

RADICAL AUTONOMY AND THE DISTORTION OF MEDICINE: A REFLECTION ON *EVANGELIUM VITAE*

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Abstract

In *Evangelium vitae*, Saint John Paul II identified “a notion of freedom which exalts the isolated individual in an absolute way...” as one of the underlying causes of the “culture of death.” This pervasive underlying philosophy has changed the practice of medicine, transforming the doctor-patient relationship from one involving a therapeutic alliance to one more closely resembling a service-consumer model. In this model, the will of the patient-customer supersedes the objective goods of his person, the common good, and the sacred character of the doctor-patient relationship. The result is the distortion of the nature of medicine and the pitting of the doctor and patient against one another. “Do no harm” becomes “the customer is always right.” The author examines the effect of this radical notion of autonomy identified by *Evangelium vitae* on the practice of medicine, and in particular, on the doctor-patient relationship.

Introduction

Saint John Paul II’s encyclical *Evangelium vitae*, The Gospel of Life, is one of the defining teachings of his papacy. It was in this encyclical that the Pope coined the term “Culture of Death” and lent further Petrine authority to his already robust and consistent defense of human life—and especially vulnerable human life, an emphasis that marked his papacy. As a former philosophy professor, the Pontiff was adept at exposing the philosophical errors and their consequences inherent in contemporary lines of thought. Throughout the encyclical, the Pope

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consistently critiques the radical view of human autonomy at the root of the culture of death and the growing acceptance of certain crimes against life, with a focus on abortion and euthanasia in particular. He observes the contradiction between the tendencies today to express a deep concern for rights of all kinds while at the same time justifying new ways of denying fundamental human rights, especially the right to life. Behind all of this is a “notion of freedom which exalts the isolated individual in an absolute way, and gives no place to solidarity.”² In paragraph four of the encyclical, John Paul II observes the effect this view of “rights” rooted in a radical notion of autonomy has on the practice of medicine:

Choices once unanimously considered criminal and rejected by the common moral sense are gradually becoming socially acceptable. Even certain sectors of the medical profession, which by its calling is directed to the defense and care of human life, are increasingly willing to carry out these acts against the person. In this way the very nature of the medical profession is distorted and contradicted, and the dignity of those who practice it is degraded.

This radical autonomy, far from correcting the old paternalism, degrades the practice of medicine and alters its very nature. This view of human freedom unfettered from the objective goods of the person has a deleterious effect on the doctor-patient relationship and distorts and contradicts, in the words of the encyclical, this once sacred art.

Medicine in the Hippocratic Tradition

The image of the kindly trusted family physician making a house call is even now a thing of the past and it would certainly have been foreign to the ancients. Physicians in the ancient world were not viewed with trust and admiration but more often with suspicion and fear. They held divine power—the power of life and death—and death was the more common outcome. In the *Epidemics* of the Hippocratic *Corpus*, twenty-five of the forty-two cases presented as case

² John Paul II, Encyclical on the Value and Inviolability of Human Life *Evangelium vitae* (25 March 1995), §19 *Acta Apostolicae Sedis* 87 (1995), 421.

studies for the purpose of demonstrating the art of prognosis resulted in the death of the patient.³ In today's media, doctors are generally presented as wise and benevolent, even sagacious—with the exception, perhaps, of Dr. Gregory House of the television show *House*. In fact, the show only finds its novelty and entertainment value in the very shock of the eponymous physician who does not fit the modern image of the physician as wise and benevolent. That this abrasive, uncaring, drug abusing, paternalistic Dr. House is an aberration as a physician only serves to illustrate the contemporary image of the physician as trustworthy and benevolent. House is the foil to the modern expectation of what the physician ought to be.⁴ But the opposite was the case in ancient Greece and even in the “media” of the ancient world. Physicians were largely regarded as untrustworthy and immoral. They were ridiculed as quacks in ancient theatre and feared as death dealers and “unpunished killers” even in legal discourse.⁵ The awareness of this reputation seems to drive much of the Hippocratic literature. In the *Canon*, the Hippocratic author openly laments the poor reputation of the physician:

“Although the art of healing is the most noble of all the arts, yet, because of the ignorance of both of its professors and of their rash critics, it has at this time fallen into the least repute of them all...Ill-repute is the only punishment and this does little harm to the quacks who are compounded of nothing else. Such men resemble dumb characters on the stage who, bearing the dress and appearance of actors, yet are not so. It is the same with physicians; there are many in name, few in fact.”⁶

Absent anything like licensing bodies or medical guilds, potential patients had to be on the lookout for frauds and those who might do them more harm than good. In their infirmity and vulnerability they might have had no choice but to trust one who claimed to be a physician. The

³ Albert Jonsen, *A Short History of Medical Ethics* (Oxford, UK: Oxford University Press, 2000), 3.

