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Quite a few months have passed since the previous issue of Health Care Ethics USA. My time has been absorbed all too much due to the additional responsibility of chairing a search committee for a new Dean of the School of Public Health at Saint Louis University. Fortunately that time consuming process is drawing to a happy close! Also, with this issue the Center is moving to the publication of three issues each year of Health Care Ethics USA in order to streamline the production costs and time. As we plan ahead we hope to increase the number of essays while keeping costs down to provide a high quality journal for our readers. I am very pleased to inform you that we have decided not to increase the cost of subscriptions.

We welcomed into our PhD program a new student from the Philippines in January, Alvenio Mozol. Now we have 25% of our student body from other nations! And as we plan the admissions for next Fall we anticipate a strong enrollment, including a student from Canada. Also, we have good news on the faculty side too. A few weeks ago our University Provost approved a new tenure-track faculty position at the rank of assistant professor for our Center. We initiated the search immediately, and we hope to hire a new member of faculty by July 2002. Because our PhD program is interdisciplinary in nature, we have several faculty from other departments assisting us as members of the search committee. The focus of the search is to find a scholar with ethics expertise in Institutional Review Board (human subjects’ protection) related issues. Already, we are receiving very exciting applications. If you know of any qualified candidates who may be interested in joining our Center as a member of the PhD program in health care ethics, please refer them to our website: http://chce.slu.edu

Graduation season is almost upon us again – the time for caps and gowns, smiling graduates, proud families, and delightful temperatures! So far, our PhD program in health care ethics has graduated 4 students and we look forward to many more of our graduates establishing their careers in health care and in the academy. Already we have several former students establishing impressive reputations as ethicists in health care and as scholars in university life. Long may that continue! Let me take this opportunity of graduation season to thank all of our faculty, staff, and students for their magnificent work, making the Center a joyful place to be with an accomplished community of scholars. And let me thank all our readers for your support of our work and mission over the years. Graduation season is a good time to be thankful for the many blessings we enjoy at the Center.

And talking of blessings, let me conclude this column with a very special word of congratulations to Dr. Jill (Ciesla) Burkemper and her husband Mike on their first baby, Juliana who was born just a few weeks ago. Jill is a member of our faculty and it is wonderful for us all at the Center to celebrate a new baby among us! Both Jill and Juliana are in fine health.

As usual, this issue of Health Care Ethics USA has three essays. The first essay, on the increasingly urgent issue of terrorism, is by Griffin Trotter, MD, PhD, one of the Center’s tenure-track faculty. Griffin presents a bioethics prospectus that addresses how we might approach the war on terrorism. The second essay is by James DuBois, PhD, DSc, another member of the tenured faculty at the Center. Jim discusses the controversial issue of financial incentives for organ donations from a principle perspective. The third essay is by Martin Onwu, JD, who is a senior student in our PhD program. Martin analyzes the debate on the moral status of the early embryo from a public policy perspective. I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future essays.

Professor Gerard Magill, PhD
Executive Director & Department Chair
Bioethics And The War On Terrorism: A Prospectus

Historian James Shenton of Columbia University lived the first 16 years of his life without seeing a serviceman in uniform. But Pearl Harbor followed and normalcy was forever transformed. Fifty-seven years later, the American people are once again at the crossroads of a major transformation. Many of us have never seen an airline passenger frisked at the gate, or a child fearful of opening mail. In the wake of September 11th, this will change.

Perhaps it is possible to say with little hyperbole that everything will change, even in bioethics. In this essay, I will examine the interface between bioethics and the War on Terrorism. I will outline three important ethical challenges and two compelling opportunities for long-term improvement in American healthcare. My thesis is very general: that we should rise to the challenge and seize the opportunities – and that this will require a lot of work.

