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A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

Also in this issue: "The Ebola Outbreak in the DRC" by Paulo Lumicao

The Catholic Perspective on Death with Dignity

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In her *New York Times* article "Let Dying People End Their Suffering," writer and former National Public Radio host Diane Rehm argues for the legalization of physician-assisted suicide.[1] While euthanasia is illegal in the United States, physician-assisted suicide is legal in nine states and Washington, DC, and efforts to expand it continue.[2]

The contemporary movement promoting physician-assisted suicide took root in the 1930s but grew in earnest in the 1970s after *Roe v. Wade*, in the 1990s with the notoriety of Jack Kevorkian (Dr. Death), and in 2014 with the media attention to twenty-nine-year-old Brittany Maynard.[3] This effort is bearing fruit, and a recent Gallup poll found that almost 70 percent of Americans are in favor of doctor-assisted suicide.[4]

Given the momentum in favor of legalization, Rehm's article provides an opportunity to assess the arguments and assumptions used to justify and promote physician-assisted suicide, in light of Church teaching. Supporters often share the impassioned pleas of those who have personally experienced devastating suffering at the end of life. Rehm's article is no exception, recounting both her husband's and her close friend's deaths. These deeply personal and intense emotions cannot be ignored by anyone arguing against physician-assisted suicide.

Rehm's article argues for the reinstatement of a California law, which allowed competent patients with terminal illness, and without psychological disorder, to choose physician-assisted suicide. The thrust of Rehm's argument is based on the principle of respect for autonomy. The patient should be respected by the state as an autonomous agent and "be given the freedom to choose a death that completes the integrity and coherence of his life as he understands it."[5] In applying the principle of autonomy, Rehm essentially holds that informed consent is necessary and sufficient to justify physician-assisted suicide.

Rehm's respect-for-autonomy argument flows from her conception of death with dignity. Supporters of physician-assisted suicide believe this means being in control of how and when one dies. Ultimately, one's autonomy gives one dignity, and autonomy is to be respected for this reason.[6] Accordingly, if one loses autonomy as a result of illness, then one loses dignity, and physician-assisted suicide allows one to die before or once one's dignity is lost. Furthermore, autonomy, respected in an absolute way, allows one to subjectively determine when one's life no longer has value, for whatever reason. Rehm presents physician-assisted suicide as a reasonable choice. She asserts that it is not in fact suicide, but *compassionate* medical care, since it intends to limit suffering.

Lastly, Rehm contends (rightly) that the end of life is an extremely personal experience, and only the subject "can define when [one's] suffering has become unbearable." Yet she extends this contention, saying that the terminally ill patient may decide when life is no longer worth living, and he or she is as good as dead. Rehm uses this quality-of-life argument, with her husband as an example, to show why physician-assisted suicide is not suicide. Being as good as dead already, the patient does not in fact choose to kill oneself, but "would choose life if [he or she] could."[7]

While it is noteworthy that those on both sides of the debate agree that patients should be able to die with dignity, there is a fundamental difference in the meaning of, and assumptions underlying, death with dignity. The Church believes that human dignity is the basis for ethical medical decision making, and that respect for autonomy is a guiding principle in medical ethics. However, the Church conceives of human dignity, respect for autonomy, and the relationship between the two differently than do supporters of physician-assisted suicide. This difference leads the Church to deny that respect for autonomy morally justifies physician-assisted suicide.

The Church teaches that human dignity is not determined by autonomy, but that it is inherent in our human nature. Dignity ultimately flows from our origin in, redemption by, and destiny with God. Such infinite human worth

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exists "prior to society and must be recognized by it,"[8] and it cannot be diminished by personal or societal quality-of-life assessments.[9] Autonomy is an aspect of human dignity. It is a relative good compared with the absolute good of human life. Finally, respect for autonomy is a middle principle, which is modulated by other moral considerations in reference to objective moral law. Conversely, supporters of physician-assisted suicide believe that autonomy determines human dignity, and that dignity is lost when one is no longer autonomous. Human life is a relative good compared with the absolute good of autonomy. Finally, respect for autonomy is an absolute principle, which reflects a subjective moral order.[10]

Thus the Church affirms that autonomy is authentic, should be respected, and is exercised legitimately when it is in accord with inherent human dignity—that is, when it pursues human flourishing and is directed toward the attainment of authentic human goods, as guided by God's objective moral law.[11] Rehm locates autonomy in a radical subjectivity, where the subject determines what is moral, since there is no objective moral order. The Church does not respect the autonomous choice of physician-assisted suicide since the action violates human dignity by going against the inherent good of life.