⁴ Even the character's name seems to be a deliberate reference to whom he serves as a foil, namely, the house doctor, or the doctor who performs house calls.

⁵ Jonsen, *A Short History*, 4-5.

⁶ G.E.R. Lloyd, ed., *Hippocratic Writings*, trans. J. Chadwick and W.N. Mann (London, UK: Penguin, 1950), 68.

novelty of the Hippocratic approach to the doctor-patient relationship then, is an indication of the way in which physicians and their art were viewed in antiquity.

It is not difficult to see why it would change the very nature of medicine for a group of practitioners to declare ahead of time to their patients that they are not like other physicians, that there are certain things that they promise to do—and to *not* do, with the latter perhaps the more important. It is no exaggeration to say that the Hippocratic Oath is *primarily* concerned with the doctor-patient relationship. The sacred *Oath* is, above all, a promise on the part of the Hippocratic physician to engage in a certain kind of relationship with the patient. This promise is at the very heart of the Hippocratic *Oath* and is what makes it revolutionary. Its historical importance does not depend on a novel worldview, technique, or skill. It introduces no new remedies or salves. It is not an advancement in the technological sense. Rather, it is *promise*. Its positive declarations promise that the Hippocratic practitioner will be a practitioner of a certain *kind*, that he will be chaste and religious, loyal to his art and to the sacred nature of the profession, that he will keep the sacred *Oath*, and so on. The negative precepts in the *Oath* promise that the physician will *not* behave in certain ways that were no doubt feared as all too common among those “dumb actors” Hippocrates warned against—to not give a deadly remedy, to not practice surgery (often more dangerous than the very thing it aimed to treat), to not take sexual advantage of patients, nor to break confidentiality. It is this commitment that set the Hippocratic practitioner apart and that explains the emphasis the Hippocratic school placed on the moral qualities of the physician.⁷

⁷ Beyond the *Oath*, the Hippocratic *Corpus* is full of descriptions of the moral qualities of the physician from the kind of person well-suited for the practice, from the physician’s bedside manner to his diet and physical appearance. See especially *On the Physician* and *Decorum* in W.H.S. Jones, trans., *Hippocrates* vol. II (Cambridge, MA: Harvard University Press, 1923), 311-313 and 279-301.

The most well known passage from the *Corpus* is the dictum that has become a kind of informal motto for the practice of medicine, *Primum non nocere*—“first, to do no harm.” The phrase is found in Book I of *Epidemics*, “make a habit of two things, to help or at least to do no harm.”⁸ It is echoed in the *Oath’s* promise to “abstain from harming.”⁹ Because the ancient physician’s repertoire of treatments was severely limited, cures and treatments were to be considered bonuses. Hippocratic medicine was aimed primarily at prognosis and care and not at curing. But even if he could not help, at the very least the Hippocratic practitioner vowed not to harm. “The authors of the Hippocratic literature,” Jonsen notes, “are acutely aware that the work of the Greek physician was inherently dangerous.”¹⁰ The degree of trust required of the physician on the part of his patient did indeed lend toward paternalism, or a “doctor knows best” approach, wherein the patient was expected to obey the superior knowledge of the physician. The Hippocratic *Corpus* treats of the doctor-patient relationship in this way, explaining that the patient ought to cooperate with the physician and instructing the physician to be on the lookout for patients who would lie about whether they have followed prescribed medical advice.¹¹ The promise to *refrain* from certain kinds of practices as inconsistent with the philanthropic nature of medicine came to be a defining characteristic of the Hippocratic physician and no doubt contributed to the more modern reverence toward physicians as moral and benevolent agents.

The Hippocratic *Corpus* recognizes that the art of medicine requires a practitioner of a certain kind because it is *philanthropic* in nature. Unless one is virtuous and has the good of the patient who is other to him in the first place, he is no good to the patient. The physician must

⁸ In Greek, “ἀσκέειν, περὶ τὰ νοσήματα, δύο, ὠφελῆειν, ἢ μὴ βλάπτειν.” See Jones, *Hippocrates*, vol. I, 165.

⁹ Lloyd, 67.

¹⁰ Jonsen, *A Short History of Medical Ethics*, 5.

