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This second issue for 2006 contains three essays. The first essay is by Mark Repenshek, PhD, who is the Healthcare Ethicist at Columbia St. Mary's in Milwaukee, Wisconsin. His essay discusses "The Mechanism of Action in Intrauterine Devices (IUD) as it Relates to Physician Billing Services." The second essay is by Birgitta N. Sujdak Mackiewicz who is an Ethics Fellow at OSF St. Francis Medical Center, Peoria, Illinois. Her essay discusses, "Can Catholic Facilities Justify the Use of Embryonic Stem Cell Therapies Developed from the Destruction of Human Embryos?" The final essay is by Ann Suziedelis, PhD, who is the Vice President of Mission Services at St. Joseph Mercy Oakland Hospital, Pontiac, Michigan. With a captivating title her essay discusses a very serious ethical concern, "Nurses: The Rodney Dangerfields of Health Care?" I hope that you enjoy the essays.

Professor Gerard Magill, PhD  
Center for Health Care Ethics, Saint Louis University
Executive Summary. This essay will examine the mechanism of action in the Mirena intrauterine device (IUD) marketed in the United States as that discussion relates to the ethics of its utility. Furthermore, the essay will argue that because the Mirena IUD is morally licit when offered in accord with the principle of double effect, Catholic healthcare ministries may also therefore licitly bill for the insertion and related costs.

Currently, there are two types of IUDs marketed in the United States. The copper T380A, (ParaGard), and the levonorgestrel-releasing intrauterine system (Mirena). The U.S. Food and Drug Administration (FDA) approved the copper T380A in 1984. The Mirena device was approved in Finland in 1990 and by the FDA in 2000. Its indications for use involve: contraception, menorrhagia (blood loss exceeding 80 mL per cycle), anemia, hormone replacement therapy, and endometriosis. Given the significant differences in the two devices, this essay will focus on the Mirena IUD.

IUDs produce, among other mechanisms of action, a local foreign-body response in the human endometrium. This foreign-body reaction results in the release of white blood cells, prostaglandins and enzymes. It was thought, for many years, that a normally fertilized egg entered the uterus but could not complete implantation in a hostile environment as a result of the IUD. New evidence on the Mirena IUD may suggest otherwise.

The possible mechanisms of action for the Mirena IUD in humans can be classified as occurring primarily before fertilization. The possible prefertilization mechanisms of action of the IUD include the following: inhibition of sperm migration and viability at the level of cervix, endometrium, and tube; slowing or speeding the transport of the ovum through the fallopian tube; and damage to or destruction of the ovum before fertilization. Hormonal evidence indicates that the IUD does not generally inhibit ovulation in humans (as seen in women who use IUDs to reduce or eliminate menstruation still have ovulatory cycles as assessed by hormonal measurement and follicular ultrasonography). The weight of current evidence, however, suggests that although the primary mechanisms of action of the Mirena IUD occur prior to fertilization, a secondary effect of inhibition of implantation cannot be completely excluded.

It seems relevant that given the number of indicated uses for the Mirena IUD wherein all such uses the Mirena IUD maintains its contraceptive effects, that the principle of double effect is relevant in an ethics analysis on its use. This essay will utilize this principle to argue that given certain criterion being met, the use of the Mirena IUD can be licit within Catholic healthcare facilities. The matter of billing necessarily follows and can be answered with relative simplicity given the conclusions drawn from the prior analysis.

The principle of double effect (PDE) is used in the Roman Catholic moral tradition to resolve dilemmas concerning human acts that bring about two effects: one good and permissible and the other prohibited. The PDS turns upon the distinction between intended and merely foreseen effects. Proper applications of the PDE use this distinction (i.e., between intended and foreseen effects) to render permissible those acts which foresee a prohibited effect, but do not intend this prohibited effect. Use of this principle allows the Roman Catholic moral tradition to permit acts that would otherwise be impermissible were the prohibited effect of the human act directly intended. In other words, the PDE does not function as a principle that justifies certain human acts, nor as a principle that grants exceptions to moral norms. Rather the principle "has a heuristic and confirming function" which serves to confirm a case's congruency with paradigm cases in the Roman Catholic moral tradition.
It is generally accepted that there are four conditions that govern legitimate use of the PDE. Although variation exists concerning the precise content of these four conditions, Joseph Mangan constructs the modern formulation of the principle. He states: "A person may licitly perform an action that he foresees will produce a good and bad effect provided that four conditions are verified at one and the same time: (1) that the action in itself, from its very object, be good or at least indifferent; (2) that the good effect and not the bad effect be intended; (3) that the good effect be not produced by means of the bad effect; (4) that there be proportionately grave reason for permitting the bad effect.”

