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The CDF’s Response to a Question on the Liceity of a Hysterectomy in Certain Cases: A Fundamental Turn

Peter J. Cataldo, Ph.D.

Author’s Note: This analysis is provided in my individual capacity as an ethicist.

On December 10, 2018, the Congregation for the Doctrine of the Faith (CDF) issued a responsum to the question whether it is morally permissible to perform a hysterectomy when a uterus is in such a state that in a future gravid condition it is likely to cause a spontaneous abortion prior to fetal viability. The CDF answered that a hysterectomy in these circumstances is permissible because it does not constitute a direct sterilization. The CDF characterized such a case as “extreme” and argues that the case is morally different in kind from the cases that received a negative response in the 1993 responsum by the CDF. In this analysis I hope to show that the 2018 responsum case is not morally different from the cases denied in the 1993 responsum and to suggest what the implications of their similarity might be.

I believe that the reasoning of the 2018 responsum contradicts the 1993 responsum and that the moral standards on which both responsa rest cannot both be true if their respective conclusions are to be justified. This contradiction is not discoverable through the explicit language of the 2018 responsum but mainly through the implicit assumptions that underlie its conclusion. I will also suggest that by contradicting the 1993 responsum, the 2018 responsum establishes a new moral criterion by which it evaluated its case of hysterectomy and that this standard has several possible implications. This new moral standard suggests that tubal ligation might be an equally legitimate intervention for the case considered in the responsum, and the logical extension of the standard suggests that hysterectomy and tubal ligation in the cases rejected in the 1993 responsum might be morally acceptable.

I wish to make it clear that in providing this moral analysis I am not opposing Catholic teaching on direct sterilization nor the magisterial definition of direct sterilization as articulated in Quaecumque Sterilizatio: “Any sterilization which of itself, that is, of its own nature and condition, has the sole immediate effect of rendering the generative faculty incapable of procreation, is to be considered direct sterilization . . . .” What my analysis does is to suggest that what counts as indirect
sterilization in the 2018 responsum appears to be more expansive than what is identified in the 1993 responsum. This is not contrary to the definition of direct sterilization insofar as the cases examined are consistent with the notion of procreation found in the 2018 responsum and because the procedures entail more than one immediate effect. My intent is not to oppose the teaching but invite dialogue about how to understand the definition in light of the new responsum.

A FUNDAMENTAL CONTRADICTION BETWEEN THE RESPONSAS

The CDF argues in its 2018 responsum that its question is essentially different from the 1993 responsum question because the 2018 responsum pertains to a uterus that is incapable of sustaining a pregnancy, whereas the negative responses of 1993 responsum pertain to a uterus that while compromised may still sustain a pregnancy, and also to situations in which a pregnancy will likely exacerbate an underlying pathological condition of the mother. The 2018 responsum describes the situation of the 1993 responsum as “a defective, or risky, functioning of the reproductive organs.” The difference between the 2018 and 1993 responsas is the difference between the biological inability to achieve the final end or telos of the procreative process on the one hand, and “difficulty” of uterine function, or “risks of greater or lesser importance,” related to a preexisting maternal condition on the other.\(^5\)

The 2018 responsum states the following: “Furthermore, the response to the question does not state that the decision to undergo a hysterectomy is always the best one, but that only in the above-mentioned conditions is such a decision morally licit, without, therefore, excluding other options (for example, recourse to infertile periods or total abstinence).” The fact that natural family planning and total abstinence are referenced as options in addition to hysterectomy begins to indicate one way in which the 2018 responsum contradicts the 1993 responsum.

The 1993 responsum made the possibility of using NFP or total abstinence a moral criterion for assessing whether hysterectomy or tubal ligation constitute direct sterilization in certain cases. The 1993 responsum concluded that “the described procedures [hysterectomy and tubal ligation] do not have a properly therapeutic character but are aimed in themselves at rendering sterile future sexual acts freely chosen. The end of avoiding risks to the mother, deriving from a possible pregnancy, is thus pursued by means of a direct sterilization, in itself always morally illicit, while other ways, which are morally licit, remain open to free choice.” For the purposes of this analysis, this conclusion may be called the moral standard of the 1993 responsum.

From the perspective of the 1993 responsum, the fact that a free choice exists between
hysterectomy and tubal ligation on the one hand, and on the other, NFP or total abstinence as means to achieve the end of avoiding a dangerous pregnancy, indicates that both hysterectomy and tubal ligation constitute direct sterilization in such cases. The reason why this choice makes a moral difference is because “the uterus in and of itself does not pose a pathological problem for the woman” in contradistinction to when the uterus is at imminent risk of rupture and hemorrhage and poses “a serious present danger to the woman independent of a possible future pregnancy.” The 1993 responsum conclusion implies that so long as the avoidance of pregnancy and preservation of health may be achieved by a choice of means that does not involve the removal or impairment of the reproductive organs, there is a moral obligation to achieve the end by such means. To choose otherwise under these circumstances is to have a contraceptive intent and to take actions that are by nature contraceptive.

This circumstance is exactly what the 2018 responsum allows. In so doing, it contradicts the standard of the 1993 responsum.

To understand this contradiction, it is necessary first to see how the case of hysterectomy that is allowed in the 2018 responsum is essentially the same in its moral aspects as the case of hysterectomy that the 1993 responsum rejects. In both responsa, the ultimate end of hysterectomy for these similar cases of uteruses that are presently non-threatening and non-gravid is the prevention of death to human beings. In the 2018 responsum, avoidance of pregnancy is the means by which the foreseen death of a fetus is prevented. It cannot be validly claimed that the ultimate end of the hysterectomy in the 2018 case is merely to remove a uterus that will not function properly. The reason why hysterectomy is allowed in the 2018 responsum is not simply to prevent uterine dysfunction, but to prevent the death of a human individual because of the uterine dysfunction. The two are inextricably linked. The responsum argues that the uterus may be removed because it cannot attain its procreative end; but the moral significance of not attaining its procreative end is identical to the fact that a new human life will be lost. Consider a woman who has medically confirmed sterility. The mere fact that her reproductive organs cannot fulfill their procreative end does not justify their removal. Preventing the procreative dysfunction of the uterus in the case of the 2018 responsum is identical with preventing the death of a future child. Thus, the intention and action to prevent the dysfunction of the uterus in this case is necessarily one and the same with an intention to prevent the grave harm of death.

The non-hemorrhaging hysterectomy case examined in the 1993 responsum is similar to the case examined in the 2018 responsum insofar as hysterectomy is proposed as a means of preventing serious harm. The relevant case in the 1993 responsum is described as the situation in which the uterus “is foreseeably incapable of carrying a future pregnancy to term without danger to the mother, danger which in some cases could be serious.” For both the 1993 and 2018 responsa, the ultimate end of hysterectomy in non-hemorrhaging hysterectomy cases is the prevention of serious harm to human beings. The fact that in one case possible harm is prevented for an existing individual and in the other possible harm is prevented for an individual not yet conceived is an accidental, not an essential difference. They share the same purpose and the same moral implications.
reasoning. Furthermore, their moral evaluations are based on uteruses that in their present non-pregnant state do not constitute a danger to the woman. This second shared moral component is not altered by the fact that the pathophysiological conditions of the uteruses might be different in each of the cases; this also is an accidental difference. The fact that the 2018 responsum case shares two essential moral components with the rejected cases in the 1993 responsum is an important indication of the fundamental difference between the responsa.