¹¹ Numerous implicit and explicit examples of this run through the *Corpus*. See *Decorum XIV* in Jones, *Hippocrates*, vol. II, 297.

keep in mind the patient's good if he is to perform his art well and this is what guides the prescriptions in the *Oath* and throughout the *Corpus*. We read in the *Precepts* that the physician should even offer his services for free on occasion, especially when the patient is incapable of paying. This is not unlike the image of the Good Samaritan in the parable from the Gospel of Luke. The Samaritan, who is a stranger to the injured man, is nevertheless "moved with compassion." (Luke 10:33 *NABRE*) He places him on his own animal and pays for his care himself, promising even to return and pay whatever else is necessary. It is clear why the earliest Christians saw the Hippocratic approach as consistent with and perfected in the healing ministry of Christ, even depicting the Hippocratic *Oath* in the form of a cross and referring to Christ as *Christus Medicus*—"Christ the physician". Christianity, as Jonsen notes, not only approved of the Hippocratic approach but endorsed it—we can even say *elevated* it.¹² Christians continued to practice philanthropic medicine and continue to do so today through the vast network of Catholic and Christian health care institutions.¹³ Returning to the *Precepts*, the rationale for this compassionate practice of the art is explained: "Where there is love of man [philanthropy], there is also love of the art [of medicine]."¹⁴ Like the Good Samaritan, the physician who offers his art out of love of the patient and his good performs his art not just well, but does so *qua* the art. Philanthropy is the *sine qua non* of the art of medicine.

¹² Jonsen, *A Short History of Medical Ethics*, 14.

¹³ The United States Conference of Catholic Bishops recalls the obligation of Catholic health care institutions to offer care regardless of the patient's ability to pay. The *Ethical & Religious Directives for Catholic Health Care Services* states: "In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured..." See *Ethical & Religious Directives for Catholic Health Care Services*, 5th edition. (Washington, DC: USCCB, 2009), no. 3.

¹⁴ Jones, *Hippocrates*, vol. I, 319.

Denying Human Goods and Bodily Ontology

Medicine is motivated by the love of the patient and his good. But the prevailing postmodern radical view of autonomy John Paul II critiques in *Evangelium vitae* presents new pitfalls in the practice of medicine and the doctor-patient relationship. The 20th century has seen a number of declarations of the dignity of the human person and recognition of his autonomy which has no doubt led to renewed emphasis on individual rights, as John Paul II recognizes.¹⁵ But it has also led to a justification of new affronts to human dignity and distortions of medicine. Here we see a “remarkable contradiction”, as the Pope calls it, for the very thing a renewed focus on individual freedom is meant to protect ends up being “trampled upon.”¹⁶ “Rights” language drives the push for the justification of the abuses of human dignity the Pope so prophetically speaks about. “Rights” are claimed not on the basis of some objective goods of human nature, that is, on a notion of ontology, but on autonomy itself, which “carries the concept of subjectivity to an extreme.”¹⁷ Desiring the good of the patient, let alone working toward actualizing that good is impossible without identifying in the first place what those goods are. There are certainly many identifiable goods of the patient including his social, spiritual, and personally identified goods. According to Elio Sgreccia, a personalist vision of health must refer to the whole person and not merely to any one aspect of the person in particular.¹⁸ Good medicine addresses all of these goods, to be sure, though because they are inseparable from one another insofar as they are goods of the person in his totality, we will not parse them out here.¹⁹ But

¹⁵ John Paul II, *Evangelium vitae*, no. 18.

¹⁶ See John Paul II, *Evangelium vitae*, nos. 18-19.

¹⁷ John Paul II, *Evangelium vitae*, no. 19.

¹⁸ Sgreccia identifies the four dimensions of health as biological, psychological and mental, social and environmental, and ethical. See Elio Sgreccia, *Personalist Bioethics: Foundations and Applications*, eds. John A. DiCamillo and Michael J. Miller (Philadelphia, PA: National Catholic Bioethics Center, 2012), 149.

¹⁹ Pellegrino distinguishes between four senses of what is meant by the “good of the patient”, though this breakdown is beyond the scope of our purposes here. These are compatible but not identical with Sgreccia’s four dimensions of

suffice it to say that the most immediate good that concerns the practice of medicine is the *bodily* good of the person. The physician is primarily concerned with the goods of the body and this should be obvious enough—one feels a mysterious pain or ache and so visits the doctor. Medicine relies on scientific biological knowledge but is not reducible to it since the end of medicine is not merely knowledge about bodily functioning but promoting in and restoring to this body here and now the functioning and harmony proper to its nature. The body has a particular nature and its parts act toward particular ends that in themselves contribute to the flourishing of the whole. This is why medicine is an art and not a science since it is not concerned with a body of knowledge but a productive kind of action.²⁰

To say that there are goods of the body means admitting the reality of bodily *ontology*. Pope Pius XII remarked on this essential aspect of medicine in an address to physicians of the World Medical Association: “...medical ethics should conform to the essence of human nature, and to its laws and immanent relations. All moral norms, including those which pertain to medical science, necessarily proceed from corresponding ontological principles. Whence comes the maxim ‘Be what you are!’”²¹ Medical-moral principles, the Pope suggests, must flow from a real identification of human goods in keeping with human nature. Being what one is, that is, being a well human, means essentially being human *well*, at least in terms of human corporeality. If philanthropy is the efficient cause of the form “medicine”, then “an ontology of the body is the matter which establishes the form of medicine, its source and end of explanatory theory, and the

health. See Edmund Pellegrino, “Moral Choice, the Good of the Patient, and the Patient’s Good” in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, eds. Tristram Engelhardt Jr. and Fabrice Jotterand (South Bend, Indiana: University of Notre Dame Press, 2008), 164-175.

