MEDICINE

The clinical medicine literature over the past few months has yielded a variety of articles that deserve comment by a Catholic physician. I categorize the most interesting ones according to their major clinical themes. These articles could also be grouped by their concordance, at least implicitly, with sound Catholic moral teaching. In effect, there are three general categories: (1) articles that seem to affirm what we know already from well-formed consciences regarding the moral rightness or wrongness of various actions and behaviors, (2) articles that convey no moral sensitivity to specific actions (e.g., abortion), and (3) articles in which some moral sensitivity seems to be acknowledged, while the moral implications of the subject remain unclear. The reader must be mindful, however, that these articles are not discourses on medical ethics. They are clinical studies, essays, and opinions, all appearing, with one exception, in the recent clinical medicine literature.

Moral Absolutes in Medicine

In the December 2005 issue of *Theoretical Medicine and Bioethics*, a volume devoted to the memory of renowned bioethicist David Thomasma, Dr. Edmund Pellegrino provides a refreshing discussion of moral absolutes ("Some Things Ought Never Be Done"). Pellegrino, a prominent Catholic physician and ethicist, current chairman of the President's Council on Bioethics, and a member of the editorial board of this journal, eloquently discusses the matter of moral relativism and argues that some moral absolutes must be retrieved in clinical ethics. Clinicians will readily identify with his description of the forces which aim to make patient autonomy an absolute principle in practice today. With the attention to cultural sensitivity and moral pluralism in today's world, it is easy to understand the erosion of moral absolutes. Pellegrino carefully chooses to focus on the clinical encounter to illustrate a few moral absolutes. They are: Do not kill, act for the good of the patient, keep solemn promises, never compromise a patient's dignity, never lie, and avoid formal complicity with evil. How remarkably like the Decalogue are these absolutes. Clinicians will derive some comfort from Dr. Pellegrino's affirmation of Catholic values.

Conduct of Physicians

There is little dispute that proper professional values and a well-founded personal ethic or moral code will manifest themselves in a person's professional conduct. Persons who develop sound moral judgment and conduct themselves ethically in their personal lives are likely to display the same level of ethical conduct in their professional activities.

It is no surprise, then, to read in the December 22, 2005, issue of the *New England Journal of Medicine* that disciplinary action filed against practicing physicians was strongly associated with unprofessional behavior in medical school ("Disciplinary Action by Medical Boards and Prior Behavior in Medical School"). Maxine Papadakis and her colleagues performed a case-control study in which they identified 243 physicians who had been disciplined by state medical boards; 235 of these had medical school records available for review. The disciplined physicians had graduated from three medical schools between 1970 and 1999. Investigators blinded to the status of the physicians culled from the records negative excerpts about professional behavior. These data were then rated, ranked, and analyzed with other variables, such as age, gender, GPA and MCAT scores, grades for medical school courses, and scores on the national medical boards. The violations for which the state boards took disciplinary action were classified into three categories: unprofessional behavior, incompetence, and violation with the category not determined. At least 74 percent of the violations were based on unprofessional behavior. Most of the disciplined physicians had committed multiple violations, and in 94 percent at least one violation involved unprofessional behavior. The types of unprofessional behavior included irresponsibility, diminished capacity for self-improvement, immaturity, poor initiative, impaired relationships with others (students, doctors, nurses, patients, and families), and behavior associated with anxiety, insecurity, and nervousness.

These data support the maintenance of high standards of professionalism in medical schools and training programs, and reinforce the need for close scrutiny of medical school applicants by medical school admission boards.

HIV Prevention and Treatment

In the December 1, 2005, issue of the *New England Journal of Medicine*, Thomas Frieden and coauthors draw attention to the apparent underutilization, in the HIV epidemic, of various public health measures for controlling infectious diseases ("Applying Public Health Principles to the HIV Epidemic"). They call for more widespread screening for HIV and programs to link testing to treatment for HIV-positive persons, recommending that, "Voluntary HIV screening and linkage to care should become a normal part of medical practice, similar to screening for other treatable conditions, such as high cholesterol levels, hypertension, diabetes, and breast cancer."