*Humanae Vitae* makes use of the PDE to resolve the moral ambiguity concerning human acts that have both a contraceptive and therapeutic effect. Use of the principle allows the Roman Catholic tradition to consider therapeutic actions licit that would not be permissible were their contraceptive effect directly intended. Pope Pius XII recognized use of the principle as being legitimate in his addresses to urologists and hematologists. Therein, Pope Pius XII appealed to the PDE to render morally permissible those therapeutic acts necessary to cure disease, which may have, as an unintended side effect, a contraceptive effect. Subsequently, *Humanae Vitae* (HV) references these exceptions to the negative moral norm prohibiting contraception when it renders licit therapeutic means that indirectly act as an impediment to procreation.

Using the PDE as it applies to the use of the Mirena IUD, the following analysis is relevant:

1. the action in itself (i.e., use of the IUD), from its very object, be good or at least indifferent. Insofar as the IUD is considered in and of itself, it is morally neutral. The moral object of the act is using a therapeutic hormonal intrauterine device.
2. the good effect and not the bad effect be intended. The IUD's use is determined by the clinical circumstances of the case. As such where the directly intended use of the IUD is non-contraceptive in nature the agent directly intends to achieve the non-contraceptive beneficial effect of the IUD.
3. the good effect be not produced by means of the bad effect. Where appropriately indicated, the use of an IUD for non-contraceptive intentions does not achieve the contraceptive effect by virtue of the non-contraceptive effect. In fact, the two effects are unrelated. As such, the contraceptive effects of an IUD in this set of circumstances are merely a foreseen, but indirect effect.
4. there be proportionately grave reason for permitting the bad effect. Treatment or in certain cases cure of these diseases or pathologies is proportionate to the foreseen but unintended contraceptive effect.

It has been shown that in the case of the Mirena IUD, as with many other hormonal therapies, the directly intended use of this therapy may not be contraceptive in nature. Additionally, this essay argues that the use of the Mirena IUD is supported and appropriate when utilized for a number of purposes that are not in conflict with the *Ethical and Religious Directives for Catholic Healthcare Services*, and where the four criteria of the principle of double effect are met. As such, IUDs can be licit in specific circumstances. Therefore, in these situations, it is clear that one can cooperate and should cooperate with the moral goods achieved through the use of an IUD. Furthermore, related to the matter of billing, where the above criteria have been met, it is appropriate for Catholic health ministries to bill for the licit use of the Mirena IUD and its related costs.

Mark Repenshek, Ph.D.
Suggested Readings


15. Pope Paul VI, Humanae Vitae, 15.

Can Catholic Facilities Justify The Use Of Embryonic Stem Cell Therapies Developed From The Destruction Of Human Embryos?

Birgitta N. Sujdak Mackiewicz

Executive Summary. Determining whether the future use of therapies developed from embryonic stem cells (ESC) may be justifiable in Catholic facilities requires the application of the principle of cooperation. This application recalls the justification by the Vatican for the use of vaccines derived from the cells of aborted fetuses. The essay explains that the Catholic Church may support limited utilization of ESC therapies.

The Catholic Church has no opposition to the use of emerging medical technologies provided they respect human dignity. However, the Church condemns the derivation of embryonic stem cells for research or therapy. The condemnation is because ESCs are acquired by the removal of the inner cell mass from the blastocyst of an early embryo created via in vitro fertilization (IVF) or somatic cell nuclear transfer (SCNT), also known as therapeutic cloning, which destroys the embryo. In Catholic teaching, this is tantamount to direct abortion, an intrinsic evil. Future use of ESC therapies in Catholic facilities may however be acceptable, as discussed below.

Currently there are no established ESC therapies. If discovered they may revolutionize medicine, e.g., reducing the need for organ transplantation, repairing damaged spinal cords, or curing diseases such as Parkinson's. This essay discusses whether Catholic facilities may justify the use of ESC therapies. The Church has not formally condemned the use of existing ESC lines for research or therapy; the ethics question about this use remains open. By applying the principle of cooperation and noting the similarities between this question and the Vatican's response regarding the question of the use of vaccines tainted by abortion, one may conclude that in principle the Church could support the future use of some ESC therapies.