²⁰ The word “physician” comes from the Greek *φύσις* for “nature”, as in “one who restores nature.”

²¹ Pope Pius XII, “Address to the Participants in the VIII Congress of the World Medical Association” (30 September 1954), *Acta Apostolicae Sedis* 46 (1954), 596.

basis of its judgments and axioms.”²² This is the primary end, the final cause, we could say, of medicine. Sgreccia refers to this as “respect for reality” and sets it as opposed to a disposition of ideology.²³ In practice, the ideology of radical autonomy amounts to the denial of bodily ontology by subordinating it to the exercise of freedom for its own sake. Human goods and the ontology they are rooted in become irrelevant. John Paul II explains, “When freedom...shuts out even the most obvious evidence of an objective and universal truth, which is the foundation of personal and social life, then the person ends up no longer taking as the sole and indisputable point of reference for his own choices the truth about good and evil.”²⁴

This conflict is especially evident in debates concerning so-called sex reassignment surgeries and Catholic health care. How should a physician, for example, consider a request from an individual experiencing gender dysphoria to have his or her otherwise healthy body parts surgically altered to conform to the patient’s own perception about their gender identity?²⁵ In early January 2017, a woman in New Jersey seeking to have her uterus removed as part of her sex reassignment transition process filed a complaint for injunctive relief against St. Joseph’s Healthcare System for refusing to perform a hysterectomy on her otherwise healthy uterus. The complaint brought against the Catholic hospital describes the hysterectomy as “medically

²² Edmund Pellegrino and David Thomasma, *A Philosophical Basis of Medical Practice*, (New York, NY: Oxford University Press, 1981), 102.

²³ Sgreccia, *Personalist Bioethics*, 237.

²⁴ John Paul II, *Evangelium vitae*, no. 19.

²⁵ In his recent encyclical on ecology, Pope Francis affirms the importance of recognizing the body as a good and the limits this respect for reality imposes on human freedom. He writes, “The acceptance of our bodies as God’s gift is vital for welcoming and accepting the entire world as a gift from the Father and our common home, whereas thinking that we enjoy absolute power over our own bodies turns, often subtly, into thinking that we enjoy absolute power over creation.” See Encyclical *Laudato Si* on Care for Our Common Home (24 May 2015), §155 *Acta Apostolicae Sedis* 107 (2015), 909.

necessary”, which denies the very reality of bodily ontology and a respect for reality.²⁶ In this case, a hysterectomy would not constitute authentic medicine since it would be an act of mutilation and not healing or treatment.²⁷ The assumption of the plaintiff in the case is that her autonomy supersedes any obligation to the autonomy of the Catholic healthcare institution itself and even to the reality of her own bodily ontology. A view of freedom absent any reference to the truths of bodily ontology (or any ontological aspect of the person) makes authentic medicine impossible by severing the notion of freedom for the patient’s good from “its essential link with the truth.”²⁸ Both doctor and patient exercise an authentic autonomy when it is ordered toward this respect for reality. Physicians then are right to refuse to engage in procedures that violate bodily integrity and totality. Only if a physician remains free to also *refuse* certain treatments and courses of action can they be truly free for the patient’s good both morally and ontologically.

The Doctor-Patient Relationship

The doctor-patient relationship is the real point of contact for medicine and medical ethics, which is why the Hippocratic literature consistently emphasizes this aspect of the art. One could say that it is precisely what Hippocratic medicine is about, which again, is why Christianity took so easily to the Hippocratic school of medicine. But radical autonomy, John Paul II warns, ends up pitting individuals against one another. He writes, “If the promotion of the self is understood in terms of absolute autonomy, people inevitably reach the point of rejecting one another. Everyone else is considered an enemy from whom one has to defend

²⁶ See *Jionni Conforti v. St. Joseph’s Healthcare System, Inc.* 2:17-cv-00050-JLL-JAD (Dist. N.J. 2017). See complaint at <https://www.courthousenews.com/wp-content/uploads/2017/01/trans.pdf> (accessed Nov. 11, 2017).

²⁷ See USCCB, *Ethical & Religious Directives*, nos. 28 and 29.

