evidence of her wishes.[67] The courts in particular were very prominent in solving certain questions, for example:

a) When there were allegations and counter-allegations raised between Terri's husband and Terri's parents.

b) When Michael claimed that a gynecologist had contributed to Terri's condition by not detecting the potassium imbalance that subsequently led to the heart attack, the courts awarded Michael the money that helped to finance care for Terri.

c) The courts authorized the removal or the insertion of the feeding tube whenever it was shown that the assisted feeding was necessary and agreeable (or otherwise), a situation that depended on the multiple legal suits that were raised during Terri's illness.

d) The courts helped to establish the constitutionality or unconstitutionality of various legislative decisions that were undertaken either by the state legislature or by Congress. In particular, Chief Judge Edmundson, in declaring that the law enacted by Congress and signed by President Bush on March 21, 2005 was unconstitutional, also said that if the sacrifices of the independence of the judiciary were to be permitted, then that would set a precedent for the transgression of the constitution in the future.[68]

The prolonged illness of Terri Schiavo was itself a source of knowledge, especially for the medical team. The autopsy results revealed that her brain had shrunk considerably. The diagnosis of vegetative state was confirmed and hence contributed to the closure of the various allegations that Terri's parents had raised against her husband, particularly when they intimated that he

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[67] Kelly, *Medical Care at the End of Life*, 60- 61.

[68] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 680.

could have strangulated or traumatized her; actually, there were no findings that Terri had been neglected while she lived.[69]

The case of Terri Schiavo reveals some legal and medical knowledge that could not have been easily verified in many other medical cases. The protagonists in the case prolonged it while they all claimed to be acting in the interests of Terri and also in the interests of all humanity in general. This could have been an occasion for abuse of the privileges that surrogates have, or that any medical or legal personnel have over other people. Terri's case points out the various implicit human desires of trying to gain mileage (financial, academic, legal, or otherwise) over other people, while at the same time subjecting patients to unwarranted pain and exposing countries to unwarranted expenditure.

This case shows that despite the benefits of having a health proxy, the expression of a patient's wishes through the subjective method of substituted judgment standard is problematic and insufficient, particularly when there are multiple voices allegedly speaking for the interests of the same patient; hence there is need for some sort of objective standard in the law.[70] Considering that legal arguments often contradict one another, it may be more reliable to apply virtues, especially the cardinal virtues. Inviting the various parties to cultivate virtue may help them to reach better decisions. In particular, the virtue of prudence enables a judge to be more objective and firm in guiding the process of ensuring reliable care for a patient in case of dispute.

Despite the eventual death of patients like Nancy Cruzan and Terri Schiavo, many judicial decisions were made in defense of life rather than in support of the right to die. For example, when Nancy Cruzan's parents appealed to the United States Supreme Court after the Missouri Supreme Court failed to allow them to discontinue treatment for Nancy, the US Supreme Court

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[69] Ibid., 681.
[70] Kelly, *Medical Care at the End of Life*, 62.

ruled that it was legitimate for a state to err on the side of caution regarding termination of care because that would maintain the status quo, while any erroneous decision to end treatment would not be susceptible to correction.[71]

There are also ethical positions that challenge the "over-rated" position of autonomy. Richard McCormick, in his essay "Bioethics: A Moral Vacuum?" writes, "When the rightness or wrongness of choice is reduced to the single factor that it is this individual's choice, then morality has been impoverished."[72] The management of dying patients calls for a comprehensive approach that does not rely on a limited source of information. Healthcare workers should also have room to express their views on the treatment and not be overlooked in the expression of autonomy. As Kelly writes, "Bioethics is best served when it serves its patients, which requires considering beneficence (the best interests standard) along with autonomy (the substituted judgment standard) rather than giving automatic precedence to autonomy."[73]

Physician assisted suicide (PAS): Judges have influenced patient-physician relationships

Sick people are vulnerable, not only from the pain and discomfort that they experience, but also from the legal opportunities that they are given as beneficial forms of help. When pain and discomfort exceed a person's level of tolerance, the patient can feel the desire to end it all by dying. The development of laws that permit suicide, and agencies that finance the execution of the suicide missions for those who cannot fund it for themselves, serve to entice people to take that option. The Netherlands was the first country to legalize euthanasia through a court decision

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[71] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 693.
[72] Richard McCormick, "Bioethics: A Moral Vacuum?" *America*, vol. 180, no. 5 (May 1, 1999), 9.
[73] Kelly, *Medical Care at the End of Life*, 65.

in 1984.[74] Many other countries have since developed laws that allow euthanasia and/or PAS, among them Belgium, Colombia and Canada and some states in America.

In the Netherlands, euthanasia for competent persons older than sixteen years of age has been legally accepted since 1985.[75] Advocates of euthanasia hold that a person who is suffering has the opportunity to end the suffering by choosing to die, and that parents can make the choice for their children. When an infant is born with malformations or other challenges that cannot be relieved by medical care, and the parents and doctors assess that the child will have a low quality of life, associated with suffering and an early death, some people have chosen to end the child's life through euthanasia. Such people recognize the helplessness of medicine in resolving the challenges facing the child, problems that hinder whatever they consider to be an acceptable life. Towards this practice, the Netherlands developed a protocol called the Groningen Protocol, for cases in which a decision is made to actively end the life of a newborn.[76] This protocol involves a decision being made by the parents and the doctors and afterwards a legal team investigates the death of the baby.

Although the Groningen Protocol seems to conflict with the principle of nonmaleficence, its acceptance opens the door for the ethical permissibility of voluntary active euthanasia.[77] This is because if parents and doctors can speak on behalf of a sick neonate, then one could conclude that a suffering adult has a better idea of his/her own suffering than anyone would make regarding a child. Expressing those experiences could lead others to kill the patient.

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[74] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 701.

[75] Eduard Verhagen and Pieter J. J. Sauer, "The Groningen Protocol – Euthanasia in Severely Ill Newborns," in *Biomedical Ethics*, eds. David Deograzia, Thomas A. Mappes, and Jeffrey Brand-Ballard, 7th ed. (New York: McGraw-Hill Higher Education, 2011), 446.

[76] Ibid., 447.

[77] Alexander A. Kon, "We Cannot Accurately Predict the Extent of an Infant's Future Suffering: The Groningen Protocol is Too Dangerous to Support," in *Biomedical Ethics*, eds. David Deograzia, Thomas A. Mappes, and Jeffrey Brand-Ballard, 7th ed. (New York: McGraw-Hill Higher Education, 2011), 451.

Oregon was the first state in USA to approve physician-assisted suicide in 1994, with a vote of 52-48%. Oregon's Death With Dignity Act does not permit a physician to play an active role in ending the life of the patient, but to prescribe lethal drugs and to indicate to the patient the manner in which the drugs can be used.[78] There are some conditions that must be met according to the Oregon law, e.g., the patient must be assessed by two doctors who must confirm that the patient has six months or less to live, that the patient has no mental illness and that the patient has made two oral requests and a written request over a period of at least 15 days. In 1998, the state decided to make physician-assisted suicide available to low-income earners by financing the full cost of the procedures through Medicaid, a practice that was criticized for suggesting to patients that death was the only option available for them, especially when the state's mental-health services are underfunded.[79] While the law in Oregon protects physicians from prosecution following any act of PAS, the law leaves in doubt the legal status of nurses who ordinarily help patients to take their prescribed medications. Other states, including California, Washington and Vermont have since passed laws that allow PAS.

In some places, critics of PAS feared that there would be many people asking for the PAS once it became legally available. However, the numbers have not been as high as feared; a 2003 study showed that there were 5,000 deaths a year in the Netherlands that resulted from PAS out of 140,000 deaths in the country, and hence PAS accounted for 3.5% of all deaths.[80] In 1998, the first year under the new law that allowed PAS in Oregon, 15 people ended their lives under PAS compared to the 29,000 who died in the state that year.[81] These figures are affected by the living standards of the people and the circumstances surrounding their lives.

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[78] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 694.

[79] Ibid., 695.

[80] Ibid., 702

[81] Ibid., 696.

The economic conditions of patients can influence their decision to pursue PAS if they live in a place where it is legalized. In Holland, Dutch citizens almost universally participate in health plans that cover their medical costs and hence the individuals are not under any economical pressure to make any decisions about ending their lives.[82] However, if PAS would be made available in a country like Kenya where most people are poor and have no health insurance, the financial difficulties would be a big factor in influencing people to choose PAS. On the other hand, there is a high likelihood that cultural forces could help to block such a trend in Kenya because suicide is considered very negatively. Suicide is seen as an antisocial activity and a scandal for the person and the family.

Some advocates of PAS present the practice as a relief from human difficulty, an act that would be within the competence of a physician to accomplish. Human beings are mortal and death is generally considered to be an inevitable albeit unlikeable reality. Through medical care, a physician applies medical skills to relieve suffering while a patient continues to live and approach his/her natural point of death. A physician's act of omission can only bring about death by allowing a disease to kill a patient in the absence of treatment; however, a physician's act of commission in the context of euthanasia brings death to a person whether that person is sick or not because the doctor, not the disease, kills the person. Therefore, while a disease can be the cause of death, the moral culpability of a doctor occurs only when he/she acts in a way that kills the patient, rather than when the doctor lets a patient to die. When a doctor allows a dying patient, one whose continued treatment is judged to be futile, to die, then the doctor acknowledges that treatment is ineffective against the illness.

Wherever the treatment against the illness is judged to be ineffective, the healthcare team should provide palliative care, relieving the suffering and keeping the patient as comfortable as

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[82] Ibid., 703

possible while he/she approaches death. Without advocating for euthanasia, Daniel Callahan states that doctors ought to relieve those forms of suffering that medically accompany serious illness, to help patients recognize that the answer to suffering is not in being killed by another but recognizing illness as an evil that all human beings face; otherwise, euthanasia is a "self-determination run amok."[83]

Some doctors have argued that patients ought to be given the opportunity to commit suicide, and even to get the assistance of physicians in the process, as part of the expression of the patients' autonomy. In the case *Quill v. Vacco*, the New York Second Circuit Court of Appeals ruled that New York's laws against assisted suicide were unconstitutional when applied to physicians treating terminally ill patients that are not connected to life-support systems.[84] However, the Supreme Court ruled that the New York's laws are not unconstitutional because in those two situations, death would result from different causes and would fulfill different motives. The Supreme Court ruled that when a patient refuses life-sustaining medical treatment, he/she dies from the underlying illness, but if a patient ingests lethal medication prescribed by a physician, he/she is killed by the medication.[85]

Therefore, the intent of the suicidal patient and his/her physician (e.g., to kill the patient with a drug overdose), and the intent of the patient who rejects life-sustaining treatment (to give consent only for ordinary treatments) are different and they offer a distinction as to what the court could support or reject. The court's ruling indicated that there could be no constitutional right to assistance in suicide. The case of Karen Quinlan, who lived for many years after being

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[83] Daniel Callahan, "When Self-Determination Runs Amok", in Ronald Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 8th ed. (Belmont, CA: Thomson Wadsworth, 2008), 711.

[84] George J. Annas, "The Bell Tolls for a Constitutional Right to Physician Assisted Suicide," in *The New England Journal of Medicine* 337, No. 15 (Oct 9, 1997): 1098.

[85] Ibid., 1099.

weaned off the ventilator, shows that a person may want to stop the use of extraordinary methods of treatment but this does not mean an explicit will to die.

Legal protection for doctors

In his article, "Unauthorized Rendition of Lifesaving Medical Treatment," Kenney F. Hegland points out that the American law has granted opportunities for medical workers to work for the welfare and interests of the patients even when the workers place themselves at risk of lawsuits. Hegland argues that there is no legally enforceable right to reject lifesaving medical treatment and no such right should be recognized, particularly because there is a valid public interest in the individual's life.[86] This appreciation of the social nature of humanity and the responsibilities placed on healthcare workers help healthcare providers to provide health services that help the sick people and also promote the social relationships that we all share.

Doctors operate within the boundaries of laws, especially the laws that govern the autonomy of patients and the professional guidelines of medical practice. If a doctor knowingly insists on doing a procedure on a patient without the authorization of the patient, as opposed to cases of medical negligence, then the doctor can be sued for battery. However, the physician may ignore the refusal to consent when an insane or delirious patient does it, just as the doctor does not seek prior consent of a patient who is unconscious because all these conditions render a patient incapable of giving or withholding consent.[87] In this case, the law protects doctors but overrules the desires of patients.

The legal system identifies certain situations in which a patient's wish can be overridden by a court of law. While a court can overrule a patient's religious convictions against blood

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[86] Kenney F. Hegland, "Unauthorized Rendition of Lifesaving Medical Treatment," in *California Law Review*, vol. 53, no. 3 (August 1965), 872.
[87] Ibid., 331.

transfusion for the sake of sustaining a life that can recover from sickness, the patient's constitutional right to reject certain forms of treatment is upheld whenever there is little likelihood of recovering from one's terminal illness. For example, the judicial system was slow in forcing Karen Quinlan to act against her refusal to accept certain treatment options since there was no chance of recovery.[88] However, Karen's respirator was not deemed to be "cruel and unusual punishment" because the constitutional clauses offering that description were meant to apply to certain historical contexts of punitive excesses associated with infliction of criminal penalties.[89]

Some conflicts associated with severe illness

A person who is terminally sick, or nearly dying is quite vulnerable. The patient can become the center of struggles between the opinion about treatment that is held by the family and the opinion of a hospital or a healthcare provider. In some cases, the parents or guardians might ask for the termination of care so that the dying patient can die while the healthcare provider is reluctant to discontinue care that he/she feels to be necessary. In other cases, it could be the healthcare provider who feels that continued treatment of a particular patient is no longer meaningful to the patient and hence needs to be discontinued.

Caregivers of severely ill patients are vulnerable to being overwhelmed, especially by strong psychological challenges. Whenever a parent authorizes the termination of care for a dying child, the parent deals with strong thoughts and emotions, among them doubts, guilt and helplessness. This can never be an easy decision for the parent, just as it is difficult for medical workers. On the other hand, a parent, especially one whose religious convictions hold that human life is

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[88] Munson, *Intervention and Reflection: Basic Issues in Medical Ethics*, 733.
[89] Ibid.

sacred and should be supported as far as possible, may find it very hard to approve the termination of aggressive care even when the death of the child is imminent. Similarly, if the parent were to insist on aggressive treatment, even when the doctors consider the care to be futile, then the parent may live with a feeling of guilt for having contributed to the prolonged, and possibly painful, death of the child.

Sometimes the decisions regarding the terminally ill and the dying are made on the grounds of the quality of life that the patients have. For children with deformities, there is a great focus on the potential quality of life that a particular child may achieve later in life. For Richard McCormick, life is not a value to be preserved in and for itself; life is a value to be preserved precisely as a condition for other valuables, which are clustered around and rooted in human relationships.[90] McCormick adds that relational capacity is not subject to mathematical analysis but to human judgment. Hence, there is a risk of error and yet the risk should not lead people to abandon the effort of making decisions but to proceed with great humility, caution and tentativeness, always choosing to err on the side of life rather than otherwise.[91]

A sick person who is at risk of sudden death from an acute illness may encounter some conflict between his/her religious beliefs and his/her treatment needs. One possible source of conflict involves the need for life-saving blood transfusion. For example, when a Jehovah Witness adherent, Mrs. Jones, went to hospital with severe blood loss from an ulcer, the doctors asked a judge to rule that the hospital could transfuse her with blood against her will as a way of saving her life.[92] Her husband did not object to the transfusion as long as it was not his decision. Mrs. Jones did not approve of the transfusion but she was not willing to die. Hence, the Circuit

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[90] Richard McCormick, “To Save or Let Die: The Dilemma of Modern Medicine,” in *The Journal of the American Medical Association* 229 (1974): 175.
[91] Ibid.
[92] United States Court of Appeals District of Columbia Circuit, “Application of the President and Directors of Georgetown College Inc., a Body Corporate,” Misc. No. 2189, Feb 3 1964. 331 F.2d 1000, 118 U.S.App.D.C.80.

