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Welcome to this issue of *Health Care Ethics USA*. Each issue of the journal is archived online with access to the current and the previous issues. The new online address is: 
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This first issue for 2006 contains three essays. The first essay is by Jan Heller who is System Director in the Office of Ethics and Theology at Providence Health & Services. His essay discusses "Moral Mistakes that Leaders Make." The second essay is by Alan Sanders who is Director of the Center for Ethics at Saint Joseph's Health System, Atlanta, Georgia and Healthcare Ethicist at Catholic Health East. His essay discusses "Assent in Medical Decision-Making with Children." The final essay is by Martin Onwu who is an Assistant General Counsel, United States Department of Justice, Office of Community Oriented Policing Services, in Washington D.C. His essay discusses "The Relevance of the Principle of Cooperation for the Ethical Debate on Embryonic Stem Cell Research and Therapies." I hope you enjoy the essays.

In addition, I am pleased to include as front matter in this issue, just before the essays, an important announcement from the Director of the Center for Health Care Ethics about an exciting new partnership between Saint Louis University and the Catholic Health Association to publish *Health Care Ethics USA*.

Professor Gerard Magill, PhD
Center for Health Care Ethics, Saint Louis University

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Announcement from the Director of the Center for Health Care Ethics at Saint Louis University

Health Care Ethics USA has traditionally been edited by the Director of the Center for Health Care Ethics, first Fr. Kevin O'Rourke, OP (1993-1998), then Dr. Gerard Magill (1999-2005). When I assumed the position of Director in January 2006, I requested that Gerry Magill continue as editor of HCEUSA while I pursued an exciting publication arrangement for HCEUSA. Gerry kindly agreed and will continue as editor for volume 14 (2006).

I am very pleased to announce that beginning in January 2007, HCEUSA will be jointly published by the Catholic Health Association (CHA) and the Center for Health Care Ethics at Saint Louis University. Dr. Ronald Hamel, Senior Director of Ethics at CHA, will assume the role of editor. Scott McConnaha at CHA will serve as the managing editor, while Sr. Pat Talone, VP of Mission at CHA, and I will serve as Associate Editors. Beginning in January 2007, HCEUSA will become a free benefit to members of CHA. Non-members of CHA will still be able to subscribe to HCEUSA at the same low rates by contacting the managing editor by email at smcconnaha@chausa.org.

Volume 14 (2006) will continue in its current format. However, beginning with volume 15 (2007), HCEUSA will include a number of new features:

- **Feature articles**: 1 or 2 in each issue, 1,500-2,000 words per article
- **In the News**: short blurbs about relevant ethics topics that have been covered in the media
- **Ethical Currents**: short write-ups about ethical issues that are especially relevant to Catholic health care
- **From the Field**: resources for ethics committees such as case studies with discussion questions and possibly with commentary, suggested readings related to the case, sample policies, successful educational units/programs, various tools, etc.
- **Readers' Forum**: a place to comment on previous issues of the newsletter
- **Resources**: such as bibliographies on a particular topic, book notes [250-500 words], book reviews [500-750 words], helpful ethics-related websites, etc.

HCEUSA will be published electronically in pdf (Adobe) format with supporting materials online. The pdf format is meant to offer the same convenience and cost-savings of other electronic formats while allowing readers to print high-resolution, journal-quality copies of HCEUSA. I hope that these new arrangements will enable HCEUSA to serve our faithful readers as well as a large audience of new readers for many years to come and in creative new ways.

James M. DuBois, PhD, DSc
Mäder Professor of Health Care Ethics
Center Director and Department Chair
Moral Mistakes that Leaders Make
Jan C. Heller, Ph.D.

Executive Summary. This article introduces a novel understanding of the moral failure of leaders, based in cognitive psychology. In contrast to theories of the moral failure of leaders based in self-interest alone, here we explore moral failure as a mistake that grows out of the tendency of leaders to make exceptions for themselves and their followers.