Principles

From the outset, bioethics has been concerned with protecting the rights of individual conscience and autonomy against threats of medical paternalism and the intrusive state. Its narratives reverberate with indignation over cases such as Tuskegee (dangerous government-sponsored research without consent), Quinlan (permanently unconscious patient kept on ventilator against family’s will) and Geissenger (young patient harmed in genetic research). Bioethics, and especially clinical ethics, has been ruled by a principle of permission, holding that individuals cannot be touched, treated or otherwise appropriated unless they (or their devoted agents) freely consent. This focus on individuals has been challenged at times by communitarians who seek a fuller appreciation of the common good, by purveyors of comprehensive social justice, and by those who seek to counterbalance clinical ethics with a concern for the health of populations. Until now, these efforts have elicited only sporadic success – especially in individualistic America. But there is a new mood, bringing tension and change.

For the first time in one hundred and thirty-six years, the United States is fighting a war on its own soil. This War on Terrorism is odd in many ways – with a nebulous, largely invisible foe, and an uncertain cadre of civilian combatants. Yet it brings the familiar wartime sentiments: patriotism, obsession and fear. As we have learned so many times in the past, these emotions are pliant. They can breed heroism, sacrifice and resolve, but also frequently bring panic, paranoia and stupidity. Already we’ve seen plenty of each. In the medicine, we have experienced a tidal wave of volunteerism, of charity and creative energy. On the opposite end of the spectrum, we have clinicians who fuel public phobias and risk public health by prescribing antibiotics where they are not indicated, and individuals who testify endlessly about their own limited vulnerabilities while ignoring those who are truly in harm’s way.

Amidst the turmoil, there is a definite trend toward expanding government powers. The Center for Disease Control (CDC) recently introduced a Model State Emergency Health Powers Act. If enacted, it will enhance states’ rights to order testing, vaccination and quarantine, and to require private physicians to participate. It also empowers health officials to seize hospitals and other property. On Capitol Hill, there was talk of facilitating antibiotic stockpiling by stripping pharmaceutical company Bayer of its patent on ciprofloxacin (Canada quickly commissioned generic production of this drug). Privacy is giving way to security, as the Bush administration and congress rush to enhance police powers and to set up mechanisms for identifying early victims of bioterrorism. There is also a new urgency about government-sponsored medical research on measures such as immunization for anthrax or smallpox. Meanwhile, Senate and House patients’ rights bills – a hot topic last summer – are virtually forgotten.

A first new challenge for bioethics is to preserve the principle of permission and correlative concerns about individual privacy, confidentiality and informed consent. No doubt, the threat of terrorism may require some rescission of individual prerogative. But it is important that we keep a balance, especially
in times of high emotion when public anxieties are tweaked and political gestures proliferate. In particular, we need to be vigilant about counteracting unfounded suspicions and false beliefs about Islam and in recognizing the special burdens that our faithful Islamic citizens will bear in the fight against terrorism.

This challenge is in tension with a second, equally important concern. Bioethics needs to expand its focus and develop a richer understanding of public health and how it contributes to (rather than constitutes) community well being. In the future, bioethics will need to investigate and balance four aims: (1) promoting the health of individuals, (2) promoting the overall well being of individuals, (3) promoting the health of populations, and (4) promoting the overall well being of communities. Traditionally, bioethics has focused intensely on balancing the first and second aims. The doctrine of informed consent and development of advance directives are predicated on the notion that individuals are the best judge of their own well being, and that well being trumps merely medical concerns about maximizing health or eradicating disease. Public health has traditionally confused the third and fourth aims – so thoroughly, in fact, that the World Health Organization has institutionalized the confusion with their vague and user-unfriendly definition of health. Even before September 11th, efforts were being made to correct such errors. David Buchanan, for instance, has argued that programs for enhancing public health need to be structured by broader, moral concerns. Now bioethicists must recognize, perhaps for the first time, that the well being of communities requires the security of polities. In times of war, this requirement is accentuated and temporarily skewed in the direction of national defense. Considerations of national security apply in the domain of clinical ethics, where clinicians are beholden to cooperate with sensible surveillance measures, to prescribe antibiotics responsibly, to participate in disaster preparation, and, most importantly, to provide accurate, balanced information about medical aspects of biological and chemical terrorism. In public health ethics and public policy, national security is clearly a pressing value. Bioethicists should cultivate a posture of impartiality as we balance traditional concerns about patients’ rights with claims about the urgency of developing vaccines or quickly locating the initial victims of bioterrorism.

