Compassion has always been an essential aspect of medicine, but in the past fifty years, medicine has changed significantly—it has lost its sense of compassion. Human beings experience concern for the physical suffering of others, if for no other reason than because they could imagine such suffering happening to themselves.

This empathy was essential when diseases were not well understood and often not treatable. In the past fifty years, this situation has changed dramatically. Yet paradoxically, societal and scientific advances have made medicine less personal and therefore less compassionate.

**Patient Autonomy**

Medicine is both an art and a science. Early on, art was emphasized over science because there was very little medical experimentation, at least until Hippocrates, who employed observation and deductive reasoning. The scientific revolution in medicine began with Andreas Vesalius, William Harvey, and Rudolf Virchow, among many others. As their discoveries were applied to clinical situations, evidence-based medicine gradually became the standard, and diseases could be treated more reliably and more frequently cured.

Some came to the mistaken conclusion that the physician’s role in healing was less critical than that of the laboratory researcher. Soon patients were questioning many of their doctor’s decisions and taking advice from druggists, magazines, and television, often trusting these sources more than their family doctor. Inevitably, the doctor’s sense of compassion became less of a factor than the doctor’s expertise in the recovery of health.

In our own time, the ever-growing principle of patient autonomy has superseded “doctor knows best.” If the patient is able get something off the drugstore shelf that is effective and cheap, then why would he make a time-consuming visit to a crowded doctor’s office? As physicians became more dispensable, patient autonomy became ascendant. Patients who had previously depended on physicians for their health care turned to the notion of autonomy as the new standard in medical care.

Autonomy as a movement began with the Enlightenment’s “turn to the self.” Most prior philosophy was realist, that is, external reality was accepted as a given that informed the mind. With René Descartes’ “Cogito, ergo sum,” the mind or self became the focus; it supposedly had the independent power to structure the world through its own ideas. This subjective zeitgeist reflected the “individualism” of the Enlightenment period, which then begat “autonomy.” This trend accelerated after 1900, abetted by philosophers such as Fredrick Nietzsche, Sigmund Freud, and Georg Wilhelm Friedrich Hegel, and was coincident with the unprecedented horrors of World War I. The roaring, decadent 1920s followed, which laid the seeds for the later appearance of the women’s liberation movement, free sex, birth control, and a more general revolt against authority. Individual autonomy gradually became the ruling principle.

**Effect on Medicine**

Medicine was not immune to these changes. Autonomy is in great part the antithesis of compassion. As we focus on ourselves, we think less of others. This is reflected in the fundamental changes seen in the various medical philosophies, oaths, and declarations that set forth the governing principles of the art of medicine.

Up until about 1900, the Hippocratic and Galenic medical ethos prevailed. Abortion and euthanasia were expressly forbidden. Medical oaths throughout antiquity (using the Hippocratic Oath as a prototype) emphasized the sacredness of individual human life. This respect for human life is found in ancient Jewish and Muslim medical codes and is even expressed in the oath for Russian physicians in 1992. In the West, the World Medical Association advocated for “respect for life from the time of conception” at their 1948 Geneva Convention. This focus changed in the 1950s, when humanitarian and social goals were emphasized. “Service to humanity,” as a generalization, rather than compassion for the individual, has since...
become the mantra of the American Medical Association as well as most medical codes.³

Medicine faces many problems: rampant sub-specialization, the technological imperative, third-party control, and most recently, the politicization of health care, to mention a few. But the greatest problem is the general and pervasive sense that autonomy should rule medicine. We must humbly accept our human frailties. Autonomy contravenes against the reality of life. We are all more dependent than autonomous.

Compassion is the essence of medicine and what it means to be human. The work of the physician suffers when autonomy becomes society's master.

Patrick Guinan, MD

Dr. Guinan is clinical associate professor in the Department of Urology at the University of Illinois–Chicago College of Medicine and past president of the Catholic Physicians' Guild of Chicago.


3 American Medical Association, “Principles of Medical Ethics” (June 7, 1958), section 1.

HUMAN DIGNITY AND PRENATAL TESTING

A new wave of prenatal genetic testing has hit my specialty of maternal–fetal medicine: prenatal chromosomal microarray and noninvasive prenatal testing (NIPT). These tests have been clinically validated recently.¹ The American College of Obstetricians and Gynecologists issued a committee opinion in December 2012 regarding the use of NIPT.²

There seems to be little bioethical debate in the mainstream OB/GYN journals regarding the introduction of these tests. In April 2014, Mary Norton and colleagues published an article titled “Noninvasive Prenatal Testing for Fetal Aneuploidy: Clinical Assessment and a Plea for Restraint.”³ This article, while calling for restraint in the use of NIPT, limited the discussion to the inappropriate use of NIPT in areas where it had not yet been shown to be clinically validated. The article does state that obstetrics providers will absorb most of the burden of discussing the complex results that come from this testing and the accompanying potential for the selective termination of fetuses with genetic defects. It does not discuss the bioethics of abortion in the context of these complex results.