As I began working on the corporate side of health care, I noticed that the CEO had a designated parking space that was very conveniently located relative to his office. Employees, we were repeatedly told, are supposed to give patients and their families the convenient parking spaces, but this rule did not seem to apply to the CEO. I mention this case not to discuss parking privileges as such, but rather to introduce a problem in organizational ethics related to leadership. Leaders make exceptions for themselves. Many leaders in health care have come to expect that they should have a convenient, designated parking space. Interestingly, followers often expect their leaders to make such exceptions for themselves and, sometimes, for these same followers as well—other executives had similar parking privileges. What is ethically interesting about such exceptions is how they grow out of and affect the moral psychology of leaders. Over time, such exceptions can affect a leader's ability to make moral judgments about other, more important exceptions he or she might be tempted to make. Viewed by others, some exceptions may be morally neutral, some may be morally justified, and some may be blatantly wrong, but the leader him- or herself will often be poorly placed to make judgments about them.

When leaders make exceptions for themselves and their followers that observers would view as morally questionable, ethicists typically attribute such exceptions to self-interest run amuck. Ethicists might disagree about whether such actions are truly in the long-term self-interest of leaders (since they are sometimes publicized and disallowed), but they generally agree that such leaders should have realized their actions were driven by their own interests and not by the moral values or principles most of us use. A corollary of this view is that the leaders are without excuse morally.

Recently, however, a new book calls into question the common view that leaders' actions in such cases can be explained by self-interest alone. In Understanding Ethical Failures in Leadership, Terry L. Price argues that leaders are, in fact, not always driven to morally questionable actions by self-interest alone—what he calls the volitional account of their actions. Rather, he argues, leaders are often mistaken about what morality demands of them, and this leads them to do morally wrong actions without fully understanding the ethical implications. For example, Price observes, leaders often agree that their morally problematic actions would have been wrong had they not been acting as leaders in the situation under consideration. If Price is correct, this complicates the ethics of leadership considerably. He calls this alternative view a cognitive account, and it is based in the complex cognitive psychology of leaders and, to some extent, of their followers.

Key to Price's argument is his characterization of leadership. He argues-plausibly, I think—that leadership should be understood as both consequentialist and partial. That is, leadership is typically goal oriented, both in fact and ethically—leaders usually think and act on the basis of arraying the costs and benefits associated with the likely consequences of proposed actions—and they tend to privilege those who help them achieve their goals. They thus find it psychologically easy to make exceptions for themselves and their followers, and morally to justify making these exceptions. The warrants for the justification are found in the collective ends their organizations are seeking to realize—ends that, Price suggests, cannot often be reduced to individual or even collective self-interest alone.

The argument for the cognitive account of ethical failures in leadership appeals directly to the beliefs leaders hold about the importance of their ends. Of course, we all believe that our ends are important; otherwise we would not have them as ends. Leaders are no different in this respect, but the collective
nature of the ends to which leaders are committed gives added justification to these ends. This is what makes leadership ethics distinctive. Leaders can believe, based on the importance of the collective ends they seek to achieve, that they are justified in making exceptions of themselves and in excluding others from the protections of morality.  

This attachment by leaders to the often noble and socially worthy collective ends of their organizations can lead to ‘moral mistakes.’ The moral mistakes leaders make, Price claims, fall into two categories. They make mistakes about the content and the scope of morality and, of these two, the second is more worrisome for Price. Mistakes about content refer to beliefs leaders might hold regarding what actions are morally permissible or right, whereas mistakes about the scope of morality refers to beliefs leaders might hold regarding the boundaries of the moral community and their duties relative to those who are inside and outside those boundaries.