²⁸ John Paul II, *Evangelium vitae*, no. 19.

oneself.”²⁹ As it manifests in medicine, this means turning the doctor and patient into enemies, the antithesis of philanthropic medicine. A model of medicine founded on philanthropy is one in which the patient, who naturally seeks his own good, recognizes that he cannot achieve bodily well-being on his own and so in his vulnerability, trusts the physician to use his knowledge and skill to work toward the patient’s good. The *Charter for Health Care Workers* describes the physician-patient relationship as “a meeting between trust and conscience.”³⁰ Here the *Charter* quotes from an address of John Paul II to Italian physicians wherein the Pope emphasizes the essential interpersonal aspect of medicine as based in an encounter between a “trust” (the patient) and a “conscience” (the physician).³¹ The patient and physician enter into a therapeutic alliance, with each doing his part with a view to restoring or preserving some good or goods of bodily ontology.³² The physician, through his art, has special knowledge and skill that the patient needs to achieve totality or functionality, but never at the expense of the freedom and participation of the patient in his own healing. This would be to err toward paternalism.

On the other hand, while patients remain the primary agents with regard to their healing and treatment, the physician is not an impartial actor.³³ His role is not reducible to his knowledge and technique, as if he were a kind of embodied, WebMD powered, technical automaton. Rather, “Neither the health care professional nor the patient acts independently of

²⁹ Ibid., no. 20.

³⁰ Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (1995), no. 2.

³¹ Original in Italian, translation by this author. The original reads, “Il rapporto malato-medico deve tornare a basarsi su di un dialogo fatto di ascolto, di rispetto, di interesse; deve tornare ad essere un autentico incontro tra due uomini liberi o, com’è stato detto, tra una “fiducia” e una “coscienza”. See Pope John Paul II, *Discorso di Giovanni Paolo II ai Partecipante all’81° Congresso della Società Italiana di Medicina Interna e all’82° Congresso della Società Italiana di Chirurgia Generale* (27 October 1980), §6 *Acta Apostolicae Sedis* 72 (1980), 1128.

³² Even the Hippocratic literature, which is often criticized for being too paternalistic, frequently emphasizes the need for mutual cooperation between the physician and the patient.

³³ Sgreccia, *Personalist Bioethics*, 234.

the other; both participate in the healing process.”³⁴ The physician too possesses freedom and demands of conscience. Nor is the physician merely working on an inanimate object like an automobile mechanic. The object of his art is not an object at all, but another *person*. To ignore these essential elements of the physician’s role in favor of the individual autonomy of the patient is to err in the way of the radical autonomy John Paul II warns of.

Rather than a therapeutic alliance between doctor and patient—the patient moved by trust and the physician by philanthropy—a radical notion of autonomy divides the doctor and patient and forces their relationship to begin as an encounter of suspicion. As unfettered autonomous agents, each presents a threat to the other in the exercise of his will. While appearing to enter into a partnership with what appear to be similar goals (the patient’s healing), both must remain suspicious of the other and must protect his own self-interest. In the old paternalism that medical ethics after Nuremberg sought to correct, this typically meant the subjugation of patient autonomy to that of the physician who had the upper-hand, so to speak, as wielder of knowledge and skill. We have already seen the awareness of this suspicion of patients for physicians as a major theme of Hippocratic literature and practice. The patient feared what the quack physician might do to him—the physician feared a bad reputation. Still, the patient submitted out of need and vulnerability. However, since the horrors of Nuremberg, medical ethics (or “bioethics”, since Nuremberg),³⁵ has yielded heavily in favor of patient autonomy. Discussions of autonomy today come to refer almost exclusively to *patient* autonomy. But as we have seen, in practice this does little to correct the abuses of paternalism, but simply swings the pendulum in the

³⁴ USCCB, *Ethical & Religious Directives*, Introduction to Part Three.

³⁵ Bioethics, as a distinct field, is generally said to have begun following Nuremberg and the drafting of the Nuremberg Code. See Jonsen, *A Short History of Medical Ethics*, 115-120.

opposite direction. The dynamic of suspicion remains—the patient fearful that his autonomy will be overridden and the physician defensive against the possibility of litigation.

