Prospective Medical-Moral Decision Making

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Abstract. In recent articles, Daniel Gannon argues that, according to Catholic morality, morally good decision making about life-sustaining treatment is intrinsically based on in-the-moment circumstances. Measured against this moral criterion, Gannon finds physician orders for life-sustaining treatment (POLST) to be morally unacceptable and proposes his own medical order form. The authors argue here that Catholic moral teaching and tradition do not reduce the role of circumstances to those in the present moment and that such a reductive criterion undermines many of the sources of morality, including conscience, prudence, and moral principles such as the principle of ethically proportionate and disproportionate means. The authors also show that Gannon's criterion and form generate conceptual and practical contradictions, that POLST is not intrinsically evil, and that when properly implemented, POLST can be morally acceptable. *National Catholic Bioethics Quarterly* 15.1 (Spring 2015): 53–61.

In recent articles in *Ethics & Medics*, Daniel Gannon makes the following claims: that "from a Catholic perspective, a morally sound decision regarding end-of-life care flows from informed consent in the circumstances and medical conditions of that moment," and that the morality of refusing life-sustaining treatment is "intrinsically connected to the pathologies and circumstances of the present moment."[1] The impetus for these statements is the POLST (physician orders for life-sustaining treatment) paradigm and forms, which, according to Gannon, do not consider present-moment

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[1] Daniel Gannon, "Favor DNR/DNI Orders over POLST: A Compromise without Compromise," *Ethics & Medics* 39.10 (October 2014): 1, 3.

circumstances. Because of this lack, he argues elsewhere, "the paradigm of POLST is intrinsically flawed" in its nature.[2]

In what follows, we take issue with Gannon's reductionistic "in-the-moment" moral criterion for assessing life-sustaining treatment as a criterion that diverges from the Catholic moral tradition and entangles his argument in contradictions. The tradition teaches that moral certitude is necessary to act morally, not that decisions are moral only if they are made in the moment.

Reductionist Interpretation of "Circumstances"

In his critique of POLST, Gannon makes several significant false assumptions that run contrary to the Catholic moral tradition. While it is true that in Catholic teaching the assessment and application of the universal moral obligation to conserve human life in any given case must take account of the circumstances of the particular patient, these circumstances include both present-moment and likely future circumstances, some of which may have causal implications, as in the progression of a disease. Gannon has incorrectly assumed that the meaning of the circumstances assessed is restricted to those in the present moment.[3] Not only does he wrongly reduce the assessment of circumstances to those of the present moment, but in doing so, he undercuts the moral legitimacy of determining one's ethical obligations on the basis of what can be reasonably foreseen beyond the present moment. Evaluating the morality of actions on the basis of foreseen future contingent circumstances is at the core of several moral principles and other components of Catholic moral teaching and tradition, such as the principle of double effect, the principle of cooperation in evil, the effect of foreseen and unforeseen future consequences on the goodness or badness of an act, and the virtue of prudence.

For example, the *Catechism of the Catholic Church* states that prospective moral assessment is an intrinsic dimension of the activity of conscience: "Conscience is a judgment of reason whereby the human person recognizes the moral quality of a concrete act that he is *going to perform*, is in the process of performing, or has already completed."[4] Knowledge, of course, plays an important role in the judgment of conscience and moral decision making.[5] For instance, our actual subjective knowledge of the moral order and its precise application to particular acts in concrete circumstances can admit of degrees.[6] Hence, judgments of conscience can be ignorant and erroneous or accurate and well formed.[7] Indeed, invincible ignorance can diminish subjective culpability, whereas vincible ignorance can impute it further.[8]

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[2] Daniel Gannon, "POLST and Moral Human Acts: Neglect of Medical Circumstances," *Ethics & Medics* 38.2 (February 2013): 1.

[3] See Gannon, "POLST and Moral Human Acts," 1, and "Favor DNR/DNI Orders," 2.

[4] *Catechism*, n. 1778, emphasis added.

[5] John Paul II, *Veritatis splendor* (August 6, 1993), n. 78.