Thus, CEOs might believe that the long hours they work in pursuit of their organization's health care mission, often at the sacrifice of their personal and family lives, morally justify small perquisites like their convenient parking spaces. Further, they may offer similar privileges to the other executives in order to reward and cultivate their loyalty, since these executives are the primary persons through whom the CEO will pursue the collective ends of the health care organization-ends, again, that are generally viewed as noble and good. There is not space to explore this simple case in more depth, but it does illustrate Price's point and we can easily think of other cases that might be more problematic. In any event, because leaders and their followers are apt to make such mistakes, morally conscientious leaders should take steps to counter their natural bias. An approach to decision making that deliberately considers the possible effects of decisions on stakeholders outside the immediate moral community of the leader and the leader's executive team is one step that can be taken. When in doubt, Price advocates that leaders should err on the side of inclusion rather than exclusion of other moral communities. There are other practices we might advocate to help leaders account for their natural and often commendable practice of viewing their own organization's ends as more important than other individuals' or organizations' ends. After all, we pay our leaders well to pursue the mission of the organizations that employ them, and they should do so-unless and until there is some other important moral good or community at risk in their decisions. And, when they take such risks, they should be held accountable for the decisions they make, however mistakenly.

Jan C. Heller, Ph.D.
System Director, Office of Ethics and Theology
Providence Health & Services

Suggested Readings


2. In other words, unlike those who follow the guidelines of most consequentialist moral theories (for example, utilitarianism), leaders typically do not evaluate the possible costs and benefits of their proposed actions in impartial terms.
Executive Summary. As maturing individuals, children and adolescents tread the line between possessing decision-making capacity regarding their own medical decisions and needing others to make medical decisions in their best interest. This essay discusses the role of assent in medical decision-making with children, including consideration of their decision-making capacity and of acting in their best interests.

Young children to adolescents present unique challenges to parents and health care professionals in medical decision-making, especially when the child's condition may be critical and the prognosis difficult to determine. Unlike adults, children's decision-making capacity is continuously developing; they may or may not have the decision-making capacity required to make a particular medical decision. Oftentimes, children are asked for their assent, not informed consent, in medical decision-making.

Assent is a modified version of informed consent aimed at the appropriate inclusion of children in medical decision-making based upon their age or psychological development. Assent is often defined as (a) informing the child about their condition and possible medical treatment in a manner that they can understand and (b) soliciting the child's reaction to proceeding with treatment. Assent is intended to respect the child as a developing individual by allowing participation in their medical decisions. However, it may not be in the best interest of a child to ask her if she would like to proceed with treatment when her decision-making capacity is questionable. Sometimes this error is made because assent may be easily confused with informed consent.

Consider, for example, an 8-year-old child who requires a tonsillectomy because of recurrent infections that obstruct her breathing pathway. The child may refuse the surgery based upon an irrational fear of hospitals, even though the surgery is likely in her best interest. Rather than give her a choice about a decision she may not be ready to make, health care professionals may present to the child her condition and required treatment in a manner that she can understand. The child may then be allowed to express her thoughts and emotions about the situation. In other words, the parents and the healthcare professionals can make the child as comfortable as possible with the required treatment, not ask her whether she agrees with the decision.

Of course decision-making capacity is an important consideration for such actions. A particularly mature adolescent who is still technically a minor may have an adequate understanding of her medical condition and may have valid reasons for refusing medical treatment. An adolescent who has undergone numerous rounds of chemotherapy and radiation treatment, for instance, may develop a mature outlook on life and make a sound decision that further treatment is too burdensome. However, children and adolescents often have difficulty developing a long-term outlook and may make rash decisions based upon their immediate emotions and frustrations.

This is why in cases when the decision-making capacity of children is questionable, it may not be in their best interest to ask them whether they are willing or unwilling to proceed with treatment. Rather, the process of seeking assent may be a mechanism intended to make them feel as comfortable as possible with the decision. If the child or adolescent feels strongly opposed to the decision, she should be allowed to express these feelings in an open and trusting environment. The adults in the situation may then address those feelings. The adults may either alleviate the child's concerns to the extent possible, or, further communication may reveal that the child has adequate decision-making capacity. This process avoids giving the child or adolescent false expectations while at the same time allowing them a certain amount of influence in the process of the decision.

From this perspective, assent is more about allowing the child to participate in the process of treatment rather than to make a decision about treatment. The 8-year-old requiring the tonsillectomy...
may influence the course of discussion and may even postpone the surgery, if medically acceptable. This allows the child to have an appropriate amount of participation, and it respects her as a person without violating her trust in her parents and the health care professionals.