The argument for respect for autonomy is absurd when applied to physician-assisted suicide. By respecting autonomy and allowing suicide, one eliminates the source of autonomy.[12] Furthermore, Rehm's assertion that physician-assisted suicide is not a choice to kill oneself is self-defeating, because she simultaneously argues that we must respect the patient's choice and denies that the patient makes a choice.

Notably, the respect for autonomy Rehm advocates has strong overtones of a dualistic anthropology. The terminally ill patient seeking physician-assisted suicide views biological life as "a good *for* the person," to be eliminated when it is of no use, or burdensome. The dualism lies in the distinction between the body and the person, whereby the conscious, choosing, autonomous mind is equated with the person, who disposes of the body as if separate from him or her. This conception is opposed to the Church-held anthropology of a body–soul unity, in which the body is a "good *of* the person … [and] although human persons are *more* than their bodies … they are nonetheless *bodies*, *living flesh*."[13] An attack on the body is an attack on the person and therefore violates inherent dignity.

But what about the horrible end-of-life situations described by Rehm? Does the Church teach that we are to preserve life at all costs? When one's life inevitably nears its end, the Church teaches that it is not necessary to use every measure to prolong life. While one may never morally commit suicide, one may licitly refrain from treatments that would extend one's life, under certain conditions. The Church uses the key distinction between ordinary and extraordinary treatment to determine whether a treatment is morally obligatory. While the details of each situation are essential to consider, in general, ordinary treatment is morally obligatory because it offers a reasonable chance of benefit without excessive burden. If a treatment is useless or poses excessive burdens relative to benefits, then it is not morally obligatory, even if refraining from such treatment results in death.

Rehm seems to conflate withdrawing or withholding extraordinary care and choosing physician-assisted suicide. According to the Church, the object of the act of physician-assisted suicide, killing oneself, is intrinsically evil and cannot be justified by intention (alleviate suffering) or circumstances (terminal illness). Withholding extraordinary treatment can be moral if such a decision is made because the treatment is burdensome or useless, and not made with the intention killing oneself. In Catholic bioethics, it is legitimate to consider quality of life as related to the *treatment*, but illegitimate to consider life as having no value.[14] Thus one may forgo treatment if it results in a quality of life with excessive burden—in relation to one's physical and moral reserves—but not forgo treatment because it prolongs a life one deems worthless.

Ultimately, those on both sides of the debate can agree that we all bear responsibility for decreasing the demand for physician-assisted suicide. According to Catholic bioethicist Janet Smith, if a person requests our help to die, we must respond to the reasons for the request and lovingly accompany the person in his or her fear, anguish, and dependency. We should not necessarily acquiesce to all the person may ask for against his or her own good. In doing so we truly help loved ones die with dignity.[15]

Endnotes

1. Diane Rehm, "Let Dying People End Their Suffering," *New York Times*, June 7, 2018, https://www.nytimes.com/2018/06/07/opinion/california-end-of-life-aid-in-dying.html.
2. Compassion and Choices, "Our Accomplishments: Improving Care and Expanding Options for the End of Life," accessed August 27, 2019, https://compassionandchoices.org/resource/accomplishments-improving-care-expanding-options-end-life/.
3. William E. May, *Catholic Bioethics and the Gift of Life*, 3rd ed. (Huntington, IN: Our Sunday Visitor, 2013), 256–261; and Ronald Piana, "The Debate over Physician-Assisted Suicide Continues, State by State," *ASCO post*, November 10, 2015, https://www.ascopost.com/issues/november-10-2015/debate-over-physician-assisted-suicide-continues-state-by-state/.
4. Andrew Dugan, "In U.S., Support Up for Doctor-Assisted Suicide," *Gallup*, May 27, 2015, https://news.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx.
5. Nicanor Pier Giorgio Austriaco, OP, *Biomedicine and Beatitude: An Introduction to Catholic Bioethics* (Washington, DC: Catholic University of America Press, 2011), 151.
6. May, *Catholic Bioethics*, 256–257.
7. Rehm, "Let Dying People End Their Suffering."
8. *Catechism*, *n.* 1930.
9. May, *Catholic Bioethics*, 265–266.
10. Austriaco, *Biomedicine and Beatitude*, 152.
11. May, *Catholic Bioethics*, 268–269.
12. Austriaco, *Biomedicine and Beatitude*, 152.
13. May, *Catholic Bioethics*, 266, 267, original emphasis.
14. Ibid., 271.
15. Janet E. Smith and Christopher Kaczor, *Life Issues, Medical Choices: Questions and Answers for Catholics* (Cincinnati, OH: Servant, 2016), 102–105.

