Health Care Ethics USA

CHI Edition

2006 - Vol. 14 No.3

A publication of the *Catholic Health Ethics Partnership* at Saint Louis University's *Center for Health Care Ethics®*

- From the editor...
- Ethics in Vaccine Development & Production: Transforming Health Care
- Human Dignity in Patient Care: Keeping Persons at the Center of Moral Discourse
- Reconsidering Catholic Teaching on Withdrawal of Artificial Nutrition and Hydration

More information on how to subscribe to *Health Care Ethics USA*.

Review the Health Care Ethics USA *Index of Past Publications*.
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: http://chce.slu.edu/Partnerships_HCE_Intro.html

This third and final issue for 2006 contains three essays. The first essay is by John F. Brehany, Ph.D., S.T.L., who recently left his position as Director of Mission Services and Ethics at Mercy Medical Center in Sioux City, Iowa to accept an appointment as the Executive Director and Ethicist for the Catholic Medical Association in Philadelphia, Pennsylvania. His essay discusses "Ethics in Vaccine Development & Production: Transforming Health Care." The second essay is by David Belde, Ph.D., who recently left his position as Director of the Center for Ethics in Healthcare at Saint Joseph's Health System in Atlanta, Georgia to accept an appointment as Administrative Director of Ethics & Mission at Bon Secours Richmond Health System in Richmond, Virginia. His essay discusses, "Human Dignity in Patient Care: Keeping Persons at the Center of Moral Discourse." The final essay is by James Hynds, LL.B., Ph.D., who recently completed a two year post-doctoral clinical fellowship at the University of Toronto's Joint Centre for Bioethics and has accepted an appointment as Clinical Ethicist at the UCLA Healthcare Ethics Center in Los Angeles, California. His essay discusses, "Reconsidering Catholic Teaching on Withdrawal of Artificial Nutrition and Hydration." I hope that you enjoy the essays.

Professor Gerard Magill, PhD  
Center for Health Care Ethics, Saint Louis University
Executive Summary. Immunization efforts in the USA are being challenged for several reasons, including new ethical questions. Responding appropriately to the fact that several common vaccines rely on cell lines derived from elective abortions can provide an occasion for Catholic health care institutions and providers to transform medical practice and research.

Childhood immunization is widely recognized as one of the most important factors in reducing death, disease and suffering over the last century. However, the social consensus that has supported universal immunization has been eroding. Continuing concern, since the disclosure in the late 1990s that cell lines used to develop and produce many childhood vaccines have their origins in elective abortion, threatens to further undermine this support.

In the United States, vaccines for hepatitis A, (some) rabies, rubella, chicken pox, (varicella), shingles, and bivalent or trivalent combinations of these (such as MMR), depend on human diploid cell lines (MRC-5, WI-38, HEK-293, IMR-90, RA273) derived from elective abortions for their development and ongoing production. The ethical debate that arose after this discovery has focused on whether or not parents were obligated to accept vaccinations for their children if they objected in conscience to the nexus with abortion. The terms of the debate shifted somewhat in 2005 with an intervention by the Pontifical Academy for Life (PAFL).

The PAFL declaration, *Moral Reflections on Vaccines Prepared from Cells Derived from Aborted Human Foetuses*, recognized the complex ethical situation faced by parents and health care professionals. The PAFL highlighted the importance of vaccination for protecting the public (particularly against rubella) and the remote, material, passive cooperation involved for parents and children seeking vaccination. The PAFL recognized that parents could abstain in accord with Catholic moral conscience, but said it must be done in such a way as to avoid significant risk to the population. At the same time, the PAFL called for those involved in the preparation, distribution and marketing of these vaccines to denounce their unethical origins and work expeditiously to develop alternative vaccines. Similarly, PAFL enjoined physicians and parents to use alternative vaccines whenever possible, and to put pressure on health systems, pharmaceutical companies and politicians to make available, or develop, alternative vaccines. In July 2005, the Catholic Health Association issued a statement summarizing the PAFL declaration and providing resources to member organizations to address the issue.