Judge Skelly Wright, in Washington D.C., ordered that the doctors could administer blood to the patient. This shows that the Court of law can overrule a patient in terms of blood transfusion, or in another treatment plan, for the sake of the community's interests. In the case of Mrs. Jones, the judge pointed out that Mrs. Jones sought medical attention and placed on the hospital the legal responsibility for her proper care.[93]

Sometimes tension can develop between the process of treating a serious illness and the upholding of human rights. Every person, whether sick or healthy, is entitled to certain human rights and dignity. There are rights and liberties that influence the way people deal with one another in society. These rights confer on a person the opportunity to be protected from harm and to be allowed to thrive. However, the rights also put a limit to what the person can do so as to protect the rights and welfare of others. The expression of certain rights can interfere with the rights of others, e.g., the right to free speech could be used to incite other people to do wrong things and hence there are limits placed on the right to free speech.

In all these circumstances, I conclude by acknowledging the difficulties associated with caring for the sick and the dying. Despite the progress in technology and legal systems, particularly in the developed world, the threat of imminent death is still associated with difficult decisions. The medical decisions have a direct impact on the available resources, especially financial and human resources. Recognizing these issues is helpful for me while I prepare myself to address health challenges in a developing country like Kenya, where the threat of spending too much money on imminently dying patients is becoming noticeable. Subsequently, I will explore the various ways in which ethical decisions can be made to serve people who are severely ill or at the point of imminent death. In Kenya, one example is the use of palliative care, which

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[93] Ibid.

respects the dignity of the dying person and also compliments the work that is done by healthcare providers. Prudent ways of spending limited healthcare resources are respectful of the dignity of human life, and also help people to recognize that there is a time when death is inevitable, regardless of any heroic attempt to use advanced technology.

Since human life is precious and should be treated with dignity, care for the sick needs to be evaluated ethically so that patients are not denied the available and necessary treatments and services. At the same time, the society's resources should be used appropriately, always considering the needs of other patients in the society whenever attending to any one patient. I will now examine the role of virtues as appropriate ways of developing ethical care.

Chapter 2

Cardinal virtues: guides towards good healthcare decisions and actions

Serious illnesses present difficult challenges to patients, healthcare providers and the society in general. The management of these illnesses needs to recognize and reflect the various dimensions of the illnesses (medical, financial, social, psychological, etc.) and hence offer solutions and different possible means of providing solutions. Balancing the needs of patients with those of the family, the caregivers, and the general society in ethically acceptable ways requires that the different actors also maintain a certain level of integrity. Among the tools that could guide this process are virtues, particularly the cardinal virtues.

In this chapter, I will explore some different ways in which virtues can be applied in the delivery and uptake of health services that involve critically ill patients. I will lay particular emphasis on the four cardinal virtues: prudence, justice, fortitude and temperance. I will look at the understanding of each cardinal virtue as taught by Thomas Aquinas and as applied by other scholars, and then suggest ways how each virtue could be applicable to the care of sick people.

The teaching of Aquinas is influenced by his Christian faith; my application of the virtues follows the same Christian tradition. As patients and caregivers live virtuously, they become more open to the multiple outcomes that could result from illnesses (disability, death, prolonged suffering, etc.), and also more caring towards themselves and one another. Virtues change people by helping them to become better moral agents and to make good decisions for themselves and for others. Virtues invite patients and caregivers to reflect on the rightness of their actions and not to be overwhelmed by emotions and biases, especially in the face of impending death.

As Jean Porter affirms, Aquinas understood virtues as “qualities that perfect the intellectual and affective capacities of the human person, in such a way as to enable the individual to act in certain characteristic ways."[94] Virtues thus influence how human beings behave, relate to one another and respond to different situations. For Keenan, the task of virtues is "the acquisition and development of practices that perfect the agent into becoming a moral person while acting morally."[95] This involves focusing on the moral agent more prominently than on the moral actions.

Unlike any modern ethical theory that concentrates on developing rules, principles, and exact methods of determining the moral status of specific acts, virtue ethics is more agent-centered and less concerned with the analysis of problematic actions. Hence, virtue ethics moves the focus away from an exclusive or privileged focus on specific acts to other moral dimensions like character traits, personal commitments, community traditions and the conditions necessary for human flourishing.[96] Aquinas holds that as moral agents, human beings engage in actions that have some desired ends, deliberate on the means for attaining those ends and desire to attain those ends. He supports the pursuit of a virtuous life as the appropriate means to achieve this end, particularly through the cardinal virtues of justice, temperance and courage under the direction of prudence.[97]

Virtues make people to be goal-directed, i.e., to aim at becoming certain kinds of persons, to become good moral agents. When that goal includes the promotion of the dignity of human life, even for a patient who is imminently dying, then virtuous people can direct their communal resources to good use for the common good. This can help to overcome the desire to either

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[94] Jean Porter, "The Virtue of Justice (IIa IIae, qq. 58-122)," in *The Ethics of Aquinas*, ed. Stephen J. Pope (Washington D.C.: Georgetown University Press, 1996), 274.

[95] James Keenan, "Proposing Cardinal Virtues," *Theological Studies* 56 (1995), 711.

[96] Kotva, *The Christian Case for Virtue Ethics*, 5.

[97] Nelson, *The Priority of Prudence*, 39.

neglect or harm the vulnerable members of the community, or to overspend resources disproportionately on a few privileged members at the expense of others.

The cardinal virtues are important as guides to our behavior in different ways. Prudence helps us to use rationality in determining the means to pursue towards our desired goals; justice helps us in our relationships with others; courage helps us to deal with our struggles and temperance helps us to deal with our desires. Aquinas strongly supports the tradition that ranks the cardinal virtues ahead of the other virtues, appreciating the significant influence that the four cardinal virtues have on virtuous people.

In the context of healthcare provision, the cardinal virtues influence not only the patients but also healthcare workers. When healthcare providers pursue virtuous lives, then their actions help to defend and promote the dignity of patients and the value of human life. When the healthcare providers treat their clients with dignity and respect, holding truthfully to the understanding that human life is of great intrinsic value, the caregivers become good advocates in the eyes of the wider human society that human life is valuable and worthy of respect and protection. However, if healthcare providers do not protect human life, and hence medical work is not seen in the eyes of the public as an activity that promotes human flourishing, then the society risks lowering the value given to human life, especially the lives of the sick and the dying. The respect due to the dignity of the human person is influenced by the credibility of the persons who are entrusted to care for the sick and the dying.

Some practices that are associated with the character of healthcare workers influence the uptake or rejection of the services that medical science can offer. For example, some people feel that the legalization of PAS creates a risk of lowering the credibility of the doctors and may keep away patients from doctors, and such observations have been made both in Australia and in the

United States.[98] On the other hand, the willingness of doctors to discuss various management strategies with their patients (and the patients' families) makes it easier for the patients to deal with the illnesses and reduces the cost of care, even in the face of impending natural death. This positive outcome arising from the doctors' willingness to discuss the end-of-life wishes with their patients has been shown to be successful in La Crosse, Wisconsin, where the end-of-life costs were brought down to just over half the national average.[99]

We live in a world where historical circumstances and contexts change and thus it is important for us to develop virtues that would help us to deal with the different situations and issues. Among the issues that bother people in modern times are the end-of-life challenges, some of which are associated with prolonged illnesses or dilemmas concerning the timing and the acknowledgement of death. We need to develop an ethical way of dealing with medical challenges. Virtue ethics offers one way of dealing with the difficult issues associated with the process of dying. As Kotva affirms, virtue ethics deals with the temporal acquisition of the virtues that are necessary to traverse the dangers and opportunities that are intrinsic to the character of our existence while also moving our focus from rules and acts to agents and their contexts.[100]

Virtue ethics focuses on morality by emphasizing the character of the moral agent, that is, by shifting the focus of ethics from judging the rightness or wrongness of the human actions and instead, focusing on the person, the moral agent. Therefore, virtue ethics involves the exercise of responding to questions like: who am I?, who ought I to be?, and how am I to get there?[101] This process of discovering ourselves and growing into more virtuous persons makes us aware of the

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[98] Kelly, *Medical Care at the End of Life*, 130.
[99] Gawande, *Being Mortal*, 180.
[100] Kotva, *The Christian Case for Virtue Ethics*, 9.
[101] James Keenan, "Virtue Ethics," in *Christian Ethics: An Introduction*, ed. Bernard Hoose (Collegeville, MN: The Liturgical Press, 1998), 84.

complex ways in which we face challenges, make decisions, interact with other people and conduct our lives. When we develop certain character traits or habits, those habits influence our process of acting or making decisions whenever we are faced with a challenge, for example, a severe illness.

The cardinal virtues help us to set personal goals and to seek the attainment of those goals. Since virtue ethics leads a person to ask who he/she is and what he/she ought to do, the pursuit of virtue helps the person to set goals that he/she strives to fulfill. The attempt to become a certain kind of a person, e.g., a just person, makes the person to strive to develop the virtue of justice. Hence, the task of the moral life is to develop a vision and to strive to attain it.[102] Any event in our lives participates in shaping our moral growth since it gives us an opportunity to live out the virtues and to let them perfect us. In this case, the virtues help us to develop the means of attaining our goals in life.

The relationship between emotions and virtues is crucial. Emotions are significant parts of our humanity that help us to express our feelings and human impulses and also to appreciate some cognitive aspects of our desires. Hence, emotions – such as anger, love, fear and others that influence our moral actions – are integral to morality. In some way, our emotions manifest the kind of character we have developed, allowing us to be happy when something good has happened to us and to other people, and also to be angry when other people are faced with difficulties. Since virtues are related to the human realities of emotions and friendship, then certain virtues like courage and compassion necessarily include affective dimensions.[103] The virtuous healthcare workers are emotionally affected by the welfare of the people they care for; therefore, the caregivers are drawn to more virtuous ways of offering services when they

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[102] Ibid., 85

[103] Kotva, *The Christian Case for Virtue Ethics,* 11.

recognize the relationship that they have with their patients. Kotva writes, “emotions are intrinsic to certain virtues, and, combined with desires, they witness to the quality of one’s character and help direct one’s actions.”[104]

Virtues are thus the states of character, acquired over time, that contribute to the realization of the human good, and that involve both the intellect and the will.[105] In the *Prima Secundae* of the *Summa Theologica*, Aquinas points out that the will is supposed to be guided by reason in making moral decisions in such a way that every will that is at variance with reason, whether right or erring, is always wrong.[106] Subsequently, every person ought to make effort to ensure that his or her reason is correct. Virtues are thus important in helping to guide reason so that a person’s decisions are good.

The development of virtues is closely related to human relationships and the human good. Many virtues, including justice and courage, draw their purpose from social connections. We only get to realize the role of those virtues in our lives when we recognize how we interact with one another and especially when we show concern for the wellbeing of others. At the same time, the pursuit of a virtuous life is expected to lead people to happiness. For Devettere, “Happiness in ethics is a collective term describing the right balance and coordination of all the important goods in a person’s life.”[107]

When a person is enjoying good health or having many good life options, then the choice of pursuing whatever action would cause happiness would be easy to make. However, in the context of severe illness, a person may have no feasible way of seeking a favorable route towards happiness and would need to avoid any worse outcome that would undermine his/her good life.

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[104] Ibid., 12.

[105] Ibid., 26.

[106] ST, I-II, q. 19, a. 5.

[107] Raymond J. Devettere, *Practical Decision Making in Health Care Ethics: Cases and Concepts*, 3rd ed. (Washington D.C.: Georgetown University Press, 2010), 24.

In such a situation, one would acknowledge that virtuous action is the action that is undertaken for the sake of living well and happily or, when happiness is no longer a realistic option, for the sake of avoiding as far as possible whatever undermines living well and pursuing happiness.[108]

Cardinal virtues

According to Aquinas, the four cardinal virtues are special or foremost because they contain all the other virtues or because all the other virtues share in them. The cardinal virtues have primary concerns compared to other virtues, that is, temperance governs the pleasure of touch, fortitude governs the fear of death, justice has to do with relations between equals, and prudence commands actions.[109]

The cardinal virtues are an important way of assessing the morality of any action that human beings undertake. Aquinas identifies the cardinal virtues as being linked to the powers of the soul. For an act to be good, all four powers must be engaged properly with each power being the seat of a virtue, that is, intellect for prudence, the will for justice, the emotions for courage, and desire for temperance.[110] The different cardinal virtues are thus useful whether in isolation or when applied together because they not only guide the decisions that are reached but also help to shape the character of the moral agent. The practice of the cardinal virtues can thus help people in making significant decisions and acting on those decisions; such a process would be quite significant in the context of healthcare.

Virtues lead a person to act according to reason. Prudence is the perfection of reason, justice puts the order of reason in all human affairs, fortitude helps to control emotions since fear of

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[108] Ibid., 27.
[109] Nelson, *The Priority of Prudence,* 77.
[110] R. E. Houser, "The Virtue of Courage (IIa IIae, qq. 123-140)," in *The Ethics of Aquinas*, ed. Stephen J. Pope (Washington D.C.: Georgetown University Press, 1996), 307.

mortal danger leads human beings to retreat from the good of reason, while temperance guides a person because the pleasures of touch could also prevent the good of reason more than other things do.[111] Therefore, in describing the role of each cardinal virtue, Aquinas ranks them by saying that prudence is the most important cardinal virtue, justice the second most important, fortitude the third most important, and temperance the fourth most important.[112] In the same section of the *Summa Theologica*, Aquinas holds that virtues regard the good rather than the difficult, and hence the greatness of a virtue is measured according to its goodness and not based on its difficulty.

Any person – regardless of culture and religious faith – can pursue cardinal virtues as long as the person intends to act in a morally virtuous way. As described in the writings of Aquinas, virtues concern rightly ordered lives and acquired virtues are accessible to all people.[113] Christianity has a great potential of influencing people to grow in virtue. Most of the virtue theory is not tied to any particular religion. Hence, virtues are a moral feature that is shared by adherents of multiple religions in different ways. Virtue ethics does not strongly emphasize some of the teachings of Christianity like forgiveness, reconciliation or the kingdom of God.[114] However, the desire to become a virtuous person helps a Christian to develop the habit of following what one considers to be good, and eventually to live the Christian life more faithfully. While Christianity helps a person to recognize the work of God's grace in the life of the individual, the growth in virtue empowers. Hence, the interaction of religion and virtue involves both a passive and an active dimension.

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[111] ST, II-II, q. 123, a. 12.
[112] Ibid.
[113] Keenan, "Proposing Cardinal Virtues," 717.
[114] Kotva, *The Christian Case for Virtue Ethics,* 61.

