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This is the second issue of the revised format of the ejournal, Health Care Ethics USA, published by the recently expanded Catholic Health Ethics Partnership (CHEP). The ejournal will continue to use the year and number identifiers in continuity with the original format. As editor of the ejournal, I welcome our new health system members. The journal is designed to assist ethics committee members and other health professionals in Catholic health care. And the electronic format is adopted to facilitate easy and widespread distribution of the ejournal across different health systems. The new format for the ejournal presents essays of just 1000 words (previously they were considerably longer) with a brief executive summary - the new format is designed to make it easier for busy health professionals to find time for the essays.

The original version of each issue of Health Care Ethics USA is archived online for CHEP members who have online access to the current and all of the previous issues at: http://chce.slu.edu/chep.html. After connecting to "log in to the current issue", the User Name is, hceusa (lower case only), and the Password is, 2005.

This second issue of the new format for Health Care Ethics USA contains three essays. The first essay is by Jan C. Heller, PhD, who is the System Director of Ethics and Theology at Providence Health System. His essay is on "Discussing the Theological Grounds of Moral Principles" in the context of Catholic health care. The second essay is by John Paul Slosar, PhD, who is the Director of Ethics at Ascension Health, Saint Louis, Missouri. His essay considers "Discontinuing Implantable Cardiac Devices & the ERDs." The third essay is by John Brehany, PhD, who is the Director of Mission Services and Ethics at Mercy Medical Center in Sioux City, Iowa. His essay discusses "Nontraditional Sources of Pluripotent Stem Cells: A New Chapter in the Debate about Embryonic Stem Cell Research."

I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future issues. For ejournal email, please contact: hceusa@slu.edu.

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Executive Summary. Discussing the theological beliefs that ground Catholic moral principles can make some people uncomfortable, even while others will appreciate it. But these reactions will sometimes be revealed not as the emotions they are, but as objections to the relative independence or dependence of morality on foundational beliefs. In the end, context should dictate whether one displays the theological beliefs that ground Catholic moral principles.

When teaching ethics or doing an ethics consultation in Catholic health care organizations, one sometimes hears objections raised that may be somewhat peculiar to Catholic health care settings. On the surface the objections concern the relationship of Catholic theological beliefs to Catholic moral principles, and they can represent two, seemingly opposite positions. Thus, some may object that the moral principles should always display a clear and unequivocal reference to the relevant theological grounds on which they are based. For example, when referring to the respect that is properly due to persons, some might claim that one should also reference the belief that persons are due this respect because they are believed to be created in the image of God. The second, seemingly opposite objection will sometimes be heard when, in fact, one tries to make clear the Catholic theological grounds for the moral principles in question. In such cases, some may claim that the moral principles are sufficient in themselves or that it is inappropriate to discuss theological grounds in a pluralistic setting, notwithstanding its Catholic identity.

There is a long and interesting debate in Christian, and especially Catholic, ethics concerning the relationship of theology and morality, and of the relative dependence or independence of morality on theology, with those working in the natural law tradition generally arguing for greater independence. But the above objections may not, in fact, concern how theology and ethics are related. For both views grant that theological beliefs can indeed ground moral principles, and both seem to grant that the moral principles can stand with or without reference to their theological grounds. They disagree only about the relative importance or desirability of calling attention to those grounds. Said differently, these objections may be less about the relation between theology and morality and more about the comfort or discomfort different people feel in discussing theological beliefs in a Catholic health care setting.

Indeed, the objections may represent an intellectualization of what is in fact an issue on the emotional level of some individuals. And, to the extent that this is true, then to that extent it may be important for ethics committee members and others who may have occasion to teach ethics or do ethics consultations in Catholic health care organizations to understand this. Those desiring to display the theological grounds of morality may be eager to remind us of the Catholic identity of the organization, perhaps because they are proud of the contributions Catholic theology has made and continues to make to medical ethics generally or perhaps because they believe this is a good way to reinforce that Catholic identity. Those who do not wish to have the theological grounds of moral principles displayed or highlighted may not share the theological beliefs (even though they would espouse the moral principles in question) or may not think it appropriate to make reference to particular theological beliefs in a pluralistic health care organization, notwithstanding its Catholic identity. The expression of theological beliefs in public for these people, even when they hold such beliefs, can make them very uncomfortable. Talking about theological or, more generally, about religious beliefs in the United States may be akin to talking about salaries - it generally is not done easily, and when it is it can make some want to leave the room.