The contradiction between the 1993 and 2018 responsa is also evident in the problematic way in which the 2018 responsum defines direct sterilization. The 2018 responsum states that “the precise object of [direct] sterilization is to impede the functioning of the reproductive organs, and the malice of sterilization consists in the refusal of children: it is an act against the bonum prolis.” However, the object of direct sterilization is not merely to impede functioning, but to impede the functioning of reproductive organs qua reproductive; and yet, this is exactly what the responsum allows. Contrary to the 1993 responsum, the 2018 responsum permits a procedure that impedes the functioning of a non-threatening, non-gravid uterus precisely in its reproductive dimension for the purpose of preventing future harm, the fact that the uterus’ reproductive functioning is defective notwithstanding.

If we apply the 1993 responsum standard to the case of the 2018 responsum, it is evident that there are means available to achieve the end of avoiding pregnancy other than removal of the uterus, which poses no threat to the woman. However, contrary to the 1993 responsum, the 2018 responsum permits hysterectomy when the uterus does not pose a serious threat to the mother in order to prevent serious harm (to a future child). In this way, the 2018 responsum contradicts the 1993 responsum on the two essential grounds that disqualified hysterectomy in the non-hemorrhage case for the earlier responsum: (1) the uterus is in a non-threatening state, and (2) the hysterectomy is undertaken to prevent future harm. Therefore, the 2018 responsum is morally valid only if the moral standard of the 1993 responsum is false.

Because the 1993 responsum relies heavily upon Quaecumque, we need to ask whether the 2018 responsum contradicts Quaecumque. It does but only if the meaning of “procreation” in Quaecumque is reduced to conception. Such a reduction is not evident. Quaecumque defines direct sterilization and its implications in this way:

Any sterilization which of itself, that is, of its own nature and condition, has the sole immediate effect of rendering the generative faculty incapable of procreation, is to be considered direct sterilization, as the term is understood in the declarations of the pontifical Magisterium, especially of Pius XII. Therefore, notwithstanding any subjectively right intention of those whose actions are prompted by the care or prevention of physical or mental illness which is foreseen or feared as a result of pregnancy, such sterilization remains absolutely forbidden according to the doctrine of the Church. And indeed the sterilization of the faculty itself is forbidden for
an even graver reason than the sterilization of individual acts, since it induces a state of sterility in the person which is almost always irreversible.

It is clear from this text that the CDF is referring to all procreative aspects of reproductive organs (female and male) insofar as it makes a distinction between the sterilization of the generative faculty itself and sterilization of individual acts, together with the fact that the term “procreation” is not qualified. The various aspects of procreation include conception, implantation of the embryo, gestation, and birth. Direct sterilization occurs when the “sole immediate effect” of the procedure renders “the generative faculty incapable of procreation.” The 2018 responsum is not contrary to Quaecumque because a uterus that is already incapable of the final end of procreation as the final stage of the procreative process cannot be rendered incapable. If one aspect of the procreative process is incapable of functioning, then even though other aspects have capacity it cannot legitimately be said that the procedure is the cause of rendering procreation incapable. Thus, despite the fact that Quaecumque does not recognize the intention to prevent future harm as a moral justification for direct sterilization, the 2018 responsum hysterectomy case does not contradict the essential definition of what constitutes direct sterilization.

LOGICAL IMPLICATIONS OF THE 2018 RESPONSUM

The contradiction between the two responsa indicates another fundamental difference between them that has potentially significant implications for a change in Catholic teaching on sterilizing interventions for medical reasons. The fact that the 2018 responsum permits the removal of the uterus that in its non-pregnant present state does not pose a serious threat implies the following moral standard that is in direct contradiction to the standard of the 1993 responsum: underlying conditions of the reproductive organs, or the known risk of them, which do not pose a present problem but can cause the grave harm of death for a woman or a fetus with a future pregnancy, constitute a morally sufficient basis to determine that direct action on those organs is not direct sterilization.

Since the 2018 responsum recognizes the moral validity of surgically affecting female reproductive organs that do not present a dangerous threat to the woman or a fetus (not yet conceived) for the sake of preventing the grave harm of death to a fetus with a future pregnancy, then it is legitimate to ask the following question: Does consistency require that the standard on which this responsum is based also validly apply to other situations in which there is a desire to prevent death with a future pregnancy due to other underlying pathological conditions? Examples of such conditions include a uterus that is so compromised from previous pregnancies that there is a likely risk of uterine rupture with another pregnancy, or cases involving serious underlying cardiac or renal condition of a woman which could be exacerbated to the point of causing grave danger for her and her child in a future pregnancy, or even a salpingectomy to prevent death from ovarian cancer.

Moreover, if all these cases share the same moral basis upon which the 2018 responsum affirmation rests, then it is also legitimate to ask whether a medically indicated (e.g., less
invasive) tubal ligation ought to be permitted rather than hysterectomy, to prevent pregnancy consistent with the moral standard of the 2018 responsum. The responsum argues that a uterus in the condition being considered is not capable of fulfilling its procreative function. The responsum states that “the objective of the “procreative process” is to bring a baby into the world,” and that for the case considered, this objective cannot be realized; therefore, removing the uterus is not direct sterilization. Biological processes are comprised of integral parts. The uterus as an organ does not exhaust the “procreative process.” Integral to this process is the functioning of the fallopian tubes as conduits of the gametes and the embryo. Even though the fallopian tubes may retain their normal function in the case considered, there is a relevant sense in which their function too is disordered because another integral part of the process (the uterus) is incapable of contributing to the end of this process. The fact that the uterus in a pregnant state may not be a primary cause of death does not alter the fact that the uterus cannot contribute to the end of the procreative process.

Moreover, because the 2018 responsum does not restrict its description of the procreative process to the uterus, but rather refers to “reproductive organs” that together “are not capable of fulfilling their natural procreative function” is consistent with the implication drawn here regarding the role of the fallopian tubes in the procreative process. For all these reasons, the two cases share not only the ultimate end of preventing grave harm to human beings, but also the proximate end of removing a non-threatening reproductive organ that cannot contribute to the procreative process. In this regard, what the 2018 case accepts with respect to the uterus (and implies with respect to fallopian tubes), the 1993 responsum rejects, viz. the notion that reproductive organs in a non-threatening state may legitimately be judged as not being able to contribute to the procreative process; and it is partly on that basis that these organs may be either removed or prevented from functioning.

Thus, we may draw two conclusions from the reasoning of the 2018 responsum and its application to methods and cases beyond what the responsum explicitly considered. First, to perform tubal ligation rather than hysterectomy, if medically warranted, is to prevent the grave harm of death to a future fetus for the same moral reason that hysterectomy prevents this harm according to the responsum; namely, tubal ligation causes a non-threatening reproductive organ to cease functioning as part of a disordered procreative process that cannot attain its end. Second, in cases of women with underlying conditions that are not directly related to the uterus itself but will be exacerbated with a future pregnancy, the likely death of the mother in such cases means that, as with the 2018 responsum case, the procreative process will not reach its end. The difference between the “incapability” of the uterus in the case of the 2018 responsum and the high risk of maternal (and fetal) death in the other cases does not alter the fact that in both sets of cases surgical action takes place on non-threatening reproductive organs whose functioning cannot contribute to the final end of the procreative process, and will result in the likely death of one or more human beings.

Therefore, I maintain that the 2018 responsum contradicts the 1993 responsum and implicitly relies on a moral criterion that was rejected in 1993. The moral standards of the 2018 responsum implies that a woman’s reproductive
organs (not simply the uterus) may be deliberately impaired when they do not pose a threat in order to prevent likely grave harm or death. The consistent application of this criterion would also permit tubal ligation for cases in which an underlying pathology that does not directly affect the non-pregnant state of the uterus and would likely be exacerbated to the point of endangering the life of mother and child in a future pregnancy. Just as with the 2018 responsum case, and for the same reasons, these other cases would not necessarily involve a contraceptive object or intent because they involve actions that entail impairment or removal of organs that could not achieve procreation in any case.

