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Also in this issue: "Reflections on Revising Part 3 of the *ERDs*," by John F. Brehany

The Human Being as Biological and Transcendent

Andrew St. Stephanos

To engage in a public discourse on human life issues, it is necessary to *begin with* reason and experience (and observation and reflection) and so *build a bridge* between those who tend to leave all moral decisions up to individual a reductionist view of the human being, emotions, and arbitrary definitions and those who profess a definitive belief in the inherent and inviolable dignity of every human being from fertilization until death. From this bridge between two seemingly disparate worlds, we can engage the people of our time with the idea that the human being is created in the image of God with inherent dignity and is worthy of respect and protection.

To respect and protect all human beings, we need to help people see the reality of what it means to be human, both materially and transcendently, in all its beauty and mystery, and perhaps also help them onto the bridge leading to an integration of faith and reason. To succeed, it is essential to understand where people are in their beliefs and *begin the conversation in that place* to help lead them to truth. Human beings are *both* bodily and transcendent. If we were only bodily, we could never *go out of ourselves* and experience non-bodily realities. The body would be limited to itself and not experience that which is outside itself.

The first task, then, is to establish a correct definition of the human being. We need to encompass two aspects. First, we need a broad and all-inclusive category if we are to capture every human being in its net and so formulate policies that respect and protect human beings as such. The broad *categorical definition*, therefore, answers the question, "What is it?" and helps assure that we include every single definable human being under "full human being deserving respect." The second definition examines the many overlapping and unified facets of what it means to be human, such as the biological, rational, emotional, and spiritual realities. This *descriptive definition* answers the question, "Who is it?" and helps us understand *why* every human being deserves respect and protection.

Categorical Definition

What is a human being? The first and obvious definition is *biological*. This is most apparent in the field of genetics. At the very first moment we can ascertain that a new biological human being exists, we have a complete—although not completely developed—human being aimed at full development. It is quite easy to know through genetic testing, in fact, the historically undisputed reality that the entity growing in a mother's womb is a human as opposed to a raccoon, tiger, or acorn. We know without any scientific doubt (though some erroneously attempt to obfuscate these facts) that at the very moment the ovum is fertilized by the sperm there is a genetically new and complete human being called a zygote. This genetically complete human being *will direct its own development* to become an embryo, a fetus, an infant, a child, and an adult. All this new human being needs is nutrition and protection to follow his or her genetically programmed journey.

Let us be clear here about two facts. First, the new human being possesses its own genetic code that is directing its own development aimed at completion as a mature adult. Therefore, he or she is not the mother, a part of the mother's body, or a blob of tissue, but a *unique individual*, a human totality. Second, every one of us was once a zygote, an embryo, and a fetus with the exact same genetic code that we possessed as children and now as adults. The only difference between an embryo, a child, and an adult is the stage of development with its corresponding developmental milestones.

Here we have only identified what it is: a human being, not an animal like a squirrel and never a vegetable like broccoli. This can be established simply and reasonably through observations on the biological and material reality. The categorical definition of *human being* is broad and all-inclusive, which is necessary, otherwise we venture into highly dangerous territory.

Descriptive Definition

But are we only *bodily* realities and nothing more? Very few reflective and intellectually honest people would arrive at this conclusion. Beyond nutrition and protection, we need nurturing *love* to survive and develop in a physically, emotionally, and spiritually healthy manner to adulthood. In addition, we actively seek such realities as *beauty*, *goodness*, *truth*, and *community* to facilitate human flourishing. Even though some people attempt to live as though they were nothing more than bodies, and make decisions that reflect this philosophy of life, they cannot truly flourish on a material diet alone. We cannot escape nonmaterial realities. They are written into our souls.

We can identify the transcendent and spiritual reality of the human being by reflecting on reason and human experience. Simple observation and reflection on the world around and within us reveal a great deal of data to this end. For example, we possess *reason* and so the ability to think and reflect upon ourselves, on ultimate realities, on the meaning of life, and on suffering and death. Moreover, we can contemplate universal ideas such as love, happiness, truth, goodness, beauty, freedom, eternal life, unity, and so on. No animal is capable of this.

Some may object that not all human beings are able to reason, to exercise freedom and experience spiritual realities, because of a lack of intellectual development or some disability. Some may say that this deficit makes them less than human. Quite the contrary, these capacities are present *ipso facto* in every human being regardless of circumstances. If, normatively, human beings have potentialities that become realities, then *all* human beings have these same capacities even if they do not manifest in some. The very fact of possessing the human *capacity* for love, happiness, goodness, purpose, truth, beauty, freedom, unity, and so on, sets a human being apart from lower animals and vegetative life. Their full manifestation is not necessary. By contrast, these capacities are not even "built into" lower animals and vegetative life. They can never realize them nor were they ever meant to.

