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A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

Also in this issue: "Morally Illicit Cells in Medical Reasearch" by Alan B. Moy, MD

The Abandonment of Suicidal Patients

Julie Grimstad, LPN

For millennia, practitioners of medicine have promised, "I will give no deadly medicine even if asked." Why? They shoot horses, don't they?

Proponents of euthanasia and assisted suicide suggest that animals are treated better than humans because we can "put down" animals when they become lame, sick, or old. Veterinary practice includes euthanasia as a kindness to dumb animals who are suffering. Why do we not do this to humans?

Christianity has the definitive answer. God created human beings in his image, bestowing dignity on us that is not based on our abilities or competence. The founding fathers of our great nation recognized the self-evident truth that all human beings "are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life." Suffering and dependency on others, therefore, does not cause human beings to lose their inherent dignity, nor does it justify taking another human life or forfeiting our own.

Traditional Standards of Medical Ethics

The vast majority of people have long believed in the inviolability of human life, and patients have trusted their health care providers never to kill. Physicians and nurses have traditionally refused to kill their patients, because they recognize that human life is unique even if some of them cannot quite put their finger on why this is so.

Addressing European culture, Pope Francis rued "a vacuum of ideals which we are currently witnessing in the West" as well as a "forgetfulness of God," which explains the chipping away at historical standards of medical ethics based on Judeo-Christian principles.[1] The most basic of these is concisely stated in the *Catechism of the Catholic Church*: "We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of" (n. 2280).

Fortunately, the American Medical Association (AMA) still retains its ethical opposition to disposing of patient's lives by physician-assisted suicide even though for more than two years, pro-assisted-suicide members of the AMA have aggressively sought to change its position from opposed to neutral.[2] Bear in mind that neutrality gives the green light to physician-assisted suicide as surely as support does.

Many national and state medical associations have now adopted either a neutral or supportive position regarding the practice, although some of them use linguistic deceptions such as *aid in dying*, *death with dignity*, and *physician-assisted death* as euphemisms for *assisted suicide* to combat the stigma associated with suicide.

The American Academy of Hospice and Palliative Medicine took "a position of studied neutrality"in 2007.[3] That same year, the American Medical Women's Association declared their organization "supports the right of . . . ill patients to advance the time of death."[4] The American Public Health Association is quoted as saying their organization "supports allowing [an] . . . adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death,"as detailed in a 2008 policy statement.[5] Following suit, the American College of Legal Medicine now "recognizes patient autonomy" and the patient's "right" to "hasten"the end of life.[6]

In 2013, the American Nurses Association stated that it "prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of Code of Ethics for Nurses."[7] Now, in 2019, the ANA is proposing to change not only its position, but also the Code of Ethics for Nurses in radical ways. The ANA's draft statement, "The Nurse's Role When a Patient Requests 'Aid in Dying,'" endorses physician-assisted suicide and requires nurses to neither influence a patient's decision nor intervene as a patient commits suicide.[8]

Furthermore, while claiming that nurses' consciences should be protected, the statement goes onto say, "Nurses unable to provide care on moral grounds should ensure the ongoing care of the patient by identifying nurse colleagues willing to do so." Compelling nurses to be accomplices in

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assisted suicides is a grave violation of nurses' conscience rights. Although it has been years since I have practiced nursing, I am mortified that the ANA is abandoning both conscientious nurses and suicidal patients.

Assisted Suicide versus Suicide Prevention

If you become sick and depressed, do you want nurses who are indifferent about whether you choose life or death? Or do you want nurses who value your life, who will do everything they can to comfort you, who assure you that you are worth the attention and cost of care, and who will refer you for mental health counseling? If you spot a person about to jump off a high bridge, is not your first instinct to save him? Should you quash that impulse and be a passive observer or, worse, an enabler of suicide? That is what the ANA proposes to demand of nurses, requiring an indifference that is frightening to imagine.

The ANA draft statement is completely counterintuitive to standard suicide-prevention efforts. It tells nurses to be "nonjudgmental" regarding a patient's "voluntary choice" to commit suicide. To be nonjudgmental of a terminally ill patient's choice to kill himself actually is to be biased—it is to say to the patient, "I do not value your life enough to try to talk you out of killing yourself."