Informed consent remains an important principle even in secular ethics and may in fact be one of the only real operating ethical principles remaining in secular ethics. However, when the autonomies of patient and physician are pitted against one another, informed consent protocols can seem mainly concerned with establishing and governing the parameters of the dynamic of suspicion rather than actually providing for informed consent—itsself a sign that something has gone awry in the doctor-patient relationship. Sgreccia explains:

The relationship between physician and patient, in the changed cultural conditions of today, is mediated by a legal instrument known as *informed consent*. In principle, informed consent is not reducible to a simple informative paper that the patient (or the patient's representative) has to sign: it constitutes the reference point for the physician-patient relationship...Informed consent is often used as a form of legal protection—there is an encounter between two autonomies, two wills, and two rights, but no longer on the basis of trust.³⁶

Of course, informed consent is an important moral principle governing the doctor-patient relationship and is not reducible to its legal function. Informed consent is what allows the doctor and patient to work together in an alliance and enter into a relationship of mutual trust. But if the autonomy of either the doctor or patient is made in principle to supersede the other—as one of them must if they are in conflict and if neither moral nor bodily goods are the primary determining criterion of clinical decision-making—then the relationship of mutual suspicion becomes one of *coercion*. Since today, as Pellegrino says, "...patient autonomy is elevated to the status of a trumping principle," the physician is *prima facie* prevented from receiving a

³⁶ Sgreccia, *Personalist Bioethics*, 238-239.

patient from a place of philanthropy.³⁷ He must take a defensive stance, as his patient's autonomy is his potential enemy. This dynamic clearly constitutes a distortion of the doctor-patient relationship, degrading it from one grounded in trust into one of suspicion and coercion. The foundational principle of informed consent which flows from the freedom of both doctor and patient runs the risk of being motivated by self-interest rather than a condition for mutual trust.

Medicine and the Common Good

Plato recognized the social dimension of medicine when he referred to the physician as a “statesman”, or someone concerned with the well-being of the State.³⁸ The work of the physician in making the sick and weak well again was a service to the *polis* in that it prevented the potential spread of illness and made more members of the State capable of contributing to the functioning and activities of the State—in other words, to the common good. But individual autonomy as the dominant value in medicine distorts the social dimension of medicine, first by making enemies of the members of society, as the Pope points out: “This view of freedom leads to a serious distortion of life in society. If the promotion of the self is understood in terms of absolute autonomy, people inevitably reach the point of rejecting one another. Everyone else is considered an enemy from whom one has to defend oneself.”³⁹ The doctor-patient relationship can become distorted by potentially pitting the two against one another in a battle of wills, making compassionate medicine and the therapeutic alliance impossible. This may also have legal consequences. Physicians must not only protect themselves from malpractice suits, but against any potential denial of the autonomy of the patient. A refusal on the part of the physician

³⁷ Edmund D. Pellegrino, “Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship” in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, eds. Tristram Engelhardt Jr. and Fabrice Jotterand (South Bend, Indiana: University of Notre Dame Press, 2008), 216.

³⁸ Quoted in Jonsen, *A Short History of Medical Ethics*, 6

³⁹ John Paul II, *Evangelium vitae*, no. 20.

to engage in certain elective practices could result in a lawsuit from a patient or even exile from the profession all together.⁴⁰ But the negative precepts of the Hippocratic *Oath* are an indispensable part of the promise on the part of the Hippocratic physician. They constitute perhaps the most important parts of the *Oath*. They are the foundation of the guarantee the patient has against mistreatment on the part of the physician. The refusal to engage in certain practices is what set the Hippocratic practitioner apart from the “dumb actors” and is what fosters the trust necessary for an authentic encounter rooted in compassion. In the encyclical *Veritatis Splendor*, John Paul II notes this same importance of the negative precepts of the Decalogue: “[In the Decalogue] are moral rules formulated in terms of prohibitions. These negative precepts express with particular force the ever urgent need to protect human life.” He goes on to say, “The commandments thus represent the basic condition for love of neighbour...They are the first necessary step on the journey towards freedom, its starting-point.”⁴¹ Freedom, the Pope suggests, is a starting point for the pursuit of other goods. The negative precepts of the *Oath*, like those of the Decalogue, represent “basic conditions” without which philanthropy and authentic freedom are impossible. Authentic autonomy then, will necessarily involve the refusal to do certain things. Protecting the possibility for the physician to refuse to engage in certain acts even if freely requested by the patient protects the autonomy of the physician. This consideration cannot be set aside since the physician is not an impartial agent. He acts with and on the patient toward some good, making him a moral agent. And

⁴⁰ There is increasing social and institutional pressure for physicians to perform elective procedures (such as abortion) or refer for them or risk professional or legal consequences. The American Civil Liberties Union (ACLU) recently tried to sue the United States Conference of Catholic Bishops for the prohibition against Catholic hospitals performing abortions found in the *Ethical & Religious Directives* no. 45. See Kathy Schiffer, “Courts Deflect ACLU Attack against Catholic Hospitals,” *National Catholic Register* (11 April 2016), <http://www.ncregister.com/blog/kschiffer/courts-deflect-aclu-attack-against-catholic-hospitals> (accessed July 20, 2016).

