Rebutting Distortions of How the Sanctity of Life Doctrine Applies to the Perivable

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Abstract

In the September article “Should Parents of Neonates with Bleak Prognosis Be Encouraged to Opt for Another Child with Better Odds? On the Notion of Moral Replaceability,” (Tännsjö 2018, S552-57), the author contrasts how three different moral philosophies can be applied to medical decision-making for perivable babies. Unfortunately, the sanctity of life doctrine is critically misrepresented. Unlike what is stated in the article, this doctrine is not a framework that unconditionally advises the resuscitation of all extremely premature babies at all costs under any circumstances. Instead, by considering the degree of usefulness and burdensomeness of medical treatments, the sanctity of life doctrine exercises a prudent stewardship over finite resources while simultaneously honoring the inherent dignity in every human being.

Keywords

Applied ethics, Difficult moral questions, Dignity of the human person, Ethics at the lower limit of neonatal viability, Life issues, Medical decision-making, Moral status, Neonatology, Ordinary and extraordinary means, Withdrawal/withholding of life-sustaining treatment

In the September 2018 *Pediatrics* article “Should Parents of Neonates with Bleak Prognosis Be Encouraged to Opt for Another Child with Better Odds? On the Notion of Moral Replaceability” (Tännsjö 2018, S552-57), the author compares three different moral philosophies: the sanctity of life doctrine, the moral right theory, and utilitarianism. He then discusses the different philosophies’ recommendations for resuscitating babies born at the edge of viability. Unfortunately, the sanctity of life doctrine is gravely misrepresented in multiple ways, particularly the conclusion that all perivable babies must always be resuscitated or the doctors are guilty of killing them. This misinformation has serious ramifications for how neonatologists and parents navigate a medically and ethically difficult decision.

well as “many adherents of other monotheistic religions” (p. S554). He states that this doctrine is “deontological” because specific behaviors are illicit, “regardless of the consequences in an individual case, instances of them are wrong, period” (Tännsjö 2018, S553-54). The particular “instance” Tännsjö is referring to is the resuscitation of a baby born at the edge of viability. He correctly notes that according to the sanctity of life doctrine, killing an innocent human being is always wrong. However, he then concludes that because babies born at the edge of viability are innocent, the doctrine states that all lengths must always be taken to save them

Inaccurate Definition

Tännsjö (2018) asserts that the sanctity of life doctrine has its roots in the thinking of Thomas Aquinas, and the “up-to-date version” is held by “the Pope” as

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(Tännsjö 2018, S554). If the babies are not saved, then by an act of omission, one is guilty of killing them (Tännsjö 2018, S544). This interpretation reveals a lack of understanding about what the sanctity of life doctrine actually says.

It is true that Aquinas defended life's sanctity, but an essential component of the doctrine predates him. The biblical fifth commandment states, "you shall not kill" (Catechism of the Catholic Church 1994, 544). This commandment, along with the other nine, forms the essential basis upon which today's Catholic ethical and social teachings are built. In the fifth commandment, the Hebrew word used for killing is "ratzach," which specifically means to kill a person by stealth or murder (there are different Hebrew words for killing in other circumstances such as on a battlefield or in self-defense). Although Tännsjö (2018) correctly identifies the Church's position as it is "wrong to intentionally kill an innocent human being" (p. S554), he erroneously asserts that because the Church makes no "distinction between acts and omissions," "stop[ping] life-sustaining treatment means intentional killing the infant" (Tännsjö 2018, S554). In reality, under the sanctity of life doctrine, the intention of the physician, guided by the specifics of each individual patient, matters. In situations where we are powerless to rescue a perivable baby, allowing the infant to die without applying every possible medical intervention is not equivalent to intentional, premediated murder. There are babies, that for a variety of reasons, are beyond our ability to heal. Tännsjö erroneously claims that according to Church, not starting or stopping treatment is a de facto murder plot. In reality, it is usually an agonizing decision made with the family as everyone attempts to determine what can or cannot be done to provide the best possible care for one of our most vulnerable.

