Ethically Speaking...

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Provides news, articles and information from the Canadian Catholic Bioethics Institute at Assumption University in Windsor, Ontario.

We welcome comments and feedback. Should you have suggestions for future articles or inserts, please contact the Editor at CCBI-A@assumptionu.ca or call 519-973-7033 Ext. "0"

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Healthcare Workers, PAS and Euthanasia

by Rev. Leo Walsh CSB, STL STD

As a preface to this article, let there be no doubt that physician assisted suicide and euthanasia are objectively gravely immoral. This means that, objectively, they are sacrilegious, desecrating the dominion that God has over the life of all human beings and the holiness of all human life which is made in the image and likeness of God. Accordingly, all cases of physician assisted suicide and euthanasia should be abhorred. All participation in such cases should be avoided as far as possible.

In "Bioethics Matters" (March 2017) a publication of the Canadian Catholic Bioethics Institute, Dr. Moira McQueen has a succinct and clear statement of accepted Catholic moral teaching on referrals, assessments and transfers when assisted death is requested.

I wonder, though, despite what I said above about distancing ourselves from participation in euthanasia and PAS, whether we are making too fine distinctions in such matters.

Assessments

Let's begin with assessments. Obviously, context matters here. If a person, for example, asks out of curiosity, how a person would go about requesting PAS, that would be one thing. If another person, using the exact same words, is asking with the intent of getting physician assistance in killing themselves, then these questions are truly different. So too with assessments. McQueen points out, assessment for competence is necessary before any patient is considered fit to agree to any treatment.

She adds, though:

> Is a request for assessment for capacity to access assisted death procedures different from the more preliminary and non-standardized assessment which happens when patients first come into contact with health care professionals? It is true that discussing the request might allow some time for the physician or nurse practitioner to dissuade the patient from moving towards assisted death, and that would be morally acceptable.
>
> On the other hand, if the patient persists in requesting assisted death or makes use of the government forms issued to help patients gain access to the procedures, of which the first step is assessment, then that would be a "standardization" that formalizes the assessment. The actual method of assessment in these cases *per se* may be similar, but there is a difference in the reason for which it is sought: one is for treatment of an illness, the other is for assisted death. If a patient is asking for the assessment that is specifically required as the first step in obtaining assisted death, then a conscientiously objecting institution, physician or nurse practitioner cannot comply. [1]

Let's look at cooperation in evil. Formal co-operation demands action and approval. In the cases we are discussing, there is presumably no approval. There is material cooperation, but it is neither immediately connected to the killing nor proximately so. It is not connected necessarily with the actual killing, because most people who go through the assessment do not proceed to the actual killing. The proportionate reason for doing the assessment would be precisely for this reason, to allow for peace of mind for the patient. Simply to know in these days of exaggerated autonomy that one still has options (not necessarily moral ones) allows one to relax and to allow him or her to accept death rather than cause it.

We return to our abhorrence of being associated with killing. If the assessment can be done outside of the Catholic institution or by third parties who can come into the institution, then this is preferable. It distances the institution further from the immoral act of killing. This is important in itself, but also it may prevent scandal for persons who do not understand the circumstances.

Effective Referrals

The matter of effective referral is perhaps the most unacceptable requirement of a conscientious healthcare worker. If we look at other areas of morality, it becomes clear that effective referral towards the achievement of an immoral result is to be rejected by a conscientious person.

A pedophile approaches you in order to obtain access to children. You not only refuse to do so, but you also refuse to refer the pedophile to a man three streets away who is willing to accommodate the pedophile. This is true even if the pedophile threatens you, physically or otherwise. (In case we get sidelined here, of course the pedophile should be reported to the police.)

In the matter of referral for euthanasia or PAS, there certainly can be cases where the referral is immoral. If Dr. X conscientiously refuses to be involved in PAS, he may not refer the patient to Dr. Y who is willing to kill patients. Nor may a Catholic hospital simply refer a patient to a public hospital where such killings are sanctioned.

Dr. McQueen's general moral principle with respect to a patient's request for PAS is that the onus for application to a third party agency removed from the patient/doctor or patient/institution relationship lies solely with the patient. She claims further that a patient who cannot apply to the agency is giving evidence that he or she is not competent to be making application for PAS.