During my training as a licensed practical nurse, the good sisters whom I was blessed to have as teachers drilled into us that we had a sacred duty to protect every life entrusted to our care and to view every patient as having equal value with every other patient.

The basis for suicide-prevention centers and hotlines is that suicide is not a rational act—it is a desperate act. Regardless of circumstances, suicide contradicts the natural inclination to preserve one's own life. Doctors and nurses are taught to stop people from committing suicide and to place them in institutional care against their will if necessary. A person who has been diagnosed with a life-threatening health problem should not be discriminated against, but should be treated with appropriate preventive measures just like any other suicidal person.

Karl Benzio, a psychiatrist and the Pennsylvania state director of the American Academy of Medical Ethics, puts it this way:

> Our impatient and all-knowing society selfishly imposes premature finish lines. We often leave at half-time and miss the great comeback, or at intermission and miss the show's awesome turnaround. All life's seasons are valuable, especially the last one. Great relational, spiritual, and psychological richness to the individual and loved ones come from our last days when we've all seen people persevere past hospice predictions, be outright cured, or reconciled with an estranged family member.
>
> I have treated many suicidal patients, who, after being stopped from killing themselves, then appropriately treated, were grateful for the prolonged and now enjoyable life they were blessed to live.[9]

Threat to the Medical Profession

Oregon's Death with Dignity Act went into effect in 1997. Subsequently, six additional states (Washington, Vermont, Hawaii, California, Colorado, and New Jersey) and Washington, DC, have legalized physician-assisted suicide. Contrary to some reports, the Montana Supreme Court did not legalize the practice in 2009, but it did rule that a patient's consent was a defense for an assisting physician. Compassion and Choices, the organization leading the charge to legalize physician-assisted suicide across the nation, celebrates when medical societies support the practice. Their cooperation in this evil enterprise gives the illusion that assisted suicide is a legitimate medical treatment and melts the resistance of legislators.

The ANA, in its draft statement, asserts, "In states where aid in dying is legal, patient self-determination extends to include a patient's autonomous, voluntary choice and informed request to self-administer medication to hasten death." Patient autonomy (voluntary choice) is important, but it is never the only factor in a decision and must never be used to countermand overarching professional ethics. If medical professionals are required to violate their consciences and discard their ethical principles, they will either become participants in the culture of death or leave the practice of medicine. Those who treat some lives as not worthy of their protection are unworthy of the name doctor or nurse.

The ANA has been sold Compassion and Choices' pro-choice snake oil. Pro-life people across this country must combat the arguments for physician-assisted suicide. If we fail to win this battle, the systematic degradation of medical ethics will lead ultimately to the ruin of the entire medical profession.

We must speak up *now*, demanding that every medical professional protect and advocate for life—every life! And we must start by asking this of our own personal health care providers.

Notes

1. John L. Allen Jr., "Pope to Europe: Get Your Social and Spiritual House in Order," *Crux*, November 25, 2014, https://cruxnow.com/.
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3. American Academy of Hospice and Palliative Medicine, "Statement on Physician-Assisted Dying," June 24, 2016, http://aahpm.org/.
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5. American Public Health Association, "Patients' Rights to Self-Determination at the End of Life," October 18, 2008, https://www.apha.org/.
6. Miles J. Zaremski, "ACLM Policy on Aid in Dying," American College of Lifestyle Medicine, October 6, 2008, available at https://c.ymcdn.com/.
7. American Nurses Assocation, "Euthanasia, Assisted Suicide, and Aid in Dying," policy statement, April 24, 2013, https://www.nursingworld.org/.

8. The link to the draft statement has been removed from the ANA website.
9. Karl Benzio, "Physician Assisted Suicide is Dangerous to Everyone," Pennlive.com, March 30, 2019, https://www.pennlive.com/.

Morally Illicit Cells in Medical Research

Alan B. Moy, MD

Since its inception in 2006, the John Paul II Medical Research Institute has received countless inquiries from pro-life individuals around the country asking whether it will develop ethical alternative human cell lines to replace those derived from aborted fetuses.

Morally illicit cell lines are used in a variety of pharmacological products such as vaccines, biologics, and gene therapies. Perhaps the institute is so frequently approached because we have the largest pipeline of human adult stem cells. The institute also recently published the first-in-class virus-free and oncogene-free induced pluripotent stem cell to replace the embryonic stem cell.[1] Thus, individuals of moral conscience often call on the institute to address and replace the aborted fetal cell lines used in pharmaceutical products.