If true, this observation does not mean we should ask people not to talk about such beliefs; nor does mean we should not refer to them in Catholic health care settings. But it does suggest we should make such references with sensitivity to our audiences. Different people will have different levels of emotional tolerance for hearing others talk about their theological beliefs or for talking about their own, and those of us who are teaching ethics or doing ethics consultations within Catholic health care
should work to find ways to introduce our audiences to the theological grounds of Catholic moral principles in ways that minimize their discomfort while, at the same time, we continue to honor the Catholic identity of the organization. For example, when we discuss the Christian belief that all persons are due respect because they are created in the image of God, we can also acknowledge that other faiths and secular humanists share this same moral principle, though perhaps for different reasons. This allows the audience to see both that the Catholic belief is not idiosyncratic and that, if others have such foundational beliefs, that it may be "okay" to talk about them in pluralistic settings. In the end, though, context should determine whether one discusses the theological beliefs underlying Catholic moral principles. If the context is educational in nature, there may be more time to address the theological beliefs and it may be viewed as more appropriate. If the context is a hurried ethics consultation in the hospital hallway, there may be less time and it simply may not be appropriate at that point to stress the theological beliefs. Those in charge of the class or the consultation should model this sensitivity to context and to their audiences' different levels of comfort or discomfort in discussing theological beliefs.

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Suggested Readings


Executive Summary. Ethics committees are used to questions concerning the withdrawal of life-support. Such questions become increasingly complex when that life-support is implantable, like a pacemaker. This essay seeks to address the question of under what, if any, circumstances it would be permissible to discontinue the use of such implantable devices.

Ethics committees are generally well practiced in addressing questions concerning the discontinuation of life-sustaining treatments, e.g., respirators or feeding tubes. Such questions increase in complexity when the treatment in question is implantable, like a pacemaker or Implantable Cardioverter Defibrillators (ICDs)? This essay addresses the question of under what, if any, circumstances it would be consistent with the *Ethical & Religious Directives for Catholic Healthcare Services*, 4th ed., to discontinue the use of such devices.

Though pacemakers and ICDs are implantable devices intended to prevent sudden cardiac death, they function in different ways. Pacemakers monitor and regulate the electro-activity of the heart to prevent atrial fibrillation and generally have no or very minimal burdens associated with them.¹ In contrast, ICDs provide an electrical shock to the heart in response to ventricular fibrillation or pulseless ventricular tachycardia. The purpose and function of ICDs parallel that of using a defibrillator during a code. The electrical shocks from an ICD can be painful, may be frequent, and can lead to hematoma, pneumothorax and infection along with psychological distress.² Given these burdens and the purpose of ICDs, a decision to discontinue their use parallels that of a decision to enact a Do-Not-Resuscitate (or "Allow-Natural-Death") order, and can more easily be justified under an application of the principle of disproportionate means than can a decision to turn off a pacemaker.

As articulated in the ERDs, a disproportionate means is any treatment that in the judgment of the patient either does not offer a reasonable hope of benefit or entails disproportionate burdens.³ To be precise, the burdens to which the ERDs speak are only those burdens caused by or directly associated with the treatment itself. It would not be consistent with respect for human dignity as understood within the Catholic moral tradition to say that continued life itself is ever a burden, even if an individual has a very low quality of life. If, in fact, the intention of discontinuing a life-sustaining treatment is to end a person’s life because the quality of that person’s life is deemed - even by the person herself - unacceptable, then this would be considered euthanasia as defined in Catholic Church teaching.⁴ This does not imply that “quality of life” judgments may never be considered when applying the principles of proportionate and disproportionate means. Such judgments may be considered insofar as whether a particular treatment offers a reasonable hope of benefit or not depends not only on whether it prolongs one’s life, but also on whether it improves or, at least, maintains one’s existing quality of life.⁵ The difference between forgoing a disproportionate means and euthanasia is that the intention in the former is to avoid a treatment that is either excessively burdensome or non-beneficial, whereas the intention in the latter is to end the person’s life.