A third challenge for bioethics is in helping to delineate the characteristics of appropriate wartime solidarity. We are aware of the danger of an overly vigorous war spirit – unjust internment, racial and religious persecution, cruelty and widespread jingoism. Yet we must also recognize that war occurs only when negotiation, compromise and mutual cooperation are no longer possible. The necessity of war is that we kill people and destroy their resources, until it is possible to reestablish an acceptable rule of law. It is an ugly, savage business; and it requires intense resolve. What are the characteristics of the good citizen, the virtuous clinician or the able politician during a time of war? These difficult questions beg more reflection.

Discussion

Many doctors have been very busy since September 11th. Infectious disease experts have been working to develop our capacities to identify, treat or vaccinate against microbes that might be in the bioterrorists’ arsenal. Public health experts have tried to sort out the most effective mechanisms for large-scale surveillance, prevention and response to threats of biological, chemical or violent terrorism. Internists and family physicians have been swamped with requests for ciprofloxacin, the most well advertised treatment for anthrax. Emergency physicians, on the other hand, have been disappointingly on the sidelines. They were mobilized in New York, but had few survivors to help. Generally at the forefront of disaster medicine, their role has been de-emphasized because of the tendency to assume that future terrorist acts will be like the current ones – violent acts with few survivors or microbial attacks that require good sleuthing rather than rapid rescue. This assumption is a mistake. Some of the most likely and most dangerous terrorist scenarios will involve large numbers of potentially treatable casualties who require immediate medical attention, delivered under the most difficult circumstances. Chemical agents, for instance, are relatively easy to obtain, maintain and disperse; and they can be devastating. First described by Thucydides in ancient times, chemical weapons caused over a million casualties (over 90,000 fatal) in World War I. These agents sometimes spread quickly from afflicted patients to caregivers, decimating hospitals and clinics that are unprepared for proper decontamination. With nerve agents such as saran, rapidity of diagnosis, decontamination and treatment often determine whether patients (and sometimes clinicians) live or die.

Chaos of this sort is the traditional domain of the emergency department (ED). However, in recent years, the ED has been utilized for purposes other than rescuing the emergently afflicted. Since passage of the Emergency Medical Treatment and Active Labor Act (EMTALA) in the 1980s,
emergency departments have become America’s designated safety net – required by federal statute to screen all comers and either to stabilize emergency medical conditions or to document the absence of these conditions, often without reimbursement. Stabilizing emergency conditions is well and good. But documenting their absence – especially in large numbers of uninsured or indigent patients who go to the ED not because they think they have an emergency, but because ED physicians are the only physicians who will see them – amounts to proving a negative for skeptical bureaucrats. It is an exercise in futility and it can impede physicians’ ability to efficiently treat genuine emergencies.

Amidst the War on Terrorism, several EMTALA-related questions emerge. In a disaster scenario, will emergency physicians be allowed to divert non-emergent patients and quickly triage victims to appropriate wards and facilities? When hospitals and EDs are used as staging areas, will they still fall under EMTALA? How can emergency physicians prepare adequately for rescue operations while providing routine evaluations for large numbers of non-emergent patients? Rather than confronting these problems with more patchwork, it may be better to abandon EMTALA altogether and to provide truly adequate clinical access for previously uninsured patients. In other words, the opportunity may be at hand for justifying universal access – not on previously unsuccessful egalitarian or charitable grounds, but as a matter of national security. Such arguments would constitute a critical shift in bioethics.

A second opportunity is closely related. In the War on Terrorism, citizens are combatants. Though they will not be expected to form militia units, as in ages past, contemporary American citizens will be expected to cultivate a degree of alertness, savvy and readiness for terrorism. They will be asked to perform in concert to support the economy, to aid the afflicted or to help with surveillance. To be effective, this call to solidarity requires the articulation of a coherent and compelling public philosophy. Suddenly questions about the meaning of democracy, the defense of freedom, or even the virtues of the American way are no longer passé. This war, like so many others before, should be a powerful stimulus for reflection.