By clarifying that the meaning of procreation is more than conception, the 2018 responsum indicates (contrary to the 1993 responsum) that direct interventions on female reproductive organs to prevent harm associated with a future pregnancy do not constitute a sole immediate effect and can be consistent with the magisterial definition of direct sterilization. The 2018 responsum has provided a moral standard and line of reasoning that warrants revisiting the question of what constitutes direct and indirect sterilization in Catholic moral teaching.10

Peter J. Cataldo, Ph.D.
Senior Vice President, Theology and Ethics
Providence St. Joseph Health
Renton, Wash.
Peter.cataldo@providence.org
Creating Dialogue

What similarities and differences do you see between the 1993 and 2018 responsa from the CDF regarding the liceity of a hysterectomy in certain cases?

Describe the moral implications of each responsum.

Discuss the key components of the procreative process that are addressed in each of the responsa.
ENDNOTES

1 Congregation for the Doctrine of the Faith, Response to a Question on the Liceity of a Hysterectomy in Certain Cases, December 10, 2018, http://press.vatican.va/content/salastampa/it/bollettino/pubblico/2019/01/03/0005/00014.html#. The responsum allows a hysterectomy when medical experts have reached “the highest degree of certainty that medicine can reach” that a spontaneous abortion will occur. It is important to note that medical certainty is usually not absolute. In many cases, the level of certainty is a moral or prudential certitude, which is the same sort of certainty that would obtain in other types of high risk pregnancies. Moreover, what counts as the “highest degree of certainty” is not the same in each case but varies depending upon the condition and the particular circumstances.

2 The CDF uses term “sterilization” (sterilizzazione) but means “direct sterilization.” This is clear from the sense in which “sterilization” is used throughout the document and from the explicit reference to “direct sterilization” (sterilizzazione diretta) in the sixth paragraph.


5 As will be explained below, the 2018 responsum does not reduce “procreation” to one event but understands it as a process comprised of multiple components, including its final end, which is the live birth of a child.

6 For an example of not recognizing the underlying circumstantial and moral similarities between the two cases of the 1993 and 2018 responsa that lead to the moral contradiction between them, see the statement by the ethicists of The National Catholic Bioethics Center, “Commentary on the CDF Responsum of December 10, 2018, https://www.ncbcenter.org/resources/news/commentary-cdf-responsum-december-10-2018/.

7 Responses to Questions Concerning Sterilization in Catholic Hospitals, n. 1.


9 Included among the kinds of cases that the moral standard of the 2018 responsum might justify would be tubal ligation following endometrial ablation to prevent the likely risk of miscarriage with a possible future pregnancy, or Asherman’s Syndrome which involves intrauterine adhesions and scarring.

10 The limited goal of this analysis precludes the articulation of these other arguments for this article.
The Inner Life of Ethicists: The Importance of Cultivating an Interior Life

Paul J. Wadell, Ph.D.

Editor’s Note: Dr. Wadell delivered a version of this paper during his presentation at CHA’s annual Theology and Ethics Colloquium, March 13-15, 2019 in St. Louis.

I’d like to explore the connection between spirituality and the work you do as health care ethicists. We don’t always see a connection between the two and we may even assume they are completely unconnected. In fact, there is a dynamic relationship between health care ethics and spirituality, a relationship in which each shapes and informs the other.

Why does this matter? Why is the inner life—the spiritual life—of health care ethicists worth exploring? One obvious reason is that Christianity maintains that human beings are not just rational and emotional beings, but also spiritual and religious beings. Since this is so, not paying attention to our spiritual lives leaves us with an incomplete and even distorted understanding of ourselves.

I suspect that many of you devote a lot of time addressing the moral and spiritual formation of the people you serve but I wonder how many opportunities you have for your own ongoing spiritual formation, especially formation that connects to your work in Catholic health care ethics.

Reflecting on the relationship between ethics and spirituality matters because your profession isn’t always easy. At times, it can be challenging, difficult, occasionally frustrating, and emotionally draining as well. The more we see a connection between what we do in our work and spirituality, the more we will persevere and flourish in our callings.

I will explore the deeper meaning and significance of what you do and the relationship between your work and spirituality in four steps. First, I will focus on what might be most meaningful and fulfilling about your work and what might be most challenging. Second, I will offer a theology of spirituality that sees our work and our spiritual lives as intrinsically connected. Third, I will explore a theology of work that offers a vision of work that is an alternative to the current cultural view. Rather than envisioning work to be primarily about career advancement and professional achievements, this alternative vision suggests that your work in health care ethics is better understood as a gift from God that you offer as a gift to others. Fourth, I’ll conclude by considering three virtues that might help you grow in your spiritual life through your work.
MEANING AND CHALLENGE

In *An Altar in the World: A Geography of Faith*, Barbara Brown Taylor writes: “Call me a romantic, but I think most people want to be good for something. I think they want to do something that matters, to be part of something bigger than themselves, to give themselves to something that is meaningful instead of meaningless”1.

I suspect all of you, whether you are in clinical ethics or organizational ethics, relate to those words. You entered the field of health care ethics because you wanted to do something that matters, because you wanted to be part of something bigger than yourselves, and because you wanted to give yourselves to something genuinely meaningful and important. In the best sense of the word, you were idealists. You wanted to take what you learned in graduate school in your study of philosophy, theology, and medicine and use it to help others, both personally and institutionally.

I asked several ethicists how they found meaning in their lives. Several things stood out. Helping people at very difficult moments of their lives, whether helping them make difficult decisions regarding their care or helping them accept and prepare for death. You can have a profound impact on people’s lives in ways that neither they nor their families will ever forget. One ethicist put it this way:

> It is immensely fulfilling and satisfying when I leave my day knowing that full humanity was expressed in the work that I did because I was able to bring together the beautiful art and science of medicine with the realities and messiness of real life circumstances and everything that comes with that so that the end result is that somebody walks away feeling fully human.

• You also mentioned the experience of a greater appreciation for human vulnerability, for the fragility of life and how important it is to be present to people at moments of sometimes frightening vulnerability. In this way, you imitate God who in Jesus entered our world and became vulnerable for us.

• You value being in an environment where you have the opportunity to share your deepest beliefs, values, and convictions, including your understanding of the Gospel, of who Jesus is, and of God’s compassionate love and care for us, in institutions that share those same beliefs, values, and convictions. Thus, what you do and where you do it resonates deeply with who you are and want to be.

• Finally, you mentioned the satisfaction of helping health care organizations and institutions live with integrity, doing what you can “to nudge things closer to the reign of God,” and shaping the rapidly changing field of health care ethics, including what it means to be an ethicist.

We know that nothing worthwhile is easily achieved, so there are also ample challenges and frustrations. These include:
• Dealing regularly with situations that are emotionally and psychologically difficult, situations that generate “moral distress.” You find yourself at the center of a controversy and are trying to help people sort it out. Maybe a patient makes a decision you disagree with because you know it won’t be good for them. To be regularly immersed in situations of human suffering and conflict can be overwhelming and exhausting. How do you do this without becoming hardened and detached? How do you keep that essential human connection?

• Dealing frequently with complex or unusual situations. Your work is specialized but also somewhat isolating because not many people face what you face or want to hear about some of the challenging realities you regularly encounter. You deal with aspects of life that most people want to postpone considering for as long as possible.