Recognizing that not all cooperation with evil can be avoided, the Church carefully delineates when cooperation is acceptable. The use of ESC therapies may be justified by the principle of mediate material cooperation: the cooperator (the treating clinician) acts in cooperation (using ESC therapies) with the principal agent (the researcher who destroyed embryos to develop ESC therapies), but does not intend the evil (embryo destruction). This cooperation is permitted provided: 1) the act is morally good or neutral, 2) one does not intend or condone the evil with which one cooperates, 3) the good does not result from the bad effect, 4) the good which occurs is proportional to the negative effect resulting from cooperation, and 5) it is possible to avoid scandal - the appearance that Catholic facilities condone or do evil to bring about good.

The first type of potential ESC therapies whose use does not require the destruction of additional embryos is perhaps easier to justify, i.e., ESC therapies developed from the currently existing stem cell lines that are eligible for federal funding (based on the policy of President G.W. Bush). Unlike the principle agent, the cooperator's intent and act can be good: to preserve the patient's health and life using ESC therapies. One might argue that accepting the future use of these types of ESC therapies will encourage further embryo destruction because it may possibly create a demand for more therapies requiring new stem cell lines with the concomitant destruction of embryos. However, the cooperator's act is not necessarily dependent on any further evil acts of embryo destruction, and hence does not "fail to prevent" further destruction. Ideally, there should be no demand for continued embryo destruction. Further, Catholic facilities had no ability to prevent the original destruction of embryos that were used to derive the currently approved federally funded cell lines.

There are other types of ESC therapies however which depend on the ongoing destruction of embryos, i.e., to keep the cell line viable or to provide personalized therapies. Unlike therapies which do not encourage the future destruction of embryos, these types of therapies are not acceptable for Catholic facilities. Their use constitutes immediate material (or some might argue, formal) cooperation
which is not justifiable as it represents grave attacks on human life which are always illicit. Here the cooperators share the same intention of the principal agent - (continued) embryo destruction to harvest ESCs and develop or renew ESC therapies. Their action creates a demand for and even requires continued embryo destruction. For example, in personalized therapies using SCNT technology to harvest genetically identical ESCs for an individual patient, the clinician and patient directly intend to kill the SCNT embryo, thereby creating a direct causal relationship between the therapy and the embryo destruction.\footnote{6}

The justification of the use of ESC therapies which do not rely on the ongoing destruction of embryos is similar to the justification of the use of vaccines derived from cell lines obtained from aborted fetuses, such as the rubella and chicken pox vaccines, for which there are no alternatives. The Church recognizes that despite their morally reprehensible origins one may, and indeed ought to, utilize them in some instances. There was no causal relationship between the abortions and the vaccine development. Like those who use the vaccines, those who utilize ESC therapies do not cooperate with the destruction of life and arguably do not facilitate it, nor do they intend the destruction. Further, using ESC therapies that are derived from the currently federally funded self-renewing cell lines seems similar to using cell lines for vaccines: using them does not deplete the cell supply in a significant way and thus does not necessitate or encourage further destruction of human life.\footnote{7}

Finally, recalling that cooperation requires a proportionate reason and the avoidance of scandal it is important to discern whether the reason for utilizing ESC therapies is proportionate in relation to the level of cooperation with evil and whether scandal can be avoided. If the therapy is life-saving the good, preserving life,\footnote{8} can be proportionate. If the therapy brings about some lesser good, one must discern in good conscience whether its use can be properly justified. Once it has been determined that the use of the ESC therapies constitutes a proportionate reason, reasonable attempts to avoid scandal must be made to justify cooperation. ERD 71 advises that scandal might be avoided by: proper explanation, extensive patient and staff education, public relations campaigns, transparency, a consistent commitment to life, and research and lobbying for alternate therapies. It may be impossible to avoid all scandal, but careful examination of whether proportionate reason exists and adherence to ERD 71 can justify the use of some ESC therapies.

In conclusion, using ESC therapies which meet the requirements of mediate material cooperation is an act in which nothing "inherently immoral" exists. By providing these types of ESC therapies Catholic facilities have an opportunity to communicate the Catholic vision of life and its inherent dignity.\footnote{9} This enables a discernment of the appropriate course of treatment that recognizes both the value of the embryo and the goods at stake. This cooperation should, however, be understood as temporary. If equally effective therapies are developed that would not require cooperation with evil one is obligated to utilize the alternatives if doing so does not create grave difficulty.

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Suggested Readings


Nurses: The Rodney Dangerfields of Health Care?
Ann Suziedelis, PhD

Executive Summary. Why do nurses, so indispensable to healthcare, often express feelings of not being respected or empowered to act in accord with their education and level of service? This essay considers ways that organizational and clinical ethics committees can work together to mediate discussions throughout a hospital to address and remedy this situation.