The Ebola Outbreak in the DRC

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A recent outbreak of Ebola starting in August 2018 has spread rapidly in North Kivu and Ituri, northeastern provinces of the Democratic Republic of the Congo (DRC). This is the tenth outbreak in forty years.[1] Nevertheless, Tedros Ghebreyesus, the director-general of the World Health Organization (WHO), recently stated that the outbreak is not yet a "public health emergency of international concern." Declaring such an emergency would trigger "a response across the United Nations, mobilizing multiple agencies, funding, and personnel . . . the sort of global response that belatedly resolved the [Ebola] epidemics in Liberia, Sierra Leone, and Guinea in 2014 and 2015."[2] Instead, the WHO and its partners are working with the DRC Ministry of Health to mount a more local response.

Effect on National Health Care Agencies

As of July 28, 2019, the WHO has recorded 2,577 confirmed cases of Ebola and 1,696 confirmed deaths.[3] Most cases have occurred in the Beni health zone; however, the incidence of new cases in this area is now decreasing.[4] Nevertheless, the outbreak is still intensifying in other regions.[5]

The Ministry of Health, the WHO, and their partners continue to respond and are supportive of Ebola response mechanisms. As this is the tenth outbreak, the Ministry of Health has experienced health care professionals, who are coordinating preventing efforts with a two-hundred-fifty–person WHO team.[6] A WHO scientific advisory committee concluded that the DRC, together with existing international support and expertise, is "capable of handling the crisis."[7] However, the WHO raised several concerns, such as "the volatile security situation; sporadic incidents of community reluctance, refusal or resistance; continued reporting of confirmed cases; and the risk of spread to neighboring countries."[8] It is indeed a pressing problem which raises questions about the ability of health care agencies to respond to the needs of the community given inadequate health care resource, weak assistance from the national government, and poor security.

The current Ebola outbreak in the DRC is unique. It is the first Ebola crisis accompanied by unprecedented, violent attacks. These stem from ethnic hatred in the DRC and ultimately compromise the security of all civilians, including health care professionals and responders.[9] Part of the DRC is currently identified by the US Centers for Disease Control and Prevention and the US Department of State as a "do not travel" zone because of the increased risk of violence targeting civilians, including its health workers.[10] As a result, the CDC staff were recently pulled from the field in the DRC because of government concerns about security. Ultimately, the armed conflict in the affected area obstructs response efforts of health care professionals from both national and international health care agencies, who all seek to provide medical assistance and health care for the sick and poor in the DRC.

Similarly, Doctors Without Borders and the Red Cross are not able to deploy their seasoned Ebola responders—those believed to have succeeded in halting prior epidemics by "scouring homes and villages for people who had contact with known Ebola victims, testing family members for infection, creating rings of vaccination to form social barriers to disease spread, and stopping all normal funeral procedures to prevent mourners' contact with highly contagious cadavers."[11]

Health care professionals have a legitimate reason to be concerned about their personal safety. Ghebreyesus emphasized that every possible measure must be taken to ensure that all health care professionals and staff are kept safe; however, as more staff are sent to the field, the risk of accidents and kidnappings increase.[12]

Furthermore, reports have surfaced on the spread of Ebola near the Ugandan border, increasing the risk that the epidemic will become a pandemic.[13] The WHO warned that the epidemic had reached a "critical juncture" amidst widening reports of violence, which has forced more than half a million people from their homes.[14]