• Experienc[ing moral distress that sometimes emerges from the inability to close the gap between the mission-driven aspirations and the business and financial realities of health care. Lack of resources—or resources that are given to other areas—may prevent you from doing what you should do and want to do to fulfill the mission of Catholic health care. This can be demoralizing and it can lead to clashing narratives. Catholic health care is informed by the Gospel and the Catholic moral tradition, but those narratives can be dramatically at odds with the dominant narratives of capitalism, business, and science. As one ethicist said, “Things like spirituality, prayer, and the Gospels are effective, but not in the way that business and science typically measure effectiveness. Consequently, we’re constantly looking for ways and metrics to prove our worth to the organization.”

• Dealing with people who view ethics “as only black and white,” who don’t understand that moral situations are often ambiguous so that no clear choice presents itself. No matter what decision is made, something less than ideal could result. Consequently, ethicists may be viewed as trying to undermine the Catholic moral tradition by people who don’t know that tradition or present a very distorted account of it or fail to grasp its essentially prudential nature.

THEOLOGY OF SPIRITUALITY

These are some reasons why an interior, spiritual life is so important to an appreciation of the value of what you do. The great missionary and physician Albert Schweitzer recognized this tension:

I wanted to be a doctor so that I might be able to work without having to talk. For years I had been giving of myself in words, and it was with joy that I had followed the calling of theological teacher and preacher. But this new form of activity would consist not in preaching the religion of love, but in practicing it. Medical knowledge would make it
possible for me to carry out my intention in the best and most complete way, wherever the path of service might lead me.\(^2\)

That’s a wonderful description of authentic Christian spirituality. For Christians, spirituality is not a matter of “preaching the religion of love,” but of “practicing it.” Theologian Richard Gula writes: “A sign of authentic spirituality is the life it engenders”\(^3\) which suggests that spirituality is all about making connections between our faith and our everyday lives. A vibrant spirituality is one that moves from our heads to our hearts and then to our hands, from our minds to the depths of our inner lives and then to the everyday actions of our outer lives whether at home, in our communities, in dealing with strangers, but also in our work.

There is a tendency to compartmentalize our lives in ways that suggest that spirituality pertains to certain areas of our lives, but not to others. We connect spirituality to practices such as going to church, setting aside time for prayer and meditation, making a point to have periods of silence and solitude in our lives, or perhaps making an annual retreat.

All of these are vitally important. We can even say that a spiritual life begins in these practices, must remain centered in them, and must grow out from them because through them we show that God is the center of our lives and the most important relationship of our lives.

St. Thomas Aquinas said that Christians are called to a life of friendship with God and saw friendship with God as the very heart of the spiritual life. Friendships die if friends never have time for one another, if they never are available to one another, and it’s no different with friendship with God. Friendships require work, commitment and presence, and create a certain way of life. Spiritual practices such as prayer and meditation nurture our relationship with God. They create an opening for God to enter our lives, an opening that can easily close if too many other things, including our work, begin to take precedence over our relationship with God. These practices create and sustain a resilient intimacy between God and ourselves, an intimacy that must be the foundation of our lives.

But the spiritual life cannot stop there. Our friendship with God is never meant to stay just between God and ourselves but should continually open up in love and friendship for others and permeate our lives and work. In the Gospel, Jesus distinguishes our love for God from our love for our neighbors, but he does not separate them. The depth and authenticity of our love for God is measured in our willingness to extend it to others, to gladly share it with all the neighbors who cross our path each day, including the neighbors we meet through our work. Ultimately, the spiritual life requires a moral vision that enables us to see how all of life is lived in the presence of God and how that awareness informs how we think, how we speak, and how we act in every area of our lives.

The Second Vatican Council insisted that an authentic spirituality hinged on making connections between who we say we are and how we live. In Lumen Gentium, its document on the church, the council said that through baptism all Christians become part of the priesthood of Christ and are called to bear witness to Christ. Nobody can be on the
sidelines because all are called to do God’s work in the world in different ways.

For Christians, Christ is the reference point for understanding who we are called to be, the paradigm to understand and measure our lives. As Gula remarks: “If we are to be disciples today and live faithful to Jesus, then our character and actions ought to resemble, rhyme with, or harmonize with the pattern we find in his story.” How can who you are and what you do in Catholic health care resemble, rhyme with, and harmonize with Christ? Gula’s comments suggest that Christian spirituality is looking for ways to make our lives resonate with the life of Christ. The council expressed this beautifully when it said that we are all called to “contribute to the sanctification of the world” and to “manifest Christ to others” by bringing the Gospel to bear on every area of life (LG, 31,33).

That’s an inspiring way to think about what you do in health care ethics, especially on those days when you may wonder if what you do makes a difference. In your work as health care ethicists you contribute to the sanctification of the people you meet and the places where you work; you are Christ to others by letting the Gospel inform every dimension of your work. When you make the connection between your work life and your faith life, everything is transformed, everything is seen in a new light. You are, Lumen Gentium says, the means by which “the world may be filled with the spirit of Christ and may the more effectively attain its destiny in justice, in love and in peace” (LG, 36). When you see what you do as health care ethicists through the lens of Christian spirituality, you realize that you are participating in Jesus’ mission of building the reign of God (LG, 36). That’s Christian spirituality.

What can we glean from this overview of Christian spirituality? First, it suggests that when we bring spirituality into conversation with ethics we realize that we have to extend our understanding of ethics beyond dealing with tough cases, beyond knowing how to apply the right moral principles to complex situations, and beyond trying to ascertain the possible consequences of an action.

But there is a more fundamental question: Who do I want to become? What kind of person am I making of myself each day? What would it mean for me to be a good person who lived a good life? How do I want to be remembered? And how do I have to live today in order to make that possible? These questions demonstrate how spirituality enables us to connect the work we do with what we want to be the overall trajectory of our lives.

Second, linking spirituality to health care ethics enables us to distinguish what we do in our careers from what we live for. Theologian Gary Badeock says a career ought to be understood in light of a more comprehensive life project and ought to serve that life project. For Badeock, our career focuses on what we do, but a life project articulates what we live for, what we take to be the overarching goal and purpose of our lives.

That life project could be trying to be a force for good in the world. It could be always striving to make life better for others or working for a world where life abundant is possible for all persons and creatures. It could be bringing God’s love and compassion to bear in every relationship of our lives. Linking
Your work has an undeniable sacramental character because like Jesus you often find yourself at the center of somebody’s pain, somebody’s affliction, somebody’s sorrow, somebody’s loss. Your work is a sacrament because like Christ, rather than fleeing those moments, you enter into them in order to help.

They want to be magnanimous. He believed that the majority of people want to be idealistic inasmuch as they want their lives to be guided by noble ideals and convictions.

But Schweizer also said that most of us live out those ideals and convictions in the ordinary routines and circumstances of our lives. That means our actions, even if they remain unrecognized and uncelebrated, make a lasting difference in the world. Cultivating an interior life helps us connect the best ideals and convictions of our lives to the routines of our daily lives. I think Schweitzer captured perfectly the true meaning of magnanimity and of Christian spirituality when he wrote:

One can save one’s life as a human being, along with one’s professional existence, if one seizes every opportunity, however unassuming, to act...
humanly toward those who need another human being. In this way we serve both the spiritual and the good. Nothing can keep us from this second job of direct human service. So many opportunities are missed because we let them pass by. 

One way of understanding Christian spirituality is to see it as forming us into the kinds of persons who seize “every opportunity, however unassuming,” to act humanly toward those who need another human being. And yet we miss so many opportunities. But when we bring our spiritual life into our work life we become much more attuned to those opportunities; we not only wait for them, but we also seek them and are poised to receive them.