Christians look at Jesus as the revealed Son of God, and in following Him, desire to be like Him and to live with Him in eternity. In Christianity, every person's goal is to become like Jesus, a way of faith that in the communion of saints involves transformation of the self; this is a goal that involves more than following rules.[115] Thus for believers, Christianity has a goal, a *telos*. This focus on a desired *telos* is related to the growth in virtue, in which each person aims at becoming virtuous, and to develop a way of life that is inspired by certain qualities. While Aquinas considers that there is an ultimate end, the good and the source of happiness that is to be found only in God, different people may consider their happiness to be associated with other ends, and hence such people make their goals to be earthly achievements. As Nelson writes, "According to Thomas, the one ultimate human good is God, but not all are aware of that reality in the course of willing particular ends perceived as good."[116]

When Christianity informs the practice of virtues, then the person who seeks the human good pursues that goal in both its individual and communal dimensions. The good to which Christians aim is "a shared, social reality that includes and makes possible the individual's thriving and excelling."[117] In such a case, any patient who seeks healthcare should also be inspired to consider the effects of personalized care on the welfare of other members of the community. The pursuit of virtues by the Christian would thus inform the person to view human excellence as an achievement that involves loving service to God and to others.

Prudence

Prudence is the first cardinal virtue. Prudence is an intellectual virtue that is concerned with doing things (unlike the other three cardinal virtues that belong to the will). Prudence concerns

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[115] Ibid., 89.
[116] Nelson, *The Priority of Prudence*, 45.
[117] Kotva, *The Christian Case for Virtue Ethics*, 148.

three acts of reason: deliberating well, judging rightly, and commanding what one should do or not do.[118] The virtue of prudence is closely linked with a person's moral reasoning and a person's intended exercise of well-ordered actions. James Keenan points out the importance of the virtue of prudence when he writes, "Prudence has a privileged place among the cardinal virtues: it recognizes the ends to which a person is naturally inclined, it establishes the agenda by which one can pursue those ends, it directs the agent's own performance of the pursued activities, and, finally, it measures the rightness of the actions taken."[119] Hence, the virtue of prudence acts as a guide in a person's process of doing morally significant actions.

Prudence helps people in making decisions that affect them as individuals and as a group because "prudence regards both the private good of the individual and the common good of a community, and these goods constitute specifically different ends."[120] While the ends of human life are fixed, the means of reaching those ends are parts of ordinary human affairs, and the knowledge concerning those means is acquired through discovery, either by experience or by instruction.

Prudence guides people to develop the means towards any desired ends. For example, when people are sick, the desired end is healing or recovery of health as much as possible. In some situations, especially when a person has an incurable disease, then the end is to achieve the most favorable outcome. That outcome may involve partial recovery, or arrest of the decline in health, or a slowing down of the rate of disease progression. All these outcomes are related to the individual person. However, at the community level, the desired end of healthcare provision is to cure all the sick people in the community or to minimize the disease burden. In such a communal

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[118] Richard J. Regan, *Aquinas: The Cardinal Virtues* (Indianapolis: Hackett Publishing Company, 2005), 1.

[119] James Keenan, "The Virtue of Prudence (IIa IIae, qq. 47-56)," in *The Ethics of Aquinas*, ed. Stephen J. Pope (Washington D.C.: Georgetown University Press, 1996), 259.

[120] Regan, *Aquinas: The Cardinal Virtues*, 1.

dimension, some of the sick people may encounter greater suffering from the illnesses but the general welfare of the community benefits from any measures that apply to the general population. Allocation of resources, development of health bylaws, triage of patients, and such other practices may give some people priority over others; however, these steps involve the virtue of prudence and help to get the desired end.

When death is imminent at the end of earthly life, the virtue of prudence guides people to prepare for that eventuality since it is reasonable for human beings to desire to eventually get a "good death." It is helpful for people to recognize ways that could ensure human dignity, minimize pain, build relationships with one's loved ones and leave the family and friends consoled when a loved one ultimately dies. When the desired end is a good death, then prudence helps people to decide what could be the right means to that end, and to plan according to such a decision.

When dealing with the illnesses of dying patients, the decisions of families and patients can be strongly influenced by emotions. People's inclinations are quite easily drawn towards the social circles that have given them meaning during their earlier parts of life. The love of one's life and family draws people to desire healing and often a longer life. We mourn the death of loved ones because death causes a painful separation. However, the moments that surround death sometimes call for difficult decisions to be made, especially when it is clear that a person's process of dying cannot be reversed or stopped. The virtue of prudence influences the manner in which human beings act and even how they apply other virtues.

In the article "Habits and Virtues," Bonnie Kent writes, "The argument that no proper moral virtue can exist without prudence makes more sense if one recalls that a virtue cannot be put to bad use."[121] The cardinal virtues work together to guide a person, with prudence playing a pivotal role. "Prudence is the rational activity of deliberation, preceding choice, which coordinates and directs the activity of the other virtues. The other virtues, in turn, determine our apprehension of the goods about which we wish to deliberate."[122] The provision and utilization of healthcare services is one way in which a community attends to the needs of its members and, in this case, virtues can guide the conduct of individuals in a community.

As rational beings that desire to be virtuous, we would be morally expected to aim for the perfection of our inclinations. This could concern the inclinations of the patients and of the healthcare providers since they all make decisions regarding treatment. For Aquinas, prudence is a virtue that influences us with regards to things to be done, that is, the things that have their being in the doer.[123]

The virtue of prudence motivates people to make good judgments regarding various decisions, especially decisions that have moral significance. For Keenan, "Specific moral judgments can only be determined in the concrete order by prudence, which determines the means and thus directs the practical reason and the inclination toward the end to be attained."[124] Prudence thus enables people to reflect on the human good, whatever is good for the individual and whatever is good for the community. According to Aquinas, "Since it belongs to prudence rightly to counsel, judge, and command concerning the means of obtaining a due end, it is evident that prudence regards not only the private good of the individual but also the common

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[121] Bonnie Kent, "Habits and Virtues (Ia IIae, qq. 49-70)," in *The Ethics of Aquinas*, ed. Stephen J. Pope (Washington D.C.: Georgetown University Press, 1996), 123.
[122] Nelson, *The Priority of Prudence*, 52.
[123] ST, II-II, q. 47, a. 5.
[124] Keenan, "The Virtue of Prudence (IIa IIae, qq. 47-56)," 264.

good of the multitude."[125] Prudence helps people to handle decisions that are tied to the people's attitudes towards treatment, health, mortality, and the welfare of others.

Working prudently helps people to become better agents at the work they do. For healthcare providers, as they attend to more and more patients, they gain experience and improve on their medical skills. However, with prudence, they not only grow in professional skills but they also become better people who are able to make more ethical decisions or to live better lives. As Keenan indicates, "In prudence, the agent's operation, his or her practical reason and personality are perfected simultaneously."[126] In a world where the number and diversity of medical dilemmas continue to rise, the healthcare workers who have allowed their moral reasoning to develop virtuously will have the potential of making better decisions.

According to Aquinas, prudence, like the other cardinal virtues, is not bound to religion. Whether a person is in mortal sin or not, a believer or nonbeliever, the person can attain to our natural ends through prudence; however, prudence needs charity to be disposed to the supernatural end.[127] The impact of faith, which Aquinas ties to the virtue of charity, would expand the influence of virtue on the life of a patient or a caregiver in ways that affect the decisions that revolve around care. A dying Christian who is charitable may be open to learn that earthly life is near its end and hence he/she could look forward to the life after death, while a patient without such faith may find it very hard to accept that medical care may no longer be able to sustain or prolong his/her earthly life.

Prudential judgment influences the way certain actions are carried out in the context of a medical dilemma. For example, while some people accept certain difficult and heroic treatment options to be pursued, there are others who shy away from any medically futile actions. At times,

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[125] ST, II-II, q. 47, a. 10.
[126] Keenan, "The Virtue of Prudence (IIa IIae, qq. 47-56)," 265.
[127] Ibid., 266.

a medical team and a family take the bold steps of exploring ways in which therapeutic care may be given and situations in which aggressive care would be unnecessary or inappropriate. Implementation of some of these decisions would allow a patient to die from the disease, and that would be different from any attempt to actually kill the patient. David Kelly identifies five types of actions that are associated with letting a person die as opposed to killing a person, and this differentiation can help to articulate the morality of handling the final moments of the life of a patient. These are:

a) Withholding life-sustaining treatment: failing to introduce the use of morally extraordinary means of treatment for a terminally ill patient would be considered an act of allowing a patient to die, rather than an act of killing.

b) Withdrawing life-sustaining treatment: this could be considered an act of letting a patient to die when it becomes clear that the treatment method is morally extraordinary.

c) Pain relief that hastens death: when the aim of a certain treatment procedure is to relieve pain rather than to cause death, then that intervention can be considered an ethically acceptable means of treatment that is morally supported by the principle of the double effect.

d) Physician-assisted suicide is considered to be wrong not only in the Catholic tradition but also in most of the states in America.

e) Euthanasia is considered wrong both by the Catholic tradition and by the legal system in the United States.[128]

Prudence is a virtue that allows a person to apply law to particular cases. Prudence involves being able to discern the true end of human conduct and to develop the right means of achieving that end. The application of prudence can be noted in some practical cases. In the case of Nancy Cruzan, in 1989, the United States Conference of Catholic Bishops (USCCB) opposed the

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[128] Kelly, *Medical Care at the End of Life*, 12-20.

removal of the feeding tube.[129] This opposition was based on one of the interpretations of the established Catholic tradition. While the removal of the feeding tube would be acceptable by the Catholic tradition, by allowing patients to refuse the use of extraordinary methods of treatment (the argument that Nancy's parents relied on), it would be possible for some people, who could benefit from such a tube, to want to discontinue the feeding tube for the sake of suicide or as the expression of the right to privacy and autonomy. This right to privacy is constitutionally based and some people could use it to promote abortion on demand or euthanasia, and the Catholic Church's teaching is opposed to these two practices.[130]

The bishops recognized that the act of removing a feeding tube could be the means of expressing multiple motives, e.g., to avoid burdensome extraordinary treatment (which Catholic teaching would approve), to commit suicide (which Catholic teaching opposes), or simply to express personal autonomy over one's body. Certain advocates of personal autonomy, e.g., those who justify abortion or euthanasia (claiming that these are ways of expressing autonomy), may claim to have the support of the Catholic Bishops since the two groups would support Nancy's desire to discontinue the use a feeding tube. In the face of such a risk or confusion, the bishops could have chosen to avoid any association with a campaign to remove a feeding tube in such a highly publicized and controversial case.

Based on moral and legal grounds, people would be free to accept or reject morally extraordinary means of treatment. However, some competent people sometimes reject morally ordinary treatment, e.g., Jehovah Witness adherents reject blood transfusion, and yet the

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[129] Ibid., 54.

[130] Ibid., 55.

Constitution allows them to hold such an opinion.[131] The First Amendment already protects religious-based arguments for accepting or rejecting medical procedures.

Human moral actions are done towards a given end that is considered to be good and hence they are the results of the powers of reason and will of the moral agent.[132] In particular, different opinion holders or stakeholders approach medical decisions from the perspective of what each person considers to be the good, even when the decisions involve complex dilemmas.

Prudence would be a very important virtue for a doctor who has to make difficult medical decisions regarding a patient, or to advise a patient on what would be important decisions to be made. As a virtue, prudence would help the person in weighing the demands of every aspect of the disease or the treatment protocol, and in assessing what would be the appropriate decision for the patient in particular, and for the community in general. As Nelson writes, "A prudent person deliberates in a measured and careful way, judges circumstances accurately by attending to all their relevant features, consistently resists the undue influence of the passions in the pursuit of the good, and completes deliberation and judgment by commanding the performance of an appropriate action."[133]

Justice

The virtue of justice has been given extensive coverage by Aquinas, as he identifies this virtue as the only cardinal virtue that directly concerns the distinctively human capacity for rational desire, and that is directly concerned with external actions. Hence, Aquinas "analyzes and coordinates the different perspectives on justice, as a general virtue, as one particular virtue among others, as the virtue preeminently concerned with right relations among people, and as an

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[131] Ibid., 56.
[132] Nelson, *The Priority of Prudence,* 33.
[133] Ibid., 83.

integral component of the Christian life."[134] Justice orients a person to the welfare of other human beings and hence it is a virtue that possesses a social character. Aquinas defined justice as a "habit whereby a man renders to each one his due by a constant and perpetual will."[135]

According to Regan, "Justice is the most important moral virtue, both because of the subject in which it inheres (the will) and because of its object (the good of other human beings)."[136] This privileged position of the virtue of justice follows the teaching of Aquinas who affirmed, "If we speak of legal justice, it is evident that it stands foremost among all the moral virtues, for as much as the common good transcends the individual good of one person."[137] The expectations of justice can be related to the way the medical and legal fraternities deal with the patient who is very sick. Once the process of dying has begun and the death is confirmed to be imminent, medical and legal forces could be applied to attempt to halt that progression even when it is clear that a person is dying in the near future, e.g., when the body is sustained by mechanical ventilation and artificial nutrition.

On the one hand, medical futility could be based on a patient's living will, made when the patient was competent, or on the insistence of the patient's family when the latter demand heroic treatments. On the other hand, medical efforts could be abandoned when the patient is severely ill but not about to die, as occurs when a patient is in a vegetative state in which he/she is fed through a gastric tube and yet the family (or the patient through his/her earlier directives) decides that the feeding should be declared to be extraordinary means of treatment, and hence discontinued.

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[134] Porter, "The Virtue of Justice (IIa IIae, qq. 58-122)," 272.
[135] ST, II-II, q. 58, a. 1.
[136] Regan, *Aquinas: The Cardinal Virtues*, 34.
[137] ST, II-II, q. 58, a. 12.

Aquinas describes the relationship between the two types of justice, distributive and commutative. Commutative justice is concerned with the mutual dealings between two persons, while distributive justice directs the relationship between a person and the community, ensuring that the common goods are distributed proportionately.[138] Justice affects the way people relate to one another and to the community at large. Justice is "essentially directed toward securing right relations with others, with the community as a whole in the case of legal justice, or with other individuals, in the case of particular justice."[139] Decisions that one person makes in the distribution of resources have a direct impact on the rest of the society.

Justice is a virtue that makes people to recognize the social dimension of humanity in ways that do not emphasize the individual at the exclusion of the wider society. Kotva affirms, "A virtue conception of justice insists that we see ourselves as members of a community whose good we seek together. Justice is grounded in community and is guided by a shared understanding of the common good, which includes both the individual's and the community's good."[140]

The virtue of justice can be applied to help the patient, the family, the medical team and even the legal team to establish what is right for a particular patient depending on the circumstances. On the one hand, a dying patient requires his or her dignity to be respected, and for that reason the process of death should not be prolonged unnecessarily. On the other hand, any sick person with a chance of survival should also be cared for as a matter of justice. The medical establishment and the family owe the patient the care that he or she deserves as a human being. However, the care of any patient should not be the reason for many other people to miss healthcare, otherwise that would be an expression of injustice towards the others. The tendency

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[138] ST, II-II, q. 61, a. 1.

[139] Porter, "The Virtue of Justice (IIa IIae, qq. 58-122)," 276.

[140] Kotva, *The Christian Case for Virtue Ethics*, 149.

for the rich or influential people to want to have everything that is medically possible to be done to them at a time when the poor people do not have basic needs is a practice that fails to honor the demands of justice.

The biblical understanding of justice is preoccupied with the needs of the weak, the poor, the disadvantaged, and the oppressed and thus less concerned with individual merit or excellence.[141] In this case, human helplessness and needs are the basic criteria for determining the distribution of benefits. A virtuous Christian is thus inspired to see the needs of other people, particularly the poor, so as to determine the more just decision regarding healthcare. Under such circumstances, a dying person could possibly forego some medical procedures for the sake of letting other poorer people get some benefit rather than spending a lot of resources on himself or herself.