In August 2013, an article in the New England Journal of Medicine titled “A New Era in Noninvasive Prenatal Testing” warned that NIPT “seems to be drifting into routine practice ahead of the evidence.”⁴ This article was concerned with the inappropriate use of this technology within the setting of prenatal diagnosis, but did not address the bioethical issue of whether or not this type of testing should be used at all. In both this and the Norton article, it was assumed that this technology is already accepted and may become the standard of care; it was even referred to as an “exciting new technology,” while discussing the need for restraint with its use. Neither article addressed the more fundamental issues, such as pregnancy termination after ambiguous results or the decision to selectively terminate fetuses with detected genetic problems.

Pope Benedict XVI, in his writings on the topic of conscience, states that one source of morality is community:

A crisis in morality occurs in a community when new areas of knowledge emerge with which the current life patterns cannot cope, to the point that what up until then appeared as supportive and proven appears now as insufficient or, indeed, contradictory, or as an obstacle to the new knowledge and reality. Then the question arises, How can the community find a new way of life that will once more make possible a common moral existence for life and for the world itself? It remains true that morality needs a “we” and that it requires a link with the experience of past generations and with the primitive wisdom of humanity.⁵

Is the reason that there is limited bioethical debate about these tests because the current “life patterns” that exist in our community are more than able to cope with this new technology? Is it possible that this new era of prenatal testing faces no moral obstacle in our communities because it does not appear contradictory to current “life patterns”?

In Evangelium vitae, Pope John Paul II discussed the “culture of death” that had come about due to many cultural factors, not the least of which was the legalization of abortion.⁶ There may be no crisis in morality within our community concerning this new prenatal testing because it does not appear to contradict our current way of life. It has been introduced into a “culture of death” that allows abortion and does not recognize that the inherent dignity of human life begins at conception.

If NIPT and prenatal chromosomal microarray testing had been introduced prior to the legalization of abortion, then maybe there would be a more robust ethical debate regarding the links between abortion and testing. This technology would certainly still have been introduced, but it seems likely that only the potential benefits would have flourished. The community would not consider abortion or the selective termination of fetuses with disabilities, such as autism, to be morally justified. We would only look to the early intervention programs that improve the outcomes for these individuals, rather than worrying about whether or not these children would be terminated prior to birth. We would only be discussing transitions of care from pregnancy to childbirth and from infancy to childhood and attempting to build an infrastructure that would facilitate these transitions. We would not be focusing on
how to build an infrastructure that would facilitate the termination of individuals with Down syndrome or a myriad of unidentified neurodevelopmental delays that can now be detected. Would the infrastructure for the support of these individuals and their families be more of the focus if abortion were illegal?

Reflecting on the words of Benedict XVI, we can see that the new knowledge and reality of prenatal testing should be guided by the inherent dignity of every human life. Our current life patterns should resist the temptation of abortion and demand a robust ethical debate about pre-natal testing. This does not seem to be the case. Following Benedict XVI, we need to reassess how our communities can find a way of life that will once again validate a common moral existence for life and for the world itself.

Jay J. Bringman, MD

Jay J. Bringman, MD, MBA, is a specialist in Maternal Fetal Medicine at Geisinger Medical Center in Danville, Pennsylvania.


6 John Paul II, Evangelium vitae (March 25, 1995), n. 12.

TOLLEFSEN ON THE PHOENIX CASE

In the Euthyphro, Socrates asks whether something is good because it is loved by the gods or is loved by the gods because it is good. The first view is a form of legal positivism; on this account, something is good or evil simply because those in authority have declared it to be so. Legal positivism sees the law as an arbitrary invention of human beings. The second view is that of traditional natural moral law: something is recognized to be good or evil by nature. Those in authority understand that it should be favored or forbidden under the law because of what it is in its own right, independent of human judgment; they legislate in accord with that natural moral understanding. Thus, the written law follows nature.