⁴¹ John Paul II, Encyclical Regarding Certain Fundamental Questions of the Church's Moral Teaching *Veritatis Splendor* (6 August 1993), §13 *Acta Apostolicae Sedis* 85 (1993), 1144.

insofar as he is a moral agent, his own freedom and conscience must be considered just as much as the patient's. In fact, protecting the physician's autonomy against radical patient autonomy also protects, in some cases, the patient. It is possible that a patient may request something of the physician that is not in keeping with the patient's good, a fact that might be unknown to the patient but known to the physician as the knowledgeable party.

Another social distortion of medicine resulting from a radical view of autonomy concerns the role of the State itself. The Pope warns, "...broad sectors of public opinion justify certain crimes against life in the name of the rights of individual freedom, and on this basis they claim not only exemption from punishment but even authorization by the State, so that these things can be done with total freedom and indeed with the free assistance of health-care systems."⁴² There is a tendency to enshrine into law whatever comes to be seen as a "right". Of course, this is the proper role of law and of the State when it concerns genuine human rights. But as we have seen, rights grounded not in ontology but in freedom itself distort the very concept of rights and consequently the role of law which ought to protect rights. When this happens, physicians must concern themselves not only with defense against litigation and the individual demands of misguided patient autonomy, but also against the increasing presence of the state. A physician who refuses to perform unnecessary elective surgery, for example, may be accused of "discrimination" since he refused to carry out the wishes of the patient. Medicine further degrades into a kind of commercial transaction with the patient in the role of the "customer" who purchases "services" from a service provider.⁴³ The laws of the marketplace replace personal encounter and therapeutic alliance as the norms driving the doctor-patient dynamic. The

⁴² John Paul II, *Evangelium vitae*, no. 4.

⁴³ In so-called abortion rights verbiage, abortion itself is often referred to falling under the heading "health care services" or "reproductive health".

Hippocratic motto may have been, “*primum non nocere*,” but under the tyranny of the new autonomy and the authority of the state, *do no harm* becomes *the customer is always right*.

The intrusion of the State into the physician-patient relationship, especially in state-run healthcare models does little to protect the authentic autonomy of the patient or the physician. In State-run models, the physician may be coerced by force of law to submit to the autonomy of the patient, which is of course a violation of his own autonomy, but he is also forced to act as an agent of the *State*. This may especially take the form of healthcare rationing resulting in a turning of the physician against the patient for the sake of the interests of the State, which are usually financial or worse, ideological. The physician becomes, as Sgreccia suggests, a “double agent”.⁴⁴ He must protect his own autonomy all the while acting in the interests of both the patient and the state, remaining fearful of the danger both present to his autonomy, his conscience, and the practice of his art. In a chillingly prophetic passage from *Evangelium vitae*, the Pope warns that when certain crimes against life come to be seen as “rights”, then “the State is called upon to give them legal recognition and to make them available through the free services of health-care personnel.”⁴⁵ In the United States in particular, these questions are currently being debated at a national level because of the mandates of the Affordable Care Act and the prevailing radical view of autonomy. In June 2014, the United States Supreme Court decided 5-4 in favor of Hobby Lobby and two other privately held companies, stating that the Health and Human Services’ contraceptive mandate in the Affordable Care Act violated the Religious Freedom Restoration Act.⁴⁶ The mandate would have required the employers to provide potentially abortifacient contraceptives to employees as part of their health insurance

⁴⁴ See Elio Sgreccia, *Manuale di Bioetica*, Vol. II (Milan, IT: Vita e Pensiero, 2011), 668-670.

⁴⁵ *Ibid.*, 11.

⁴⁶ See *Burwell v. Hobby Lobby*, 573 U.S. ___, 134 S. Ct. 2751 (2014).

coverage and in violation of their religious beliefs or risk facing crippling fines. In August 2016, a suit was filed against a proposed rule in the Health and Human Services mandate that would have required physicians to perform sex reassignments when requested under the guise of non-discrimination based on sex.⁴⁷ In the Health and Human Services regulation, “sex” is redefined so as to refer not to one’s biological sex, but to “an individual’s internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual’s sex assigned at birth.”⁴⁸ The regulation not only aims to erode physician autonomy, but does so in the name of state-mandated non-respect for reality and bodily ontology. Further, it actually considers respect for reality, which is a fundamental tenet of the very nature of medicine, to be *a form of discrimination*. Legal cases and decisions such as these which have widespread ramifications for the practice of medicine demonstrate the increasing need for robust conscience protections for physicians and healthcare professionals against the unbridled autonomy of the patient with the legal backing of the State.

Recovering the Sacred Art

Medicine today is often marked by over-specialization and the domination of technology. Patients are likely to be met by teams of medical specialists who may spend only a few precious

⁴⁷ See *Franciscan Alliance, Inc. v. Burwell*, No. 7:16-cv-108 (N.D. Tex. 2016). The case is now captioned *Franciscan Alliance, Inc. v. Price* in recognition of the Senate confirmation of President Trump’s HHS Secretary, Thomas Price. Secretary Price himself has now stepped down. Should the case continue, a substituted party is anticipated as the first named defendant.