While transfusion-related and perinatally transmitted HIV has been almost eliminated through widespread screening and treatment, the reduction of sexually transmitted HIV remains challenging. The authors claim that condoms are not widely available and their use is not strongly promoted. Citing a 2004 study (Stephen F. Morin et al., "Missed Opportunities: Prevention with HIV-Infected Patients in Clinical Care Settings," *Journal of Acquired Immune Deficiency Syndromes* 36.4 [Au-

gust 1, 2004]: 960–6), they state that condom distribution and promotion of condom use is uncommon. In calling for a greater application of public health principles, the authors assert not only that the health of HIV-infected persons will improve, but that HIV infection may be prevented in tens of thousands of people in the United States in the next decade. This exhortation seems appropriate, particularly when we consider the importance of efforts to reduce transmissible disease.

The wearing of condoms to prevent sexual transmission of AIDS, however, differs in important ways from the wearing of masks to minimize risks of contracting avian flu, or the wearing of gloves by health-care professionals. To some degree the differences have to do with the principle of double effect, which when properly applied does not permit a good effect to be gained if it depends on an evil effect. So while a good may be realized from condom use, the very use of a condom is itself contrary to natural law. Thus, since the good effect (reduced transmission) depends on a violation of natural law, it cannot satisfy the principle of double effect, and remains immoral. In defending this position, clinicians may gain some support in recalling John Paul II's exhortation to the clergy, religious, and laity in Africa concerning the scourge of AIDS:

> Against the background of widespread poverty and inadequate medical services the Synod considered the tragic scourge of AIDS which is sowing suffering and death in many parts of Africa. It noted the role played in the spread of this disease by irresponsible sexual behaviour and drafted this strong recommendation: "The companionship, joy, happiness and peace which Christian marriage and fidelity provide, and the safeguard which chastity gives, must be continuously presented to the faithful, particularly the young." (*Ecclesia in Africa*, September 14, 1995, n. 116)

The next two articles—the first concerning embryonic stem cell research and the second a commentary on prisoners of the war on terror—acknowledge ethical issues but do not address them, leaving it to readers to make ethical judgments based on their own moral compass.

Embryonic Stem Cells

Davor Solter, M.D., provides readers of the December 1, 2005, *New England Journal of Medicine* with an interesting perspective on the manipulation of human embryos ("Politically Correct Human Stem Cells?"). Dr. Solter discusses two potentially viable options for deriving human embryonic stem cells without destroying human embryos. The first of these techniques, successfully done in mice but not humans, involves taking a single cell from an eight-cell embryo, and using the single cell to provide stem cells while the remaining seven-cell embryo goes on to develop normally—or so it goes in mice. A second, more complicated technique is a variant of altered nuclear transfer (ANT), which has been discussed extensively in these pages. ANT basically involves the inactivation (in the donor nucleus) of a gene necessary for embryonic development. After the gene has been inactivated, the donor nucleus is injected into an enucleated ovum and the zygote is stimulated to divide. Theoretically, the resulting blastocyst could never develop into a human embryo, but could yield stem cells for culture and research. Further genetic manipulation of the stem cells would turn the inactivated gene back "on" so that the cells revert to "normal."

From a moral perspective, the first technique, at the very least, exposes the human embryo—already a person and never to be used as a means to an end—to disproportionate risk, with no benefit. From the Congregation for the Doctrine of the Faith in *Donum vitae,* we read:

> If the embryos are living, whether viable or not, they must be respected just like any other human person; experimentation on embryos which is not directly therapeutic is illicit.
>
> No objective, even though noble in itself, such as a foreseeable advantage to science, to other human beings or to society, can in any way justify experimentation on living human embryos.… Moreover, experimentation on embryos and fetuses always involves risk, and indeed in most cases it involves the certain expectation of harm to their physical integrity or even their death. (I, n. 4)

In regard to the variant of ANT, the technique may be morally justifiable if a human embryo is never produced. However, Solter points out that there can be no guarantee that the blastocyst created by this method will always be incapable of normal development. He also points out that research into the feasibility of this technique in humans would unavoidably involve experimentation with human embryos, and this alone would render this method unethical.