After initial discussion by Catholic health care organizations, significant follow-up actions have failed to materialize. There might be several reasons for this. First, some who took steps to identify currently available, equally safe vaccines might think they did enough. Second, some might hold that the unethical actions (i.e., the elective abortions from which the cell lines were derived) are sufficiently remote, in years and causal nexus, from current vaccinations as to obviate any moral concern. Third, some might hold that the ethical issue, while real, is negligible when compared to other pressing challenges, and when compared to the good achieved by universal immunization. Fourth, some have noted that the PAFL is not binding Church teaching. I contend, however, that the issue is significant enough to warrant further reflection and action.

First, the nexus between elective abortion and vaccine development does not belong exclusively to the past. New cell lines for current vaccines will be required because the original cell lines are nearing the end of their natural lifespan, and new vaccines continue to be developed. In both cases, pharmaceutical companies show every indication of resorting to cell lines derived from elective abortions. In fact, a new cell line for vaccine research and development, PER C6, derived from an elective abortion in the late 1980s, was introduced into the U.S. in 2003.
Second, ethical analysis can and should be refined. The analysis to date, both among moral theologians and by the PAFL itself, has taken place in the framework of the principle of legitimate cooperation. Within this framework, there is general consensus that the element of "cooperation" involved for parents seeking immunization of their children is mediate, remote, and passive. However, this analysis does not take account of an important recent development in ethical analysis. In 2000, M. Cathleen Kaveny called for the principle of legitimate cooperation (PLC) to be supplemented by the principle of appropriation of evil (PAE). For Kaveny, recognition of PAE better deals with the fact that more ethical dilemmas today involve a moral agent deciding to make use of the fruits of unethical action performed in the past. Drawing on the renewal of virtue theory, PAE analysis focuses renewed attention on the character of the moral agent and the dangers that come with too-easy an acceptance of evil performed in the past and/or by others.

Third, the debate over the nexus between abortion and vaccines is quickly becoming subsumed into the debate on the permissibility of human embryonic stem cell research (HESC). Politicians on both sides of the political spectrum and issue, e.g., Sen. Harry Reid, D-NV and President George W. Bush, have appealed to the historical role of abortion in vaccine development to justify some forms of HESC. This is where the application of Kaveny’s principle of appropriation of evil becomes salient. American society, and Catholics in particular, should re-examine the extent to which they are comfortable appropriating the evil that was done in the recent past in the name of healing, for such appeals will only strengthen in the face of efforts to legitimize HESC and other forms of destructive research on human beings.

The analysis above shows the need for renewed consideration of the nexus between vaccines and abortion, and expanded efforts to address all the recommendations of the PAFL. Catholic health care organizations and providers are uniquely positioned to assist in this analysis and action. Several possibilities suggest themselves immediately. First, Catholic institutions and providers are well-positioned to educate patients and the public at large about the scientific and ethical issues involved. Indeed, they could view this education as a dress-rehearsal for the kinds of education they will need to do when therapies based on HESC are proposed. Moreover, a thorough educational effort could help to avoid grass-roots campaigns to opt out of immunization regimens. Second, Catholic institutions and providers are well-positioned to help make alternative vaccines available in a timely manner. Safe, effective alternatives for all vaccines (except for varicella) already exist in Europe or Japan. By using the purchasing power they possess, Catholic health care institutions and providers could quickly create a "market" for alternative vaccines that pharmaceutical companies could not ignore. Finally, this same market power, combined with professional and political pressure, could help persuade pharmaceutical companies to develop alternative cell lines for many future vaccines.

Taken together, these efforts could not only transform current trends in medical research and therapy, but future developments as well.

John F. Brehany, Ph.D., S.T.L.
Executive Director and Ethicist
Catholic Medical Association
Philadelphia, Pennsylvania

Suggested Readings

Executive Summary. Human dignity can be understood as a universal attitude of regard that informs our individual and collective moral judgments concerning the inherent value of person’s in their particular environment and experience. From this description we can craft a set of practical moral requirements for caregivers and institutions.