As with a DNR order, a decision to turn off an ICD would be justified if the intention is to avoid or to eliminate the iatrogenic burdens associated with the device when, in the judgment of the patient, those burdens outweigh the benefits. Discontinuing ICD use could also be justified when a patient is nearing death as natural consequence of an underlying pathological condition, and the device is merely interrupting that process. Regarding pacemakers, however, it is highly questionable that the clinical reality would support a disproportionate means judgment based on iatrogenic burdens or psychological distress caused by the device itself. Though patients sometimes request that a pacemaker be turned off due to psychological distress caused by other circumstances in that patient’s life, the discontinuation of the pacemaker in this case is not itself the means by which those burdens are eliminated, insofar as the pacemaker itself is not causing those burdens. However, if it is the
reasonable clinical judgment of a physician that continued use of the pacemaker would only interrupt the natural dying process due to an underlying pathological condition, then it's continued use would not necessarily offer a "reasonable hope of benefit," and turning off the pacemaker could be consistent with the ERDs. While it is questionable that a pacemaker would interfere in the dying process, this is a medical judgment - not an ethical judgment - that would need to be made on a case by case basis.

While this analysis does not significantly depart from more traditional analyses regarding the discontinuation of other forms of life-support, it is subject to two interrelated objections that would not apply in other cases. The first is that, because the pacemaker is an indwelling "biofixture", analogous to an artificial heart valve, it becomes an "integral part of the person" rather than an extrinsic medical intervention, and interfering with its functioning is more akin to "killing" than to "letting die." The second objection is that, while it may be ethically justifiable to turn off a pacemaker in certain circumstances, it is not accepted as sound clinical practice to withdraw or discontinue the use of such biofixtures. The biofixture argument is suspect for two reasons. First, though such devices may be part of a person's physical "reality", these devices do not become an integral part of the person in a morally relevant way, at least from the Catholic perspective, insofar as neither fundamentally alters the person's human nature as created in the image and likeness of God and destined for eternal union with God. As is the case with extrinsic medical interventions, both devices are medical means intended to improve a person's ability to function in characteristically human ways and pursue the goods of human life. Second, whether implanted or extrinsic, the evaluation of whether there is an obligation to use such means is dependent upon a burden-benefit analysis in light of the intrinsic value of human life. The moral reason why it is not customary to remove an artificial heart valve, for example, is because the procedure itself would have more iatrogenic burdens than continued use of the valve. In the case of a pacemaker, however, discontinuing its use would not entail such iatrogenic burdens.

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Suggested Readings


David J. Lane, "Is It Ethical to Withdraw Low-Burden Interventions in Chronically Ill Patients?" JAMA 284,11 (2000): 1380-1381

4. See, Sacred Congregation for the Doctrine of Faith, "Declaration on Euthanasia," in Vatican

Nontraditional Sources of Pluripotent Stem Cells: A New Chapter in the Debate about Embryonic Stem Cell Research

John Brehany, PhD

Executive Summary. Recent efforts to resolve the political impasse over human embryonic stem cells (ESC) have generated proposals for obtaining ESC while avoiding the destruction of human embryos. This new chapter in the scientific and ethical debate provides an important opportunity to introduce additional ethical considerations to enhance public discourse.

For several years, ethical and political debate has been swirling over whether, and how, to utilize stem cells for research, drug testing, and regenerative medicine. Many scientists advocate use of embryonic stem cells (ESC) because of their near-universal, "pluripotent" flexibility. However, the fact that their derivation requires the destruction of human embryos, or close collaboration with abortion in the case of stem cells derived from the gonadal ridge of young embryos, has rendered them ethically suspect and excluded from federal funding under the Dickey Amendment and the Bush administration policy of 2001. Adult stem cells (ASC), on the other hand, have been derived from an increasing list of bodily tissue, utilized in an increasing list of cures, and have demonstrated unprecedented flexibility in changing into alternative types of cells. However, because ASC are considered at best "multipotent," rather than pluripotent, many scientists continue to demand access to ESC.

