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## A PUBLIC POLICY OPTION ON THE TREATMENT OF SEVERELY HANDICAPPED NEWBORNS

James J. WALTER

*RÉSUMÉ.* — *Le besoin d'élaborer une politique chrétienne cohérente quant au traitement des nouveau-nés gravement handicapés est critique en notre société pluraliste. L'argument central de cet essai est que les écrits de Richard A. McCormick, s. j., contiennent implicitement une méthodologie systématique normative grâce à laquelle il construit une option de politique publique chrétienne quant au traitement ou au non-traitement de ces enfants. La conclusion générale de l'essai, c'est que la position de McCormick est non seulement solide et cohérente, mais est la meilleure option publique disponible relativement à cette question.*

*SUMMARY.* — *The need to elaborate a coherent Christian public policy on the treatment of severely handicapped newborns is critical in our pluralist society. The central argument of this essay is that the writings of Richard A. McCormick, S.J. implicitly contain a systematic normative methodology by which he constructs a Christian public policy option on the treatment/nontreatment of these children. The general conclusion of the essay is that McCormick's position is not only sound and coherent but the best public option available on this issue.*

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**P**UBLIC ATTENTION is increasingly focussing upon the decisions to treat or not treat severely handicapped neonates. Society is groping for a public policy option which might be employed in order to aid in deciding this important issue. The complexity of the issues involved has not only made the search for a public policy difficult, but the plurality of voices offering options has made the adoption of any one option impossible up to this time.

The primary intent of this essay is to offer a public policy option on the treatment of severely handicapped newborns based upon the writings of Richard A. McCormick, S.J. Although McCormick is no newcomer to the field of medical ethics, he has not yet addressed the issue of severely handicapped neonates in any extensive way. Notwithstanding this fact, I want to argue that his writings implicitly contain a

systematic methodology by which one could construct a Christian public policy option on the treatment of these children. I will argue that there are seven components which make up McCormick's methodological movement from a normative anthropology to a normative understanding of patient-centered care for neonates. In doing so, I will articulate what I take to be McCormick's theological and ethical contexts for his public policy option. The second purpose of the essay will be to assess critically McCormick's position while essentially adopting his policy option and its criteria.

Two things need to be stated from the outset about McCormick's movement from anthropology to a patient-centered approach to decision-making in cases of never-competent patients. First, both the structure and the individual components which make up the movement are *normative* (what *ought* to be the case), not *descriptive* (what *is* the case). Second, each of the components is logically distinguishable, but taken together they form an unfolding coherent approach to deciding the issue of treatment or nontreatment for severely handicapped children. Although I will proceed deductively in explicating his approach, McCormick almost always begins with patient-centered care and moves to his anthropology. In brief outline form, then, McCormick's policy option moves methodologically from (1) a normative theological/philosophical anthropology which seeks to emphasize our essential sociality; to (2) a normative moral order which is available to human insight; to (3) a normative understanding of what a reasonable person *would* want; to (4) a normative understanding of "best interests"; to (5) a normative understanding of what a patient *ought* to want; to (6) a normative understanding of what an incompetent patient *would* want; to (7) a normative understanding of patient/centered care. Let us briefly look at each one of these components in turn.

### (1) *Normative Anthropology*

Like most Catholic anthropology, McCormick's construing of humanity's situation is articulated through both theological and philosophical insights. Theologically, McCormick maintains that the Christian story contains some perspectives, themes and insights which are related to biomedical ethics. The Christian story illumines for us the fact that we are created by a God who is preserver of our lives; God is the end and purpose of our lives; we are on a pilgrimage and thus have no lasting home in this world; in Jesus' life, death and resurrection we have been totally transformed (personally and communally); we remain subject to sin, although both sin and death have met their victor; the ultimate significance of our lives consists in developing new life; the ultimate destiny of our combined journeys is the coming of the "Kingdom"; we are offered eternal life in and through Jesus Christ; and, the central manifestation of this new life in Christ is love for each other made manifest in concrete forms of justice, gratitude, forbearance and chastity.<sup>1</sup> For McCormick, these perspectives which are drawn from the Christian story illumine the ultimate