THEOLOGY OF WORK

In the beginning God created. (Genesis 1:1)

God saw everything that God had made, and indeed, it was very good. And there was evening and there was morning, the sixth day. (Genesis 1:31)

So, God created humankind in God’s image, in the image of God they were created; male and female God created them. (Genesis 1:27)

Our society typically thinks of work primarily in terms of career advancement and professional achievements. This is why a career is different from a calling. We are the focus of our careers, but God and doing the work of God is the focus of a calling. A Christian theology of work offers an alternative vision to the dominant cultural narrative about work because it flips the focus from ourselves and what’s in it for us to the good we can do through our work. As theologian Darby Ray says, our work is a gift entrusted to us from God that we offer as a gift to others. 

Why is this? The scriptures depict God in a variety of ways. They reveal God as a God of love, as a God of justice, as a God of mercy and compassion. But they also reveal God as a worker. Yahweh is not an idle God who rejoices in doing nothing, but a creative, imaginative, and even playful God who delights in bringing beautiful things to life.

In the Judeo-Christian tradition, God works. This is why it is not wrong to think of God more as a verb than a noun. As Darby Ray notes, “God works not to exert dominance or achieve superiority but to make the world an inviting, diverse, and harmonious place.” If that is true for God’s work, it should also be true for our work. God’s work is a labor of love and, therefore, our work too should be a labor born from love.

What is the connection between God’s work and ours? Human beings are created in the image of God. That means there is some correspondence, some similarity, between who God is and who we are and between what God does and what we are called to do. It means we are, in our own fashion, to do what God does. If God is a community of persons—Father, Son, Spirit—bonded together in unbreakable love, then we image God and grow in likeness to God in the giving and receiving of love. If God is passionate about justice, especially to the poor, then it is through justice that we image God. If God is a worker, then our work is a very important way that we imitate God and grow in likeness to God.
“We humans are workers. We were created to work as God works and to support God’s great work of creating, loving, and sustaining the world in all its complexity and diversity.”

Through our work we are to share in and continue the good work that God began. God creates, heals, sustains, mends, comforts, and makes whole. You do all those things as health care ethicists. You fulfill the biblical mandate “to cultivate and care for” creation in your work with patients, their families, with your colleagues, and in your institutions.

God’s work did not stop with creation but continued when God became human and entered the world in Jesus. Jesus’ work immersed him in the chaos, messiness, sorrows and sufferings of people’s everyday lives just as your work does for you. In the Gospels, Jesus so often finds himself at the center of somebody’s pain, somebody’s affliction, somebody’s sorrow, somebody’s loss. He finds himself surrounded by people who need help. He doesn’t flee those situations, he doesn’t turn away from them but enters into them. “Rather than being above the fray, he is in the thick of it.”

And so are you. This is why you can think of the work you do as health care ethicists as sacramental. A sacrament is something that mediates the sacred. A sacrament brings us into contact with God. Sacraments are said to be “Christ events” because through them Christ continues to feed, to heal, to comfort, and to bless. Your work has an undeniable sacramental character because like Jesus you often find yourself at the center of somebody’s pain, somebody’s affliction, somebody’s sorrow, somebody’s loss. Your work is a sacrament because like Christ, rather than fleeing those moments, you enter into them in order to help.

In that way you continue Christ’s work in the world by being agents of Christ’s love, healing, comfort, and compassion to others.

Through your work you also love your neighbors—the neighbors who happen to be patients and their families, the neighbors who are your colleagues, and the neighbors who comprise all the people who come to you for guidance and support. You fulfill this commandment to love when you take time to listen, when you offer comfort and compassion, when you are patient, and when you are honest and truthful, particularly when doing so is hard.

Second, this theology of work suggests that from a Christian perspective what you do as health care ethicists is truly a special calling or vocation. Seeing your work as a calling—a special vocation—is to know that God cares for the world through you. It means, as the theologian Elizabeth Newman writes, that “our vocation is not ultimately about us as individuals but about what God is accomplishing” in and through us. When you see your work as a calling, your primary concern is not what it makes possible for you, but what it makes possible for others.

The language of calling puts everything we do into a larger perspective, because it incorporates our own personal and institutional narratives into the much more sweeping narrative of God’s love and redemption. This means that in living out your calling you contribute to a narrative of lasting significance, a narrative that began long before you and will continue long after you. The great benefit of seeing our work as part of this larger narrative is that it frees us from defining life on our own terms by instead offering our lives to the saving work of God. Thus, you use your gifts—and your passion and
love for what you do—to meet a deep human need and, in doing so, serve the plans and purposes of God.

THREE VIRTUES

In this last section, I will consider three virtues that might help you continue to grow spiritually through your work. Although many virtues could be considered, these three seem especially important: the virtue of attention, the virtue of gratitude, and the virtue of humility.

First, the virtue of attention. A most basic calling is to pay attention, to open our eyes and our hearts to what God, other people, our communities, our work, or life itself might be asking of us each day. To pay attention is to see what truly matters. It is to be attuned to the world in which we find ourselves. The virtue of attention forms us into persons who are fully present to life and fully present to others. Steven Garber notes: “All day, every day, there are both wounds and wonders at the very heart of life, if we have eyes to see. And seeing—what [French philosopher Simone] Weil called learning to know, to pay attention—is where vocation begins.”

With the virtue of attention, we let the world speak to us and draw us out of ourselves for the sake of others, rather than bend the world to our own interests and needs. Attentiveness is the virtue that opposes the vice of self-absorption. A temptation most of us at least occasionally struggle with is to turn in on ourselves—to shrink the horizons of the world—especially when we are tired, frustrated, discouraged or disillusioned. But if we turn in on ourselves and thus begin to live inattentively, we miss the different ways that we can encounter God in the people around us and in the work we do.

A life characterized by attentiveness is a life without regrets because attentive people are alert to the surprising graces that are right in front of them. It may be seeing something special in someone we had previously barely noticed or perhaps even disliked. It may be seizing opportunities for kindness that were always right in front of us but that before we were too busy to notice. Or it may be the life-saving grace of recognizing how sad it is to pass up any opportunity to love whoever is standing right in front of us.

The virtue of attention keeps us morally and spiritually alert, which is why it is a kind of prayer. As Barbara Brown Taylor observed:

> Prayer, according to Brother David, is waking up to the presence of God no matter where I am or what I am doing. When I am fully alert to whatever or whoever is right in front of me; when I am electrically aware of the tremendous gift of being alive; when I am able to give myself wholly to the moment I am in, then I am in prayer.

Like prayer, the virtue of attention awakens us to God’s presence no matter where we are or what we are doing. It forms us into the kind of persons who are “fully alert to whatever or whoever is right in front” of them. In this respect, the virtue of attention rescues us from being so taken over by distractions that we don’t see what we need to see.
A second important virtue for growing spiritually in our work is gratitude. From the beginning gratitude was recognized as an essential characteristic of the Christian life. In Ephesians 5:20, the members of that early Christian community are exhorted to give “thanks always and for everything.” Gratitude was to be the mantra of their lives. They were not to give thanks occasionally or sporadically or selectively, but everyday for everything. Their lives were to pulse with gratitude and praise because they knew that God’s love and goodness were the foundation of their existence and because they knew that to know the world is to know a gift.

These early Christians were instructed to see blessings everywhere not because they closed their eyes to the sufferings and hardships, and sometimes—sheer cruelty of life, but because they were seized with gratitude for God’s goodness toward them and for God’s unbreakable love. This is why Karl Barth, the great twentieth century Protestant theologian, said that gratitude is not only the very center of the Christian life, but also a Christian’s true identity.  