Conclusion

Bioethics is a reflective enterprise addressing a wide range of private and public concerns that intersect in clinics, hospitals and other healthcare enterprises. As America experiences a cultural shift, borne of the War on Terrorism and its many challenges, bioethics will also change. Despite the regrettable brutality that precipitated it, this war provides an opportunity to sharpen our public morality and forge new pathways for understanding and protecting individual conscience, community well being and good health.

Griffin Trotter, MD, PhD


Suggested Readings


Questions for Discussion
1. In which ways (if any) is providing good healthcare an important aspect of protecting our national security? What are the implications of the War on Terrorism for health policy reform?

2. To what extent are intrusions on personal liberty and privacy – as in quarantines and medical event surveillance – justified by the need to protect citizens from threats of violence? Are there useful rules or principles for distinguishing between legitimate intrusions and illegitimate ones?
Every year we hear new statistics describing how many people are waiting for an organ transplantation and how many have died waiting. And every year the statistic is worse than the year before. Similarly, every few years or so we hear about a new plan to increase the number of organ donors, either by increasing the number of potential donors or by increasing consent rates to donation.

Last month the American Medical Association recommended investigating whether offering financial incentives for organ donation might increase consent rates. At present, it is against the law to sell or purchase organs. However, the AMA has for years encouraged the use of financial incentives that arguably fall short of a “purchase.” Moreover, the AMA knows that laws change with changes in public sentiments, and that the latter are often shaped by the opinions of professional bodies.

Traditionally, organ donation has been viewed as a gift. The gift model has been understood and evaluated in at least three ways: as a slogan for encouraging donation, as a sociological model for understanding organ donation and transplantation, and as a way of justifying organ procurement. Each aspect deserves ethical analysis. However, this essay will restrict its focus to the last of these aspects. Specifically, it will explore why organ donation needs to be justified and whether the gift model provides the most appropriate justification.

Principles

The principle of beneficence dominates most public discussions of organ donation. Organ donation is a remarkable way to benefit another human being. The vast majority of people who are listed for organ transplantation will die without one. Donated organs can improve both the quantity life (possibly extending it for 20 or more years) and the quality of life (e.g., by freeing patients from the burdens of dialysis). Medicine rarely offers such dramatic benefits to patients.

Equally important, however, is the principle of respect for persons. Whereas beneficence regards primarily the organ recipient, this principle regards primarily the organ donor. We show respect for organ donors in two ways. First, by ensuring that organ donation does not kill the donor. This is accomplished by insisting that death be determined prior to procuring vital organs. Second, by obtaining informed consent for organ donation. Consent is sometimes obtained prior to death, e.g., through the act of signing one’s driver’s license, and sometimes obtained after death by proxy, e.g., through the consent of family members.

That respect for persons requires informed consent to perform invasive medical procedures enjoys the status of a dogma within contemporary health care. An evaluation of financial incentives for organ donation could, of course, explore this norm in some depth. For example, financial incentives can be compelling, especially for the poor. This fact has been given a fair amount of attention within research ethics, in the context of participant recruitment. While transplantation is no longer experimental, the situation is analogous to research because donors and their families are like biomedical research subjects insofar as their “participation” is often meant to benefit persons other than themselves.

While the above norms deserve significant attention, the following discussion will hone in on a more controversial norm that flows from the principle of respect for persons. It might be called a norm of “charitable intentions.” It states that certain acts that pertain to human life (e.g., sexual acts or acts of war) are justifiable only out of charity or beneficence (or in rare cases justice); they must not be forced, nor motivated primarily by financial profit or personal gain.

Discussion
Organ transplantation once invoked images of Frankenstein; today it has become almost commonplace. Because it has become routine, we need to remind ourselves how amazing organ donation is and always will be. A recent op-ed piece encourages us to consider the following.