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1. Richard A. McCORMICK, S.J., "Theology and Biomedical Ethics", *Église et Théologie*, 13 (Winter, 1982), pp. 317-318.

meaning of ourselves and the world. Thus, it is the Christian story which “tells us the kind of people we ought to be, the goods we ought to pursue, the dangers we ought to avoid.”<sup>2</sup>

From the theological side of his anthropology McCormick consistently draws two conclusions. First, our love of neighbor is in some very real sense our love of God. McCormick reasons that if God is truly our end and purpose and if our love of neighbor is in some real way our love of God, “the meaning, substance and consummation of life are found in human *relationships*.”<sup>3</sup> Second, he maintains that in the Judaeo-Christian story God relates to and covenants with a people. This covenant relation underscores two aspects of our personhood: our essential equality and our radical sociality. The latter suggests that our well-being is always interdependent, i.e., it can never be pursued independently of the goods of others. Thus, our shared status in Christ must be understood in such a way that our well-being and the rights which protect the flourishing of our well-being cannot be construed in isolation from others.<sup>4</sup>

McCormick’s philosophical insights into the nature and condition of humanity are informed by a revised understanding of natural law theory. Drawing upon the writings of J. de Finance, G. Grisez, et al., McCormick argues that our human nature contains a certain limited number of basic inclinations (*inclinationes naturales*). These inclinations, e.g., the tendency to preserve life, the tendency to seek out other persons and seek their approval (friendship), are what ground our pursuit of basic underived values. Our choices to pursue these basic values and not to act against them unjustifiably constitute at least part of our human flourishing. In fact, the morality of our conduct is determined by the adequacy of our openness to these values. As McCormick himself states it, “(E)ach of these values has its self-evident appeal as a participation in the unconditioned Good we call God. The realization of these values in intersubjective life is the only adequate way to love and attain God.”<sup>5</sup> Although we apprehend these basic values spontaneously, McCormick is always clear that the inclinations themselves and our perceptions of the values to which they lead us are inexorably culture-conditioned.<sup>6</sup>

## (2) *Normative Moral Order and Epistemology*

McCormick’s insistence upon the objectivity of normative morality (normative moral order) and its knowability (epistemology) through human experience and insight are grounded in his theology and philosophy of humanity. Humanity is fallen,

2. *Ibid.*, p. 318.

3. *Ibid.*, pp. 323-324. Emphasis McCormick’s. Also, see his *How Brave A New World?: Dilemmas in Bioethics* (Garden City: Doubleday & Company, Inc., 1981), pp. 345-346.

4. MCCORMICK, “Theology and Biomedical Ethics”, pp. 325-326.

5. Richard A. MCCORMICK, S.J., “Bioethics and Method: Where Do We Start?”, *Theology Digest*, 29 (Winter, 1981), p. 305.

6. *Ibid.*, pp. 304-307. Also, see Richard A. MCCORMICK, S.J., “A Commentary on the Commentaries”, in Richard McCormick and Paul Ramsey, eds., *Doing Evil To Achieve Good: Moral Choice in Conflict Situations* (Chicago: Loyola University Press, 1978), p. 251.

to be sure, and we continue under the influence of sin until the eschaton. However, humanity is neither so fallen nor so deprived of God's grace that God's creation is destroyed. In fact, we are both personally and communally transformed through the saving acts of Jesus Christ. These theological claims actually ground McCormick's philosophical speculations about both the essential indispensability of the natural inclinations as the roots of our moral obligations (normative morality) and our ability to reflect normatively about what we ought to be and do (epistemology). Thus, our created-redeemed nature provides us with the data upon which we can reflect for the discernment of our general moral obligations.