Gratitude opens our eyes to see the beauty and goodness of life, a beauty and goodness that has always been there, but that ingratitude keeps us from seeing. Gratitude is a matter of vision; it is learning to look for what is there instead of what is missing. So much depends on what we notice or fail to notice. Grateful people notice, they see what others overlook. Grateful people recognize that life, even when it is hard, is still filled with gifts. Grateful people know that life doesn’t always give us what we want, but it does give us unexpected goods and pleasures, as well as blessings we never thought would come our way.

Why is gratitude so important for growing spiritually in your profession? Gratitude helps us resist the stubborn inclination to put ourselves first, to secure our interests, needs, and well-being over the interests, needs, and well-being of others. Gratitude fights the temptation to pull back, to become calculating, or to harden ourselves to the needs of others.

Moreover, gratitude fortifies us against resentment, complaining, cynicism, petty bickering, discord and negativity, each of which is toxic for professional relationships, especially for the collegiality we need to do our jobs well, and for the institutional cultures in which we find ourselves. “These forms of ingratitude are deadly: they kill community by chipping away at it until participants long to be just about anywhere else,” Christine Pohl writes. “While gratitude gives life to communities, ingratitude that has become established sucks out everything good, until life itself shrivels and discouragement and discontent take over.”

But maybe the most important reason that gratitude is indispensable for your work in health care ethics is simply because your calling requires deep and abiding generosity. You cannot do what you do well without generosity. Your work demands the ongoing expending of yourselves for the sake of something good, and there is no way to succeed at that without generosity. Callings live on generosity and it is much easier to be generous when we are grateful. Finally, we need the virtue of humility to nurture our interior life. The philosopher Robert C. Roberts said that the “virtue of humility has fallen on hard times.” It’s true that humility rarely makes anyone’s list of the most important virtues, but maybe that’s because it is common to associate humility with its counterfeit versions.
Humility is not insufficient self-regard or an unhealthy lack of confidence. And it certainly has nothing to do with denying one’s dignity, worth, and sacredness as a human being. Richard Gula captures true humility when he says, “Humility is not low self-esteem, but low self-preoccupation.” He says that according to C.S. Lewis, “Humility is not thinking less of yourself, it’s thinking of yourself less.”

Humility characterizes people who know that the world does not revolve around them.

The word “humility” is derived from the Latin word *humus*, which means “ground,” “soil” or “of the earth.” In fact, “humility” and “human” share the same root. Humble persons are well grounded or rooted; they are genuinely “down to earth” because they have a healthy sense of themselves, both their gifts and their limitations. They don’t have to make themselves the center of attention. And because they don’t pretend that they are more than they are or other than they are, they can appreciate, depend on, and celebrate the talents and accomplishments of others. As Gula notes, “With humility, you are more concerned that good be done than that others recognize you for what you do. Humility is the virtue that knows there is no limit to what can be done when it doesn’t matter who gets the credit.”

Humility might best be described as clarity of vision about ourselves and how we stand in relation to others. It is clarity of vision that enables the cooperation and collaboration that is necessary for any organization to achieve its mission. Leaders marked by humility know they have a special role to play, but they cannot do it all. They do what they can but readily encourage the gifts of everyone who can do what they cannot. And because they are secure in their own identity, humble leaders are not threatened by the gifts and successes of others.

Humility nurtures collegiality. A humble person recognizes that none of us, no matter how highly educated, trained, and skilled, knows or can do everything. Because our knowledge and expertise are limited, we have to be willing to listen to and learn from others. We have to be open to their insights and suggestions, be willing to consult them, and be ready to admit when their ideas and arguments may be better than our own. And humility nurtures the spirit of graciousness by which we assume the best of others, give them the benefit of the doubt, and interpret what they say and do in the best possible light.

Without humility, we can be overly confident in our abilities and judgments, assuming we know best without taking time to listen to our patients and their families or to consult with our colleagues. Humility contributes to an institutional culture characterized by mutual respect, open communication, and ongoing collaboration. One ethicist captured the importance of humility in health care with these words:

> “Sometimes I think I’ve seen it all and know the answer to every situation. I need to remind myself to come into every situation with open eyes to see what is needed for this patient or this coworker. That is why my prayer everyday is focused on humility.”
CONCLUSION

In your work as health care ethicists, you are doing something that matters, you are part of something that is bigger than yourselves, and you are expending your talents, time, and energy on something that is truly meaningful because you are continuing the healing work of Christ. As Barbara Brown Taylor said:

“Call me a romantic, but I think most people want to be good for something. I think they want to do something that matters, to be part of something bigger than themselves, to give themselves to something that is meaningful instead of meaningless.”

That work is too important not to do as well as you can. There is an undeniable spiritual character to the work you do. And that is why, cultivating a vibrant spiritual life can help you grasp what your work truly is: God’s gift to you that you offer as a gift to others.

Paul J. Wadell, Ph.D.
Professor of Theology and Religious Studies
St. Norbert College
De Pere, Wis.
Paul.wadell@snc.edu
Creating Dialogue

What is the connection between spirituality and the work of health care ethicists?

Describe how you currently pursue your own spiritual formation and opportunities you see to foster continued growth.

What is the theology of work and how does it apply to health care ethicists?
ENDNOTES


4 Gula, 9.


8 Schweizer, 35.


10 Ray, 67.

11 Ray, 44.

12 Ray, 45

13 Ray, 51

14 Elizabeth Newmann, “Called Through Relationship,” *Christian Reflection Project*, (Waco, TX: Baylor University, 2004) 20-28, at 23


16 Taylor, 178.


18 Pohl, 18.


21 Gula, “Happiness Does Not Happen by Happenstance.”

Ethical Currents

The Rapidly Evolving Debate Over CRISPR

Paul Scherz, Ph.D.

Editor’s Note: Dr. Scherz delivered a version of this article during his presentation at CHA’s annual Theology and Ethics Colloquium, March 13-15, 2019 in St. Louis.

In November 2018, Chinese researcher He Jiankui, Ph.D., made the surprising announcement that he had performed human germline gene editing. Using the CRISPR/Cas9 gene editing technology (which I will refer to as CRISPR), he claimed to have mutated a gene in two zygotes which he then transferred to the mother, who gave birth to them last year. A bioethics scenario debated for the last 70 years may have come to pass with no public, regulatory, or ethical oversight. That seems to be the story at least. What actually occurred is less clear. The details are unpublished, so we are relying on the testimony of a few scientists to whom Dr. He revealed some of the data. It is unclear that they will ever be published, since he disappeared from public view soon after his announcement and is under investigation by Chinese authorities. Given experiences of fraud in the past over supposed breakthroughs, many ethicists are wary of putting too much faith in this announcement.

Whether or not He succeeded though, the mere plausibility of this scenario shows the need for continued reflection on the ethics of gene editing. Over the last three years, researchers in a number of countries have used CRISPR on human embryos with the blessings of regulatory authorities, secular bioethicists, and the scientific community. He’s work shows how thin the wall is between research and reproductive gene editing – all it takes is the step of transferring the embryos into a woman’s uterus. This case also shows the dangers of depending on the scientific community’s self-regulation. A number of U.S. researchers were aware of He’s experiments but did nothing to notify authorities or the public.

While many scientists, including the inventors of CRISPR, have argued for a moratorium on germline editing, others have seen this as a welcome opportunity to push further ahead.

It is essential that a more diverse group of ethicists, theologians, and the public participate in these conversations. There will be many voices promoting the promise of this technology, but we must also be aware of its dangers and limitations.