Every human being, regardless of his or her level of ability, is part of the set called *human being*. It is neither reasonable nor advisable to assert that there are different sets of human beings, those with actualized capacities, those with unrealized capacities, and those with various levels of capacities realized or not. This attitude becomes a recipe for atrocity because it defines a group of people with unactualized capacities as somehow "less than fully human."

Universal Ideas

Every human being has a longing to love and to be loved—not with just *any* love, but a *perfect, endless love*, which is hardly an earth-bound, or mere bodily, reality. If you doubt this, go to a wedding or listen carefully to love songs. In a related way, every human being wants happiness, and interestingly, we have a sense of perfect love and happiness, and continually desire and seek them, even though we have never actually experienced them in their fullness. Moreover, human beings can reflect on the general idea of infinity and eternity even though, at least in our human body, we are finite. Our existence on earth deteriorates and ends, meaning we are limited, at least materially. It is as though we contain the entire universe within ourselves because we can think and reflect upon the whole of reality. We are both finite and eternal.

In reflecting on such non-bodily realities, we need to ask, "Where are the mind and universal ideas located within the *body*? What is free will (as a capacity), and where is it located within the *body*?" Clearly, these and other universal longings and realities, as well as the capacities for them, cannot be entirely contained or definitively located within the confines of a human body. They cannot be so limited by space and time. They are beyond such limits. They are *transcendent*, or nonmaterial, and yet we feel as though they are an intimate part of us that makes us whole and that we should have. They belong to us.

The bodily and transcendent reality that is me is experienced as *I*. In a sense, these realities are both within us *and* beyond us, and this is something most human beings can reflect on even as it remains somewhat of a mystery to us. After all, can one contain beauty within oneself? Is goodness confined within my body? We contain these realities, while at the same time, they are too vast for any single human being to grasp and contain. It is an amazingly beautiful mystery that a human being can write a symphony or paint a portrait or write a poem. With a little reflection and humility, it becomes apparent that although a work of art was created by the individual human being, it is larger and more profound than what could emanate from mere flesh and blood.

We may reasonably conclude, therefore, that there is a transcendent and spiritual dimension to the human being, one that we can recognize and *know*. Even the act of *reflecting* upon the self is a transcendent and spiritual act—a standing outside oneself and looking in at our own existence. Yet we remain a unity of body and soul, matter and spirit. We remain one *I*. The human person is a totality. We are not separated from ourselves when we figurately step out to look in.

In addition to the act of reflection, we can identify more examples of transcendence. Is not the act of love a *going out of oneself*? When we engage in authentic love, we are required to forget ourselves, at least largely, for the sake of the one who is loved. Lovers are givers. They *go out of themselves for the sake of others*. They sacrifice a part of themselves for others. Those who authentically love may risk their own lives to run into burning buildings to save others; they give up comforts, even their own health, to serve as missionaries or to help the poor, the sick, and others in need. Rather than taking for myself, or even preserving myself, the one who loves loses himself for the sake of others.

Beauty is another example. Does not authentic beauty often sweep us away to another world outside our bodily realities? A beautiful piece of music or art, or a sublime sunset, takes us out of ourselves, out of the confines of our material bodies. We can become *lost*, transported by authentic love and beauty. Nevertheless, we enter them without ever actually leaving bodily existence.

With these definitions in hand, we are ready to engage the debate. We must insist on the universality of our biological reality in the categorical description of the human being. But this is not enough. Once that point is admitted, we must then appeal to the descriptive definition to show that each of us transcends the merely bodily and exists as a spiritual being.

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Reflections on Revising Part 3 of the *ERDs*

John F. Brehany

Fourth in a series reviewing the current ERDs *and reflecting on what changes would be necessary or helpful in their next major revision.*

The content in part 3 of the 1995 *ERDs*, "The Professional–Patient Relationship," addresses issues in clinical care and health care delivery that fall outside the typical spectrum of ethical issues found at the beginning and end of human life.