Based on Aquinas' teaching, "human laws are just if they are ordered to the common good, fall within the powers of the lawmakers, and lay proportionately equal burdens on citizens."[142] While other virtues have a great focus on the character of the moral agent, justice as a virtue emphasizes the relations among people. As Jim Keenan writes, justice is the only relational virtue, that is, the virtue that alone "orders not only the agent, but the agent in relationship to others."[143] For this reason, patients, families and healthcare workers need to appreciate the influence of the virtue of justice in the decisions they make, whether concerning themselves or other people. Hence, the people in positions of authority should be virtuous in order to ensure that justice is done for all. The people entrusted with the promotion of justice should themselves be just in their lives and work. For example, Aquinas holds that a lawyer should not knowingly defend an unjust cause, since that would entail a serious sin that is contrary to justice; however, a

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[141] Ibid, 148.
[142] Regan, *Aquinas: The Cardinal Virtues*, xvi.
[143] Keenan, "Proposing Cardinal Virtues," 719.

lawyer who defends an unjust cause thinking that it is a just cause can be excused on the grounds of ignorance.[144]

Fortitude

"Fortitude is the moral virtue by which one resists difficulties that repel the will from acting according to reason."[145] The human will is prevented from following the right reason in two ways:

a) being attracted to other ways by something pleasurable, and hence the virtue of temperance addresses that impediment;

b) being repelled from doing the good that is in accord with reason, and hence the virtue of fortitude helps to resist that difficulty.[146]

According to Cicero, who was influenced by Plato, the virtue of fortitude is the conscious undertaking of dangers and the endurance of hardship and it has four parts, namely, magnificence, confidence, patience and perseverance.[147] However, Aquinas used the work of Aristotle to replace confidence with magnanimity.[148] Aquinas held that magnanimity is the virtue whose matter is great honor and it makes a person to tend to such things as are deserving of honor.[149] Aquinas considers magnanimity a Christian virtue that makes a person to recognize the gift of God that makes human beings worthy of honor. Aquinas writes, "Accordingly magnanimity makes a man deem himself worthy of great things in consideration of the gifts he holds from God."[150] (ST II-II, q. 129, a. 3, reply to obj. 4). Magnanimous healthcare workers

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[144] ST, II-II, q. 71, a. 3.
[145] Regan, *Aquinas: The Cardinal Virtues*, 106.
[146] ST, II-II, q. 123, a. 1.
[147] Houser, "The Virtue of Courage (IIa IIae, qq. 123-140)," 305.
[148] Ibid., 308.
[149] ST II-II, q. 129, a. 2.
[150] ST, II-II, q. 129, a. 3, reply to obj. 4.

would desire to maintain the honor of their work by giving good and dignified services to their patients. Magnanimous patients would esteem themselves to be worthy of God's gifts and hence would seek the kind of care that upholds their human dignity.

The pursuit of virtues also leads us to know the other qualities that stand in the way of good decisions. For example, Aquinas identifies certain traits that are opposed to magnanimity, and these include presumption, ambition and vainglory.[151] Aquinas presents ambition as an inordinate desire for honor that makes a person desire to be honored while neglecting the honor that is due to God and to the neighbor; therefore, Aquinas invites people to seek the honor of God and one's neighbor.[152] In this way, the virtue of magnanimity, and by extension the virtue of fortitude, can help a patient to think beyond personal needs and hence consider the relationships that human beings share with God and with others.

Aquinas holds that magnificence is shown when great deeds are done for God and for the community.[153] When magnificence inspires people to accomplish great things, not just for themselves but also for God and for others, such people demonstrate not only generosity but also a form of detachment from the desire to retain their personal resources, thereby demonstrating their courage when they let go of their resources. Magnificence would lead healthcare workers to shift part of their focus from any particular patient or a privileged group of patients, and make themselves available to serve the needs of the whole society. Thus the pursuit of magnificence could help a society to make good decisions regarding sick people particularly when the caregivers desire not only the welfare of a few patients but also the welfare of the wider community and the glory of God. This practice is highly needed in the provision of medical care to people in a world where resources are often inadequate. This attitude of considering the needs

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[151] ST, II-II, questions 130-132.
[152] ST, II-II, q. 131, a. 2.
[153] ST, II-II, q. 134, a. 3.

of others expresses the virtue of magnificence, and by extension the virtue of fortitude in ways that can help not only in managing a terminal illness, facing death, and caring for a particular dying person, but also recognizing the needs of the other people.

Aquinas describes patience as a virtue that is related to fortitude because patience involves tolerating what presently harms us, and therefore that which is an obstacle standing in the way of realizing our goals.[154] In the face of death, the fear of death and the pain associated with grief can act as strong forces that influence decision-making. Hence, the practice of patience could help a person to remain resolute in the face of difficulty and eventually make a morally good decision concerning treatment.

Perseverance is also a helpful manifestation of the virtue of fortitude since it helps a person to bear with a difficult situation until an end is achieved.[155] In one sense, Aquinas considered perseverance to be a special Christian virtue, that is, an infused habit whose matter concerns a whole life geared to the beatitudes, while in another sense, it has a secular aspect of energizing other specific virtues to their specific ends.[156] Hence, perseverance while caring for a dying person would help healthcare providers to make ethical choices. Similarly, a patient cultivates perseverance by moderating the fear that is connected with the danger of death and enduring the challenges associated with severe illness. This virtuous approach could possibly involve accepting the end of life when it becomes imminent without aiming for medical futility, or waiting for a natural death when medical help cannot restore health without the desire to shorten one’s life, as happens when people choose to commit suicide.

Aquinas holds that the virtue of fortitude helps a person to deal with fear, particularly in circumstances that would cause a person to sin. He writes, “Yet one’s sin would be extenuated

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[154] ST, II-II, q. 136, a. 4.
[155] ST, II-II, q. 137, a. 2.
[156] Houser, “The Virtue of Courage (IIa IIae, qq. 123-140),” 316.

somewhat, for what is done through fear is less voluntary, because when fear lays hold of a man he is under a certain necessity of doing a certain thing […] these things that are done through fear are not simply voluntary, but a mixture of voluntary and involuntary."[157] A threatening situation makes a person to decide whether to attack the cause of danger (to express boldness) or to endure the challenge (to suppress one's fear). Fortitude concerns both fear and boldness against the threat. Fortitude helps the person to act according to reason, and is better expressed by the more difficult of the two choices, which is, to show endurance rather than to attack the danger. Aquinas holds that "fortitude is more concerned to allay fear than to moderate daring."[158]

Fortitude involves acts of attack and acts of endurance. The virtue has four parts associated with it. Regarding the acts that attack the causes of mortal dangers, a virtuous person has confidence, which helps him/her in preparing an attack, and magnificence, which helps a person to execute the thing one has begun confidently. Regarding the acts of endurance, a person requires patience, in order that the difficulty of the threatening evils does not break the spirit through sorrow and cause it to fall from its greatness, and perseverance, which prevents a person from becoming weary to the point of giving up when the suffering of difficulties is lengthy.[159]

Some medical decisions are closely related both to the virtue of fortitude and the virtue of temperance. For Nelson, "An individual possessed of the virtues of fortitude and temperance is one who fears only the right things, in the right time and place, and to the appropriate degree, and whose desires for apprehended goods are also appropriately directed and moderated."[160] For such a person, any act that is prompted by fear is actually a voluntary action in which the person wills a particular act as good in order to avoid an evil that the person fears. Some of the human

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[157] ST, II-II, q. 125, a. 4.
[158] ST, II-II, q. 123, a. 6.
[159] ST, II-II, q. 128, a. 1.
[160] Nelson, *The Priority of Prudence,* 41.

choices that are associated with fear within a medical context include the fear of a quick death or even the fear of a prolonged process of death. On the one hand, in the case of the fear of death, a person could identify an alternative end as good, and that could involve any attempt to hold on to life at all cost – what is sometimes called vitalism. On the other hand, one could fear the prolonged process of dying and hence desire and choose to provoke a quick death – a situation that is associated with suicide.

Temperance

Temperance involves the moderation of appetites that would go against reason, whether it is the desire for things that are pleasurable, or the emotions that are associated with sensibly perceptible and bodily evils. While referring to Aquinas, Diana Fritz Cates identifies temperance as a virtue that moderates the affections of the soul and the movement of sense appetites, hence ordering the sense desires and pleasures, and restraining the powerful impulses that threaten the appetitive integrity of the soul.[161] The virtue of temperance helps a person to pursue goodness and happiness in ways that do not harm the person's goal or the common good. Alongside other virtues, temperance leads a person to act rightly as a matter of habit.

When Aquinas wrote about the virtue of temperance, he emphasized on the sensible goods that are associated with food, drinks (particularly alcoholic drinks) and sexual activity. Hence, he presented the virtue of temperance as a way of leading people to abstinence, sobriety and chastity. Thus temperance is the disposition that orders desires and pleasures connected to the use of food, drink, and sexual relations.[162] Virtues are expected to urge people to follow the measure of reason and divine law. Hence Aquinas implies that reason and divine law require that

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[161] Diana Fritz Cates, "The Virtue of Temperance (IIa IIae, qq. 141-170)," in *The Ethics of Aquinas*, ed. Stephen J. Pope (Washington D.C.: Georgetown University Press, 1996), 321.
[162] ST, II-II, q. 142, a. 1.

persons desire, use, and enjoy sensible goods in ways that protect and enhance the quality of human life and community under the reign of God.[163]

Fritz Cates writes, "Temperance is about the desires and pleasures that are elicited by objects of sense experience."[164] This implies that the dominant view of temperance has focused on a person's habit of responding to sense pleasures, a situation in which temperance promotes the practice of self-control, and helps a person to avoid the likelihood of overindulging in pleasurable activities or pursuing fulfillment of every possible pleasurable act. Such an attitude could be extended to include the possibility of helping a person to bear with situations that are not pleasurable at all, for example, to cope with a time of bodily illness during which a person is unable to pursue or enjoy pleasurable activities. Many people struggle to acknowledge the onset of illness, especially when they have opportunities to enjoy various pleasurable things that they can access in life. This ability to possess and enjoy life's opportunities and goods, and the desire to maintain interpersonal relationships, would lead people to place a great value on a longer earthly life even when a person is very sick or inevitably dying.

As human beings, we recognize that we have a duty to protect life and promote health as much as we are able. One could argue that life's pleasures are the forces that draw us to desire to live long. However, the desire to cling onto life, whether our lives or those of our loved ones, needs to be moderated by the readiness to accept mortality when natural death ultimately comes. We need to be virtuous and to have control over our desires, understanding that we can only enjoy the pleasures of the world to a limited degree.

Aquinas holds that there is a relationship and also a difference between continence and temperance. He affirms that the temperate person ensures that pleasant actions are in keeping

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[163] Cates, "The Virtue of Temperance (IIa IIae, qq. 141-170)," 334.
[164] Ibid., 322.

with reason while a continent person aims to fight against unruly passions.[165] While Aquinas held that temperance should be considered a cardinal virtue, he described continence as a mixture of something that is of virtue (because reason stands firm against passions) and something that is not of virtue (because continence has to keep fighting against vehement passions that could arise in the sensitive appetite and that are against reason). The temperate person's desires and pleasures are so well ordered that he/she does not have to struggle to keep them in order, while the continent person is one who is successful in his or her struggles against unruly impulses because he/she lacks rational order in the soul.[166] Hence, the virtue of temperance is held to be much higher than continence.

The desire for pleasure can influence healthcare workers and risk preventing them from making objective decisions, for example, the pleasure that is associated with being praised or held in high esteem by a family may make a doctor fail to disclose to a family the sad news about a patient's failing health. While it is important for a doctor to be realistic, it is also difficult for the doctor to be the one diminishing the hopes of a patient and telling the patient that nothing more can be done. When it is inevitable, the doctor must announce the onset of death; however, technological advances can make the doctor to prolong a patient's process of dying while the medical team and the family explore "other" options of care.

Summary

In conclusion, I would like to emphasize that the cardinal virtues are important sources of inspiration and guides for moral agency and behavior for all people. The decisions that need to be made in the context of severe illness are among the most serious decisions that one could

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[165] ST, II-II, q. 155, a. 1.

[166] Cates, "The Virtue of Temperance (IIa IIae, qq. 141-170)," 323.

make in life. Many of those decisions involve the end of life and the preparation for death. Mistakes that one does in such circumstances can be fatal and many of those actions can hardly be reversed. The way we live influences the way we make decisions. Therefore, pursuing a virtuous life prepares us for the ethical challenges that we could encounter in life, especially with regard to illness. Many virtues are involved in helping a person to act and live well. However, the cardinal virtues "perfect the fundamental anthropological dimensions of being human that are needed for the integrated virtuous behavior."[167]

The cardinal virtues work together rather than in isolation. As a person perfects his/her life through one virtue, the other virtues are also expressed. Therefore, as shown in this chapter, the cardinal virtues would guide patients and healthcare providers in exploring available and ethically appropriate options, and taking the steps that help not only a particular patient but also the general community as a whole.

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[167] Keenan, "Proposing Cardinal Virtues," 714.

Chapter 3

Virtuous provision of healthcare in Kenya

Christianity complements the medical and legal developments

The judicial system in America has set precedents that deal with various ethical dilemmas. The resultant legally established practices are currently influencing the management of patients in an environment that is associated with highly specialized medical technology and a high degree of awareness of constitutionally protected rights. This American experience could guide the developments of similar practical steps in other countries, e.g., Kenya. Recognizing that human life has special value, we need to explore various ethical ways of caring for the sick in which we support both the rich and the poor.

Medical and legal developments come with their own associated risks. The temptation to seek or offer heroic care can be overwhelming whenever we feel that the law and the medical apparatus can support us and yet we could end up spending resources in ways that are not prudent. We could spend a lot of energy and resources trying to stretch out lives of a few dying patients by a short duration of time (in intensive care units) while failing to seek greater comfort and peace for them, and leaving out important opportunities that would be utilized in the company of their loved ones, and more significantly, failing to recognize the needs of all the other patients who need the resources we are using. At the same time, it would be more prudent to just use what is necessary, i.e., ordinary means of treatment, in the interest of the common good.

When caring for people in the end-of-life situations, it is important to acknowledge the reality of natural death when it comes since human beings are mortal. At the same time, it is necessary that resources be focused not only on the welfare of the dying person but also to consider the feelings and welfare of the wider family and the interests of other needy people. The decisions concerning the death of loved ones can never be easy. Therefore, it is necessary that there are protocols to guide the people who get involved in providing the end-of-life care. In this chapter, I show how Christianity defends the dignity of human life, and how virtuous people – patients and caregivers alike – can promote the same dignity by supporting ethical healthcare services, particularly when people appreciate that human life receives its dignity from God.

Theological reflection over legal and medical developments helps a person to recognize the influence of God on the lives of people, and to acknowledge that the voice of God speaks to us in our experiences. Christianity teaches us to recognize God as the Creator of all that exists, and hence the source and sustainer of all human life. The act of caring for people, especially at the end of life, is a process that honors God and shows respect for the sanctity of human life. Inspired by Christianity, human actions need to not only help the dying patients but also benefit the rest of humanity, particularly in the care of other sick people. Therefore, healthcare-associated medical and legal activities should help us to appreciate God's work and to obey God's will.

By acknowledging the call of God for people to act in an ethically appropriate manner, we can utilize medical and legal progress to develop better care for humanity, especially for sick people in general, and for the dying ones in particular. As I reflect on the situation in the United States, I intend to use this theological reflection as a guiding light to show how legal and medical developments could be applied to the Kenyan context in practical ways.