Lastly, "pockets of mistrust" among families were noted in some towns where residents refuse preventive care and treatment. This largely is brought about by poor response mechanisms in the national government and health care agencies.[15]

Obligations of Health Care Agencies

Both conditions in the DRC and US foreign policy raise several questions within the sphere of both secular and Catholic bioethics. There is a responsibility of health care agencies to uphold social and distributive justice. Furthermore, in light of Catholic social teaching—a "treasure of wisdom about building a just society"—there is also an obligation for health care professionals to adopt methods that ultimately serve vulnerable populations—in this context the residents of the DRC and neighboring regions, the health care professionals treating the Ebola patients, and the wider society.[16]

The WHO must take a political lead by convening the DRC's national security and legal experts to address security obstacles that may disrupt the efforts of health care

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professionals and responders. In addition, the WHO must ideally extend this political effort not only to agencies in the DRC, but also toward the global sphere as a collective humanitarian effort. The WHO recommends the implementation of synergistic, multi-sectoral strategies for the prevention and control of Ebola outbreaks in light of the current security problems in the DRC.[17]

The DRC must also consider incorporating the principle of subsidiarity in its efforts. The principle of subsidiarity holds that decision making should take place at the lowest appropriate level, which allows distribution of authority, autonomy, and accountability. This can be realized by providing the proper support and resources at all governmental levels, including opportunities in policies, processes, and practices for local agencies to exercise responsible decision making.

The principle of solidarity must also be considered. The United States, as a country with sufficient resources to provide assistance, must realize the importance of supporting the global commitment to the development of marginalized sectors of society. In this way, the United States can participate in a collective humanitarian effort.

Most international health financing opportunities are misaligned with national strategies and systems. Implementation of strategies by the government may remain poor because of political factors (e.g., corruption), and marginalized populations are often unable to participate in policy decisions which affect their health. Consequently, it is essential to empower the DRC's government to capitalize on these opportunities, and to adopt a strategy, informed by Catholic social teaching, that recognizes the value of distributive justice and the common good of society.

Endnotes

1. Laurie Garrett, "Welcome to the First War Zone Ebola Crisis," *Foreign Policy*, October 18, 2018, https://foreignpolicy.com/2018/10/18/welcome-to-the-first-war-zone-ebola-crisis/; World Health Organization (WHO), "Ebola Situation Reports: Democratic Republic of Congo," accessed September 3, 2019, https://www.who.int/ebola/situation-reports/drc-2018/en/; and Jamie Ducharme, "Security Concerns Are Threatening the Ebola Response in the DRC: Here's What to Know," *Time Magazine*, October 17, 2018, http://time.com/5426847/democratic-republic-congo-ebola-outbreak/.
2. Garrett, "Ebola Crisis."
3. WHO, "Ebola Situation Reports."
4. WHO, *Ebola Virus Disease: Democratic Republic of the Congo*, external situation report 21, December 27, 2018, 2, 3, table 1.
5. Ducharme, "Security Concerns."
6. Garrett, "Ebola Crisis."
7. Ibid.
8. WHO cited in Ducharme, "Security Concerns."
9. Garrett, "Ebola Crisis."
10. US Centers for Disease Control and Prevention, "Ebola in Democratic Republic of Congo," travel alert, updated August 29, 2019, https://wwwnc.cdc.gov/travel/notices/alert/ebola-democratic-republic-of-the-congo.
11. Garrett, "Ebola Crisis."
12. Tedros Adhanom Ghebreyesus, Address to the UN Security Council meeting on the Ebola Outbreak in North Kivu, Democratic Republic of the Congo, October 3, 2018, https://www.who.int/dg/speeches/2018/un-security-council-ebola-north-kivu/en/.
13. Ducharme, "Security Concerns."
14. Garrett, "Ebola Crisis."
15. Ghebreyesus, Address to the UN Security Council.
16. US Conference of Catholic Bishops, *Seven Themes of Catholic Social Teaching* (Washington, DC: USCCB, 2005).
17. WHO, *Ebola Virus Disease*, 5.

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