Part 3's introduction first strives to summarize the professional, personal, and organizational elements operative in contemporary health care. One particularly striking development can be seen in the part 3 title itself. Rather than employ the traditional term "physician–patient" relationship, the title refers to the "*professional*–patient" relationship, thus recognizing the many different personnel now involved in the care of patients. While referencing the "team of providers" caring for patients, the introduction nevertheless emphasizes the *personal* character of all clinical encounters. A final paragraph connects this diversity of health care professionals and patients to the mission of Catholic health care, gently insisting that all utilizing Catholic health care must respect its commitment to Catholic teachings on the dignity of the human person.

Part 3's fifteen directives cover a range of topics. Directive 23 requires that the inherent dignity of all persons be respected; dirs. 24–25 address the topics of advance directives and surrogate decision makers; dirs. 26–28 cover the basic issues surrounding informed consent, and relatedly, dir. 31 addresses consent in the context of medical experimentation; dir. 29 briefly outlines the principles of integrity and totality; dir. 30 addresses organ transplantation from living donors (postmortem organ donation and transplantation are covered in dirs. 63–65); dir. 32 introduces the principles of ordinary and extraordinary means; dir. 33 briefly mentions the principle of proportionality; dir. 34 addresses the need to respect patients' privacy and to maintain confidentiality regarding patients' information; dirs. 35–36 address abuse, violence, and appropriate responses to sexual assault; and dir. 37 covers the need for ethics committees and resources for ethics consultations. Yet despite this wide range of issues, only the topics covered in dirs. 24–25 and 35–37 were truly new to the *ERDs* in 1995. Most directives retained or updated guidance from the 1971 *ERDs*.

Reflections on Revising *ERDs* Part 3

Opportunities to improve and update guidance in part 3 can be organized into three sets: (1) minor (but necessary) changes in terminology or formulation, (2) major revisions to key current directives, and (3) new guidance on issues in health care delivery.

There are at least two changes in terminology alone that would significantly improve part 3. First, the term *provider*, which is used in both the part 3 introduction and throughout the *ERDs* as a generic reference for physicians and health care professionals, should be replaced. Physicians and medical societies justly criticize using this term to refer to physicians, because it is potentially confusing and because it contributes to a commercialized understanding of the healing relationship.[1] While some use of the term may be legitimate (e.g., to refer to health care institutions) and convenient, it should be replaced where it is used to refer to physicians and individual health care professionals. Second, ending use of the term "fertilized ovum" in dir. 36 should be among the *first* actions taken in a revision of part 3. Use of this term "is scientifically incorrect, has no objective correlate in reality, and is therefore very misleading."[2] Moreover, this term contributes to the dehumanization of newly conceived human beings. Finally, dir. 24 should be revised to address physician or medical orders for life-sustaining treatment (POLST, MOLST, and MOST). While well intentioned, these instruments pose unique challenges to ethical decision-making, to care at the end of life, and to the conscience rights of health care professionals.[3]

Reflections on Revising Key Part 3 Directives

Directives 29 and 36 in particular require significant updating. Directive 29 briefly summarizes the principles of totality and integrity. In brief, as embodied persons, we are required to protect the good of our bodies and to sacrifice parts or functions based only upon sound ethical criteria.[4] This principle is operative in decision-making about amputations of gangrenous limbs and mastectomies in cases of breast cancer. However, proper application of this principle has been challenged by the recent rise of transgenderism, or gender ideology, a new philosophy of sex holding that one's sexual or gender identity can be determined by subjective belief even if this contradicts healthy bodily development. This philosophy and these beliefs are driving significant demands for clinical interventions, societal acceptance, and a host of accommodations in health care, education, and public services. In terms of clinical interventions alone, demanded and prescribed services include puberty blockers and cross-sex hormones, sex reassignment surgeries, and therapeutic affirmation. Demands for accommodation of new or altered identities bear upon electronic health records, forms of personal address (names and pronouns), and various forms of institutional welcoming.[5] Finally, while clinical interventions formerly were reserved to adults, changes in medical and public policy now encourage immediate affirmation and intervention for children and adolescents.[6] Clearly, dir. 29 needs significant and substantial updating to provide much-needed guidance for Catholic health care.

Directive 36 outlines an ethical response to sexual assault. Key provisions in this directive describe the goals and limits in attempting to prevent conception from occurring from an act of sexual violence. Since this directive was written in the early 1990s, clinicians and Catholic health care ethicists have struggled to implement this guidance with integrity. Changes in drugs and devices used to prevent pregnancy, and complexities inherent in establishing their mechanisms of action, have generated controversies over time. Almost thirty years after being drafted, dir. 36 needs updating to address new concerns and new drugs. First, an obligation should be very clearly stated to refrain from using drugs and devices that cannot, based on their mechanism of action or conditions of use, be demonstrated to achieve the legitimate ends described in dir. 36.[7] Next, it is essential to exclude with greater force any interventions that could function as abortifacients. Significant concerns about the efficacy and post-fertilization effects of Plan B,[8] and about the moral dangers of using ulipristal acetate (ella),[9] have been brought forward.