Organ donation often involves accepting that a person can be dead despite the fact that he or she is still on a ventilator and still pink and warm. This sometimes requires a change in how we view death. Organ procurement involves major surgery in which the body is cut and major organs are removed from the deceased. This sometimes requires a change in the way we believe a corpse should be treated. In some forms of organ donation (so-called non-heart-beating donation), medications may be given to the donor that are not for his or her benefit. Organ donation increasingly requires a change in how we view the practice of medicine. Organ donation normally involves making requests of families at a vulnerable time. The discussion requires courage of families. It requires the ability to think of others at a time of tragedy. None of these dimensions of organ donation poses an insurmountable ethical problem; but each one helps us to understand why some potential donors decline organ donation. In fact, we might say that responding negatively to the request for organ donation under such circumstances is not only understandable, but ordinarily we would consider it cruel to make such a request of patients or their families during a time of crisis and loss. We do so only because it enables us to prolong the lives of numerous persons who would die without an organ transplant. But we are comfortable doing so because we only proceed with organ donation when it appears to be the free wish of the organ donor.

This leads to the main point of this essay: The gift model cannot be evaluated merely in terms of its effectiveness, but also in terms of how it helps us to justify making a harsh request in times of tragedy. The apparent cruelty of the request to procure organs gives way to honoring the patient’s wish to benefit another, that is, his or her “charitable intentions.” Moreover, we know that the families we accost often find deep meaning in knowing that some profound good was wrested from their personal tragedy.

Could the use of financial incentives provide an equally satisfying justification? Perhaps an analogy will help us find an answer. In these days post 9-11, we have a heightened awareness of heroes in our midst. Currently, we may think of organ donors and their families as heroes. One popular advertising slogan tells us that they give “the gift of life.” They are persons who make sacrifices for others – much like the men and women in the armed services. Our soldiers accept grave risks for our nation. They may have to overcome qualms and change their views in order to do what is necessary. Their families may also be asked to show courage and to think of the common good.

Yet it is interesting that while soldiers are often recognized as heroes, mercenaries are not. Risking one’s own life or taking the life of another can sometimes be noble when motivated by love of country or faithfulness to convictions. But these same acts are always ugly when motivated by money.

Thus far we have considered only organ donors and their families. Yet it is interesting to note that survey research has consistently shown that most transplant personnel resist the idea of offering financial incentives to increase donation. Perhaps some fear that incentives could backfire, that they might offend families and lower donation rates. Perhaps some fear that even modest incentives could be coercive to the poor and interfere with truly free, informed consent. But perhaps some simply prefer to think that when they have their hands in someone’s abdomen, they are enabling a gift, not trading commodities.

Conclusion

This essay intentionally explored the relationship of the gift model to a relatively controversial norm, a norm that maintains that certain acts that pertain to human life (e.g., acts of war, sexual acts, and acts of organ donation) should not motivated by financial profit; they are justifiable only out of charity or beneficence. To taint motives with financial considerations risks changing the way we view the human body. We risk losing sight of the human being as an embodied person; we risk viewing the person instead as a bodily commodity.

Such arguments are necessarily controversial in our pluralistic society. First, the principle under discussion focuses on intentions. For those of a strictly utilitarian bent, it will carry little weight. Nevertheless, such concerns have been taken very seriously by ethicists and jurists, as evidenced by
the prominence given to the principle of double effect (which regards intentions first and foremost) in certain contexts. Second, the main argument in this essay seems to suggest that there is a canonical view of the human body as sacred or deserving of certain specific forms of respect. Does establishing policy on such a view violate the rights to privacy and liberty that our nation holds so dear and that our Supreme Court finds so prominent in our Constitution? This question cannot be easily answered with reference to legal precedence. On the one hand, prostitution has always been illegal in the US, perhaps for reasons of principle of the sort discussed in this essay. On the other hand, it is legal to “donate” eggs and sperm for financial gain.

An easy answer to this question of political commitments is not forthcoming. Thus, the question of financial incentives may merit further study. But it does not merit the sort of utilitarian, empirical study the AMA has recommended. It rather requires soul searching about the principles we are committed to.

James M. DuBois, Ph.D., D.Sc.