[6] Thomas Aquinas, *Questiones disputatae de veritate*, q. 17, a. 2, trans. James V. McGlynn (Chicago: Henry Regnery, 1953), http://dhspriory.org/thomas/QDdeVer17.htm#2.

[7] *Catechism,* nn. 1783–1788.

[8] Ibid., nn. 1790–1793.

Despite the potential influence of ignorance, the Catholic tradition affirms that human persons can make retrospective ("*consequent*"), concomitant, and prospective ("*antecedent*") judgments of conscience.[9] Further, as the sacrament of Reconciliation beautifully illustrates, each of these is a necessary component of ongoing conscience formation. We form our antecedent conscience by learning from our consequent conscience and other windows of moral truth. Antecedent judgments of conscience are therefore a basic element of the moral life. These judgments inform our prospective moral deliberations and help us freely choose our future actions. There is no sphere of future action that is excluded from such judgments, including decisions about possible future medical treatment and care. Gannon's in-the-moment criterion runs contrary to these well-established pillars of the Catholic moral tradition.

The issue of conscience formation illustrates a further point. Catholic teaching emphasizes the obligation to properly form one's judgment of conscience.[10] In the health care context, the physician–patient relationship serves as a fundamental context for conscience formation. There one's judgment is (or should be) formed through discussion regarding current diagnoses, prognoses, and relevant goals of care. This allows decisions about specific treatments to arise from a place of calm and considered discussion rather than in the heat of the moment. How often has panic driven committed caregivers, even professionals, to make decisions in the moment, without proper consideration of likely future circumstances, that they know the patient would not have wanted and that cause the patient unnecessary burden? Enforcing a reductionist in-the-moment criterion conflicts with the traditional concept of conscience formation; indeed, the latter is more philosophically aligned with advance care planning, which includes future-oriented, prognoses-based physician orders.

Conflating Epistemological Requirements

Second, Gannon's reductionist approach appears to arise from a conflation of the requirement to have moral certainty in order to act and the requirement that a decision must be made in the moment in order to act. The assumption here is that one can only have sufficient knowledge for moral certitude in the moment. Such a position is not supported by the Catholic tradition. The Church's expertise in human nature also leads her to recognize our epistemic limitations. That is, our historicity makes it difficult to know *all* the circumstances or consequences of any of our actions, whether past, present, or future. Thus, the Catholic moral tradition holds that moral certitude is a necessary and sufficient condition for moral action. Moral certitude, as Pope Pius XII explained, "excludes all prudent doubt, being based on positive reasons."[11] The traditional principles of moral reasoning—and other principles, such

[9] Thomas Slater, *A Manual of Moral Theology for English-Speaking Countries*, 5th ed. (London: Burns Oates and Washbourne, 1925), 1:30.

[10] See *Catechism*, nn. 1783–1788.

[11] Pius XII, Allocution to the Roman Rota (October 3, 1941), in T. Lincoln Bouscaren, *Canon Law Digest* (Milwaukee: Bruce Publishing, 1956), 2:456. A year later, the Pope further elaborated on his definition, stating that moral certitude "is characterized on the positive side by the exclusion of well-founded or reasonable doubt" and "on the negative side, it does admit

as the principle of ethically proportionate and disproportionate means of sustaining life—are useful ways to help people attain moral certainty about the moral status of an act considered antecedently, concomitantly, or consequently.

Catholic moral teaching and tradition has recognized that evaluation of moral obligations regarding life-sustaining treatment must be made in relation to circumstances in the present moment, but this does not preclude making moral assessments based on what these present-moment circumstances reasonably portend for the future circumstances of the patient. In other words, the Catholic tradition accepts the general capacity of medical professionals to prognosticate. Admittedly, it is an inexact science. Yet this neither invalidates the practice as a whole nor entails that it is imprudent for one to make medical decisions based on prognoses. In contrast, taken to its logical conclusion, Gannon's criterion would render prognostication meaningless. It would require patients, families, and professionals to make decisions strictly on a moment-to-moment basis.