Solter concludes his essay with the comment that neither technique "can produce human embryonic stem cell lines that would be ideologically acceptable to the forces that assume the prerogative to decide such issues in the United States." He may be correct in recognizing that these techniques are unacceptable. But he is mistaken, and presumptuous, when he describes those who object to the destruction of human embryos in stem cell research as "the forces that assume the prerogative to decide such issues." The Church has a duty to object, which is neither an assumed prerogative nor an interest in manipulating science for the sake of politics. As we read in the *Catechism of the Catholic Church*:

> It is a part of the Church's mission "to pass moral judgments even in matters related to politics, whenever the fundamental rights of man or the salvation of souls requires it. The means, the only means, she may use are those which are in accord with the Gospel and the welfare of all men according to the diversity of times and circumstances." (n. 2246, quoting from *Gaudium et spes*, n. 76)

Ethics in the War on Terror

Susan Okie, M.D., a contributing editor of the *New England Journal of Medicine*, accepted an invitation to tour Camp Delta, Guantanamo Bay, Cuba, where over five hundred prisoners of the war on terror are held by the U.S. military, and she offers a perspective, titled "Glimpses of Guantanamo—Medical Ethics and the War on Terror," in the December 15, 2005, issue of the journal. She describes her visit to the detainee hospital ward, where eight of nine patients were admitted for involuntary tube feeding to stave off the medical consequences of their prolonged hunger strikes. She discusses the tube feeding and other issues related to detainees' care, including the role of psychologists who observe interrogation sessions and provide feedback to the interrogators. *Her* perspective helps broaden *our* perspective in considering issues not routinely encountered in clinical practice ethics.

End-of-Life Care

In "The Big Chill — Inserting the DEA into End-of-Life Care" (*New England Journal of Medicine*, January 5, 2006), Timothy Quill, M.D., and Diane Meier, M.D., worried that an awaited U.S. Supreme court decision in *Gonzales v. Oregon* might unfavorably affect the practice of palliative care, particularly in the prescribing of opioid analgesia to patients at the end of life. The question at the heart of *Gonzales v. Oregon* is "whether the federal government can overrule states in defining 'legitimate medical practices'" as they relate to the prescribing of controlled substances. In 2001, Attorney General John Ashcroft issued a directive suggesting that prescription of schedule 2 controlled substances under Oregon's Death with Dignity Act represented a violation of the federal Controlled Substances Act, since "assisting in a suicide is not a 'legitimate medical purpose.'" The Ninth Circuit court of appeals supported the challenge to this directive by Oregon and others, who argued that it is a state's responsibility to define legitimate medical practice, not a function of the Controlled Substances Act.

Apart from the legal wrangling over this matter, what remains important for physicians taking care of patients is to relieve pain and suffering first, and never comply with any activity which intentionally leads to or causes the death of a patient. Cases like this may receive a lot of attention, but they generally serve only to distract clinicians who are interested in doing what is morally required of them for the good of their patients. Physicians prescribing controlled substances to relieve patients' pain and suffering are not going to be prosecuted or otherwise sanctioned for doing what is ethically and medically sound. Quill and Meier, while appropriately concerned that such court decisions may cause physicians to under-treat pain by limiting the prescribing of opioids, should continue to promote best-practice guides to ensure the medically appropriate use of narcotic analgesia in the treatment of pain and suffering at the end of life.

As it turned out, the Supreme Court decided the case on January 17, 2006, after the Quill and Meier article was published, handing down a 6-to-3 decision that "the CSA does not allow the Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide under state law permitting the procedure,"[1] and effectively upholding Oregon's physician-assisted suicide law. Debates of the ethical and legal issues raised by physician-assisted suicide are likely to continue for some time.

These issues do not get any less disturbing. In the January 7, 2006, issue of the *British Medical Journal*, Clare Chapman reports that Lausanne University Hospital has become the first hospital in Europe to allow patients to commit suicide on its premises ("Swiss Hospital Lets Terminally Ill Patients Commit Suicide in Its Beds"). The patients must have an "incurable disease" and be "of sound mind." They must

[1] U.S. Supreme Court, *Gonzales, Attorney General, et al. v. Oregon et al.,* Certiorari to the U.S. Court of Appeals for the Ninth Circuit, no. 04-623; argued October 5, 2005; decided January 17, 2006; http://www.supremecourtus.gov/opinions/05pdf/04-623.pdf.

also have expressed a persistent wish to die and carry out the final act themselves. According to the article, Switzerland has one of the most liberal laws on assisted suicide in Europe, so perhaps we should take some comfort in the fact that it took two years for the hospital to reach its decision to allow this atrocity. Or perhaps it is laudable that the institution will not admit patients who just want to commit suicide or (to avoid "suicide tourism") patients from abroad.