The purpose of this article is to offer an approach to understanding the meaning of human dignity that can serve as a practical guide for moral discourse in patient care. The meaning of human dignity can be ascertained by emphasizing three important ethical notions incorporated into a practical description, as follows: human dignity can be understood as a universal attitude of regard that informs our individual and collective moral judgments concerning the inherent value of person’s in their particular environment and experience.

In order for human dignity to have a relevant place in moral discourse on patient care it must offer something that enriches this discourse, such as by keeping moral discourse properly fixed on the value of persons in their particular environment and experience. To grasp the meaning of human dignity it is worth clarifying its salient aspects as delineated in the adopted description.

1. Universal.

Human dignity is an egalitarian concept - everybody has inherent worth. This point leads to the most hotly debated question surrounding human dignity: namely, what is its ground? Theologically, some suggest that dignity is grounded by the belief that humans are created in God's image and likeness. Philosophically, some suggest that inherent human dignity is grounded in important innate human properties such as rationality or autonomy. Others ground human worth on one's mere existence in the human family. To be sure, these debates will continue. These debates center almost exclusively on the ground of the universalism claim. And because the ground for the universalism claim is controversial, that does not necessarily mean the claim itself is not ethically valid. For moral discourse on patient care, the universalism claim simply states that persons matter.

2. Attitude of Regard.

At the most elemental level, human dignity expresses an attitude of regard for the other. Human dignity means that one must pause to reflect "on the other" before moral decisions are made and actions contemplated. This is perhaps the most basic of all moral responsibilities - that is, what impact our actions will have on other persons. This makes human dignity as much affective as cognitive, as much relationally oriented as individually oriented. It also means that, as an attitude, respect for the other is a choice that will confront every moral agent. People can choose or not choose to express an attitude of regard for the other. To choose to admit that the inherent value of persons has a demonstrable impact on the moral decisions one makes is arguably the most primal of all moral notions.


The universal nature of human dignity and the attitude of regard for others that it conveys can be applied across individual, institutional, and social domains. In each of these domains, an "ethical issue" can be characterized as anything that has deep and broad impact on the dignity of persons. It is for this reason that individual and collective moral virtue requires a disciplined reflection on how and to what extent a particular course of action shows regard for the value of persons in their environment and their experience.
4. Value of Person's in their Particular Environment and Experience

Human dignity means that persons have inherent value. The nature and meaning of this inherent value is difficult to grasp if it remains a mere abstraction or moral flight of fancy. In order for human dignity to mean anything it all, it must be a reality that emerges from the respect one shows toward the lived realities of another person's life in their particular environment and personal experience.

From this meaning of human dignity, we can craft a set of practical moral requirements for caregivers and caregiving institutions. Since human dignity informs - but does not necessarily dictate - our individual and collective moral judgments about the value of persons in their particular environment and experience, these requirements must inform our moral thinking about persons in intentional ways.

Human dignity requires that:

- Persons remain at the center of moral discourse. They are to be respected, honored, and appreciated. Their history is significant; their personal narratives reveal particular moral commitments, values, and projects that have meaning and purpose for persons.
- Caregivers enter into the reality of another person's environment in ways that help contribute to that person's overall well-being.
- Caregivers respond with righteous indignation when institutional practices and processes do not place persons at the center of organizational motivation and behavior.

In sum, human dignity is not an empty moral platitude. Rather, it is a universal attitude of regard that informs our individual and collective moral judgments concerning the inherent value of persons in their particular environment and experience. Conceived in this way, human dignity simply must ensure that persons remain at the center of moral discourse. Particular moral decisions will be made in the light of all relevant circumstances and with the prudence we know that moral agents can and should bring to moral decision-making.