McCormick is quite clear that revelation or the Christian story does not give us concrete moral judgments about what we are to do. In other words, Christian perspectives do not immediately yield moral norms and rules for decision-making. Rather, the Christian story and symbols sharpen and intensify our focus on the basic human goods which are definitive of our well-being and flourishing.<sup>7</sup> Because our basic inclinations are always subject to the biases and destructive influences of a concrete culture, the Christian story aids us in steadying our gaze upon these basic values.<sup>8</sup> Furthermore, McCormick maintains that the very meaning, purpose and value of a person is grounded in and ultimately explained by the Christian story. As such, this story itself "is the overarching foundation and criterion of morality. It stands in judgment of all human meaning and actions. Actions which are incompatible with this story are thereby morally wrong."<sup>9</sup> What we find in McCormick's writings, then, are two fundamental criteria that guide our discernment of objective morality, viz., (1) the natural inclinations which disclose to us the fundamental values which define our human opportunity and flourishing, and (2) the Christian story. The problem, however, is that whereas all have access to the natural inclinations as a way of arriving at objective morality, not all have access to the Christian story.

McCormick has addressed this problem over the past several years by arguing that the perspectives, insights, etc., that are contained in the Christian story are not ultimately mysterious, that is, they are not utterly impervious to human insight without the story.<sup>10</sup> By this McCormick means the themes contained in the Christian story are inherently intelligible and recommendable, although it is difficult to discover them in a fallen world. From an epistemological point of view, then, these insights which can be gathered from the Christian story can be shared by everyone and are available in human experience.<sup>11</sup>

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7. Richard A. MCCORMICK, S.J., "Does Religious Faith Add to Ethical Perception?", in John C. Haughey, ed., *Personal Values in Public Policy: Conversations on Government Decision-Making* (New York: Paulist Press, 1979), pp. 167-170. Also, see his "Theology and Biomedical Ethics", p. 316.

8. Richard A. MCCORMICK, S.J., *Notes on Moral Theology: 1965 Through 1980* (Washington, D.C.: University Press of America, 1981), p. 638.

9. MCCORMICK, "Theology and Biomedical Ethics", p. 318.

10. See MCCORMICK, "Bioethics and Method", pp. 310-312; *Notes on Moral Theology*, pp. 626-638; and "Theology and Biomedical Ethics", p. 329.

11. MCCORMICK, "Theology and Biomedical Ethics", p. 331.

(3) *Normative Understanding of What a Reasonable Person Would Want*

It is with the third component that we encounter what McCormick calls the “reasonable person” standard.<sup>12</sup> Such a standard attempts to construe what a reasonable person in a normative sense would want, and it becomes the basis for making substituted judgments for the never-competent patient.

McCormick makes several assumptions that ground the possibility of constructing and employing the reasonable person standard. First, he assumes a normative social anthropology which views our well-being as necessarily linked to the pursuit and attainment of fundamental goods for ourselves and others. Second, he assumes that we can know the morally good and that such insights are available in principle to everyone. Third, he assumes that “the reasonable” in a normative sense is not arbitrary but objective, i.e., it is not concerned with frivolous or eccentric desires or what we might desire when we commit sin.<sup>13</sup> In other words, McCormick maintains that, “There is at least an area of the objectively reasonable; otherwise there would be no standard against which we could identify the eccentric, the idiosyncratic, the wrongful.”<sup>14</sup> Finally, he assumes that most people are reasonable, although he recognizes that not all are such or always want to be.<sup>15</sup>

McCormick’s definition of the reasonable person standard is not as clear as it could be. I would interpret his construction of this standard as another way of expressing that set of human insights which are considered normative. In other words, the reasonable person standard could be defined as that mutually-related set of theoretic and practical insights which are considered normative in the deliberation and decision-making for public policy. As such, these insights originate in the interplay between concrete experience and thoughtful reflection, and they are constantly open to further correction in this interplay. This set of normative insights is the closest approximation of what we can know at any given time of the objective moral order based upon the nature of persons. McCormick is not claiming that we can ever know with *absolute* certitude what is required of us as long as we are pilgrims in this world subject to the conditions of finiteness and sin. However, I would argue that he is confident that we can know our general moral requirements and their limits with *probable* certitude. Thus, the reasonable person standard is a heuristic way of expressing those moral requirements and their limits which impinge upon us all as persons. Because our moral reasons are historically conditioned, the set of normative insights can fluctuate between advance and decline depending upon our/society’s historical-cultural situation. McCormick is interested in the Christian story because he argues that it can steady our gaze upon our fundamental human goods in order that we might all advance further in moral insight.