Besides the obvious immorality of assisted suicide, what concerns me greatly is that the principle of patient autonomy is so often unopposed, and is accepted as an absolute. The hospital's ethical director says, "it is not up to us to decide whether a person should live or die. As a hospital it is up to us to respect the wishes of the patient." I often remind my medical students and physicians in training that autonomy is not, in fact, absolute. And, contrary to this director's comment, it *is* up to us, especially as physicians, not to decide on life and death, for these are providential, but to offer compassionate care throughout life. In *Evangelium vitae,* Pope John Paul II wrote,

> The request which arises from the human heart in the supreme confrontation with suffering and death, especially when faced with the temptation to give up in utter desperation, is above all a request for companionship, sympathy and support in the time of trial. It is a plea for help to keep on hoping when all human hopes fail. (*Evangelium vitae*, n. 67)

The decision at Lausanne Hospital has already prompted the Geneva University Hospital ethics commission to recommend that the hospital lift its ban preventing voluntary euthanasia groups from operating on their premises, and other Swiss hospitals are considering similar moves. We see here the beginning of an erosion process which is, sadly, too familiar. This article, like the commentary on HIV spread, offers no moral perspective on the relevant issues.

In contrast, David Todres, M.D., Elizabeth Catlin, MD, and Mary Thiel, M.Div., are to be applauded for a study, published in the December 2005 issue of *Critical Care Medicine,* in which they report their experience with a unique clinical pastoral education program for health-care workers in intensive care units ("The Intensivist in a Spiritual Care Program Adapted for Clinicians"). They adapted a clinical pastoral education program originally designed for clergy, and offered it to committed health-care workers. They found that the program provided graduates with "knowledge, language, and understanding to explore and support spiritual and religious issues confronting critically ill patients and their families," and they suggest that incorporating spiritual care into clinical practice is an important advance in caring for the whole person.

In my experience, many issues that seem to be matters of clinical ethics (e.g., continuing life-sustaining therapy when it is apparently medically futile) often arise not so much from ethical dilemmas as from a failure of clinicians to attend to the concerns of patients and their families. An aptitude for listening attentively to patients is very much needed in clinical practice, and the publication of this article in a mainstream critical care journal is an important step in raising the awareness of critical care physicians, who often encounter life and death ethical issues, to be more attentive to the spiritual needs of patients, and perhaps their own.

Abortion

Three articles discuss various medical consequences of abortion. The first concerns the occurrence of fatal toxic shock syndrome following the administration of mifepristone (RU 486, or "the morning-after pill"). This appears to be a rare complication following the use of this abortifacient, but it has nonetheless drawn the attention of the *New England Journal of Medicine* (Marc Fisher, M.D., et al., "Fatal Toxic Shock Syndrome Associated with *Clostridium sordellii* after Medical Abortion," December 1, 2005). This brief report describes the cases of four women who presented, four or five days after taking mifepristone, with acute illness that rapidly progressed to severe sepsis and death despite intensive medical care.

It is especially tragic when young and presumably otherwise healthy women die from abortions. The article provides a straightforward presentation of the clinical data, but the societal malady underlying the deaths of these women and their babies is enormous. Two other articles point to additional consequences of this evil.

An article in January 2006 issue of the *Journal of Child Psychology and Psychiatry* describes an interesting study of the mental health consequences of abortion in young women (David M. Fergusson, L. John Horwood, and Elizabeth M. Ridder, "Abortion in Young Women and Subsequent Mental Health"). Professor Fergusson and his colleagues analyzed data gathered from a longitudinal study of a birth cohort of 1,265 children in an urban region of New Zealand, who were studied from birth to age twenty-five years. Just over five hundred female participants were separated into three groups, depending on pregnancy status from ages fifteen to twenty-five years: not pregnant by age twenty-five, pregnant and did not have an abortion, or pregnant and had an abortion. Mental health was assessed and a variety of other variables were examined, including family socioeconomic background, criminality, abuse, behavior problems, educational achievement, sexual behaviors, and substance use. There were significant associations between rates of mental disorders (major depression, anxiety, suicidal ideation, illicit drug dependence, and the number of mental health problems) and abortion, even after controlling for potential confounding variables.