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These must be addressed in the course of a future revision. Finally, Catholic health ministries should be formally encouraged to adopt ongoing quality improvement efforts to provide more discretely, or to refrain from providing, interventions to prevent conception based on clinical effectiveness and ethical principle. There are multiple tools and examples from other areas in health care, such as improving "door to treatment" times, from which to draw.

Guidance on New Issues in Health Care Delivery

There are many potential clinical issues that could be addressed in a revised part 3. In fact, now that Catholic health ministries own and operate clinics and related service lines, there are multiple issues in primary care that were not anticipated in the 1995 *ERDs* that could be covered in part 3. Below I briefly note two new issues involving drug prescription that should be considered in the next revision and that may stimulate additional reflections on this topic.

Pre-Exposure Prophylaxis for HIV (PrEP). PreP is a pharmaceutical regimen recommended by the CDC and the US Preventive Services Task Force for patients at risk of contracting HIV from sexual activity or intravenous drug use. On the one hand, avoidance of dangerous infections can be a physical and moral good. For example, spouses of persons infected with HIV could benefit greatly from the protection provided by PrEP. On the other hand, PrEP can be used by individuals or health care professionals to facilitate immoral sexual activities. And the provision of PrEP can be demanded by individuals and medical societies as an expected service and standard of care. Clinicians may have prudential or conscientious objections to providing PrEP to some patients in some circumstances. Providing *ERD* guidance on this issue can help Catholic health ministries to witness to important Catholic teachings at stake in this complex issue.

Viagra for unmarried men. Viagra is one of three commercially available drugs (along with Levitra and Cialis) that can help to address issues of erectile dysfunction for men. This is a sensitive issue for many men, and these drugs have proved to be overwhelmingly popular. While there is no principled objection to their use by married men, prescribing such drugs for unmarried men presents issues of cooperation in evil and theological scandal.[10] Addressing this issue in the *ERDs* can help Catholic health ministries to witness more effectively to the unique good and benefits of marriage and to the virtue of chastity.

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Notes

1. Jennifer Weiss, "'Physician' not 'Provider' Is Better for Doctor and Patient," *Permanente Medicine*, December 16, 2019, https://permanente.org/physician-not-provider-is-better-for-doctor-and-patient/; and American Academy of Family Physicians, "Provider, Use of Term," position paper, 2018, https://www.aafp.org/about/policies/all/provider.html.
2. Dianne N. Irving, "When Do Human Beings Begin? 'Scientific' Myths and Scientific Facts," *International Journal of Sociology and Social Policy* 19.3–4 (March 1, 1999): 22–36, citing Ronan O'Rahilly and Fabiola Müller, *Human Embryology and Teratology* (New York: Wiley-Liss, 1994), 16.
3. See Christian Brugger et al., "The POLST Paradigm and Form: Facts and Analysis," *Linacre Quarterly* 80.2 (May 2013): 103–138, doi: 10.1179/0024363913z.00000000027.
4. Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, DC: Georgetown University Press, 1997), 219.
5. Joint Commission, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide* (Oak Brook, IL: Joint Commission, 2011).
6. Edward J. Furton, ed., *Transgender Issues in Catholic Health Care* (Philadelphia: National Catholic Bioethics Center, 2021).
7. For a brief description of the practical limits on Plan B's ability to effectively affect sperm capacitation or transport, see Thomas Berg et al., "Emergency Contraceptives and Catholic Healthcare: A New Look at the Science and the Moral Question," Westchester Institute, June 2011, 1, n.10.
8. Rebecca Peck and Juan R. Vélez, "The Postovulatory Mechanism of Action of Plan B: A Review of the Scientific Literature," *National Catholic Bioethics Quarterly* (Winter 2013): 677–716.
9. John F. Brehany, "No Consensus on Ella," *Ethics & Medics* 41.2 (February 2016): 3–4.
10. See, for example, Catholic Medical Association, "Should a Physician Prescribe Viagra to Unmarried Men?" June 26, 2009, https://www.cathmed.org/resources/should-a-physician-prescribe-viagra-to-unmarried-men/.

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