1. As of January 4, 2002, UNOS had 79,446 patients on its national waiting list. See www.unos.org. While this number has steadily increased, the number of cadaveric donors has remained relatively constant. From 1994-2000, there were between 5,000 and 6,000 donors per year. In a letter sent to members in January 2002, UNOS President, Jeremiah Turcotte estimates that more than half of the people on the waiting list will die before receiving an organ transplantation.

2. The National Organ Transplant Act of 1984 prohibits the sale of organs for transplantation. Tissue banking, in contrast, is often a for-profit endeavor. One investigation found that a single dead body can yield in excess of $220,000 worth of “products” for tissues banks and companies. See M. Katches and W. Heisel, “Fierce wars waged over cadavers.” Orange County Register, May 4, 2000. The consent process for organ and tissue donation does not routinely disclose this fact.

3. See the AMA Code at 2.15. “Incentives should be limited to future contracts offered to prospective donors. By entering into a future contract, an adult would agree while still competent to donate his or her organs after death. In return, the donor’s family or estate would receive some financial renumeration after the organs have been retrieved and judged medically suitable for transplantation [sic].” This recommendation was passed in 1994. See J. Menikoff, “Organ Swapping.” Hastings Center Report, 29 (1999): 28-33. Menikoff questions whether certain incentive programs currently in use actually comply with prevailing norms and with the 1984 NOTA legislation.

4. See, e.g., L. Siminoff, “The Fallacy of the ‘Gift of Life’,” Hastings Center Report, 29 (1999): 34-41. Siminoff investigates primarily the sociological question, and raises ethical issues related to recipient’s feelings of indebtedness. AMA above all proposes to investigate whether other models are superior from the first perspective, i.e., as an inducement to donate. Interestingly, the recent AMA proposal was inspired in part by a questionable statistic, namely, that only about 1/3 of all eligible donors agree to donate their organs. In fact, donation rates are most reliably assessed at a regional level, and in some regions considerable majorities consent to donation.

5. Clearly, the “principle of respect for persons” here is understood to extend beyond the principle of autonomy, and to include things owed to persons out of dignity, e.g., the right not to be killed.

6. See the author’s “Should We Pay Organ Donors?” St. Louis Post-Dispatch, January 2, 2002. Some of what follows also draws on this piece.

7. Fortunately, transplant personnel know that offering financial incentives is not the only way to increase organ donation rates. Studies have shown that consent rates are affected by advertising campaigns, by who makes the request, by the timing of the request, and by a willingness to answer questions and address unspoken fears. Of course, no change in practice or policy will ever produce a 100% donation rate as long as we seek the free and informed consent of patients. We need to accept this hard fact.
Suggested Readings


Questions for Discussion

1. Is it right for a pluralistic society to exclude the profit motive from transactions like organ donation? Can it do so not merely out of a concern to protect the consent process, but also to protect a certain vision of the human body and human acts?

2. What is the likely consequence of abandoning the gift model? Can donor families be expected to welcome such a change or to react with indignation?

3. What options should be explored both to increase consent rates and to decrease the demand for organ transplantation?
The Missing Link in the Public Policies on Human Embryo Research

Early embryos are proving to be valuable subjects of genetic engineering research in recent years. Stem cells extracted from these embryos are said to be the best and perhaps hold the key to providing several therapies to millions of people afflicted with lethal and dreaded diseases. Yet, because the research has a tendency to endanger or destroy the fragile embryonic life, establishing public policies to guide such research has been difficult and controversial.

Since 1996, the appropriation bills of the Department of Health and Human Services have banned federal funding of research in which embryos are destroyed, discarded or knowingly subjected to risk or injury. Yet, on August 23, 2000, the National Institute of Health released its guidelines permitting scientists using public grants to research on human embryonic stem cells (ESC) derived without federal funds. The guidelines required the stem cells to be derived from excess embryos that were originally created in the course of infertility treatment, derived with informed consent of donors, and without any financial inducements to the donors. On August 9, 2001, President George W. Bush, in a televised speech, announced new guidelines for ESC research, limiting federal funding for ESC research. Under the guidelines, ESC must be derived with informed consent of donors, from excess embryos created solely for reproductive purposes, without any financial inducements to the donors, and must have been created prior to the time of the announcement. Approximately 64 cell lines potentially meet such criteria. Some members of the Congress are proposing introducing legislation to expand ESC research, despite the President’s veto threat.