Christopher Tollefsen, in his “Response to Robert Koons and Matthew O’Brien’s ‘Objects of Intention: A

Hylomorphic Critique of the New Natural Law Theory,” argues that Bishop Thomas Olmsted was right to find fault with the decision made at St. Joseph’s Hospital in Phoenix in its treatment of a pregnant women who suffered from pulmonary hypertension—but only on legalistic grounds.

Tollefsen holds that the bishop properly applied directive 45 of the Ethical and Religious Directives for Catholic Health Care Services (ERDs) to the case, but because that directive is not correctly written, what Olmsted condemned was not, in fact, immoral. To put it in terms that Socrates would have used, the surgical procedure was wrong because it was condemned; it was not condemned because it was wrong.

Tollefsen’s Argument

Tollefsen asserts that

One could acknowledge that the Phoenix procedure was an intentional termination of a pregnancy (and thus forbidden by ERD 45) yet deny that every such intentional termination (including, perhaps, this one) is an intentional killing. Indeed, NNL theorists do deny that; and, by at least my lights, ERD 45 should be revised so as not to conflate the intentional ending of a pregnancy (something that could be done, for example, by removing a previable child to an artificial womb) with intentional killing (which would not occur in the artificial womb case).

In other words, Bishop Olmsted’s decision was good because it conformed to the will of the United States Conference of Catholic Bishops as laid down in the ERDs. The bishop’s decision was not necessarily good when considered from the perspective of the natural law—at least not as that tradition is now interpreted by the new natural law (NNL) theorists.

Tollefsen’s remarks are significant because the work of the NNL theorists has been used to justify the decision at St. Joseph’s. In her “Moral Analysis of a Procedure at Phoenix Hospital,” a defense officially commissioned by the hospital, M. Therese Lysaught, like Tollefsen, argues that what occurred there was not a direct abortion.

The central moral question, as I understand it, is whether it is possible to directly strike the body of an innocent person, and so cause that person injury or death, without intending to cause the injury or death. Under the principle of double effect, one may indirectly cause harm to someone in the pursuit of a significant good; for example, a woman with a cancerous uterus may undergo radiation treatment even though the treatment indirectly harms her unborn child. The direct object of her act is the cure of the cancer; she does not intend to cause the child injury.

The problem in the Phoenix case is that the action of the physician appears to have been a direct assault on the body of the child. Lysaught tells us as much—and she had access to the relevant medical records. Tollefsen thinks highly of Lysaught’s analysis. He describes it as “the clearest and most thorough defense” of the case that he has seen so far. Like Lysaught, Tollefsen assures us that the “Phoenix procedure” should be understood as an act of unintentional killing.
Nub of the Question

On what grounds does Tollefsen defend the view that one may directly strike the body of an innocent person, and so kill that person, without intending to do so? This is the nub of the question put to the NNL theorists. It has been raised many times, but the answer given has always been—at least for me—exceedingly obscure. The reasoning of the NNL theorists seems to contain a hidden code that is intelligible only to fellow members of the club. Arguments are heavily nuanced and couched in hypotheticals. In the quote above, Tollefsen gives us his answer, and true to form, he answers with a hypothetical. Let us suppose, he says, that we terminate a pregnancy by removing the child and placing him into an artificial womb where he continues to grow and thrive. In such a case, the pregnancy has indeed come to an end (it has been “terminated”), but the child is not harmed! Interesting example, but it seems completely disconnected from the facts at hand. Tollefsen implies that not all intentional terminations of pregnancy are direct abortions. Agreed. But can we conclude from this that what happened in the Phoenix case was not a direct abortion?

In the Phoenix case, there was no effort to use an artificial womb. In fact, artificial wombs do not exist. Is Tollefsen’s point simply that so long as an artificial womb is a theoretical possibility, what happened in the Phoenix case is permissible? Why should a mere theoretical possibility have any bearing on the case at all? That approach makes this an argument not about practice but about logic. Later, Tollefsen acknowledges the possibility that managing a miscarriage could have been the physician’s intent is apparently sufficient to justify what the physician did indeed do, even if what he did was perform a D&C on a baby before fetal demise.

These are exceptionally difficult cases, but in the end, ethics is a practical discipline, not a theoretical one. Arguments need to address the facts of a given case, not reason from hypotheticals. The NNL theorists need to ask themselves how they can successfully persuade others in practical, rather than theoretical terms.

Edward J. Furton, MA, PhD
Editor, Ethics & Medics

2 Ibid., 772.
4 Tollefsen, “Response,” 774 note 53.
5 Ibid., 773, original emphasis.