In today's competitive healthcare environment, keeping persons at the center of moral discourse can be difficult. We all have seen how easy it can be to stray from the basic moral requirement that persons remain at the center of moral discourse. Many healthcare organizations have chosen to fix their gaze on financial growth and market share, on technological advancement as well as physician and consumer satisfaction. To the extent that these goals are explicitly motivated by the simple notion that the good of persons is an organizing principle for the business of healthcare, then perhaps we have little reason for concern. The practical requirements of human dignity can and should be made explicit in every decision we make in healthcare. They cannot be merely an after-thought to the operational decisions we make in healthcare.

David Belde, Ph.D.
Administrative Director of Ethics & Mission
Bon Secours Richmond Health System
Richmond, VA

Suggested Readings

Reconsidering Catholic Teaching on Withdrawal of Artificial Nutrition and Hydration

James Hynds, LL.B., Ph.D.

Executive Summary. The essay considers Pope John Paul II's 2004 allocution on life sustaining treatments, discussing whether it recognizes the principle of double effect as the appropriate rule for ethical analysis and whether it reprobates withholding or withdrawing artificial nutrition and hydration.

On March 20th 2004 Pope John Paul II delivered an allocution on the morality of providing artificial nutrition and hydration (ANH) to patients diagnosed as being in the persistent vegetative state (PVS). His statement was widely interpreted, for better or worse, as definitively resolving the debate among Catholic theologians on this issue.

This essay discusses if and how the Papal allocution pertains to the application of the Principle of the Double Effect (PDE) in end-of-life care. Two questions will be addressed specifically. The first question is whether the allocution recognizes that the PDE is the appropriate rule for ethical analysis of decisions concerning treatment withholding or withdrawal. The second question asks whether or not the allocution specifically reprobates the withholding or withdrawal of ANH, thus removing it from the scope of the PDE.

On the first question, it should be noted that the PDE is not explicitly referred to in the allocution. However, the rule governing ordinary and extraordinary treatment is referred to. Does this amount to a rejection of the PDE in favor of the rule on ordinary and extraordinary care? No. The rule governing ordinary and extraordinary treatment belongs to the PDE inasmuch as it is an application of the rule requiring proportionate reason in the choosing of effects. By affirming the obligatory nature of ordinary and proportionate care the allocution insists that one of the central elements of the PDE governs correct decision making with regard to the withdrawal of treatment at the end of life.

There is, however, more to the PDE than the condition requiring the exercise of proportionate-reasoning. The primary focus of the PDE is on agent intentionality. The intentions with which agents bring about an effect are crucial to a moral evaluation of their actions. Where agents intend the bad effect of their action, the action cannot be justified by the PDE. Where agents do not intend the bad effect of their action, even if they foresee the occurrence, the action may yet be justified provided there is a proportionate reason to permit the bad effect in pursuit of attaining a greater good. Does the allocution propose that the moral evaluation of decisions to withdraw treatment (specifically ANH) include an evaluation of the intentionality with which treatment is withdrawn? Does it endorse the distinction between what is intended and what is foreseen? If so, it implicitly affirms the applicability of the PDE in these cases.

The answer to both these questions is yes. This becomes clear when one looks at the allocution's teaching on euthanasia. Concerns over the practice of euthanasia are clearly at the heart of the allocution. Indeed, section 4, which contains the allocution's substantive analysis of the morality of ANH withdrawal decisions, concludes by identifying the withdrawal of ANH, at least in certain circumstances, with euthanasia by omission. The allocution is clear, however, about the conditions necessary to justify such a negative judgment of a decision to withdraw ANH. Referring back to his teaching on the subject in the Encyclical Evangelium Vitae, the Pope declares that to constitute euthanasia, the act or omission must be one that by its very nature and intention brings about death. Euthanasia involves a deliberate killing. Applying this to the act of discontinuing ANH, such an act can be judged to be an act of true and proper euthanasia if, but only if, the resultant death is willed. Far from excluding considerations of agent intentionality from its evaluation of the withdrawal of ANH, these considerations are central to the allocution's purpose of unmasking practices that amount to euthanasia.
Moreover, the allocution briefly addresses the issue of the difference between intention and foresight. The allocution first notes that where ANH is withdrawn, death by starvation or dehydration is the only possible outcome. Where ANH is withdrawn, therefore, death should be foreseen as the result of the act of withdrawal. Indeed, it should be foreseen as a certain result of that act. But the allocution differentiates such foreknowledge of inevitable results from intention. For a withdrawal of ANH that results in death to amount to euthanasia, the agent of withdrawal must proceed with both knowledge and will (if done knowingly and willingly). The allocution's requiring both knowledge and will seems, at least implicitly, to recognize an ethically relevant distinction between knowledge that death will ensue and a will that death should ensue.