Many magisterial texts show how Catholic teaching recognizes moral certitude beyond the present moment in making decisions about life-sustaining treatment and care. The following texts are instructive:

> Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement.[12]

> In any case, 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. … It is also permitted, with the patient's consent, to interrupt these means [high-risk experimental procedures], where the results fall short of expectations. … The latter [physicians] may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen. … Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected.[13]

> Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment.[14]

There are two important points to note about these texts with respect to Gannon's criterion. First, while the moral obligations regarding ethically proportionate and

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the absolute possibility of the contrary." Pius XII, Allocution to the Roman Rota (October 1, 1942) in Bouscaren, *Canon Law Digest* 3:607.

[12] John Paul II, *Evangelium vitae* (March 25, 1995), n. 65.

[13] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980), IV.

[14] *Catechism*, n. 2278.

disproportionate treatment articulated in the texts are explained in relation to particular circumstances, there is no restriction of these circumstances to the present moment. Second, the fact that the circumstances under which these moral obligations are assessed in the texts are not conflated with in-the-moment circumstances allows the magisterium to explain these obligations in terms of "prospects" and foreseen or expected results beyond the present moment. The underlying presumption of the texts is that present-moment circumstances represent a basis on which to project future circumstances, which in turn becomes a basis for evaluating one's moral obligations about treatment in the future.

Moreover, the *Catechism* shows that traditional Catholic sacramental theology affirms the validity of prospectively oriented judgments and actions. The sacrament of Marriage specifically involves a present judgment about how the couple will behave in the future without knowledge of all possible or significant future circumstances—for example, the judgment that they will not commit adultery.[15] Likewise, the Latin Rite practice of administering the sacrament of Baptism to infants even affirms our ability to make current decisions about the future behaviors of parents and godparents (that is, to educate the child in the faith) not only for oneself but for others (that is, the child who will be raised in the Church).[16]

In brief, the Catholic moral tradition strongly affirms the ability of persons to make moral judgments and decisions about their future behaviors despite their limited capacity to know the entirety of future circumstances or the consequences of their actions. Gannon's reductionistic in-the-moment criterion diverges from this tradition and undermines foundational moral and theological principles.

Contradictions

Gannon's argument faces other problems as well. His criterion is so sweeping that it ensnares his argument in both theoretical and practical contradictions. If it is true that the determination of our moral obligations regarding life-sustaining treatment is reducible to in-the-moment conditions, then there is no moral justification for any sort of advance care planning, including no justification for Gannon's own version of the DNR/DNI (do-not-resuscitate/do-not-intubate) order. Contrary to Gannon's principle, use of his medical provider order for cardiopulmonary resuscitation (CPR) and intubation assumes the moral legitimacy of refusing life-sustaining treatment on the basis of circumstances that are beyond the present moment. This is evident in his description of his DNR/DNI form as effectively addressing "the major goal of POLST, namely, giving very fragile older adults with serious medical conditions the opportunity to decline resuscitation."[17] This opportunity is not restricted to the in-the-moment circumstances of an acute-care situation, because he allows for the form to be completed and placed in homes, apartments, and nursing homes in recognizable

[15] *Catechism,* nn. 1625–1633.

[16] Ibid., nn. 1250–1252. The fact that these examples do not pertain to the life-impinging acts of not receiving life-sustaining treatment does not affect their moral validity as examples of prospective judgments that are not based solely on present-moment circumstances.

[17] Gannon, "Favor DNR/DNI Orders," 3.

colors for emergency personnel (who presumably would comply with the orders before the patient is examined at the hospital) prior to any of the in-the-moment circumstances in which the orders would be applied.[18] Moreover, it is contradictory for Gannon, on the one hand, to stipulate that the order would be valid only until the patient arrived at the hospital, when an "'in-the-moment' comprehensive care determination" would be made and, on the other, to allow an individual to complete the DNR/DNI form in advance and allow emergency personnel to comply with the completed form prior to the in-the-moment care determination.