As a rule of thumb, one could agree with Dr. McQueen that competency required for PAS implies competency to take the steps necessary to initiate the process towards PAS. It does not follow necessarily, however, that a patient who cannot, for one reason or another, make the application himself or herself does not fulfill the requirement of competence necessary for PAS. There could be different reasons why a patient may desire PAS but be unable to initiate the process (i.e., assessment). Simply to make known to this particular patient what is public knowledge does not seem to be immoral referral.

We have to be careful in our use of the word "referral". Take for example, the document put out by The Hospice of Windsor and Essex County to help guide its volunteers which states:

> If our physician is the Most Responsible Physician, he or she is legally obligated to make an effective referral to a physician willing to perform the first assessment by calling a 1-800 number created by the Ministry of Health and Long Term Care (MOHLTC). The Hospice and our physicians are not involved in MAID beyond this point.[2]

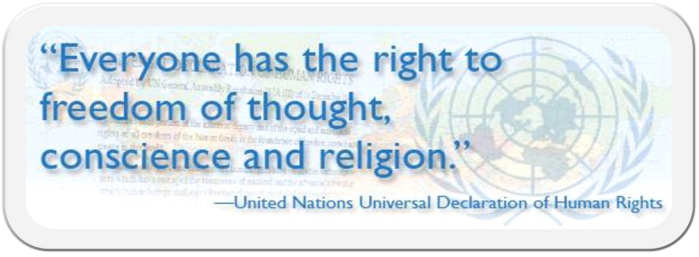
First, language is important. The volunteer document should not give the unintended impression that outside forces (government or professional bodies) directing action should be obeyed as morally binding. Nor should such bodies be obeyed if the demand is immoral simply to avoid consequences.

Second, what Hospice is prepared to do in directing its Most Responsible Physician to inform an outside agency about the request for first assessment is not "effective referral" in the sense that has to be avoided by a conscientious doctor or institution. What Hospice proposes is not morally objectionable.

There is no necessary approval of PAS and the involvement with an external agency dealing with a first assessment is not proximate to the physician assisted suicide itself.

Attacks on conscience abound. In Ontario a total of 338 people have died by medical assistance in the province; of those who died by lethal injection 26 have donated tissue or organs. (National Post 2017) Some bioethicist and transplant experts argue that people who qualify for assisted dying deserve to be offered the chance to donate their organs after assisted dying and that would be ethically acceptable if the person is competent and under no pressure to choose either (Allard, Fortin 2016). For physicians to use such organs is immoral complicity in killing. To try to force conscientious physicians to comply is an attack on conscience, and should be resisted. Further, such a practice could put pressure on those who qualify for assisted suicide to choose death. Furthermore the question that must also be addressed is - do organ recipients who have a moral or religious objection to euthanasia have a right to know the organ came from someone who chose assisted death? Typically, the cause of death isn't disclose unless there is a valid medical reason to do so.

In summary, we have to oppose the immoral killing of patients, even in face of government impositions. We do this by showing reverence for life, all life, and by refusing to be participants in the process of killing. Taking action which is not intrinsically connected to the actual killing, however, is not necessarily immoral.[3]



REFERENCES

1. Bioethics Matters, March Edition 2017

2. MAID: A Guide for Hospice Volunteers" Hospice Windsor Essex County . The fact that Hospice keeps the patient's bed free for possible change of mind is indicative of its hopes.

3.When Alex Schadenberg and others refer to "direct" cooperation through first assessment, they are using a word not traditional in the context of cooperation with evil, and could mean anything. The traditional terms are "formal" and "material" cooperation. See "Lifesite", June 26, 2017.

Doctors harvesting organs from Canadian patients who underwent medically assisted death. Kirkey, S. National Post, March 20, 2017.

Allard J, Fortin M Organ donation after medical assistance in dying or cessation of life-sustaining treatment requested by conscious patients: the Canadian context *Journal of Medical Ethics* Published Online First: 28 December 2016. doi:10.1136/medethics-2016-103460