Some people have advocated the pursuit of either vitalism or subjectivism when dealing with dying patients, two extreme positions that easily lead to difficult disagreements. While rejecting both extreme positions, the Roman Catholic tradition upholds the sanctity of life. The

Church also emphasizes that there should be some aspects of quality of life in the patients being cared for, implying that life need not be prolonged under every set of circumstances.[168]

According to Aquinas, the first principle of practical reason is that human beings should seek things that are good for them as human beings and avoid things that are bad for them as human beings.[169] In this way, nature inclines human beings to preserve themselves (like all substances), to beget and educate offspring (like all animals), to know truths about God and God's plan for creation, and to live in community with other human beings as rational beings.[170] This Christian view denounces some of the modern practices like euthanasia since the deliberate destruction of human life stands opposed to the Christian teaching that God is the sole giver and master of human life. Hence, human beings should respect and protect human life up to the moment of natural death.

In the "Declaration on Euthanasia," the CDF highlights the place of humanity in the eyes of God and insists that human life is of great value. Hence, human beings should not be killed and nobody should ever have to ask for death, either for the self or for another. The CDF writes:

> Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly, nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity.[171]

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[168] Kelly, *Medical Care at the End of Life*, 6.
[169] ST, I-II, q. 94, a. 2.
[170] Regan, *Aquinas: The Cardinal Virtues*, xv.
[171] Sacred Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," ii.

The main reason for defending the dignity of a person is because until the moment of natural death, a person is entitled to God-given dignity that cannot be eliminated by illness or any other physical decline. Peter F. Ryan argues that the patients in vegetative state still maintain the human ability to suffer harm or to receive multiple benefits, for example, a married woman in such a state remains in a marital relationship with her husband and receives honor from his faithfulness whether she is aware of it or not, and she would also benefit spiritually if she were anointed through the sacrament of the sick.[172] Kevin O'Rourke argues that since the goal of human life is friendship with God, some people have lost their ability and potency of performing some human acts now and in the future, and therefore, "it seems that there is no moral obligation to prolong the life of persons in vegetative states from which they most likely will not recover."[173] In this way, O'Rourke opposes the prolongation of life rather than, as would be expected, opposing the prolongation of the process of death.

The attitude of healthcare workers can very significantly determine the quality of care that the dying patients receive. Healthcare workers also influence the social attitudes that a society has towards the dying. If healthcare workers have negative views towards patients, then the workers disparage the human value of patients, show the patients disrespect and ultimately push them to an undignified status. However, virtuous caregivers appreciate the intrinsic human dignity in patients for as long as patients are not yet dead. Patients, whether knowingly or unknowingly, always interact with the caregivers as human beings worthy of dignity and respect. Affirming that some patients are unable to relate to other people meaningfully (e.g., those in vegetative state) could be an excuse to support the death and neglect of those patients.

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[172] Peter F. Ryan. "The Significance of the Ultimate End for the Feeding of PVS Patients: A Reply to Kevin O'Rourke," in *Bioethics with Liberty and Justice*, ed. Christopher Tollefsen (New York: Springer, 2011), 89.

[173] Kevin O'Rourke. "Reflections on the Papal Allocution Concerning Care for Persistent Vegetative State Patients," in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient: The Catholic Debate*, ed. Ronald P. Hamel and James J. Walters. (Washington D.C.: Georgetown University Press, 2007), 249.

Virtuous people would readily acknowledge that children born with severe mental deficits, or people who were once healthy but have deteriorated to similar states, still relate to their caretakers when the latter offer nutrition, social support, emotional support and social presence even when these services are not fully appreciated or reciprocated. A health worker relates to the patient differently from relating to a machine, identifies the patient by name, and relates to relatives or friends of a patient in a social network that recognizes the humanity of the patient.

Caring for the extremely sick or the dying raises the question of using ordinary or extraordinary means of treatment. While promoting the Catholic tradition, which provides a distinction between the "ordinary" and "extraordinary" means of preserving life, Kelly points out that this categorization is a "moral distinction, not a medical one, and it relies on theological and philosophical understandings of the meaning of human life of which the practical implications, if not the theological bases, have largely been accepted."[174] This distinction is based on the proportion of the human benefit as compared to the human burden involved in the treatment option. Since the moral distinction between the two means of treatment involves the moral actions of human beings, the extent of burden that any person would be willing to bear, or to allow a loved one to bear, and the apparent benefit that one would seek from healthcare providers, varies from person to person. However, all human beings have inherent value that stems from being God's special creation.

The Christian view of humanity focuses on the Genesis story of creation, where human beings are said to have been created in the image of God, and also on the person of Jesus, who incarnated into humanity so as to draw humanity to God in a special way. The Christian moral theology, which defends this special status of human life, is different from the teaching of other faiths. Four sources that distinguish Christian moral theology are sacred Scripture, the natural

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[174] Kelly, *Medical Care at the End of Life*, 3.

law, the Christians understanding of virtues, and the Christian notion of the good.[175] These features make Christianity an attractive source of moral authority regarding human life and inspire Christians to care for all lives.

By referring to God as the source of life and defending every human life as being valued by God from the moment of conception to the moment of natural death, Christian theology offers us valid reasons to defend life even in the most vulnerable situations, particularly at the beginning and at the end. I hereby agree with Gustafson that theology "as an intellectual discipline operates within the religious consciousness, and refers to an ultimate power standing over against as well as sustaining the creation."[176] That power inspires a response of love not only for the divine Creator but also for the vulnerable and the weak.

Care at the end of life

Human beings have many concerns in life, among them health, relationships, jobs, fulfillment, pleasures, leisure, etc. Illnesses do not erase the other aspects of life, even when a person is at the point of death. The priorities of a physically sick person may change but the person still desires to have some fulfillment socially, mentally, spiritually, economically and in other ways. Dr. Atul Gawande writes:

> People with serious illness have priorities besides simply prolonging their lives. Surveys find that their top concerns include avoiding suffering, strengthening relationships with family and friends, being mentally aware, not being a burden on others, and achieving a sense that their life is complete. Our system of

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[175] Josef D. Zalot and Benedict Guevin. *Catholic Ethics in Today's World*. Rev. ed. (Winona, MN: Anselm Academic, 2011), 13.

[176] James M. Gustafson. *The Contributions of Theology to Medical Ethics*. (Milwaukee: Marquette University Press, 1975), 95.

> technological medical care has utterly failed to meet these needs, and the cost of this failure is measured in far more than dollars.[177]

For many people, death is preceded by serious illness and people attend to such occurrences in various ways. In earlier centuries, dying used to be accompanied by certain customs that the people were used to, especially in the context of Christianity. There were guides associated with the art of dying, based on the Latin texts of *ars moriendi*. As Gawande recalls, "Reaffirming one's faith, repenting one's sins, and letting go one's worldly possessions and desires were crucial, and the guides provided families with prayers and questions for the dying in order to put them in the right frame of mind during their final hours."[178]

Patients and relatives need help as they deal with prolonged illness. A prolonged life-threatening illness extends through different phases and these affect patients and families in significant ways. These stages include: the prediagnostic phase of illness (while symptoms are being investigated), acute phase (after a diagnosis has been confirmed), chronic phase (while medical treatment is given with a hope of cure or prolonged life), recovery phase (when some improvement or healing is noted), and a terminal phase (when death is anticipated and the goal of care is to provide comfort).[179]

Some patients readily accept death when it becomes inevitable while other patients commit a lot of resources to fight against the inevitable outcome. The decision not to use extraordinary medical procedures to prolong the dying process is the responsibility and prerogative of the patient or the family (or patient's surrogate) whenever the patient is incapable of doing it. However, this does not make the decision an easy medical or legal judgment. As McHugh writes,

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[177] Gawande, *Being Mortal,* 155.

[178] Ibid., 156.

[179] Kenneth J. Doka, "When Illness is Prolonged: Implications for Grief," in *Living With Grief When Illness is Prolonged*, eds. Kenneth J. Doka and Joyce Davidson. (Washington D.C.: Hospice Foundation of America, 1997), 6-8.

"It is a human decision that must be based on respect for human life, and one that is made with moral conviction, compassion and charity."[180] Clarity cannot be assured because "the criteria for distinguishing between morally ordinary and morally extraordinary means of prolonging life are not clean or precise."[181]

Whenever it becomes clear that a patient's illness cannot be cured, then a doctor has the responsibility of helping a patient to reorder his/her life within the limits imposed by the illness, and the two parties need to cooperate in order to construct the new lifestyle. As a patient moves towards death, medical care needs to adjust in such a way that the doctor focuses not so much on the patient who is failing in treatment but on a person who is undergoing tremendous change in his or life. The personhood of the dying person needs to be given its prominence rather than focusing too narrowly on the untreatable medical condition. A patient's autonomy should be given preference even if the doctor wishes to be a benevolent agent of sophisticated medical care.

Although beneficence on the side of the healthcare provider may involve prioritizing whatever the health worker believes to be good, there comes a time when the dying patient has to be allowed to choose, for better or for worse, what a patient prefers, within the bounds of possible alternatives. Drane holds, "As the patient moves from an acute and easily cured illness into chronic illness and finally into greatly reduced quality of life and the dying process, beneficence, as medical best interest weighs less, and autonomy, as patient personal preference, weighs more."[182]

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[180] James T. McHugh, Introduction to *Death, Dying and the Law,* ed. James T. McHugh. (Huntington, IN: Our Sunday Visitor, 1976), 13.
[181] Kelly, *Medical Care at the End of Life*, 9.
[182] James F. Drane. *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics* (Kansas City, MO: Sheed & Ward, 1988), 72.

In making healthcare decisions, various factors have to be weighed by patients and their families so that they can be classified as benefits or burdens. The burdens that one patient may consider as little might be overwhelming for another. Significant factors that affect treatment decisions include pain, chance of success, degree of invasiveness, social and financial costs to the patient or the family, a patient's readiness for death, etc. The suffering associated with end-of-life illness can be very traumatizing to many patients, such that some of them desire to die rather than continue to suffer.

In the face of great suffering, some people defend euthanasia and physician-assisted suicide as viable options of dealing with terminal illness. Some of the reasons that the proponents of these procedures mention include: the expression of personal autonomy that other people should respect; the principle of the right to determine when and how a person dies (the principle of self-determination); the desire to maintain human dignity up to the point of death (instead of living until the person loses control of bodily functions); the desire to avoid dependency and burden, as an act of mercy that alleviates pain and suffering; the desire to avoid being alive after the loss of a person's quality of life, and for the sake of saving resources.[183] The unrelenting suffering can lead some people to desire physician-assisted suicide. However, considering the moral challenges that accompany PAS, it is worth noting that there are possible alternatives that people can turn to.

If a person's right to life were to be pegged on the person's comfort or usefulness to the society, then many people would forfeit the right to life. The Linacre Institute of the Catholic Medical Association holds the principle that "all persons are entitled to a dignified death in God's own time, but directly killing patients or assisting in their suicide is abhorrent, regardless

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[183] Zalot and Guevin, *Catholic Ethics in Today's World*, 239-240.

of poor quality of life or survival expectancy."[184] On the one hand, David Kelly identifies some unfortunate and inhumane attitudes that some people apply towards dying patients and these include: abandonment of patients to their own devices; refusal to care for the patients when their insurance is insufficient; inadequate pain management; and paternalistic insistence on aggressive morally extraordinary life-sustaining treatment against the wishes of the patients.[185] On the other hand, Kelly points out two human and morally proper alternatives to PAS, and these are, the ethically right and legal foregoing of life-sustaining treatment, and proper pain management.[186]

The acceptance of PAS in various places opens a window for the demand of the legalization of euthanasia. As the law is now in the state of Oregon, the people that are able to take lethal medicines unaided can use the provision of the law to cause their own death since they do not require physical help from others in order to swallow the lethal drugs. However, the physically challenged, e.g., people with quadriplegia, are unable to take any medication without the help of others. Any of them can go to court and ask to be treated "equally" to the physically able ones, and hence someone would have to help them swallow the lethal drugs.

Others could suggest that an intravenous injection of lethal substances would work more effectively in the act of suicide than the swallowing of pills once the act of committing suicide has been approved, and hence the person committing suicide would ask for the assistance of a healthcare provider. By extension, the practice of PAS may extend to incorporate involuntary euthanasia, a process that would be aimed at eliminating some "unwanted people."

Despite the popularity that PAS has gained in some parts of the world, David Kelly has identified five reasons why PAS should not be legalized, and these reasons are:

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[184] Eugene F. Diamond, *A Catholic Guide to Medical Ethics: Catholic Principles in Clinical Practice* (Palos Park, IL: The Linacre Institute, 2001), ix.
[185] Kelly, *Medical Care at the End of Life*, 123.
[186] Ibid.

a) Any increase in the number of exceptions to the general principle against killing makes other exceptions easier.

b) It would be very difficult, if not impossible, to hold the line at PAS and resist moving to voluntary and to non-voluntary active euthanasia, for example, for the unconscious people or children who are unable to ask for PAS for themselves but their loved ones think that those patients may desire it.

c) In the context of resource allocation, legalization of PAS and active euthanasia could serve as socially acceptable forms of cost containment. In this case the temptation to fight poverty could include eliminating the poor people.

d) Prohibition of PAS helps to prevent active euthanasia. In the United States, the distinction between killing and allowing a patient to die has legally allowed patients to forego certain types of treatment while the law still prohibits active euthanasia.

e) To preserve the integrity of the medical profession. To maintain trust between doctors and their patients, it is important that doctors do not kill patients but offer to them the more up-to-date medical care and life saving services.[187]

According to the teaching of Thomas Aquinas, "suicide is a sin, not only because it is contrary to the love one ought to have for oneself, but also because it is contrary to justice in relation to the community and God."[188] As a community, we are linked in some way and hence the harm or death of one person affects the rest of the community. The defense of a human life extends to involve the defense of the community, and hence promotes the common good. In killing oneself, one harms the community and also sins against God who is the giver of life.[189] Christian teaching is opposed to suicide as expressed in the commandment that forbids killing of

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[187] Ibid., 125-130.

[188] Regan, *Aquinas: The Cardinal Virtues*, 64.

[189] ST, II-II, q. 64, a. 5.

people. The Christian tradition also stands against suicide since Christians are called to love themselves too rather than hating themselves (Ephesians 5:29). Christians, and by extension all people, are called to be caring towards themselves and towards others.

Despite the best of intentions, caring for the severely ill or dying patients will always be accompanied by certain challenges and these challenges influence the decisions of patients and their caregivers. Gorovitz writes, “Ethically loaded decisions are part and parcel of medical practice.”[190] These challenges involve the treatment of comatose patients, dying patients, the use of painkillers, etc. Often, decisions that involve management of patients with prolonged illnesses are generally made in the context of grief. David Price writes, “A prolonged illness, even if it is not perceived as necessarily ending in death, nonetheless entails prolonged grief.”[191] Despite these challenges, caring is a necessary part of being human.

Caring is a life pattern, a comprehensive way of ordering one’s life. Caring is a way of realizing who we are called to be in this world. This understanding helps us not only to care for others but also to allow ourselves to be cared for by others. This dual approach to care is part of the dynamics that we encounter as caregivers or as recipients of care. At the same time, we notice that competing interests can complicate the process of caring for people. We notice that there is always a paradox that arises when we try to get involved in the life of a sick person (as demanded by the call for compassion), and at the same time trying to let the other person enjoy personal freedom (by respecting his or her autonomy). Margaret Farley points out this paradoxical relationship that exists between compassion and respect when she affirms, “Compassion itself draws us to persons, arrests our gaze and focuses it, so that we cannot pass by

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[190] Gorovitz, *Doctor’s Dilemmas*, 108.