Recent efforts to resolve the impasse have generated proposals that stretch the boundaries of technology and ethics. These proposals seek to retain access to pluripotent ESC while avoiding the ethical and political consequences of destroying human embryos. The concepts for several "nontraditional" approaches to deriving ESC were presented to the President's Council on Bioethics (PCB) in December 2004. While ethically and technologically challenging, the proposals and the PCB's analyses significantly expand the public debate and provide new opportunities to introduce ethical considerations into public discourse.

Proposals for Nontraditional Sources of Pluripotent Stem Cells

The first two proposals involve the retrieval of individual blastomeres (totipotent cells) from human embryos, culturing these to develop into blastocysts (embryos at 4-5 days gestation) and then extracting human ESC from the inner cell mass. Landry and Zucker propose obtaining blastomeres from "organically dead embryos," drawing an analogy with the widely accepted practice of organ donation. Their proposal includes establishing clear and reliable markers of embryonic death and utilizing only embryos that are thawed with a view to implantation (but then fail to demonstrate organized cellular activity). The second proposal endorses extraction of one or more pluripotent blastomeres from living human embryos, then culturing these to the blastocyst stage and deriving ESC, arguing that blastomere extraction (an increasingly common practice in artificial reproductive technologies in conjunction with preimplantation genetic diagnosis) can be performed without [apparent] damage to the embryos that are allowed to survive. The ESC could then be used either for the benefit of a third party or for the future benefit of the original, developing embryo.

The third proposal is the most complex, ethically and technologically. This approach, called altered nuclear transfer (ANT), seeks to bypass destroying human embryos by creating a "nonhuman" cellular organism that could develop long enough to produce ESC. William Hurlbut of Stanford University argues that, providing an organism lacks the essential biological structures necessary for normal human development (even if it is capable of developing enough to produce stem cells) and providing that the genetic engineering that removes these essential biological structures is performed prior to conception, one can argue that no human embryo has been created, or destroyed.

The fourth and final proposal involves somatic cell de-differentiation - the return of the body's specialized cells directly to a pluripotent state, without creating a human embryo. Whether somatic cell
de-differentiation is possible in the foreseeable future remains to be seen. However, since December 2004 a more specific proposal, called ooctye assisted reprogramming (OAR) has been advanced and has garnered widespread support from opponents of traditional forms of ESC derivation.\textsuperscript{3}

**Ethical Analysis**

The PBC recognized the wide array of ethical issues raised by these proposals. Still, there is a consensus in the PBC's analyses that respect for life of human embryos is a central ethical and public policy consideration. The PBC acknowledges that both proposals involving blastomere extraction are flawed because they require the eventual destruction of a human blastocyst (despite the distance the Landry/Zucker proposal tries to establish between the source of ESC and the destruction of embryos). Based on the same principle, the fourth proposal is the least problematic because it would involve transforming "mere" parts of the human body into other parts, and not the creation and destruction of a distinct human organism. Hurlbut's proposal drew the most sustained ethical analysis and critique,\textsuperscript{4} in part because not all agreed that the proposed "artificial organism" would not be human, in part because of the discomfort created by intentionally introducing critically disabling flaws into the human genome, and in part because of the likely rejection by scientists of ESC from such a unusual source.

These new proposals, and the debate they have engendered, are welcome because they shift the focus away from the "all or nothing" terms in which many construe the debate, and they provide an opportunity to broaden the debate by introducing considerations that can enrich ethical discourse both in the Church and in the public square. One such ethical consideration is based on Foucault's recognition of the importance of "practices" (small, habitual, pervasive actions) in shaping our view of reality and our values. If any of the above proposals or a similar one becomes widespread, it likely will give rise to an industry in which the most fundamental structures of human nature and embodiment are measured and controlled. To prevent the objectification or commodification of human nature, it will be necessary to avoid, or challenge, the effect of such practices.

On a related note, Schindler draws attention to the profoundly different view of nature underlying much of modern science and technology.\textsuperscript{5} He argues that, particularly in the age of biotechnology, to adequately defend human dignity (and ensure that technology serves, rather than determines, human nature and the human good) it is not enough to propose technological solutions to ethical dilemmas. Rather, to help shape not only technological methods but also the ends of science, we must examine the underlying assumptions of all proposals and defend our own deepest beliefs about nature and human nature.

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**Suggested Readings**