McCormick argues that to appeal to the reasonable person standard is really an appeal to what most of us, in similar circumstances, would do, that is, as reasonable

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12. MCCORMICK, *How Brave A New World*, pp. 99–113.

13. *Ibid.*, p. 109.

14. *Ibid.*

15. *Ibid.*, p. 104.

people with healthy outlooks on the meaning of life and death.<sup>16</sup> The reasonable person standard is not an actual person, and in this sense it is similar to the ideal observer theory.<sup>17</sup> As a formal criterion, then, it leaves untouched the *actual* criteria that actual reasonable persons use in making decisions. McCormick states, "The judgment of reasonable people is not *constitutive* of the rightness of the decision. It is merely *confirmatory* that the criterion is close to the mark."<sup>18</sup> McCormick is arguing here that the consensus of actual reasonable people does not constitute reasonableness in a normative sense. We can presume that reasonable people will draw close to the mark, but that is because McCormick has assumed that most people are or want to approximate reasonableness. Reasonable people's consensus, then, confirms rather than constitutes what is truly reasonable.

It is important to emphasize before going to the next sections that McCormick would maintain that the reasonable person standard serves as ground and justification for both guardian substituted judgments and hypothetical substituted judgments.<sup>19</sup> What the reasonable person standard attempts to ascertain are the requirements and/or limits of moral obligations. As we will see, it is this discovery of moral requiredness or moral limits which is substituted for the newborn.

#### (4) *Normative Understanding of "Best Interests"*

Since the defective newborn cannot decide about its own treatment/non-treatment, someone must decide in its place. Whoever this "someone" is, e.g., parents, hospital committee, courts, some type of criterion/criteria must be employed in order that the decision not be arbitrary. Several criteria have been offered to guide the guardian's decision: (1) the ordinary/extraordinary means distinction<sup>20</sup>, (2) a standard-medical-care policy<sup>21</sup>, (3) parental wishes<sup>22</sup>, and (4) the best interests of the patient. It is the last criterion which McCormick adopts. However, several questions

16. *Ibid.*, p. 399.

17. For a brief summary of the ideal observer theory, see Robert VEATCH, *A Theory of Medical Ethics* (New York: Basic Books, Inc., 1981), pp. 116-118.

18. MCCORMICK, *How Brave A New World*, p. 399. Emphasis McCormick's.

19. E. Santurri and W. Werpehowski define hypothetical substituted judgments as those which judge what would be chosen or decided by a person who for some reason lacks the capacity *de facto* to make a decision in a given case. On the other hand, guardian substituted judgments objectively assess what constitutes a person's best interests all things considered. See their "Substituted Judgment and the Terminally-Ill Incompetent", *Thought*, 57 (December, 1982), pp. 484-501. I will clarify below why McCormick considers these two types of judgments to be intimately related.

20. Most former textbooks by Catholic authors on medical ethics (e.g., Gerald KELLY, S.J., *Medico-Moral Problems*, 1957) employed this distinction, and Leonard Weber is a contemporary Catholic author who continues to use it. See, L. WEBER, *Who Shall Live?: The Dilemma of Severely Handicapped Children and Its Meaning for Other Moral Problems* (New York: Paulist Press, 1976). For McCormick's criticism of such a criterion, see his *How Brave A New World*, pp. 393-395.

21. Paul Ramsey discusses and criticizes this criterion in his *Ethics At The Edges of Life: Medical and Legal Intersections* (New Haven: Yale University Press, 1980), pp. 154 and 159.