These guidelines, of course, received mixed reactions from proponents and opponents of ESC research hailing or denouncing the guidelines. The approval or disapproval of embryo research is usually influenced by one’s view of the status of the embryo because what we think of the human embryo determines what we may do to it, especially in terms of research. These guidelines and legislation often attempt to find a quick solution to the immediate concern rather than address the root of the controversies associated with the issue, i.e., determining the status of early embryos and what kind of protection they are entitled. This varied approach to issues arising from scientific research involving early embryos could result in inconsistent policies. As a result, there is a need for a coordinated approach to issues involving human embryo research.

Principles

The relevant principles applicable to the discussion are the principles of the sanctity of life and beneficence. There is an apparent conflict between these two principles when used in the context of human embryo research. Opponents of non-therapeutic embryo research apply the principle of the sanctity of life to fortify their position while proponents of non-therapeutic embryo research rely on a burden/benefit analysis of the principle of beneficence.

The primary concern about non-therapeutic embryo research, such as ESC research, is that the research in most cases involves the destruction of the embryos. The principle of sanctity of life underlies the concern expressed by opponents of non-therapeutic embryo research. They resist the manipulation and destruction of what might be a human person because for them, there is no justification to engage in research that destroys human life. Opponents further contend that the medical benefits, which might accrue for some patients from non-therapeutic research such as ESC research, do not outweigh the grave consequences for the embryo, which is killed in order to procure stem cells for medical therapy. They argue that an early embryo is a human being because it contains a complete genome and all that is needed to develop into an adult human being. Thus, opponents contend we must not end one human life in an attempt to benefit another because it is absolutely forbidden to directly destroy an innocent human life in order to help another.

On the other hand, proponents of ESC research relying on burden/benefit ratio focus on the potential
benefits of the research. They argue that the research will yield therapies that will ease the suffering of millions inflicted with debilitating diseases such as Alzheimer’s, Parkinson’s, heart failure, liver failure, cancer, and diabetes. Proponents tend to minimize the destruction of the embryos and usually argue that the potential therapeutic benefits far outweigh the harm to the embryo. They argue that it is justifiable to modify or destroy certain human embryos in the pursuit of cures for dreaded and lethal diseases.

Discussion

The differences in the debate regarding non-therapeutic embryo research usually boils down to the differences in the respective parties’ views on the moral status of the embryo. The moral status of an embryo continues to be an enigma in moral, legal, and policy discussions. Views on the moral status vary, ranging from one end of a spectrum to the other. Some view early embryos as mere tissues or cellular material, which demands little, if anything, of us morally.

Some view the embryo as a living being with potential to develop into a full human being, and as such, deserve the same moral status as a human being. The Roman Catholic Church is among those who adopt a protective stance towards embryos. In Donum Vitae of 1987, the Catholic Church asserted that the embryo must be treated with the respect due a person from the very instant of his or her existence. Thus, no objective can justify non-therapeutic experimentation on living human embryos or fetuses, whether viable or not, either inside or outside the mother’s womb. Also, in Evangelium Vitae of 1995, Pope John Paul II addressed the status of early embryos and essentially affirmed the teachings of Donum Vitae. The Catholic Church’s view is grounded in its moral teaching which views human life as a continuum. The Church views all human beings from conception onwards as being made in the image and likeness of God and as meriting the same respect for their fundamental right to life.