My goal in this essay is to first provide a brief overview of developments in this fast-changing field. I will then examine the practical and
ethical risks of this technology from the perspective of Catholic bioethics in light of Dr. He’s experiment. With these risks in mind, we must be wary of allowing the promises of technology to reduce suffering override ethical concerns.

**CRISPR AND ITS LEGITIMATE USES**

In the early 1990s, researchers studying bacteria found strange repeated genomic sequences across many species, which they called “Clustered Regularly Interspaced Short Palindromic Repeats” (CRISPR). These repeated sequences matched viral DNA and were part of a bacterial immune system targeting viruses for destruction. In 2012, a team led by Jennifer Doudna and Emmanuelle Charpentier showed that a modified form of the bacterial system could target (almost) any DNA sequence in other kinds of cells. Soon after, Feng Zheng and his collaborators showed that CRISPR could be used in human cells.

CRISPR consists of two elements. First, there is a guide RNA (gRNA) that contains a ~20 base pair sequence designed by researchers to target a specific DNA sequence. Second, there is a protein, usually CRISPR Associated Protein 9 (Cas9), that cuts DNA. When researchers introduce these two elements into cells, the gRNA binds to Cas9 and directs it to the specific DNA sequence that it matches. Then Cas9 cuts the DNA at that sequence. At this point, cells try to repair the damaged DNA through one of two mechanisms. Usually they just try to connect the two loose ends together, which leads to mistakes. One, two, three, or more DNA base pairs can be lost, introducing mutations in the targeted gene that generally make it nonfunctional. A second mechanism takes advantage of a natural repair mechanism that uses one of the cells’ pair of each chromosome (one from the father, one from the mother) to repair the other one (or even just swap elements from one to the other). If researchers introduce a well-designed piece of DNA into cells along with CRISPR, sometimes the repair process will insert this sequence into the cut, allowing researchers to introduce wholly new genetic elements into an organism. This occurs much more rarely than a mutation though.

CRISPR is an exciting technology with many uses that should be celebrated by Catholic bioethicists. Over the last five years, it has revolutionized biomedical research, promising great benefits through new discoveries. It is cheaper, simpler, and more efficient than prior gene editing technologies, and can be used in more organisms and cell types, including human cells. Second, it may be therapeutically useful for individuals with existing diseases through somatic cell gene therapy. Somatic cell therapy targets cells, generally in adults or adolescents, that are not passed on to the next generation. CRISPR would make such treatments easier. While there are risks from such therapies, as I will discuss, these risks can be balanced against current suffering, especially in the case of patients capable of informed consent. Catholic and secular bioethicists have declared these therapies to be ethical in principle.

**THE PROBLEMS OF GERMLINE GENE EDITING**

The ethical concerns over CRISPR, especially in light of He’s experiment, involve germline gene editing. This is when a genetic alteration will enter into a sperm and egg, thus passing to the next generation. Such a change could
happen through editing cells which will give rise to sperm and eggs in an adult or, as He did, by manipulating embryos. One of the remarkable things about CRISPR is that it will act when researchers inject it straight into the single-celled zygote. The concerns that such manipulations raise can be divided into two major classes, those tied to risk and those arising from the misuse of power over the next generation.

There are four kinds of risks to be considered: mosaicism, off-target effects, imprecision, and general lack of knowledge.

**Mosaicism.** One ongoing problem highlighted by He’s experiment is mosaicism. When CRISPR is injected into the newly fertilized egg, it does not always initiate editing right away but sometimes only after a cell division or two. In such cases, the embryo could have some cells that have the desired edit and some that do not, leading to mosaicism. A mosaic is an organism with different genetic variants in different cells. Mosaicism may itself lead to health risks, but it can also make gene editing ineffective. If geneticists want to target a gene that acts in the lungs (as in the case of cystic fibrosis), but the edited cells are only in the neural tissue, then the editing will have no effect. While there may be technical work-arounds, mosaicism has been a problem in almost all of the germline editing experiments so far.

**Off-Target Effects.** One of the early concerns with CRISPR was that it does not always restrict its activity to the targeted DNA but can cut elsewhere in the genome. These are called off-target effects and are dangerous because they cause unknown mutations in the genome leading to diseases such as cancer. Over the past few years, researchers have addressed these problems by better selection of the target DNA and various alterations to Cas9, meaning that these issues have become less of a concern. While significantly reducing these problems, these modifications have not eliminated them, though, suggesting the need for extensive sequencing of edited cells to ensure that no deleterious mutations have been introduced. These effects can also occur in somatic cell gene therapy, but in such situations, the patient can give informed consent, and frequently, one can sequence the genome of the edited cells to detect any major problems.

**Imprecision.** Even if CRISPR cuts the correct gene, the results can be imprecise due to the repair process, a problem that has become clearer in the last two years. As noted, the simplest repair mechanism that sticks the ends of the DNA together is error-prone. There is little ability to predict what mutation it will introduce. For example, since every DNA triplet codes for one amino acid, if CRISPR deletes three base pairs, then the gene may still be transcribed and translated into a protein, just into an unpredictable one. The protein may not work, it may work with reduced function, or it may end up with some completely different function. If a larger segment is deleted, it may affect neighboring genes. Through such mechanisms, He seems to have introduced completely novel mutations rather than the one he planned. Further, there are very few cases in which one just wants to eliminate a gene. Most genetic therapies require fixing a disease gene. While the second repair process allows researchers to introduce other DNA sequences, this occurs in a low efficiency manner. In one report, researchers found that zygotes can use the other chromosome for repair but that report is disputed. It is thus unclear that scientists can make the specific edits they want.
Lack of Knowledge. Finally, there is the broader problem of lack of knowledge. In general, we do not know all of the ways individual genes work. Genes are involved in multiple processes, so disruptions have unpredictable effects. For example, many people had thought that the CCR5Δ32 mutation that He targeted largely affected only HIV susceptibility, since it is a naturally occurring mutation. Further research revealed that people with that mutation have problems with fighting viral infections and may be more susceptible to West Nile virus. We have even less knowledge of how genes affect development. Such lack of knowledge may be acceptable when treating an adult with a serious illness capable of consent but is less acceptable with nascent human life. Moreover, once such a mutation is introduced, it has entered the human gene pool. As the National Academies report on gene editing notes, it is unclear that we will ever have full knowledge of the effects of such edits, since you cannot force the resulting child to participate in follow-up research. This problem affects most fertility experiments, such as when the parents of the three-parent child produced in Mexico City refused to participate in follow-up. More generally, there is evidence that IVF introduces health risks, but there has not been effective research on it.

POWER OVER FUTURE GENERATIONS

This points to the second set of issues surrounding germline modification, those related to power over nascent human life. Magisterial documents express concerns over current methods of germline editing because they require IVF. This opposition is related to the severing of the tie between the unitive and procreative ends of sexuality. More to the point here though is the concern over the attitude to nascent human life expressed in IVF, shown most prominently through the number of embryos discarded in the procedure. Beyond the simple loss of life, Donum vitae argues that it “can open the way to other forms of biological and genetic manipulation of human embryos.” Originally written in 1987, this statement seems like a slippery slope argument, with all the problems of uncertainty inherent in such arguments. Still, recent events have proved the Congregation for the Doctrine of the Faith (CDF) prescient, as the development of technology after technology that disregard the value of life in its earliest stages: preimplantation genetic diagnosis (PGD), embryonic stem cells, and embryonic genetic manipulation for research, primarily aimed at improving contraception and IVF. There is a self-reinforcing cycle of this technology development. This series of technologies embody what Pope Francis calls the technocratic imperative, treating the embryo as “something formless, completely open to manipulation.”