Recognizing that associations do not imply a causal relationship, the authors performed a prospective analysis, examining whether pregnancy and abortion prior to age twenty-one was predictive of mental health problems between the ages of twenty-one and twenty-five. Their results showed that pregnancy/abortion history prior to age twenty-one remained strongly associated with the number of subsequent mental health problems to age twenty-five. This conclusion contrasts with a 2005 statement from the American Psychological Association, which claims that psychological harm following abortion is low and appears no different than in the general population of women of reproductive age.[2] As the authors point out, however, this statement is not well founded on empirical research and fails to acknowledge at least three other studies demonstrating negative psychological effects of abortion.

[2] American Psychological Association, *APA Briefing Paper on the Impact of Abortion on Women* (Washington, DC: APA, January 31, 2005).

Finally, a study published in the January 2006 issue of *Sleep* examined sleep disorders in women who had abortions (David Reardon and Priscilla Coleman, "Relative Treatment Rates for Sleep Disorders following Abortion and Childbirth"). Using a data set from the California Department of Health Services, these investigators analyzed a sample of 15,345 women who had induced abortions and 41,479 women who delivered between January 1 and June 30, 1989. They examined the data set for sleep disorder treatment codes, and found that women who had induced abortions were significantly more likely to be treated for sleep disorders than women who had given birth, and that these sleep disturbances were most likely to occur within the first year after the abortion. This information comes as no surprise, but as the authors of the study note, no previous epidemiologic study had explored this relationship.

Health Related to Socioeconomic Status and Marriage

Two articles that appeared in February examine health issues in terms of two more broadly relevant factors, namely, socioeconomic status and marriage. These studies were attractive because of the robust data sets they analyzed. Both articles direct us to consider policies of global health care that may promote kinder and more just systems of health-care delivery.

The first article, which appeared in the February 15, 2006, issue of the *Journal of the American Medical Association,* concerns the association of lower socioeconomic status and mortality, and specifically examines the degree to which certain exercise physiologic characteristics (specifically, functional capacity and heart rate recovery) may account for this association (Mehdi H. Shishehbor, D.O., et al., "Association of Socioeconomic Status with Functional Capacity, Heart Rate Recovery, and All-Cause Mortality"). Over thirty thousand patients were prospectively evaluated for known or suspected coronary artery disease, and various parameters—including exercise test variables, socioeconomic status, and all-cause mortality—were analyzed. After adjustments were made for multiple potentially confounding variables, the authors found that impaired functional capacity and abnormal heart rate recovery were more common in patients who had lower socioeconomic status scores. The data also confirmed, again after adjustment for potential confounders, a strong association between mortality and low socioeconomic status. In discussing their data, the authors highlight in a general way the value of community-based public health interventions "to enhance economic conditions as a means of improving health."

There is no doubt that interventions designed to bring about more just systems of health-care delivery accord with a fundamental mission of the Church. Physicians and other health-care workers, no less than policy makers, must do their part to reduce social and economic inequalities.

The second article brings the reader to the dynamic between husbands and wives as it relates to their health and risk of death. In the February 16, 2006, issue of the *New England Journal of Medicine,* Nicholas Christakis, M.D., and Paul Allison, M.D., examine a person's risk of dying following the hospitalization of their spouse ("Mortality after the Hospitalization of a Spouse"). In this study, over 518,000 couples who were enrolled in Medicare were examined. The authors found that hospitalization of a spouse and spousal death independently increase a person's risk of death, and there appears to be a differential effect in the risk depending on the diagnosis at

hospitalization. For men the risk of death associated with spousal hospitalization was 22 percent of the risk associated with spousal death, and for women, it was 16 percent of the risk associated with spousal death. To my view, this study also implicitly affirms what we know to be true regarding the marriage bond, that "the love of the spouses requires, of its very nature, the unity and indissolubility of the spouses' community of persons, which embraces their entire life, 'so they are no longer two, but one flesh'" (*Catechism*, n. 1644). In *Mulieris dignitatem*, John Paul II says, "The image and likeness of God in man, created as man and woman ... thus also expresses the 'unity of the two' in a common humanity.… The foundation of the whole human 'ethos' is rooted in the image and likeness of God which the human being bears within himself from the beginning" (n. 7).

There should be little wonder at the findings of this study, and we will do well to remember them in our clinical encounters. With a greater awareness of the marriage dynamic, physicians may not only enhance individual care but also, on a societal level, develop policies for more efficient and cost-effective health care.

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