However, some scholars view early embryos as neither mere tissues entitled to no protection nor persons entitled to full moral protection. These scholars usually agree that an early embryo is a form of human life that deserves a respect commensurate with its progressive development. Proponents of this view base their argument on physiological evidence and philosophical reasoning. They argue that early embryos are not to be treated with respect due a person because at such an early stage in the development of the embryo, such life is not genuinely individuated in the morally required sense. For them, the early embryo though human, living, and genetically unique, is really not yet an individual in the sense in which persons are necessarily individuals. They note that these early embryos could split and/or recombine until individuation. Individuation is typically claimed to occur about fourteen days following fertilization or conception with the appearance on the embryo of the primitive streak, which indicates a decisive moment of cellular differentiation or restriction. Thus, while acknowledging that these early creatures deserve some moral protection, they would not accord them full moral protection prior to their individuation.

There is a high degree of polarization in the debate regarding the status of early embryos. The majority of the participants in the debate agree that early embryos have intrinsic worth and are not just mere tissues. An early embryo is a form of human life at the initial stage of human development. As such, the fragile embryonic life needs to be protected. However, the disagreement stems from the amount of protection that is due to the embryos.

The debate rages on regarding the status of the embryo. The debate permeates the entire spectrum of society and recently ESC research has catapulted the issue, via the media, to the larger community. Thus, the issue of the status of the embryo is not just an important issue in medical ethics, but it is also an important issue to society as a whole. It is an important question in ethics, law and politics that has significant practical implications, not only for non-therapeutic embryo research, but also for other issues regarding the embryos such as the disposition of excess frozen embryos from in vitro fertilization and cloning of human embryos. Unfortunately, the different views on the status of the embryo continue to divide participants in the debates and the gap does not appear to be closing. The lack of consensus invariably impacts the ability to enunciate public policies dealing with human embryos.

As the debate goes on, there is a need to have a coordinated public policy approach, perhaps by enacting comprehensive legislation that will address both present and future issues regarding human embryos. There is a need to establish a broad based public panel to examine the social, ethical and
legal implications of recent and potential developments regarding human embryo research. The panel would be charged to provide a broad and flexible regulatory framework using general propositions and terms, which allow for current and future issues to be addressed as they arise. A comprehensive national legislation would help curtail court battles, inconsistent executive guidelines, and ad hoc legislation, which leave the society in disarray.

Congressional legislation influenced by the panel's careful report is preferable to executive guidelines or court decisions in this instance. Executive guidelines most likely will be dependent on whoever is in charge of the executive branch of the government and this could potentially lead to inconsistencies. Furthermore, the courts are not well equipped to deal with the issue concerning embryos. Human embryos do not enjoy the constitutional rights of a person. Roe v. Wade, decided on the ground of a woman's right to terminate an unwanted pregnancy as an exercise of her right of privacy, would not be helpful because the embryos in question are ex utero. Procreative autonomy, which includes the rights to procreate or not to procreate, does not fully help in addressing all the issues involved. The issues involved are vast and significant. Courts' decisions are likely to be limited to the issue(s) before them because courts in the United States do not issue advisory opinions. Therefore, neither court decisions nor executive guidelines seem to be the adequate forum for resolving the issues.

Conclusion

The United States, unlike England and Australia, lacks a uniform approach to dealing with issues concerning early embryos. Issues such as ESC research, cloning of human embryos and disposition of frozen embryo continues to divide the nation. These issues are being addressed by the three branches of the government without an underlying comprehensive framework. As the nation's health focus shifts away from issues such as healthcare reform, cloning and stem cells, to national security and bioterrorism, Congress may take the opportunity to set a panel to provide a comprehensive framework which will influence legislation dealing with human embryo research and related issues such as the disposition of excess frozen embryos from in vitro fertilization and the cloning of human embryo. Congressional legislation providing a comprehensive framework will definitely provide the missing link to the public policies dealing with issues concerning human embryos.

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7. Pope John Paul II. Encyclical Letter; Evangelium Vitae (Vatican City: Libreria Editrice Vaticana,

**Suggested Readings**


**Questions for Discussion**

1. Should the moral status of the embryo impact the debate on human embryo research? If so, how should we resolve the debate on the moral status of the embryo?
2. What are the ethical and policy implications of ESC research and human embryo cloning?
3. Should benefit/burden ratio be employed in discussions regarding human embryo research?