Imagine a hospital without nurses. It is like trying to conjure up a restaurant without food or a crowd without people. Yet if they are so critically important, why do so many nurses feel like Rodney Dangerfield - undervalued and sometimes disregarded? It would be foolish to suggest that all nurses in all hospitals feel the same concerns, but there is a thread of deep frustration across nursing that is relevant to both clinical and organizational ethics. This is of particular concern to Catholic healthcare, since we have a special recognition of our responsibility to honor the human dignity of all persons - staff as well as patients. Employees who feel oppressed must be an important focus of organizational ethics. Similarly, since patients benefit when they are treated and cared for by a united and mutually respectful healthcare team, discontented nurses are a matter of concern to clinical ethics as well. The problem does not belong solely to ethics committees; their involvement does not negate the legitimate interest and efforts of Human Resources, Administration, and Security, among others, in addressing these matters. Instead, while ethics brings its own interests, it can at the same time be the driving force coordinating all these initiatives.

Some suggest that responsibility for nurses' dissatisfaction falls solely on the shoulders of authoritarian doctors. A recent poll of physicians at one hospital, however, suggests that part of the problem may simply lie in the lack of honest, open, and mutually respectful dialogue. The poll gives insight into how nebulous the place of nurses in healthcare can be. The physician respondents rated the nursing staff as one of the hospital's strongest assets, scoring nurses even higher than they scored their fellow physicians. Yet in that same week, and in that same hospital, a roomful of nurses agreed that they would never call for an ethics consult because they feared the possibility of retribution from attendings. Concerns vary from nurse to nurse and hospital to hospital, but that fear of retribution (as well as a sense of being too easily dismissed, left out of important conversations, and forced to endure whatever disrespect families and patients choose to show them) is an important issue, not only for nurses, but also for patients.

These concerns can be relevant to both organizational and clinical ethics committees. In conversations where they feel safe, nurses express one group of concerns that are in the purview of clinical ethics. As medical professionals with the most extended hands-on relationships with patients, nurses are sometimes frustrated about treatment choices made for their patients, and resentful of being left out of conversations about their care. For example, they sometimes express concern that too much is being done after the time has arrived to allow death to come peacefully. At other times, they worry that a family is "letting go too soon." In either case, nurses feel that some surrogates are making inappropriate decisions, and that physicians are buckling too quickly to their demands. An organizational ethics issue related to this is that the physician may be giving in to the surrogates because they are so confrontational that it is easier to do what they want than to fight them. The nurse, however, if given no choice but to take the ongoing verbal abuse, can wear down quickly. While insulting the nursing care given their loved ones can be the way a relative vents understandable frustration, fear, and grief, nurses should not be offered up as sacrificial lambs, forced to absorb it all without recourse.

Another concern nurses have is that some patients are not being told the truth about their prognoses, or are not being given sufficient information to make informed decisions. Whether or not the nurses are right that a particular patient's needs are not being addressed correctly, their lack of a sense of empowerment can cause the situation to become a source of brewing frustration. The existence of this
kind of situation is an opportunity for ethics committees to collaborate with others to instill confidence in nurses about calling consults to help mediate conversation.

In yet another area of discontent, a nurse manager with significant responsibilities in her area describes feeling invisible. Some doctors, she complains, look right past her and her legitimate authority, to take their questions over her head to Administration. The ghosts of olden days, when nurses rose and stood at attention when a physician entered the nursing station, still linger.

Organizational and clinical ethics can work together, and with others across the hospital, to address these concerns. The overarching initiative must be to bring about constructive conversation between doctors and nurses, with other efforts undergirding this focus. The first of these would be to increase the comfort level of nurses about calling an ethics consult. Toward this end, ethics committees can facilitate conversations with the Chief Medical Officer and Administration to develop a clearly understood and enforced policy to ensure that a physician will face disciplinary action if he or she intimidates or seeks reprisal against a nurse for exercising a legitimate professional obligation to intervene for the well-being of a patient. Ethics committees can work with Security to develop procedures to support nurses who feel physically endangered by a patient or visitor, and policies can be developed and enforced for the removal of a disruptive visitor from a patient's room, and possibly from the hospital. In the spirit of subsidiarity, ethics committees can work with administrators to make a commitment to politely demur from considering matters that have skipped past a nurse manager or director, returning the matter to the responsible nurse for consideration.

Once such policies are in place, HR can help nurses develop skills to implement these new approaches. The result of these efforts will be a new and more powerful nursing force, demanding and commanding well-deserved respect within a hospital that now has policies and procedures in place to ensure that they can do so effectively and safely. All of these efforts will support the success of an improved nurse/physician relationship, which in turn will bring about better patient care - the ultimate mission of healthcare.

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Suggested Readings