Cell lines like the WI-38 and MRC-5 were developed in the 1960s from aborted fetal lungs and are used in the production of vaccines.[2] PER.C6 was created in the 1980s from retinal cells derived from aborted fetuses and is used for producing vaccines and manufacturing therapeutic proteins.[3] Perhaps the most utilized cell is the HEK293, which was developed in the Netherlands during the 1970s from kidney tissue derived from aborted fetuses.[4]

The HEK293 cell line is used in the production of biologics such as Pulmozyme, which is manufactured for the treatment of cystic fibrosis.[5] It is also the most common cell line used in viral research and in the production of gene therapy.[6] As of 2017, there have been over 2,600 completed clinical trials in gene therapy.[7] Also, the HEK293 cell is used to manufacture cell therapies. Several pharmaceutical companies manufacture CAR-T cell therapies to treat leukemia, which rely on viral vectors that were produced from HEK293 cells.[8]

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Pope St. John Paul II in *Evangelium vitae* stated that "the use of human embryos or fetuses as an object of experimentation constitutes a crime against their dignity as human beings who have a right to the same respect owed to a child once born, just as to every person."[9] In 2008, the Vatican Congregation for the Doctrine of the Faith published *Dignitas personae*, which provides important guidance and moral instruction on medical research and drugs manufactured using cell lines like the HEK293.

According to *Dignitas personae*, scientists of good conscience should avoid using all morally controversial cell lines. Furthermore, the document states that scientists of conscience should find alternative cell lines or discontinue any research in areas that use these cell lines.[10]

A Missed Opportunity?

Dignitas personae was helpful, but I believe the Catholic Church missed an opportunity to be more proactive and change the course of secular biotechnology when these cell lines were first introduced several decades ago. No ethical alternative human cell lines to the HEK293, WI-38, and MRC-5 have been generally accepted by the scientific community. While some animal cell lines are used in creating safe alternative vaccines, no alternative human cell lines for producing vaccines, biologics, or gene therapy have met the scientific rigor of efficacy and safety of these cell lines.

I believe that it is inadvisable to recommend that scientists of conscience abandon a research field when there is no ethical alternative human cell line available. Do we really want scientists of good moral conscience to abandon a scientific field and leave it to those who embrace secular moral values?

Dignitas personae does not place any burden of responsibility on other stakeholders such as the Church leadership itself, Catholic universities, or Catholic health systems. Should these institutions share in some of the responsibility for supporting and developing ethical alternative human cell lines? Should the Vatican and the United States Conference of Catholic Bishops (USCCB) direct financial and logistical resources to this research? Should Catholic universities direct more research into this area? Should Catholic health systems be actively engaged, especially considering these pharmacological products will require administration in health care settings? Should Catholic foundations and philanthropists financially support this research?

The pharmaceutical industry is not likely to invest in any research toward developing ethical alternative human cell lines until there are scientific and economic justifications to change the manufacturing processes. They will say, Why should we invest money when we already have established cell lines and manufacturing processes that ensure human safety? Secular institutions also have no compelling reason to change their practices. Before industry, academia, and government will adopt and utilize new, ethical human cell lines, more research and development is required in order to create cell lines that are at least as safe, and preferably better than, the prior scientific art.

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Steps Needed

Thus, if Catholics and pro-life individuals of good conscience want ethical alternative human cell lines to conduct medical research, then the following steps must be adopted: (1) Catholics and pro-life individuals of good conscience must conduct better due diligence, support organizations that support pro-life research, and put greater pressure on secular organizations that wittingly or unwittingly support a culture of death. (2) The Vatican, the USCCB, and Catholic health systems need to offer more than words when addressing the need for ethically sound research and development.

Yes, it is both possible and within reach to create ethical human cell lines to replace current morally objectionable lines used for producing biologics (proteins and vaccines), but it will take considerable research that requires financial support. From my perspective, *Dignitas personae* should be backed by leadership and supported by stakeholders.

Notes

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10. Congregation For the Doctrine of Faith, *Dignitas personae* (December 8, 2008), nn. 34–35.

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