Gannon's in-the-moment criterion also produces other contradictions on a practical level. Gannon finds DNR/DNI orders to be essentially justifiable. However, the moral validity of a DNR/DNI order is often not based on in-the-moment circumstances. In many cases, the physician places the order when a cardiac condition or other conditions are currently manageable but, because of reasonably foreseen circumstances that are beyond the present moment, the physician knows that the use of CPR and intubation would be ethically disproportionate. Gannon's in-the-moment criterion also flies in the face of cases such as these: (1) the patient with end-stage disease who has had repeated aspiration pneumonias, for whom antibiotics against pneumonia might be successful for a few days but whose pneumonia is likely to return later, when the patient is in an even worse condition; (2) the patient with end-stage COPD or pulmonary fibrosis for whom it may be reasonably judged that a ventilator in the indefinite future would be ethically disproportionate; and (3) a nutritionally depleted frail person with end-stage esophageal cancer and an estimated lifespan of six months or less, who also has severe emphysema and cardiovascular disease and who believes that going on a ventilator or being fed artificially would have no reasonable hope of benefit, would pose an excessive burden, and would only prolong an active dying process.

Gannon finds durable powers of attorney for health care, health care proxies, and advance directives morally acceptable.[19] However, such documents are designed to include instructions for the health care agent about future treatment, but insofar as they include such instructions, they are immoral according to Gannon. Moreover, if Gannon's criterion were true, the health care agent named in these documents would not be able to fulfill his or her duties. Health professionals often need to know from a health care agent what to do regarding life-sustaining treatment under different sets of possible future circumstances, none of which are actual but which may need a decision when the agent is not available.

Gannon's DNR/DNI order also poses theoretical, or conceptual, contradictions. For Gannon, any declaration *in advance* regarding the refusal of interventions other than DNR/DNI is in principle immoral and contrary to Catholic teaching. Thus, declarations in advance regarding the refusal of antibiotics, ventilators, medically assisted nutrition and hydration, and intravenous fluids are in principle immoral for Gannon, not because refusing such interventions is intrinsically immoral but because

[18] Ibid., 2.

[19] Ibid., 3.

refusing them *in advance* is intrinsically immoral. This "in-principle" argument entails that there are no circumstances, even in-the-moment circumstances such as current diagnosis and understanding of prognosis, under which these treatments could be reasonably foreseen to be ethically disproportionate in the future for a particular patient. Whether or not Gannon recognizes that these treatments may be refused in real time on the basis of in-the-moment circumstances, he is in effect claiming that the very nature of these treatments is such that no moral assessment of their proportionality for a particular patient in the future is justified.

Gannon's in-principle distinction between DNR/DNI and the other procedures shows that the only reason why CPR and intubation—but not the other procedures—may be foregone in advance is that the other procedures are supportive care. However, contrary to Gannon's criterion, this is to base the determination of ethical proportionality on something other than in-the-moment circumstances (which we have shown also occurs with his DNR/DNI orders). Even Pope St. John Paul's statement about the in-principle obligation to use medically administered nutrition and hydration (and the 2007 *responsum* from the Congregation for the Doctrine of the Faith on the same subject) allows for a judgment, not restricted to the present moment, that *per accidens* medically assisted nutrition and hydration may not be obligatory in a given case because of circumstances of the patient.[20]

Thus, the reason that Gannon allows DNR/DNI orders is the same reason that he is also logically compelled to accept advance declarations about these other treatments—namely, that current circumstances of a patient's condition allow physicians and patients reasonably to foresee that certain treatments in the future will be ethically disproportionate. What Gannon states about the justification of DNR/DNI orders applies equally to the refusal of antibiotics, ventilators, medically assisted nutrition and hydration, and intravenous fluids as supportive care. He states that his medical provider order "can be determined ethically at a prior point in time, given what is then known about the patient's condition" and that his solution gives "very fragile older adults with serious medical conditions the opportunity to decline resuscitation."[21] The fact is that the conditions of these patients can make treatments other than CPR and intubation ethically disproportionate in the future. Therefore, these procedures may also "be determined ethically at a prior point in time."[22]

Gannon's argument is contradictory in another way as well. He singles out the illicit status of advance refusal of antibiotics, ventilators, medically assisted nutrition and hydration, and intravenous fluids. His medical provider order deliberately omits reference to any such treatments. However, this omission implicitly represents an

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[20] See John Paul II, Address to the Participants in the International Congress on Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas (March 20, 2004); and Congregation for the Doctrine of the Faith, Responses to Certain Questions of the United States Conference of Catholic Bishops concerning Artificial Nutrition and Hydration, Commentary (August 1, 2007).