22. This criterion is problematic for two reasons. First, the content of the criterion is not universalizable, and, second, it implies at least three interpretations of the parent-child relationship, viz., ownership, equality and trusteeship. I wish to thank Norman C. Fost, M.D., for making this criterion and its distinctions known to me.

immediately arise: what is the meaning of “best interests”?; how are they determined?; who is to determine “best interests” for the incompetent child?; and, are there limits to the “what”, “how”, and “who”?

McCormick argues that there is really only one test or criterion that need be applied to the never-competent patient, and this test is the “best interests” test.<sup>23</sup> For him, “best interests” must always be understood in a normative sense. As such, the terms refer to our good as human persons whose flourishing is inextricably bound up with the well-being of others.<sup>24</sup> Two things need to be noted here. First, “best interests” are normatively defined in terms of those fundamental values to which our natural tendencies incline us. As we have seen, our openness to and pursuit of these values enable us to share in human flourishing, i.e., the *summum bonum*. Second, McCormick places his definition squarely within the context of his social anthropology. Thus, “best interests” include, in part at least, the family’s interests, since the newborn’s interests are most intimately bound up with those upon whom it must rely. This does not mean that the family can decide arbitrarily, or even primarily in its own interests, because McCormick is always clear that there are limits to how and what parents can decide.

In his analysis of the Saikewicz case McCormick allows the needs, preferences and wants of a patient to count in the determination of what constitutes “best interests.”<sup>25</sup> Although Mr. Saikewicz was never a competent patient, he did have some sixty-seven years of life to be observed, and he was able to express in some form his own preferences and wants. However, a handicapped newborn has had only hours or days of life before a decision sometimes needs to be made about its treatment/nontreatment, and thus there is no sense in speaking of the neonate’s preferences or wishes. In these cases, then, “best interests” or patient-benefit need to be confined to those considerations of the fundamental values that apply to us all.<sup>26</sup> But how is that determined? Only part of the answer can be given here; the rest must wait until later.

The hermeneutic standard which determines what “best interests” means for a newborn is the reasonable person standard. As a matter of fact, McCormick argues that our perceptions contained in the reasonable person standard form the basis upon which we build our judgments about what is in the best interests of *all* incompetent patients, whether they were once competent or not.<sup>27</sup> For him, to employ the reasonable person standard is to make sure that the terms “best interests” are always understood normatively. Thus, this test must necessarily exclude all eccentric wants and preferences as well as all sinful desires. Only those desires that incline us to the fundamental goods and conform to the objective hierarchy of values

23. MCCORMICK, *How Brave A New World*, p. 112.

24. *Ibid.*, p. 101.

25. *Ibid.*, p. 103.

26. *Ibid.*, p. 376.

27. *Ibid.*, p. 108. As I indicated above, if the patient was once-competent, then McCormick would include preferences, wants, etc., into what actually constitutes “best interests.” For a further discussion of McCormick’s position, see *ibid.*, pp. 102-103.



are included in and interpreted by the reasonable person standard. What McCormick means when he says that most people are or desire to be reasonable is that most people seek what is in their best interests.<sup>28</sup> In sum, “best interests” are interpreted by the reasonable person standard, and both are normatively grounded in a social anthropology.

McCormick has claimed that we ought not deny the quality-of-life ingredient but attempt to control it within what he considers the bounds of the truly human and Christian.<sup>29</sup> His reference point for what constitutes “the truly human and Christian” is his theological-social anthropology understood normatively. He has interpreted the Judaeo-Christian tradition to mean that our love of neighbor is in some real way our love of God. Although all of us are of equal value, our physical existence alone is not a value to be preserved in and for the sake of itself. Rather, physical life is the condition of the possibility of truly human life, that is, life lived in communion with others through whom is mediated our love of God. Thus, McCormick argues that when those conditions of physical life are not present at all or are so severely damaged and burdensome so as to foreclose any real possibility of human relationships, that life need not be saved.<sup>30</sup> It need not be saved precisely because such having would not be in the best interests (normatively understood) of the dying child. In other words, McCormick includes within his “best interests” test the necessary good of human relationships as part of our flourishing and human opportunity. To save such a life either with *only* the capacity for physical existence or with *tremendous and life-long* burden is in reality to go against the dignity of the child, which, for McCormick, would be an improperly ordered choice. I would also agree with David Roy.