Informed consent typically involves informing the patient regarding the following three things: their current medical status, including the uncertainties and the uncertainties of their prognosis; their treatment alternatives; the risks and benefits of each treatment, including the risk and/or benefits of no treatment. The patient is then allowed to make her decision about what, if any, treatment she prefers.

Assent as discussed here would involve informing children of the following two things: their current medical status in a manner that they can understand and the treatment that is in their best interest. Instead of asking the child whether they want to proceed with treatment, the child is engaged in discussion in order to assess how they feel about proceeding. The child is allowed to influence the speed and manner in which the decision proceeds. And if communication is open and honest, the child's decision-making capacity may be revealed during this process. In this manner, the child is not given false expectations.

The age and psychological development of children and adolescents will always be a major factor when determining their ability to make medical decisions. The process of informing a 17-year-old of his medical condition would more than likely resemble the process of informed consent, not assent. But within this continuum of psychological development, instead of presuming decision-making capacity unless demonstrated otherwise, as we do for adults, it may be practical to presume that the decision-making of children and adolescents is questionable unless they demonstrate otherwise.

There are many ambiguities involved with determining the right of a child to make their own medical decision versus making a decision for them in their best interest. The process of assent may help, if assent is practiced as taking into consideration the thoughts and feelings of children and adolescents in the medical decision, not necessarily asking them if they are willing or not willing to proceed with treatment. In this manner, assent may help determine the decision-making capacity of the child before presenting a decision, if a decision is presented at all. In other words, assent utilized in this manner may help guide medical decisions in the best interest of children and at the same time respect them as developing individuals.

Alan Sanders,
Director, Center for Ethics, Saint Joseph's Health System
Healthcare Ethicist, Catholic Health East

Suggested Readings


Executive Summary. The principle of cooperation offers a helpful approach to find a common ground for science and medicine in the debate on human embryonic stem cell (hES) research and therapies. Under the principle, some hES research and therapies utilizing immortalized stem cell lines may be justified while hES research and therapies that entail the ongoing destruction of early human embryos remain ethically problematic.

Human Embryonic stem cell ("hES") research is one of the greatest controversies in medical ethics in recent times. The controversy followed the announcement in the fall of 1998 by two groups of scientists who had successfully isolated and cultured self-renewing embryonic stem cells. Since then, the ethics debate of hES research has flared. The debate focuses on the source of the stem cells insofar as hES research involves the use of immortalized cell lines created from stem cells isolated from early embryos. The extraction of stem cells from the early embryos results in their destruction. Many of the ethical challenges posed by hES research and therapies would disappear if non-embryonic cell sources are developed or if the extraction of the stem cells does not result in the death of the developing human embryos. Since such other sources or methods have proven elusive thus far, the issues surrounding hES research and its potential therapies will continue to elicit debate on ethics and public policy.

Those who support hES research, relying on the principle of beneficence, argue that it is justifiable to modify or destroy early human embryos in the pursuit of treatments or cures for serious diseases. Proponents, relying to some extent on consequentialist/utilitarian considerations, argue that hES research is justified because the research will yield medical therapies for most in the society. In contrast, opponents of hES research, relying on deontological theory, argue against the instrumentalization of human embryos by using them as a means to find cures for others suffering from diseases. In addition, opponents, relying on natural law principles, argue that the medical benefits derived from hES research do not justify destroying the embryos involved.

Underlying the differences in the debate is each participant's views on the moral status of the embryo. Some view early embryos as mere tissues or cellular material, which demands little, if anything, morally. In contrast, others view the developing embryo as a personal living being that warrants the same moral status as a developed human being. Some appear to adopt a posture between these two stances, viewing the early embryos as neither mere tissues entitled to no protection nor persons yet entitled to full moral protection.

While recognizing that the polarized debate on the moral status of the early human embryo will not disappear, it is nonetheless important to seek some common ground for science and medicine in the public arena. Hence, there is a need to include in the debate on hES research a broader range of considerations to help address the stalemate between those who support and those who oppose this research.