The Inherent Value of Life Becomes "Doctrine"

From the inception of the Catholic Church, the intrinsic value or sanctity of every human being has been a core belief. In the middle ages, it was the Catholic Church that founded the first public hospitals where the "Christian message led people to assist the sick and the poor . . . initially in the house of the bishop, then in monasteries and, finally, in autonomous buildings, the hospitals" (Riva and Cesana, 2013, 1). Centuries later, Pope Pius XII followed by Pope John Paul II would further develop how life's sanctity is to be honored in modern times. In the context of growing concerns over evolving

medical technologies and the feared ability to prolong death as opposed to improve life's quality, both popes delineated an ethical doctrine where individual patient's medical and personal history are made integral to medical decision-making. In 1957, Pope Pius XII spoke to the congress of anesthesiologists and said, "normally one is held to use only ordinary means [to prolong life]—according to the circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another" (May 2013, 270). "Ordinary means" are treatments that offer a reasonable hope of success and have tolerable undesirable side effects. If the treatment is ordinary, there is a moral obligation to use it. However, if a treatment is "extraordinary," one that offers minimal chance of success or exacts such a huge price (whether physical suffering or financial ruin), there is no obligation to use it, and such a treatment may be morally forgone. Pope John Paul II further explained that determining whether a treatment is proportionate or disproportionate is another way of saying the same thing. Importantly, while withholding ordinary/proportionate treatment from a patient (e.g., starving a patient to death) is morally equivalent to "killing by omission," the same is not true if the treatment forgone is *extraordinary*/disproportionate (e.g., a new experimental drug).

Today, both Popes' ideas are summarized in the *Ethical and Religious Directives for Catholic Health Care Services*. This document states, "We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. . . . The task of medicine is to care even when it cannot cure" (Ethical and Religious Directives, 2016, 20). This is the exact opposite of what Tännsjö (2018) claims the Sanctity of Life Doctrine and the Catholic Church says (p. S554). Ethical Religious Directive #57 specifically states that forgoing extraordinary treatment is ethically sound (Ethical and Religious Directives, 2016, 21). It is not an example of killing the patient by omission. Instead, choosing to forgo treatment that is disproportionate (minimal chance of success or overly burdensome) can reflect an honest assessment of what we do and do not have the ability to heal. Sometime, doctors need to get out of God's way.

Tännsjö never mentions ordinary/extraordinary or proportionate/disproportionate treatments, and these concepts that are essential to how the sanctity of life doctrine helps guide modern medical practice. Thus, under the sanctity of life doctrine, a patient

with stage 4 cancer may licitly choose to forgo chemotherapy that has minimal chance of success. These choices are not “deontological” (Tännsjö 2018, S554) but rather prudential judgments that are both nuanced and highly specific to the actual situation. An example of violating the sanctity of life doctrine would be if a neonatologist preemptively refused to resuscitate babies at twenty-six weeks gestation (today’s standard of care is approximately twenty-two to twenty-three weeks) because he or she did not believe the outcome to be good enough. This is killing by omission. Such a scenario is dramatically different than providing comfort care to a mother who goes into labor at around twenty weeks after her membranes ruptured at seventeen-weeks gestation, and the baby weighs 300 grams. In this case, resuscitation is excessively burdensome due to no chance of success. Importantly, the baby is not what is overly burdensome, the treatment is. Guided by the sanctity of life doctrine, we would intentionally offer this tiny little one care that keeps him or her as comfortable and as comforted as possible. Wrapped in perhaps a special blanket, maybe with the assistance of some blow by oxygen, such a little one could then be placed into the arms of the mother and father. This is not Tännsjö’s described death by omission, this is a valuing of life—particularly at its most fragile, delicate moments.