When biological damage is so extensive that curative, restorative, and corrective medical interventions cannot aid the patient’s development but only succeed in perpetuating or prolonging a patient’s fixation at a level of development which is not meant to be final and is far short of the variety of purposes and levels of life to which biological human life is ordained — when this obtains, then, so the canon (canon 3 of his canons of medical practice) states, medical intervention has reached its limits, works contrary to its calling in perpetuating such fixations, and should not be employed.<sup>31</sup>

I would only add, as I think McCormick would, that interventions which incur such burden would be contrary to the best interests of the child.

Precisely who determines the child’s best interests has also been a debated matter. Without discussing the merits or liabilities of each proposal, the following seem to be the likely candidates: (1) the parents, (2) a hospital ethics committee<sup>32</sup>,

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28. *Ibid.*, pp. 105 and 110.

29. MCCORMICK, *Notes on Moral Theology*, p. 109.

30. MCCORMICK, *How Brave A New World*, p. 349. Also, see David ROY, “Issues in Health Care Meriting Particular Christian Concern — A Priority Issue: The Severely Defective Newborn”, *The Linacre Quarterly*, 49 (February, 1983), pp. 60–80.

31. ROY, “Issues in Health Care”, p. 74.

32. Norman Fost adopted this proposal in a lecture which he delivered before the Lilly Seminar on Religion, Ethics and Medicine at Terre Haute, Indiana, in February, 1983.

(3) a guardian *ad litem* and (4) the courts.<sup>33</sup> McCormick has adopted the first candidate (the parents).

McCormick has offered two reasons why the parents (family) ought to be the ones who decide for the incompetent. In cases that involve the once-competent the family is normally in the best position to judge the real interests of the patient. However, since the neonate has no previous competent life, this reason is moot. His second reason for familial choice is based upon the great value that society places upon the family.<sup>34</sup> Especially in cases of the never-competent patient the family's right to self-determination should be prized. McCormick even offers theological warrants for supporting this right of the family to decide, e.g., as a tightly bound unit the family exists as a sacramental ministry to the world. However, he would not consider familial self-determination to be any absolute right. This right, like the individual's right to self-determination<sup>35</sup>, is an instrumental value that must be ordained to the good at stake. Thus, parents are limited in their familial self-determination by the best interests of their child. On the other hand, the terms "best interests" of the child are not unrelated to familial interest as McCormick has made clear not only in his social anthropology but also in his normative understanding of the "best interests" test itself. Such a view seems to give parents some latitude in discerning the best interests of their child in terms of their own good, although this latitude itself is subject to the reasonable person standard.

#### (5) *Normative Understanding of What a Patient Ought to Want*

At first sight this component seems wrong-headed, because in the case of neonates there is no moral agency that can be attributed to them.<sup>36</sup> I will argue that this component is not only not wrong-headed but that it is an essential element for determining patient-centered care. Although McCormick's original formulation of this component was fashioned within the context of nontherapeutic experimentation on children<sup>37</sup>, nevertheless it contains several insights for our purposes here. When applied to the issue of treatment/nontreatment for neonates this component attempts to discover both the "obligations" of the child (what the patient ought to want) and their limits.

33. McCormick has argued that the Massachusetts Supreme Court's decision in the Saikewicz case to entrust all judgments about his welfare to the judicial system alone would apply to all incompetent patients. In this case, the courts would become the only locus of decision-making for all severely handicapped newborns. See his *How Brave A New World*, p. 365.