The moral principle of cooperation offers a helpful approach to find such common ground for science and medicine for hES research and therapies. The principle draws a basic distinction between formally cooperating with the evil actions of others (which is not permitted) and materially cooperating with the evil action of others (which can be permitted in particular circumstances). The principle's success in resolving other public moral dilemmas suggests that it possibly can be an effective principle for this debate. For instance, the principle was effective in resolving the public debate on the use of vaccines originating from immortalized cell lines created from aborted fetal tissues. Using the vaccines entails a material connection with previous abortion via the immortalized cell lines obtained from aborted fetal tissue. But using these vaccines is not morally complicit with the previous abortion because the use is
distinct from the original abortion and there is a sufficient distance between the different acts. Given
the medical benefits that such vaccines yield, there is proportionate reason to justify their use.\textsuperscript{4}
Similarly, vaccine research is materially connected to previous abortions via the immortalized cell lines
obtained from aborted fetal tissues. But such research is not necessarily morally complicit with the
previous abortions.

Likewise, the principle of cooperation may be well suited to address the issue of hES research and
therapies. Because the principle of cooperation is a conflict principle, its use assumes the antecedent
respect for human life at the earliest stage of development. It is because of the conflict between such
respect and the pursuit of problematic research and therapies that the principle can be helpful. But
using the principle does not justify any form of medical research in this new field. For example, the
principle cannot justify therapeutic cloning which entails the creation of embryos via nuclear transfer
method and their subsequent destruction via the extraction of stem cells; moreover, the principle of
cooperation cannot justify the creation of embryos for research.

However, the future use of potential hES therapies, utilizing immortalized cell lines created from stem
cells extracted from human embryos (despite their unavoidable destruction in the process) in principle
may possibly be justified under the principle of cooperation. Such potential therapies would have a
material connection to the previous wrongdoing of extracting immortalized cell lines created from
embryonic stem cells that involved destroying embryos. But such therapies would not necessarily
make the user complicit in the previous destruction of embryos insofar as the use of therapies would
be distinct from the act of destruction and there would appear to be a sufficient distance between the
different acts. Given the medical benefits that such therapies would yield, there might be proportionate
reason to justify the use of such controversial future therapies.

Similarly, hES research can possibly be materially connected to the underlying wrongdoing of the
destruction of the embryos via extracting immortalized cell lines. But such research is not necessarily
morally complicit with the previous wrongdoing. The research on the immortalized cell lines for cures
and treatments for severe diseases must be distinct from the previous wrongdoing, and there must be
a sufficient distance between the different acts. Given the potential medical benefits, there can be
sufficient reason to consider justifying the use of the immortalized cell lines for such research.

While this essay argues that in principle hES research and therapies may be ethically justified using
the principle of cooperation, the pursuit of such research and therapies in Catholic health care facilities
would need to consider further practicalities and circumstances.\textsuperscript{5} Moreover, the success of non-
embryonic stem cell therapies would have significant ethical implications for the development of hES
therapies. Specifically, the availability of effective non-embryonic therapies or immortalized cell lines
for research would challenge whether the above reasons adduced for hES research and therapies is
proportionate.

Many researchers argue that both embryonic stem cell and adult stem cell research are necessary
and neither should be restricted. But the problem of such a sweeping approach is that for many,
respect for developing human life should not be sacrificed to discover cures or to alleviate human
suffering and disease. For those who want to respect human life from its inception and also pursue
hES research and therapies, the ethical principle of cooperation can provide guidance for both the
personal and the public domain. That is, the principle can guide both personal decisions and public
policies in the continuing debate on hES research. Perhaps the most urgent use of the principle of
cooperation for emerging research and therapies pertains to designing astute public policies that seek
to respect personal belief perspectives and also to foster medical breakthroughs for the public interest.
Martin U. Onwu is an Assistant General Counsel, United States Department of Justice, Office of Community Oriented Policing Services, in Washington DC. The views expressed in this article do not necessarily represent the view of the United States Department of Justice or the United States.

Suggested Readings


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