Tännsjö Embraces “Human Replacement,” Not the Sanctity of Life

In his *Pediatrics* article, Tännsjö (2018) states that he is a utilitarian and he agrees with the idea that there is such a thing as a “life not worth living” as well as “morally replaceable” infants (p. S555). These statements stem from utilitarianism’s “urge to maximize the sum total of happiness in the universe,” making it “wrong to inflict pain on an infant whom you try in vain to rescue” (Tännsjö 2018, S554-55). He goes on to argue against resuscitating infants at the edge of viability because even if they could be saved and then later claim to be happy, their parents may not be (Tännsjö 2018, S555-56). Such reasoning is in dramatic contrast to that of the sanctity of life doctrine. While both ethical frameworks may conclude resuscitation in a particular case is wrong, only one does so based on the likeliness of somebody winding up unhappy; the other holds that no person is worthless, but the *medical treatments* could be and therefore should not be used. The sanctity of life doctrine holds that people are inherently

sacred, which is why the concept of Tännsjö’s human replaceability is so repugnant. Humans deserve love and care, particularly as Pope John Paul II (1995) stated, when most vulnerable (p. 14). That one person could be simply substituted for another like car parts is unthinkable under this doctrine; not, as Tännsjö indicates, because of a rigid rule that is oblivious to suffering, but out of an invitation to see worth in human beings at all times and to safeguard from neglect all those who are exposed and helpless.

Correct Application of the Sanctity of Life Doctrine to Resuscitation of Perivable Neonates

Given all of the above, the answer to the question of whether or not a baby at the edge of viability should be resuscitated according to the sanctity of life doctrine is, “It depends.” Each intervention needs to be evaluated in light of the chances for success (usefulness) and the degree of burdensomeness. Unique to pediatrics, the degree of burdensomeness includes not only the patient but the family, particularly the parents, too. This is not to say that parents can morally abandon a baby out of inconvenience (or unhappiness); life is sacred. But the impact of a specific treatment on the family is part of the calculus needed to determine whether or not the treatment is extraordinary. “The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way, two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient [or parents] may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death” (Ethical and Religious Directives, 2016, 20).

Conclusion

Tännsjö has published an article contrasting how three moral philosophies, the sanctity of life doctrine, moral rights theory, and utilitarianism, can be applied to medical decision-making and particularly the resuscitation of perivable babies. Sadly, Tännsjö critically misrepresents the sanctity of life doctrine. This doctrine is *not* a framework that unconditionally advises resuscitated all extremely premature babies at all costs out of a blind duty to not kill under any circumstances. Instead, as a practicing neonatologist with a background in ethics, I find that this doctrine is an invitation to be consistently awestruck at the value of every individual while remaining humbled by what is beyond our ability to heal. In distinguishing between

ordinary and extraordinary means, the doctrine draws a clear distinction between “killing by omission” (i.e., withholding ordinary treatments) and allowing a perivable infant to die (i.e., forgoing extraordinary treatments). Tännsjö portrays the doctrine as a cruel way to prolong suffering and asserts that it fails to be accountable for the costs of wasted interventions. Instead, the truth is that by considering the degree of usefulness and burdensomeness of proposed interventions, the sanctity of life doctrine exercises a prudent stewardship over finite resources while simultaneously honoring the inherent dignity in every person at every moment of their life.

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Biographical Note

Robin Pierucci, MD, MA, is a wife, mother, and a practicing neonatologist. She also has a master’s degree in bioethics, which dovetails with her research, publications, and ongoing involvement in her hospital’s perinatal palliative care program. Also, she has been a leader in the Kalamazoo Neonatal Abstinence Syndrome Community Collaborative. This initiative has involved not only inpatient medical personnel from neonatal, obstetric, and pediatric departments but also outpatient staff from multiple community groups including mental health services, substance abuse specialists, early home health programs, and the school and court systems. She has also completed the National Catholic Bioethics Center certificate course. In the last year, she has been active with Women Speak for Themselves and has had pieces published in *The Federalist* and *The National Review—Online*.