34. MCCORMICK, *How Brave A New World*, p. 377.

35. I find McCormick's discussion of competent patients' rights to self-determination as an instrumental value one of the least nuanced aspects of his position. For a full discussion of his position, see *ibid.*, pp. 352-361. For what I would consider to be a more nuanced position on this matter, see Warren T. REICH, "Towards a Theory of Autonomy and Informed Consent", *The Annual of the Society of Christian Ethics*, Larry L. Rasmussen, ed., 1982, pp. 191-215.

36. See Paul RAMSEY, "The Enforcement of Morals: Nontherapeutic Research on Children", *The Hastings Center Report*, 6 (August, 1976), pp. 21-30.

37. See MCCORMICK, *How Brave A New World*, pp. 51-57.

The contexts for McCormick's discussion of neonatal "obligations" are his social anthropology and normative ethics. As we have seen time and again, McCormick seeks to employ insights gained from his reflection upon the nature of persons. For him, moral claims are rooted in the very nature of persons, although this does not mean that persons will always necessarily experience these claims.<sup>38</sup> The distinction McCormick seeks to draw is between what is reasonable to expect of everyone and the *experience* of such claims. It is obviously true that neonates do not experience moral claims because they do not as yet have the capacity for moral agency. However, McCormick argues that even neonates are subject to what can be reasonably expected to everyone by the mere fact that they are social human beings who are in possession of the natural inclinations which drive us all to certain underived values. Since the adequacy of our (and thus the neonate's) openness to these fundamental values constitutes the possibility of our participation in human well-being and flourishing, even the newborn is subject to the claims (but also the limits) of openness to the values. In other words, to be a human being logically implies being subject to those fundamental claims (what can be reasonably expected to everyone) that are grounded in the nature of being human with a destiny to participate in the *summum bonum*, God. Stated negatively, moral claims are rooted neither in the adult's experience of the claims nor in the adult's capacity or willingness to respond to them. To speak of what the newborn ought/ought not want, then, has no reference to the child's *experience* of moral obligations but only to what can reasonably be expected/not expected of all human beings *qua* human beings.<sup>39</sup>

What ought/ought not the child want? To answer this question we must return to an earlier component in McCormick's methodological movement. Stated simply, the child ought to want its own best interests normatively understood.<sup>40</sup> The reason for this, as we have already seen, is because "best interests" are definitive of our very human opportunity and flourishing, and thus our participation in the unconditioned Good, God. McCormick also argues that if we are able to determine the limits of what can be reasonably expected of everyone, then we have determined the limits of what the child ought to want. He claims that the child ought not want treatment because it need not want it<sup>41</sup>, that is, it is contrary to the child's best interests. Once again, the standard which interprets the child's positive obligations (to preserve its life), or limits them (not seek treatment), is the reasonable person standard.

To want treatment beyond what can be reasonably expected in the interests of the child is to indulge in arbitrary freedom at the expense of the sanctity of the child's

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38. *Ibid.*, p. 90.

39. *Ibid.*, p. 95. McCormick has been willing to drop his use of the word "ought" and accept Toulmin's emendation, which reads as follows: "the child could not reasonably object to" treatment (or nontherapeutic experimentation). However, McCormick is clear that such an emendation does not change the normative roots of his own position. See MCCORMICK, *How Brave A New World*, p. 112. Also, see Stephen TOULMIN, "Exploring the Moderate Consensus", *The Hastings Center Report*, 5 (June, 1975), pp. 31-35.

40. MCCORMICK, *How Brave A New World*, p. 359.

41. *Ibid.*, p. 95.

life. The converse is also true, namely, not to want treatment when it is within the limits of what can be reasonably expected in the interests of the child is to indulge in arbitrary freedom. What is being substituted, then, are those requirements or limits to which all of us ought to be bound in the pursuit of the fundamental values (best interests).

(6) *Normative Understanding of What an Incompetent Would Want*

For McCormick, to ask what an incompetent would want is not a senseless question, since in fact it supplies the content for what is called the hypothetical substituted judgment or “hypothetical” test. He is quite insistent that whereas the guardian judgment (best interests test) and the hypothetical judgment are distinguishable, they are not separable from one another.<sup>42</sup> These two judgments are intimately related, and both attempt to discover what ought to be done for the incompetent patient. However, McCormick is clear that the hypothetical test is subordinate to the “best interests” test.<sup>43</sup> In other words, a handicapped newborn would/would not want treatment because it is/is not in its best interests. Once again, what interprets the “hypothetical” test is the reasonable person standard.