[191] David M. Price, “Hard Decisions in Hard Times: Making Ethical Choices During Prolonged Illness,” in *Living With Grief When Illness is Prolonged*, eds. Kenneth J. Doka and Joyce Davidson. (Washington D.C.: Hospice Foundation of America, 1997), 51-52.

them in their need. Respect tells us what is required, what is just, in compassionate response. Compassion leads us within and beyond the requirements of respect."[192] There is always some paradox when we want to offer both respect and compassion.

Virtue is good but does not eliminate suffering

Being virtuous enables people to deal with many problems although it does not eliminate health challenges. The way we understand virtue and our growth in virtue influences how we become loving and caring towards others. When we are virtuous, we get inspired to work for the benefits of the people in need, not just pursuing our own personal interests. Good people do right acts; the tendency to live virtuous lives is the expression of goodness. The Church teaches that "circumstances of themselves cannot change the moral quality of acts themselves; they can make neither good nor right an action that is in itself evil."[193] A virtuous person is inspired by good intentions to do good. However, according to Kant, good intentions are not enough; a right action must be done out of a sense of duty, i.e., a desire to do the right thing solely because it is good.[194] In this case, Kant does not focus well on the possibility of a moral conflict wherever there is a choice between two good ideas. Virtue makes a good person to desire the right things because the person is virtuous, and hence the person could apply prudence to make a decision regarding multiple choices.

Virtuous health workers respect medical rules but also go beyond the rules. While virtue is not strictly tied to the fulfillment of rules, having some rules is helpful in virtue development because they help people to form habits, just as children benefit from the simple rules given by

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[192] Margaret A. Farley, *Compassionate Respect: A Feminist Approach to Medical Ethics and Other Questions* (Mahwah, NJ: Paulist Press, 2012), 80.
[193] *Catechism of the Catholic Church*, 2nd ed. (Washington, D.C.: United States Catholic Conference, 2000), 1754, accessed on December 3, 2015. Available at http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c1a4.htm
[194] Gorovitz, *Doctor's Dilemmas*, 86.

parents, e.g., for hygiene, for crossing roads safely, etc. As Kotva affirms about virtue ethics, "the important point is that rules serve the virtues; the virtues do not serve the rules. Rules and principles assist in the acquisition and execution of the virtues."[195]

Good practice of healthcare delivery involves the establishment of good patient-physician relationships. A lot of the ethically appropriate actions that doctors should or must do are not necessarily written down as rules; however, the doctors are expected to judge often whatever is beneficial to the patient and to the society in general. The character of the healthcare providers influences the quality of healthcare services and hence the workers are called upon to be virtuous.

The practice of medicine in ways that are virtuous does not entirely depend on obeying every bit of every law that is stated, particularly because the circumstances of various patients vary in some specific ways. However, a virtuous caregiver can offer services that are tailored to the needs and circumstances of every patient according to the available options. When we are led by virtues, "no formula or calculus will direct us in every instance. An outline or helps and hints can be offered, but the rest must be filled out in experience and practice."[196] Some of the decisions that involve a dying patient may be made according to various hints that the patient, or the surrogate, may have expressed.

Adjustments are always necessary to ensure that ethically acceptable actions are pursued. Therefore, different cultures and patient's contexts affect the way in which healthcare services can be offered in virtuous ways. As Drane writes, "Not everything about medical ethics which focuses on character and virtue is perfectly clear, but there is enough clarity to proceed in broad,

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[195] Kotva, *The Christian Case for Virtue Ethics*, 36.
[196] Ibid., 39.

general strokes toward outlining the content of such an ethics."[197] Benevolence helps a doctor to offer better services to a patient. Benevolence disposes a healthcare worker to take the patient's personal experience seriously and to try to work with the patient's experiences, even in the absence of objective verifications.[198] A benevolent attitude disposes a doctor to the patient's needs, intimacies, personal concerns and fears and recognizes that they are related to a patient's illness.[199] Such a comprehensive attitude enables a doctor to take care of a patient's whole person rather than treat the latter as just a body.

Virtuous actions need to be not only comprehensive but also realistic. The Christian tradition has sought a middle ground between medical vitalism (the desire to preserve life at all cost) and medical pessimism (the tendency to eliminate the life that is too burdensome, unproductive, useless or frustrating) by defending the values of life, health and responsibility in stewardship.[200] To attain this end, the doctors have to acknowledge the limits of what can be done and what cannot be done, and to discuss that with their clients. Among some scholars, there is a new level of humility to acknowledge that medicine and scientific advances cannot do everything that people desire. For example, Gawande invites other healthcare providers to appreciate the helplessness of medicine and healthcare in certain circumstances. Gawande notes that the fear of death and the desire to affirm a patient's hope for a cure has affected how we deal with one another; hence, doctors are "especially hesitant to trample on a patient's expectations."[201] However, the progression in virtues can help the doctors to face the challenges honestly and prudently.

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[197] Drane, *Becoming a Good Doctor*, 19.
[198] Ibid., 36.
[199] Ibid., 37.
[200] Richard J. Devine, *Good Care, Painful Choices: Medical Ethics for Ordinary People*, 3rd ed. (Mahwah, NJ: Paulist Press, 2004), 94.
[201] Atul Gawande, *Being Mortal*, 168.

Medical and pastoral services should be a good avenue for people to act virtuously. The success of such services is influenced by both the strategies applied and the goals desired. The services offered need to be accepted by the recipient and have a reasonable degree of success. The goals desired include helping a sick person to cope with illness, and a dying person to cope with his/her multiple challenges, which include the fulfillment of cultural obligations. This position acknowledges that all people belong to some culture and the care of people at the point of impending death is the expression of that culture. The Second Vatican Council teaches that human beings come to a true and full humanity only through culture.[202] Therefore, virtuous healthcare workers should try to balance the patient's desires (including cultural obligations) and the realistic medical possibilities, possibly by applying the virtue of prudence.

Serious illnesses cause massive changes in patients. In the face of a life-threatening illness, a patient and the family may be overly optimistic about the outcome of an illness but still recognize the possibility of imminent death; that realization becomes a source of anxiety. While they hope for recovery or a halt to the deterioration of health, they remain concerned about different possible favorable or unfavorable outcomes. Healthcare providers need to be well equipped to recognize the varieties of challenges that patients and families go through in the course of any one sickness. A palliative-care specialist, Dr. Susan Block, affirms that engaging in conversations with patients and their families regarding the end-of-life care is a procedure that requires good skills; this is because while, on the one hand, the doctors are expecting to find out information about what the people want, the family on the other hand is struggling to deal with anxiety about death, suffering, and finances, among other issues.[203]

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[202] Second Vatican Council, The Pastoral Constitution on the Church in the Modern World *Gaudium et spes:* (December 7, 1965) §53, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html

[203] Gawande, *Being Mortal*, 182.

With the rise in the risk of liability, and a greater prominence of patient's autonomy and rights, many decisions are made by a patient and/or the family rather than by medical personnel. Healthcare workers explain the options available for treatment but the patient or the family decides. This way of proceeding presents certain drawbacks eventually, especially in the process of grieving if the patient dies. While some family members may feel angry or guilty because of their decisions, the outcome may exacerbate some family conflicts if members of the family blame one another for the choices that they made.[204]

Health challenges call upon people to make decisions that are sometimes difficult. The advice that is given by physicians, friends, government policies, legal experts, etc., can be influential and yet the patient or his/her family (often in consultation with healthcare providers) has to make the final decisions. Subsequently, patients not only suffer from illnesses but also from the demands of their social circles and sometimes from the expectations of healthcare providers. The family could be exerting pressure on a patient to accept a kind of treatment that is not helpful to the patient. Under such pressure, some patients accept certain treatment plans because they do not want to cause any pain to the family. Actually, "According to Dr. Susan Block, about two-thirds of patients are willing to undergo therapies they don't want if that is what their loved ones want."[205] When the doctor realizes that a family is putting unjustifiable pressure on a patient, then the doctor could tell the family that their pressure is not helpful and that the patient may not even want the kind of procedure that they are proposing.

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[204] Doka, "When Illness is Prolonged: Implications for Grief," 12.
[205] Gawande, *Being Mortal*, 186.

Healthcare in Kenya

The Kenyan health sector has some semblance to the healthcare system in USA. While the threats of litigation in Kenya are not as serious at the moment as they are in the United States, the use of intensive care services is increasingly growing. Sometimes, families are forced to sell their property for the sake of paying for treatment. Some highly specialized hospitals have many senior doctors while many peripheral health units have very little facilities and limited personnel; this shows the skewed distribution of personnel, which is predominantly associated with the distribution of wealth.

In some ways, the Kenyan situation resembles the American situation that Charles Camosy describes as challenging. In his book, *Too Expensive to Treat? Finitude, Tragedy, and the Neonatal NICU,* Camosy argues that there is a tragic dimension in medical decisions and it is built around two inevitable conditions: that we have virtually unlimited health care needs and that we have limited health care resources.[206] Camosy's big question is whether an exceedingly high cost of treatment associated with a handicapped infant's medical treatments and care can ever be judged excessively burdensome for the society at large.[207] Camosy appreciates the ability of family members to seek the welfare of the otherwise voiceless neonate; however, the relationship among human beings extends to the wider society with whom the neonate must share limited resources, including the services of medical personnel.[208]

In Kenya, most people receive their healthcare services from governmental hospitals and health centers. In this public sector, there is a cost-sharing program that makes people to pay part of the cost of treatment out of their personal resources since the government subsidizes treatment

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[206] Charles C. Camosy, *Too Expensive to Treat? Finitude, Tragedy, and the Neonatal NICU* (Grand Rapids, MI: William B. Eerdmans, 2010), 1.
[207] Ibid., 73.
[208] Ibid., 100.

in the public health sector. For the poor people, even the subsidized healthcare services remain unaffordable and such people can only receive very basic care that the government guarantees to everyone. Some Kenyans have health insurance, often as part of employment, and this enables the beneficiaries to receive greater health services from the public sector or from the private health sector.

Many Kenyans have no health insurance and hence poverty often stops them from seeking healthcare in the first place. A study by Japheth Oyatsi Awiti showed that many poor Kenyans fail to utilize even the little healthcare services available because they cannot afford it or because the health facility is far from home.[209] To solve this problem, the government's limited healthcare allocation of resources should start by prioritizing the delivery of basic care to the marginalized people before embarking on adding more opportunities for the services that only the rich can afford. The expectations of distributive justice would demand that the government should intentionally promote the welfare of the poor and the marginalized. In another study carried out by Jane Chuma, Thomas Maina and John Ataguba, entitled, "Does the Distribution of Health Care Benefits in Kenya Meet the Principles of Universal Coverage?," the researchers recognized that in many countries there is inequality in the way people receive government's support that varies among the social classes.[210] These scholars wrote, "Although governments subsidize health services in many countries, evidence suggests that the rich benefit from government subsidies more than the poor."[211]

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[209] Japheth Osotsi Awiti, "Poverty and Health Care Demand in Kenya," in *BMC Health Services Research,* vol. 14: 560 (published online November 22, 2014), accessed on November 19, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4243287/

[210] Jane Chuma, Thomas Maina and John Ataguba, "Does the Distribution of Health Care Benefits in Kenya Meet the Principles of Universal Coverage?," in *BMC Health Services Research,* Vol. 12: 20 (published online January 10, 2012), accessed on November 19, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3280172/

[211] Ibid.

Most of the Kenyan population is unemployed and they cannot afford expensive means of treatment. There is need for strengthening the public healthcare system, including the addition of more health personnel and facilities. Kenya has less than 8,000 registered doctors, of whom, only about 2,300 work in the public hospitals to care for a population of over 40 million people while the other doctors are in the private sector.[212]

The cultivation of virtue can enable leaders to allocate health resources in ways that promote the welfare of all patients, especially the most vulnerable. Chuma, Maina and Ataguba concluded, "Kenya has had a very developed private sector for the last two decades, but public hospital services remain pro-rich. Alternative strategies to ensure that resources allocated to public hospitals benefit everyone who needs them are required."[213] They also added, "In a country like Kenya, where there is a significant private sector, and where people access public services on the basis of ability to pay, questions regarding the role played by the public health system in addressing inequities remain."[214]

Some of the ways of helping Kenyans in dealing with healthcare challenges include: encouraging the link between the needs of a patient and the strength of his/her family; encouraging people to become more virtuous in their lives; improving the dialogue between patients and physicians; providing legislation that supports better care and protection for the most vulnerable patients; strengthening the professional bodies that supervise healthcare standards; promoting the use of palliative care; promoting spiritual care; encouraging people to write their wills so as to make their desires known; emphasizing the formation of ethics

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[212] Aruyaru Stanley Mwenda, "From a Dream to a Resounding Reality: The Inception of a Doctors Union in Kenya," in *The Pan African Medical Journal* (published online on January 25, 2012), accessed on November 18, 2016, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3283025/
[213] Chuma, Maina, Ataguba, "Distribution of Health Care Benefits."
[214] Ibid.

committees in hospitals; and even consulting the wisdom that comes from people's cultural and religious traditions.

Focusing on the family in terms of care

The great level of autonomy promoted in the Western world, particularly in the United States is not prevalent in Kenya. Kenyans generally involve the patient's family in decision-making processes. Quite often, it is the family that together makes decisions regarding treatment according to the advice of the doctors. The patient's desires are closely tied to those of the family. This situation is similar to the observation made by Camosy that social considerations are "essential and primary considerations" when making treatment decisions.[215] Financial issues inevitably influence the patient's decision since it is the whole family that pays for healthcare. Very few Kenyans have health insurance and therefore most health services are financed through the support of family and friends.

Such interaction within families strengthens the social bonds among the people, influencing people to desire that the significant events of their lives be conducted within their family circles. According to Julia Downing *et al.*, a population-based street survey conducted in Nairobi (submitted for publication in August 2013) showed that most Kenyans would like to be told if they had limited time to live, and would also like to receive their end-of-life care at home in the company of their loved ones.[216]

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[215] Camosy, *Too Expensive to Treat?*, 102.
[216] Downing *et al*., "Public Preferences and Priorities for End-of-life Care in Kenya."

Promoting the practice of virtues

The making of a crucial medical decision exposes the need for the expression of virtues. Human beings are rational creatures and hence have to deliberate in their minds whatever decisions appear appropriate for every set of circumstances. When people are guided by virtues, then they are in a better position to make good decisions and implement appropriate actions, whether they choose to pursue certain medical procedures or to avoid certain procedures. As habits, virtues perfect the powers of the soul for action. As Aquinas says, virtue makes the works of a person good and also makes the person who possesses virtue to be good.[217]

Whenever a decision has to be made regarding the treatment of a patient, then any decision that is reached on a case-by-case basis can benefit from the application of the cardinal virtues. Every decision to achieve the goal of care for a patient requires a rational direction (granted by prudence), a correct choice that will produce the good ends (granted by justice), keeping one's attention on the chosen goal by moderating any inclinations that might lead away from it (fulfilled by temperance), and one must be resolute in overcoming obstacles on the way to that goal (fulfilled by fortitude).[218]

Virtue, according to Christian teaching, makes a person to aim for the supernatural end of human life, a consideration of the relationship that people have with God. This attitude invites a person to focus not just on the welfare of the bodily health but also the integrity of the soul, and by extension, the relationship of each person with God and with other people. Under such circumstances, the pursuit of health needs not compromise the human relationships that the person is engaged in. People that have different religions, nationalities or professions, could be linked by the application of virtues, particularly when such people have to work together for a

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[217] ST, I-II, q. 55, a. 3.