⁴⁸ See Department of Health and Human Services, Nondiscrimination in Health Programs and Activities, Federal Register vol. 81 no. 96, 31381. (May 18, 2016). On December 31, 2016 United States District Judge Reed O’Connor entered a nationwide injunction blocking enforcement of sections of the rule. See ORDER at 227 F.Supp.3d 660 (2016). Lori Windham, counsel for Franciscan Alliance, commented on the injunction: “This is a common-sense ruling: The government has no business forcing private doctors to perform procedures that the government itself recognizes can be harmful, particularly to children, and that the government exempts its own doctors from performing.” See <https://www.becketlaw.org/media/court-strikes-harmful-transgender-mandate/>. With the change in administrations following the 2016 presidential election, HHS sought and obtained a stay on further proceedings. It has advised the District Court that is reviewing and reconsidering the wisdom of the rule and anticipates future proposals and public comment, signifying that the government seems to be reversing its position.

minutes with each of them.⁴⁹ During their hospital stay, the patient may never see the same face twice, save for the nursing staff who tend to have the most contact with patients. A patient may be made to feel like he is merely a disease or a case study—a problem to be solved rather than an autonomous person to be received with compassion. At the same time, healthcare professionals may develop a habit of being personally removed from their patients or not being attentive to their human needs. There is little room for compassionate philanthropy in this model. Both this reality and the cases of conflict of autonomies in contemporary medicine we have examined are symptoms of a *dehumanization* of medicine. In his address to Italian physicians, Pope John Paul II emphasized that “The doctor-patient relationship must return to being based on a dialogue of listening, of respect...to an authentic encounter between two free individuals, or, as has been said, between “trust” and “conscience.”⁵⁰ But if the new emphasis on patient autonomy sought to correct a tradition of paternalism, it has over-compensated. Rather than correct abuses, it has simply erred in the opposite direction. Sgreccia observes that “Responding to the potential abuses of medical paternalism by appealing to the principle of autonomy alone does not seem to reestablish equilibrium in the physician-patient relationship.”⁵¹ Autonomy remains, to be sure, an important principle of moral medicine, but, “Autonomy cannot be a unilateral moral right for either patients or physicians,” as Pellegrino rightly notes.⁵² It can only be a legitimate exercise of autonomy—in both principle and practice—which considers autonomy as exercised in an encounter of co-equal persons choosing the good in dialogue together. This calls for a

⁴⁹ See *Ethical & Religious Directives*, Introduction to Part Three. The *Directives* go on to say that “the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient,” and that “the relationship of the person seeking health care and the professionals providing that care is an important part of the foundation on which diagnosis and care are provided.”

⁵⁰ See footnote 30.

⁵¹ Sgreccia, *Personalist Bioethics*, eds. Dicamillo and Miller, 217.

⁵² “Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship” in *The Philosophy of Medicine Reborn*, 208.

humanization of medicine as an encounter of persons with a common philanthropic objective— an encounter not merely of competing wills and medical specialization, but of mutually free individuals in dialogue with a view to the good.

Catholic healthcare professionals have a special role to play in this rehumanization. Toward the end of *Evangelium vitae*, John Paul II offers solutions to this distortion of medicine by the exaltation of radical autonomy. The Pope calls for a formation of conscience that includes “reestablish[ing] the essential connection between life and freedom” and “the recovery of the necessary link between freedom and truth.”⁵³ Catholic healthcare is “animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.”⁵⁴ The Catholic physician already has the means of such a formation of conscience through the teaching of the Church and Her rich tradition of moral medicine—a tradition which upholds individual freedom while rooting it in the objective goods of the person. The healing ministry of Jesus Christ demonstrates that autonomy of both the doctor and patient can work in harmony toward the patient’s good without becoming domineering or coercive. Physicians serve Christ in the poor and the sick through their art, for, “It is precisely in the ‘flesh’ of every person that Christ continues to reveal himself and to enter into fellowship with us, so that rejection of human life...is really a rejection of Christ.”⁵⁵ Catholic physicians can serve as models of the rightful exercise of autonomy since they have as their exemplar of compassionate philanthropic medicine *Christus Medicus*—Christ the divine physician, in Whom the earliest Christians found their inspiration to care for the sick and vulnerable, and through Whom they transformed the very nature of medicine.

⁵³ John Paul II, *Evangelium vitae*, no. 96.

⁵⁴ USCCB, *Ethical & Religious Directives*, no. 1.

⁵⁵ John Paul II, *Evangelium vitae*, no. 104.