Against his critics<sup>44</sup>, McCormick argues that it is quite legitimate to link together the following three assertions: what the child would choose, would reasonably choose, would choose if moral.<sup>45</sup> His reasons for linking these assertions should already be evident. The child would so choose because it ought to so choose because it is in the best interests of the child to so choose. Now, McCormick’s critics would be correct if it weren’t for the fact that he always understands each of these assertions *normatively* according to the reasonable person standard. In other words, if one were to construe each assertion *empirically* and *individualistically*, that is, according to an individualist anthropology which looks to what actual people might do under specific biases and eccentricities, then the linkage does not hold. But this has been my point all along, namely, the normativeness of McCormick’s methodological movement from his anthropology to his patient-centered care. In sum, the ground of and justification for hypothetical substituted judgments is the fact that the newborn ought/ought not want the treatment because it is/is not in its best interests.

(7) *Normative Understanding of Patient-Centered Care*

We have reached the final component in McCormick’s methodological movement, a point from which he actually begins. Although his policy option has been criticized for not being patient-centered<sup>46</sup>, McCormick’s reasonable person standard

42. *Ibid.*, pp. 99–113.

43. *Ibid.*, p. 112.

44. See Benjamin FREEDMAN, “On the Rights of the Voiceless”, *Journal of Medicine and Philosophy*, 3 (September, 1978), pp. 196–210.

45. MCCORMICK, *How Brave A New World*, p. 113.

46. See Gilbert MEILAENDER, “If This Baby Could Choose...”, *The Linacre Quarterly*, 49 (November, 1982), pp. 313–321.

is quite patient-centered because it attempts to discover what are the actual normative best interests of *this* patient. As a matter of fact, both the guardian and hypothetical substituted judgments are valid and justified to the extent that they are grounded in the best interests of particular patients who ought/ought not seek treatment. It is precisely because these judgments are so grounded that they are patient-centered in an objective, i.e., normative, sense.

Although I am not certain, I think that McCormick's position is very close to, if not the same as, Pius XII's on the correlation of the rights and duties of physicians and patients.<sup>47</sup> In this *Address to anesthesiologists* Pius stated that the physician has no separate or independent rights toward a particular patient. Although he was discussing competent patients, I see no reason why such a view would not also apply to never-competent patients. If we are able to discover those positive duties which impinge upon us all by virtue of our humanity, that is, what is reasonable to expect of everyone, then the physician's duties ought to be correlative to them. Conversely, if we are able to determine the reasonable limits of our fundamental duties to those values which are definitive of our well-being and flourishing, then the physician's limits in treating us ought to be correlative to them. In the case of never-competent patients, I might even want to go beyond what Pius formulated. I would say that the physician's duties to and limits of treatment are subordinated to the newborn's, as long as one understands this all in a normative, and not descriptive, sense. By saying it that way, maybe it will become clearer that this position is essentially patient-centered.

### *Conclusion*

I have sought to make explicit Richard McCormick's systematic methodology by which one could construct a Christian public policy option on the treatment/nontreatment of severely handicapped newborns. His policy option is firmly rooted in his understandings of anthropology, epistemology and normative ethics. By arranging his policy option deductively I have been able to articulate how McCormick moves methodologically from a normative anthropology to a normative understanding of patient-centered care. Such a normative movement entails both guardian and hypothetical substituted judgments which are interpreted according to the reasonable person standard. My general conclusion has been that, despite criticisms from other authors, I have found McCormick's policy option to be not only sound and coherent but the best option available on this issue.

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47. See PIUS XII, "The Prolongation of Life", *The Pope Speaks*, 4 (1958), pp. 393-398.