[218] Houser, "The Virtue of Courage (IIa IIae, qq. 123-140)," 308.

common goal, e.g., provision of healthcare to the very needy. This kind of cooperation would be very helpful in Kenya.

The virtue of prudence helps a person to apply practical reason to discern the true good in every situation and to choose the right means of achieving that good. The virtue enables a person to apply the means that are available to him/her for the sake of one's (or someone else's) health and to take the necessary steps. Some medical interventions are available in the developed countries but would be too expensive for people in poorer or developing countries. For example, a poor person from Kenya should not put his/her family under undue pressure to spend the little money that they have on very expensive treatments when facing a foreseeable death unlike what some other people in the Western world do when the latter can afford that kind of treatment. The doctors in Kenya need not to encourage such actions.

From a Christian point of view, the virtue of prudence also guides people to make decisions that do not cause scandal, either by omission or commission. This observation would be particularly important for healthcare workers, Church leaders and pastoral agents whose word may be taken as authoritative and yet it could be misinterpreted or wrongly applied. Using prudence, Kenyans can follow various protocols that include prioritized allocation of resources, development of health bylaws, triage of patients, and such other practices that help to promote good care of the citizens despite the economic challenges that the country faces.

Being a virtue, justice is not just an act but also a habit, and therefore a just person gets better by practicing justice. On the other hand, any act of injustice injures other people and also harms the acting agent by altering the person's attitude towards the larger society. In the interests of justice, the poorly funded health system in Kenya would benefit from the participation of more people in the funding and uptake of healthcare services. The call of justice would invite more people to join the available health insurance schemes, particularly the program offered by the government because it is much cheaper than other private insurance policies. The National Hospital Insurance Fund allows the participation of Kenyans who do not have formal employment and allows them to get health insurance for themselves and their families. Such an arrangement would ensure that more people share the burdens and enjoy the benefits of the healthcare that the country can offer. Such sharing of the cost of healthcare with other people would make the services more available and affordable.

The virtue of fortitude helps a person to deal with serious challenges, for example, whenever the person must confront danger in the performance of his/her duty or when facing a serious illness. When a person has to live with and care for a dying patient, as a health worker or a health surrogate, then the person needs to manifest courage in one's actions, especially in making serious health-related decisions. Fortitude does not include bold reckless actions in which a person takes unnecessary risks but neither does it involve inordinate fear that would make a person to avoid what virtue requires. Hence, in taking care of an imminently dying person, every caregiver should aim at promoting the welfare of the other person but also avoiding unnecessary risks (legal or otherwise) to the self. In Kenya, the threat of litigation associated with healthcare delivery is currently quite low. All the same, the threat of legal action should not immobilize a healthcare provider from doing whatever he/she holds to be correct or morally good.

By promoting the habit of moderating one's desires, the virtue of temperance would help a sick person not to insist on non-beneficial treatment, especially in ways that hurt his/her family or personal resources. Similarly, a temperate person would not be inordinately attached to personal comfort at the expense of treatment requirements and against any rational decision. For example, if a person has a diseased organ that needs to be surgically removed, a temperate person would be expected to let go of the diseased body part for the sake of personal health and the welfare of the other people who are hurt by the disease burden. Moreover, cultivating the virtue of temperance can help people to let go of some unrealistic expectations that block the people from making appropriate healthcare decisions, whether concerning themselves or their loved ones. In this regard, patients and their loved ones could also be encouraged to release and spend the resources that are needed to finance medical treatments rather than holding on to the resources at the expense of personal health.

As a manifestation of temperance, doctors should also be ready to discontinue certain medical interventions whenever it is medically clear that those efforts are unhelpful. For example, it may be considered inappropriate to engage in major surgery for a patient who is imminently dying rather than providing comfort care to that patient. As Diamond states, "The physician is obligated to safeguard life but he is not obligated to prolong the process of dying."[219] Such an attitude would be helpful in a poor country like Kenya.

Aquinas points out the indispensable role of the virtue of charity with regard to the application of the cardinal virtues. Charity enables people to recognize the ultimate end of humanity, that is, the supernatural end. Based on Christian teaching, Aquinas holds that the supernatural end of humanity and human works is mediated by charity and hence it is infused by God; therefore, infused prudence cannot be without charity, just as the other moral virtues cannot be without prudence.[220] In this way, Aquinas does not rule out the possibility of people having cardinal virtues that are not infused by charity, such as happens among nonbelievers, since it is possible to acquire moral virtues by human works in so far as those virtues produce good works that are directed towards an end not surpassing the natural human power.

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[219] Diamond, *A Catholic Guide to Medical Ethics*, 33.
[220] ST, I-II, q. 65, a. 2.

A virtuous person acts with integrity and puts into actions the decisions that have been made with a clear conscience. Such an attitude would be particularly helpful because certain decisions have great impact in the lives of other people. We live in a world where the resources are scarce and the demands remain high. In the use of limited resources to promote health and save lives, decisions are made to triage patients and sometimes to support only those people with better chances of benefiting from the resources and surviving. In such cases, justification for determining who should have access to limited resources could be made on the basis of relative probabilities for survival.[221] Such decisions must be made in good conscience. The subjective and intrinsic norm of human decision-making is the conscience, which could be defined as "the practical judgment of reason upon an individual act as good and to be performed, or as evil and to be avoided."[222]

A new interpretation has enriched the application of cardinal virtues in daily life, making them appropriate in addressing some very specific situations. In this regard, James Keenan identifies that the virtuous person, who has to balance the demands of different relationships, can rightly name the cardinal virtues differently; to this end, he identifies the cardinal virtues as justice, fidelity, self-care and prudence.[223] This approach could be specifically appropriate for a dying patient because all the available treatment options inevitably affect the person's multiple relationships, that is, with oneself, with one's close family or friends, and with the whole of humanity. The patient is a relational being in general and hence is influenced by the virtue of justice; he/she is also a relational being in a specific way and hence needs to be guided by the

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[221] Gustafson, *The Contributions of Theology to Medical Ethics*, 64.
[222] Kenny, *Principles of Medical Ethics*, 12.
[223] Keenan, "Proposing Cardinal Virtues," 723.

virtue of fidelity; and the patient is also a relational being in a unique way and hence he/she is called to self-care.[224]

Every person is an integral part of the community; his/her suffering or wellness affects the welfare of the entire community. Any decision that mismanages such a person, for example, by inducing a sudden death, or using undue amounts of the community's resources to prolong the person's death, would affect the whole community in the long run. Some people consider good healthcare only in the context of the benefits they notice at personal level. For such people, "adequate care means adequate benefits, benefits that meet human wants or needs."[225] Such people would hardly focus on the needs of the wider society beyond them and their loved ones. However, as Camosy affirms, "Part of what it means to live in right relationship is to use only a proportionate amount of resources available in one's community."[226]

Ultimately, virtuous healthcare workers would be a significant group in promoting proper healthcare services in a country like Kenya, despite the country's low level of development. Health workers are expected to act with a good conscience when caring for patients, especially the poor patients who have very limited resources. A doctor who assesses that a certain patient has very little likelihood of benefiting from expensive treatment should be slow to offer that option, especially if the medical intervention comes at a great cost to the patient or his/her family. A doctor is expected to offer advice that he or she holds to be accurate. The health workers have an obligation to be realistic, letting a patient and his/her family to know their options and the expectations of what can be done, and what cannot be done regarding any end-of-life situation.

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[224] Ibid.

[225] Edward Collins Vacek, "The Emotions of Care in Health Care," in *Medicine and the Ethics of Care*, eds. Diana Fritz Cates and Paul Lauritzen (Washington D.C.: Georgetown University Press, 2001), 106.

[226] Camosy, *Too Expensive to Treat?*, 204.

Promotion of dialogue between patients and physicians

In the management of severely ill patients, Kenyan healthcare workers need to work with patients and their families with a hope of making decisions jointly. Such an arrangement would not only reduce the threat of legal challenges against the medical workers but also would be respectful to the wishes of patients and promote the autonomy of the patients.

Kenya as a country can learn from, and apply some of the protocols developed by the American Academy of Pediatrics (AAP), particularly from the AAP's policy statement entitled "Noninitiation or Withdrawal of Intensive Care for High Risk Newborns." In that statement, the AAP recommends that whenever the prognosis is poor, medical decisions should be made jointly between the medical personnel and the patient's family, and in case the physician has to make a decision before consulting with the family, then the physician should choose to start intensive care and continue with reevaluation while awaiting a joint decision.[227] This ensures that any possibility of error leads to the defense of human life rather than its destruction. The AAP provides an important way of resolving differences should there be disagreement between the healthcare team and the family regarding the care of a patient in danger of death. The AAP writes, "When the healthcare team is unable to agree on a treatment strategy, the physician, serving as the team leader, should attempt to resolve existing differences by using an independent medical consultant or consulting with the hospital bioethics committee."[228]

Despite considering the welfare of parents and other persons affected by the life of a particular patient, the physician's first responsibility is to the patient. Hence, with reference to children, the AAP states, "the physician is not obligated to provide inappropriate treatment or to

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[227] American Academy of Pediatrics, "Noninitiation or Withdrawal of Intensive Care for High Risk Newborns," 402.
[228] Ibid.

withhold beneficial treatment at the request of the parents."[229] This approach of the AAP regarding the care of newborns could be applied to the care of other people whose healthcare surrogates may not necessarily be the parents.

Dialogue between physicians and patients would be very important in order to avoid some of the challenges that are associated with the desire for autonomy. In the earlier years of embracing greater respect towards the patients' views, the patient's autonomy and self-determination were expressed by refusal of treatment; however, that position has slowly expanded to include the demand for certain measures of treatment, a situation that makes the doctors to reject the various forms of treatment that they consider to be futile.[230]

Vitalism, supported by technology, can give people false hopes regarding what science can do. Some people can fail to see the reality of impending failure of treatment and the inevitable death of a loved one; hence, they insist on the misuse of scientific resources to pursue ends that are not fruitful or that are in fact wasteful. Richard McCormick, in his article "To Save or Let Die: The Dilemma of Modern Medicine," analyzes the challenges of vitalism (preserve life at all cost) and pessimism (any unsatisfying life to be ended) and shows how some people could be misguided in making crucial decisions. He suggests that a society needs to make guidelines and norms to deal with such subjective opinions.[231] Some possible objective norms could include a plan to have every difficult medical decision reviewed by an independent medical consultant or by a hospital's ethics committee.

The expression of personal autonomy requires to be regulated in certain situations. Franz Ingelfinger recognizes the challenges produced by the exercise of autonomy of patients in medical matters and proposes that strong and authoritative opinions from physicians would have

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[229] Ibid.

[230] Devettere, *Practical Decision Making in Health Care Ethics*, 53.

[231] McCormick, "To Save or Let Die: The Dilemma of Modern Medicine,"172-176.

a positive role in medical practice. He affirms that good medical care and the personal encounter between a patient and a physician should have a certain measure of authoritarianism, paternalism and domination.[232] These features need to be balanced with the patient's exercise of autonomy in a delicate balance. In this case, Ingelfinger holds that many people who have multiple choices, and those who exercise autonomy as they make their choices, can at times suffer from being unable to make viable decisions. However, those people who trust their physician to make a definitive decision have a chance of arriving at a decision and carrying on with treatment much more quickly and peacefully.

Therefore, there are some advantages associated with the practice of having doctors make the medical decisions, explain them to the patients and have the patient approve those decisions since the doctors often understand the treatment plans better than patients. However, despite this advantage and its associated efficiency, such a system would be open to abuse of the freedom of the patient. In countries like Kenya, paternalism is prevalent. This is the result of a situation in which there is a high level of trust and respect accorded to doctors, and also there is a cultural practice of following the opinions of senior members of the community rather than challenging them. Kenya has significantly fewer doctors and fewer treatment options. Hence, most people would rather go by what their doctor suggests rather than ask for alternatives. One way of improving this kind of care is for the doctor to know the patient better and not just the disease affecting that patient.

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[232] Franz J. Ingelfinger, "Arrogance," in *The New England Journal of Medicine*, vol. 303, no. 26. (Dec 25, 1980), 1507.

Legislation

Legal mechanisms can be applied in order to promote ethical practices of healthcare delivery. Just as the development of some legally binding practices have influenced healthcare in the West, Kenya can adopt certain changes that can help patients and healthcare workers. For example, Kenyans can be encouraged to write legally binding wills while they are in good health. The written directives can then help to express the person's desires if he/she becomes incompetent or unable to make healthcare decisions. Such directives can be reviewed with a medical and a legal team to ensure that the instructions contained in them are feasible.

A study carried out in various parts of Kenya supported the view that integrating legal support into healthcare enables vulnerable and marginalized groups to access justice and to address violations that undermine their health. In the study, which focused on the health of people living with HIV, Sofia Gruskin and her colleagues established that "legal empowerment programmes have the potential to promote accountability, reduce stigma and discrimination and contribute to altering unjust structures and systems."[233] The improved care helps the concerned patients and also improves public health policies because the benefits of justice extend to the wider community.

Among the legal positions that Kenyans would need to clarify would be a determination of the criteria for death, and particularly informing the public about the difference between brain death and the death associated with irreversible cardiorespiratory arrest. The brain-based criterion is often criticized because the hope of getting organs for transplantation raises a risk of declaring dead a person who is not yet dead. Some people see the development as a hidden

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[233] Sofia Gruskin, *et al.,* "Access to Justice: Evaluating Law, Health and Human Rights Programmes in Kenya," in *Journal of the AIDS Society*, 2013; 16(3 Suppl 2), (Nov. 13, 2013), accessed on Nov 18, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833108/

agenda to qualify donors for transplantation, particularly of unpaired organs.[234] Usually this risk is avoided by ensuring that the physicians involved in the transplantation do not have any contact or affiliation with the physicians that declare the patient dead.[235]

The pursuit of a patient's rights need not to become an excuse to tramp over the rights of the physicians, particularly the physicians' desire to pursue only what they consider to be right and ethical. Dr. Robert D. Truog, in analyzing a case of medical futility in Texas, stated that the medical fraternity could also express their right to proper ethical work. He wrote, "Clinicians may justify their refusal to treat on the basis of their right to refuse to participate in medical interventions that they believe violate their moral integrity."[236] This shows that while the law defends the rights of patients to be treated well, the law also needs to defend the right of clinicians to act according to good medical practices. Accordingly, the law may "serve a useful purpose when patients are subjected to unwarranted pain and suffering or when clinicians have defensible claims that these demands compromise their moral integrity."[237] The law of the land should be a neutral arbiter in such disputes.

Strengthening of medical professional bodies

The government needs to strengthen the legal status of professional bodies. Encouraging oversight and supervision of healthcare delivery through recognized administrative bodies can ensure a good degree of self-regulation in the health sector. A good system of healthcare delivery ought to be accountable to a set of rules for the professionals to follow for the benefit of the community. Accountability ensures that there is a structure that assesses the standards of care.

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[234] Diamond, *A Catholic Guide to Medical Ethics*, 29.
[235] Ibid., 30.
[236] Robert D. Truog, "Tackling Medical Futility in Texas," 2.
[237] Ibid.

Professional bodies would provide a health worker with a reliable additional mechanism of gauging the rightness of his/her actions and also provide patients with a greater assurance that they are receiving ethically appropriate services from the health sector.

There is always an ongoing risk for doctors and hospitals to be sued by patients. This risk could be reduced if the hospitals develop their own ethics committees rather than seeking judicial decisions whenever a patient feels maltreated. Some of the guidelines that professional bodies have developed place the burden of making decisions squarely on patients or their legal representatives and hence spare the doctors from some difficult decisions and any associated liability. Doctors in different specialties should develop their own guidelines for the sake of maintaining good standards (for the benefit of patients) and to serve as reference points for ensuring quality of services (an internal quality control mechanism that can also protect the doctors from getting into law suits).