Inasmuch, therefore, as the allocution, in evaluating the withdrawal of ANH, is concerned with the intention with which treatment is withdrawn, and inasmuch as it distinguishes between foresight and intention, the allocution both affirms the use of the PDE in determining the morality of treatment withdrawal decisions and makes use of it itself.

Turning to the second question, this essay argues that withholding or withdrawal of ANH can be justified by applying the PDE. The question must be asked, however, whether such a positive ethical evaluation is compatible with Pope John Paul II's teaching on the withdrawal of ANH contained in this allocution. Clearly, if the papal teaching is to be interpreted as declaring that the provision of ANH to patients unable to nourish and hydrate themselves is always to be considered ordinary, proportionate and obligatory, then ANH's withdrawal from such patients cannot be justified using the PDE. Even if it were the case that ANH was withheld or withdrawn without intending thereby to hasten the patient's death, the act of withdrawal would not meet the condition of the PDE requiring proportionality and could not thus be justified using the PDE. Where the provision of ANH is judged a proportionate care regime, its withdrawal must be held to be disproportionate and disallowed. But does the papal allocution declare that the provision of ANH is always ordinary, proportionate and as such morally obligatory?

The allocution does not in fact make such a sweeping declaration. Instead the allocution states only that in principle the use of ANH should be considered ordinary, proportionate and obligatory. The possibility is left open that there may be circumstances in which the use of ANH in practice may be extraordinary, disproportionate and thus optional. In terms of institutional policy, this means that there must always be a presumption in favor of providing ANH. Adoption of a care policy which routinely withheld or withdrew ANH from certain patients, presuming it to be either futile or disproportionally burdensome, is incompatible with the teaching of the allocution. The allocution is directed primarily against this practice. However, this presumption in favor of providing ANH, based on its being in principle ordinary and proportionate, is not irrebuttable. Each case must be assessed on its merits. It is entirely consistent with the teaching of the allocution to determine that in particular cases, the patient's concrete circumstances render the provision of ANH to be extraordinary by being disproportionally burdensome to the patient relative to the benefits it is intended to secure.

In a further refinement of his judgment on the morality of ANH use, the Pope adds that ANH is only to be considered ordinary, proportionate and hence obligatory insofar as and until it is seen to attain its proper finality. In the context of PVS patients, that finality is identified by the Pope as consisting in the provision of nourishment and the alleviation of suffering. It follows from this that the provision of ANH may and must be considered disproportionate and optional when and inasmuch as it fails to attain its proper finality by failing either to nourish the patient (presumably in circumstances where the patient's metabolism is no longer able to assimilate the nutrients) or to alleviate the patient's suffering.

We can conclude from the above that John Paul II's allocution does not absolutely preclude the withholding or withdrawing of ANH from patients in PVS or, by analogy, from other types of patients who are, by reason of elective sedation, deeply unconscious. The particular circumstances of each case must be assessed before an ethical evaluation of a concrete decision to refuse, withhold or withdraw ANH can be made. In this regard, Pope John Paul II's allocution is entirely consistent with the previous Catholic tradition both with regard to the centrality of intention in evaluating the morality of human acts and omissions and on the scope of the duty to preserve life by the consumption of food and water. At most it represents a development of traditional teaching, not a reversal thereof, merely making explicit what was implicit in the tradition.

James Hynds, LL.B, PhD.
Clinical Ethicist, UCLA Healthcare Ethics Center, Los Angeles.
Suggested Reading