[21] Gannon, "Favor DNR/DNI Orders," 3.

[22] Ibid. Gannon also inconsistently allows for an advance declaration regarding ventilators in a DNI order but not apart from a DNI order.

advance declaration that these treatments are to be accepted and authorized in the future until further notice. This implicit acceptance of them in the future by definition is based on circumstances that are not in the present moment, and yet it may be the case that the use of the treatments will constitute ethically disproportionate means. Put simply, Gannon implicitly confirms the falsity of his own position in order to argue that *certain* advance decisions are acceptable while others are not. Thus, his support of his document requires that he reject his own criterion.

Appropriate Use of POLST

In contrast to Gannon's position, Catholic moral teaching and tradition have never limited the determination of what is ethically proportionate treatment to the immediate, present-moment circumstances. The evaluation of circumstances is inclusive of both circumstances in the present moment and circumstances that may reasonably be foreseen in the future. Catholic moral teaching and tradition have also not defined the ethical proportionality of particular judgments about life-sustaining means according to the nature of treatment, nor have they restricted judgments of ethical proportionality to non-supportive care and treatments. Gannon's argument is contrary to both of these facts about Catholic moral teaching and tradition.

The philosophy underlying POLST—that is, a prospectively oriented process and tool for patients to assess potential medical interventions based on current medical diagnoses and foreseeable prognoses and then translate such assessments directly into medically actionable decisions—is, like many aspects and tools of medicine, not intrinsically evil. However, as a practical tool it is possible for these documents to be used for immoral purposes in certain circumstances. Whatever potential for abuse there may be with the design or implementation of POLST, it should be corrected.[23] However, because POLST can be put to good use, it is not intrinsically evil. The use of POLST alone without a health care agent is not morally preferable—we agree that a health proxy, such as a durable power of attorney for health care, is the most desirable—but the fact that POLST can be used without a health care agent does not make it illicit. Used in the right way as the end point of a series of discussions with a physician and only with appropriate patients, POLST can be helpful.[24] This is especially true when POLST is used with a health care agent in place. The combination of a health care agent and POLST can provide appropriate guidance that is actionable in real time.

What is needed is proper education about POLST and other advance care planning instruments together with appropriate policies, protocols, and education within

[23] For a fair assessment of potential abuses and a rebuttal of Catholic criticism of POLST, see Tom Nairn, "The Catholic Medical Association's White Paper, 'The POLST Paradigm and Form: Facts and Analysis,'" *Health Care Ethics USA* 21.3 (Summer 2013): 17–36.

[24] Gannon's critique does not take into account the fact that both the completion of a POLST form and the evaluation of a POLST form by physicians must be based on the patient's current condition, i.e., the particular circumstances of the patient at those times. As we have explained above, this evaluation includes current circumstances that suggest likely outcomes for the foreseeable future.

health care facilities. POLST is not an intrinsically evil philosophic decision-making paradigm: what is needed is not its suppression but proper development of the forms the paradigm utilizes along with proper education and training for practitioners to help shape their discussions with patients. As the *Catechism of the Catholic Church* states, we Christians are called to permeate reality with the Gospel: "The initiative of lay Christians is necessary especially when the matter involves discovering or inventing the means for permeating social, political, and economic realities with the demands of Christian doctrine and life."[25] This call applies to medical decision-making tools. However, to argue as Gannon does is to diverge from the received tradition as well as to declare POLST irredeemable. We disagree with this argument and believe that the suppression of POLST would miss an opportunity to evangelize in health care with secular tools and methods that can be used for good.

[25] *Catechism*, n. 899.