Promoting palliative care

Nowadays, palliative care is providing something close to the *ars moriendi*. While describing the historical development of the *ars moriendi* tradition, Christopher Vogt points out that the idea of a good death has strongly revolved around the practices of expressing patience in the face of difficulties, showing compassion to the suffering, and recognizing the Christian hope that is based on God's love and mercy.[238] This view emphasizes the Christian dimension of the practices that different people have engaged in the past to help them cope with the inevitable pain associated with severe illness and death.

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[238] Christopher P. Vogt, *Patience, Compassion, Hope, and the Christian Art of Dying Well* (Lanham, MD: Rowman & Littlefield Publishers, 2004), 5.

Palliative care places more emphasis on the comfort of the patient rather than on the aggressive treatment against the illness affecting a particular patient. Once an illness has been recognized as incurable, particularly when death is foreseeable in a short time, the priority of services involves providing care that keeps the patient comfortable and prepares the family for the death. The components of palliative care would include pain relief, ordinary treatment of symptoms, nursing care, spiritual support, social and psychological support, bereavement counseling, etc. Since Kenya already has a number of hospices, the government and other benefactors could allocate more resources to support the work and the extent of these establishments, and increase their number.

Some studies have shown that when people get to talk about end-of-life issues that are associated with failing health and death, they tend to make better decisions and to cope better with their illnesses. One success story occurred in La Crosse, Wisconsin, where the practice of discussing end-of-life issues with patients and their relatives led to an improvement of the general outcome of healthcare services and actually brought down La Crosse's end-of-life costs to just over half the national average.[239] The Kenyan society needs to emphasize the provision of comfort care wherever heroic methods of treatment are known to be unhelpful. According to William Lamers, hospice is "a program of care to terminally ill persons by an interdisciplinary team with emphasis on relief of distressing symptoms, provision of care in the home, inclusion of the patient and the family in the 'unit of care,' availability of bereavement services for at least one year, availability of spiritual care and respect for patient/family lifestyle."[240]

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[239] Gawande, *Being Mortal*, 180.

[240] William Lamers, Jr. "Hospice Care and Its Effect on the Grieving Process," in *Living With Grief When Illness is Prolonged*, eds. Kenneth J. Doka and Joyce Davidson. (Washington D.C.: Hospice Foundation of America, 1997), 70.

The study by Downing *et al.* shows that many Kenyans place great value on psychosocial and spiritual needs, such as feeling at peace and having a sense of meaning in life.[241] The big challenge in Kenya, as in other parts of the developing world, is that palliative care has not developed well. Although cultural issues also influence this reality, there are low numbers of trained health workers, overstretched health systems and lower economic power of the countries that inhibit this development.[242] Therefore, the uptake of palliative care would need not just the allocation of resources but also some engagement with people's cultural attitudes.

Patients and their families need to be educated appropriately regarding the care of the terminally ill, especially when death is noted to be imminent. The healthcare providers, as they understand the prognostic features of illness, need to let the other people know the advantages of palliative care, and to appreciate them. Palliative care is not a way of giving up on treatment (fighting the illness) but an alternative way of treatment (comfort care). For the people who choose to make the Do-Not-Resuscitate (DNR) or Do-Not-Hospitalize (DNH) orders, they need proper understanding of what each of these decisions mean, and the prognostic assessment of the patient that has led the healthcare providers to propose them, and to understand why cardiopulmonary resuscitation (CPR) needs not to be done.

There are some people who always expect medicine to cure or to save the life of a loved one. Therefore, "when a disease is declared incurable, people often continue to hope that some miracle of medicine or some divine intervention will alter the course of the disease."[243] In such a context, the people would not accept that comfort care is a form of care, especially because they do not see the benefits that they desire. Such people have very specific desires. There are many

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[241] Downing *et al*., "Public Preferences and Priorities for End-of-life Care in Kenya."

[242] Ibid.

[243] Russel B. Connors Jr. and Chris A. Franke, "God and an Ethic of Care: On Being Immanuel," in *Medicine and the Ethics of Care*, eds. Diana Fritz Cates and Paul Lauritzen (Washington D.C.: Georgetown University Press, 2001), 208.

such people who are not open to the possibilities that recovery is not possible, and hence they avoid being helped to deal with some of their diseases whenever total recovery is medically impossible. Those people expect medical marvels or miracles that would help them not simply to cope with but to escape from sickness and suffering, that is, they do not look for a way through the problem but a way out of the problem.[244] For the sake of such people, palliative care needs to be publicized, encouraged and made more accessible.

Provision of spiritual care

Issues of health and sickness have a religious dimension because illnesses affect the body and yet the body helps us to fulfill our vision of life, our purpose and our goals. Serious illness thus shifts our focus from our goals to our sick body. During such a crisis, patients depend on doctors, "developing respect and affection for them, depending on them for information, looking for them for advice, orientation, protection, and perhaps even for deciphering the meaning of life and death."[245] In this case, the healthcare provider could become the person to respond to a patient's questions regarding life's ultimate meaning or the sources of hope when all human possibilities seem to be exhausted.

While people go through serious illness, families could easily enter into grieving as death approaches. The moment of diminishing can be associated with guilt, anger, sadness and other negative feelings. Among the helpful strategies that the family can adopt are remembrance and rituals. Reminiscence of previous experiences helps to reassure the patient that his/her life had

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[244] Ibid., 210.
[245] Drane. *Becoming a Good Doctor*, 29.

meaning and purpose, while rituals help the family to reaffirm a sense of control in an otherwise uncontrollable situation, whether the rituals are religious or symbolic.[246]

Religious activities can help in building people's faith and courage to enable them to deal with severe illness or to face death with the hope of future life. A Christian religious message is helpful as it opens a person to spiritual support built on the Christian hope that is announced by the Church. The Catholic Church's teaching reminds people that human beings do not have the final word regarding life and that God communicates to us in different ways. Our awareness of being creatures opens us to the appreciation of God as our Creator. Spiritual activities help people to acknowledge that God influences their lives. When a physician acknowledges that a particular patient considers spiritual matters to be important in his/her life, then the physician has the obligation to render the professional services to the patient to the best of the physician's ability, to express the prognosis to the patient (and to the relatives where necessary), and to acknowledge the patient's spiritual needs, especially if the patient is in danger of death.[247]

It would also be helpful for physicians and hospitals to work with chaplains. The chaplains could engage patients and relatives (if these are willing to take the offer) in reflecting on and discussing matters of spirituality and the ultimate meaning of life, especially when the patients are facing imminent death. Chaplains offer to the patients the opportunities to feel accompanied in their struggles, and are an outlet for the patients to share their personal concerns besides discussing matters that are directly related to the illness. Chaplains supplement medical care by helping patients to explore matters that are personal or fulfilling, even when the physical health is significantly diminished.

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[246] Doka, "When Illness is Prolonged: Implications for Grief," 13.
[247] Kenny, *Principles of Medical Ethics*, 51.

Religion plays a big part in the Kenyan society. Religious organizations provide education, healthcare services, and other social amenities. A lot of people, both rich and poor, draw support from religious teachings and hence the religious leaders often have a strong influence on people's behavior. Kenya is a country where religious voices are often well respected as sources of ethics. Apart from recognizing the religious teaching on morality, many Kenyans also look at religion as a source of solutions to their problems. Some of the Kenyans believe strongly in the possibility of faith healing, which makes the pursuit of miracles a popular religious practice.

In conclusion, I would like to highlight the importance of virtue ethics to the Kenyan health sector for the benefit of patients and healthcare workers. At the same time, I would affirm that theological reflection on the management of patients helps in expressing the various ways in which healthcare workers can act ethically in order to utilize the limited available resources for the welfare of many people without compromising the dignity of any person. In the context of virtue, the needs of every person ought to be balanced with the needs of the wider society since virtue links a person to the community through various relationships. This view can help to guard against selfishness or the utilization of the community's resources on the needs of just a few people. As Kotva writes, "Virtue theory views relationships and corporate activity as essential to both the true human end and the journey toward that end."[248]

Ultimately, a doctor working in Kenya could look at the strengths and weaknesses of the American medico-legal system (that has many choices, laws and expectations), and the passionate pursuit of patients' autonomy, and use that information in formulating treatment plans with families whose relatives are seriously sick. Despite the challenges, a patient should still be offered whatever is available and affordable, and treated with all the dignity that every human being deserves. Poverty and helplessness must never become grounds for neglecting the weak

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[248] Kotva, *The Christian Case for Virtue Ethics*, 108.

members of the human family whenever something can be done to alleviate their suffering. Similarly, the desire to pursue heroic treatments should not lead to the unnecessary prolongation of the process of dying or deny the healthcare services to other patients since the health resources are lamentably limited.

Conclusion

It is clear that legal and medical developments have opened new possibilities for the management of patients and the delivery of healthcare services. However, those results have been accompanied by the rise of new challenges, and subsequently, other attempts to keep up with the resultant ethical dilemmas. For example, advances in medical care have allowed the treatment of certain neonatal conditions that were previously untreatable. Subsequently, the health workers have to decide which patients qualify for whatever treatment options. The American Academy of Pediatrics, in the policy statement entitled "Noninitiation or Withdrawal of Intensive Care for High Risk Newborns" states, "It is inappropriate for life-prolonging treatment to be continued when the condition is incompatible with life or when the treatment is judged to be harmful, or of no benefit, or futile."[249] In this way, the AAP provided a recommendation that could be applied in multiple settings regarding the management of patients who require intensive care.

Medical and legal developments in the United States of America provide a lot of knowledge that can be adapted for use in Kenya by adjusting the practices of healthcare delivery according to the differences in culture, degree of economic development and other variations. In defending the human dignity of very vulnerable patients, the American healthcare workers developed certain protocols regarding the care of patients with prolonged incurable illnesses when death is imminent. Some of those protocols can be adapted for use in Kenya alongside living cardinal virtues among patients and healthcare providers.

As far as medical dilemmas are concerned, decision-making in healthcare will never be easy. The existence of different sources of ethics makes the decision-making processes to be more complex. For example, a doctor may be influenced by medical knowledge to identify that a

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[249] American Academy of Pediatrics, "Noninitiation or Withdrawal of Intensive Care for High Risk Newborns," 403.

certain patient is approaching imminent death, and hence the patient may not benefit from aggressive treatment. However, the religion of the patient or of the doctor may provide a contrary opinion regarding the possible kinds of treatment. Therefore, ethics remains a negotiable platform where different opinions are debated and the moral character of the people concerned is expressed in handling the challenge. This shows the complexity associated with the balancing of ethical stands from the medical profession, religious groups, the secular society and the legal structures – all affecting the same patient at the same time.[250]

While it is possible to recommend certain procedures to be done for a person who is dying, the multiplicity of possibilities that can lead to a patient's death makes it very hard to establish specific details concerning the actions that a person should aim to do in the face of all deaths. However, it may be possible to propose certain ethically acceptable activities that should not be done, e.g., a person should not be deliberately euthanized regardless of his/her health condition. On the other hand, when the process of death has begun, the medical team could choose to let natural death occur without attempting to interrupt it.

Allowing a severe illness to kill a patient (when it becomes clear that a patient is imminently dying and any medical intervention would be futile) is radically different from deliberately facilitating the death of a patient. In recognizing that life is a gift from God and that death is unavoidable, the CDF calls all people to recognize the importance of acting ethically and with a good conscience and respecting the dignity of humanity. In the "Declaration on Euthanasia," the CDF writes, "When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar

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[250] Robert M. Veatch, *Hippocratic, Religious, and Secular Medical Ethics: The Points of Conflict* (Washington, D.C.: Georgetown University Press, 2012), 92.

cases is not interrupted."[251] Therefore, a dying patient should still be provided with basic care, which would include pain relief, cleanliness, and the companionship of family and friends wherever possible.

In the context of ethical conduct, some of the activities that should not be done include:

a) Procedures that are primarily aimed at causing death, i.e., positive euthanasia.

b) Procedures that would only fulfill the personal interests of doctors but not help the patients, e.g., research activities whose primary interest is not the welfare of the patient, unless a patient has given informed consent to participate in a research project for the sake of promoting medical knowledge.

c) Procedures that disregard the welfare of other patients; instead, healthcare resources should be distributed justly, caring for the needs of the wider society rather than any single patient who demands vitalism. It would be imprudent to pursue medical futility when resources are very limited and many other patients need care.

Among the procedures that may be ethically done and that are respectful of human dignity is the administration of painkillers to patients that are in pain even if that medication has a likelihood of shortening the life of the patient.

Among the procedures that should be done, wherever possible, in the interests of the seriously ill or dying patient, the patient's family, and the wider community are:

a) Notifying the patient when the attempts to cure an illness have shown no success and when there is no feasible medical cure to the patient's illness. In case such news may appear very traumatizing to the particular patient, in the assessment of health workers, then the health workers need to try as much as possible to avoid giving the patient false hope. This action

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[251] Sacred Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," iv.

demands a lot of honesty, and sometimes humility, from the physician or medical team. Atul Gawande, in his book *Being Mortal*, invites the medical personnel to work towards this reality.

b) Engaging the patient's mechanism of social support, for example, the ability to interact with family and the other significant persons in his/her life.

c) Offering the patient the opportunity to deal with issues that give him/her the ultimate meaning, e.g., spiritual support for the religiously inclined persons.

d) Paying attention to the attitudes of patients and families towards death whenever the patient's medical condition suggests that death is imminent. This involves close interaction with the patient, or the patient's health surrogate in order to mutually explore the most appropriate way of handling the events surrounding death.

e) Considering the interests of other people when utilizing healthcare resources. These resources include equipment, personnel, medical knowledge, etc.

Since it would be quite hard to establish very specific mechanisms of ensuring ethically sound activities with regard to every medical condition, then it is necessary to prepare the patients and caregivers to cultivate an ethically appropriate attitude towards healthcare, illness, death and the common good. In this case, virtues can inform the process of medical decision-making to ensure that important decisions are made with a good intention, motivation and disposition.

A virtuous person would seek not the easiest but the best solution, e.g., the control of pain and discomfort when the disease is incurable. Virtuous healthcare workers may prefer to use antidepressant treatment for patients who fall into depression in the context of an incurable illness since this would reduce a patient's desire for a quick death rather than offering the patient PAS. Patients and medical workers need courage to acknowledge the limitations of medical care in the face of incurable illness, and the humility to acknowledge that there is a limit to what can be achieved by mortal beings in the face of imminent death.

Prudence can help a medical team working with a patient or the patient's family to make a good decision even at a time when they do not fully understand the potential outcome of an illness. This is because prudence "seeks to discern what is to be done now or in the future on the basis of knowledge of the present situation and past experience. Prudence gives one a sense of moral perspective."[252] Hence, a claim by a dying person's family or health proxy regarding the type of care the particular patient had earlier indicated that he/she would prefer should be seen as a prudent way of establishing and fulfilling the patient's wish.

Virtue ethics prepares people to make morally good decisions in multiple situations. Virtues do not limit a person's conduct to specific actions but help the person to develop an inclination to act prudently, justly and honestly. They inspire a person to act in the interests of justice for every patient and for the common good. In this thesis, I have tried to show that the proper management of illness is a multifactorial issue, a meeting point of social, economic, legal, psychological, religious and moral aspects of human life.

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[252] Nelson, *The Priority of Prudence,* 81.

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