Two developments suggest that germline editing may accelerate this paradigm. First, to avoid the risks discussed above, many commentators have suggested in vitro gametogenesis (IVG). This technique would develop induced pluripotent stem cells from the parents’ cells, and then use CRISPR on these cells. After sequencing to ensure that only the correct edit was made, scientists could differentiate the edited cells into sperm or eggs in a dish before using them in IVF. This allows quality control on the edit and prevents mosaicism because the edit would be made before fertilization. While not yet successful in humans, important strides have been made in animal models. Gene editing is only one
application of IVG though, since its use has been suggested for what Julian Savulescu calls procreative beneficence. One of the problems that Savulescu sees with current PGD is that there are too few embryos to choose from because one cannot get many eggs from women. His ideal would be to generate enough gametes from parents to produce hundreds of embryos with the worst traits edited out, so that one could select the embryo with the best traits. Here we see a eugenic mentality. While there is little appetite for this technology for itself, CRISPR creates a compelling reason to develop it.

This points to a second problem area opened up by this technology - the issue of enhancement or making people better than well. The He case was especially worrisome since his goal was not to cure a genetic illness in a person with a specific mutation, but to protect against HIV by introducing a mutation. Due to the problems of imprecision discussed above, these kinds of enhancements may be easier than gene repairs. Though the distinction between therapies and enhancements is contested, most bioethicists (including Savulescu and Peter Singer) agree one should not begin human gene editing with a possible enhancement. Many Catholic ethicists have criticized the goal of enhancement. While there are issues to be raised about how enhancement affects human nature, those are not the primary grounds upon which the church criticizes it. Instead, enhancement efforts “imply an unjust domination of man over man,” by choosing arbitrary criteria upon which to value human life, thus undermining human dignity.

Although in a less acute way than other genetic modifications and testing, the focus on the perfectibility of the next generation embodied most clearly by enhancement, is ultimately dangerous to the common good.

**CONCLUSION**

While CRISPR could aid in the treatment of many genetic diseases, we should be wary of germline modifications because of the technical and social risks involved. Many people may argue that this is an obscurantist position: if we have something that might reduce suffering, we should do it. Yet, it is important to remember technological enthusiasts have promised such relief of suffering many times (the human genome project, regenerative medicine, previous incarnations of gene therapy) with few major benefits to show. Catholic health care is right to be skeptical of the glamor of high technology, especially when it asks us to cross moral lines. While CRISPR does offer benefits for research and somatic cell therapy, we should reject current models of germline modification.

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**Paul Scherz, Ph.D.**  
Associate Professor of Moral Theology and Ethics  
School of Theology and Religious Studies  
The Catholic University of America  
Washington, D.C.  
scherz@cua.edu
ENDNOTES


5 Lovell-Badge, “CRISPR Babies.”


12 National Academies, Human Genome Editing, 129.


Ceccarelli conducted a systematic comparative language analysis on the literature related to a gene editing technology from the 1970s called recombinant DNA with recent news reports on CRISPR to show how public attitudes toward gene editing technology have changed over the last half century. She finds that metaphors in news reports present CRISPR as a biological entity with agency. After observing that many popular news writers seem content to resign themselves to the inevitable control CRISPR will have over the world, Ceccarelli writes “we are carried along by a linguistic and cognitive momentum that makes it less likely that we will orient toward this technology as a tool under the control of scientists and science regulators who make decisions about whether or not particular synthetic biology projects should be undertaken.” None of this language was present in the literature she reviewed on recombinant DNA.

She recognizes the moral complacency of the public through these metaphors and presents a convincing argument that such changes should raise concern; however, she does not provide a strong analysis of the potential causes of this transition in public opinion. In the period between the two technologies she discusses, significant cultural changes—especially in the philosophy of technology—that encourage the passive acceptance of all technological advancements as inevitable have captured the moral imaginations of the informed public. Transhumanism has gained a lot of ground in bioethics over the last fifty years, and the preeminent French-German philosopher Bernard Stiegler published a multi-volume philosophy that traces the evolution of humans and their tools such that development of biology is inextricable from technology: what we shape shapes us in turn. These developments in the philosophy of technology have provided some people sufficient ground not to fear biotechnology and even to consider it prima facie good.

Despite these shortcomings in identifying causes for the change, the article is very interesting for its thorough analysis of two drastically different attitudes from two stages in gene editing technology that are sufficiently set apart in time to show just how much attitudes have changed in only two generations. Ceccarelli demonstrates convincingly that those who resist gene editing in the form of CRISPR face a greater challenge in their efforts to influence public opinion than their predecessors did. Moreover, her article mirrors back to the public a frightening moral turpitude.
Even asking if certain technologies are potentially destructive enough to the earth and humanity that we might be compelled to interfere with their evolution.


Early this year, NYU bioethicist Matthew Liao wrote a piece in response to the excitement around the birth of the CRISPR babies in China. His article provides a way to approach ethical decisions regarding how to modify genes in making so-called “designer babies.” Liao argues for a human rights approach as opposed to the libertarian approach (any modification is acceptable), the perfectionist approach (that one has a moral obligation to create the best possible life), and the life-worth-living approach (which employs utilitarian judgment of values in certain traits and may lead to euthanizing people with disabilities). He admits that more analyses are required if we are to be thorough in considering the best approach to designer babies.

Liao’s human rights approach requires that we grant two conditions: All human beings have equal value, and all humans are entitled to the fundamental capacities for a good life. The conditions for the good life include certain capacities, such as five senses, which are considered to be fundamental to humans. This leads him to argue that we must be concerned with the genetic makeup of a human insofar as these capacities are affected. He determines that we are obligated not to create or modify life in such a way that we remove or prevent natural human capacities. If we do create designer babies, we are not permitted to design babies without the capacity to hear. Liao writes that we are permitted to accept life that does not have all of its natural capacities, such as those who are expected to be born blind. Similarly, he says such capacities cannot be removed from the already born who have experienced such capacities. In this way, he makes space for disability, but he only requires acceptance of disabilities in the already born. He does not go as far as the Catholic Church does, the latter insisting that such human life must be accepted as human life despite its lack of some fundamental capacities or the potential to develop them without assistance.

Liao’s boldest claim is that if we have the ability to create a capacity where there was none, it would be impermissible not to do so. That is, we have a moral obligation, insofar as we are able, to design or modify life such that all fundamental capacities are intact. This provides an interesting problem, though, which he addresses to some extent: How do we distinguish fundamental capacities from preferences, and what is the relationship between these capacities and genetics? This is where Liao gets a bit confused. He admits that traits such as maleness or whiteness may be preferred for social reasons—to live the “best” (or perhaps a “most comfortable” would be more accurate) life—but socially privileged race and sex are not fundamental capacities of humans. He then goes into conversation about taste, which is one of these capacities. He recognizes the power to taste as a fundamental human right, but such a right does not include the power to taste and appreciate fine wine.

What troubles me about this distinction is that he conflates aesthetic judgment with nature such that one could have a genetic
predisposition to appreciate fine things. He fails to recognize that genetics has nothing to do with the appreciation of fine wine. If anything, a genetic predisposition to hypersensitive powers of taste would ruin appreciation of the wines considered to be the greatest on earth (The Holy Grail of wine regions, Bordeaux, is valued for its highly structured wines, and “supertasters” dislike highly structured wines. They’d be more inclined to enjoy new world Syrah, regardless of price.) While taste is an important capacity to appreciate the earth’s richness, and I absolutely agree that we must protect this capacity if we can, the good life does not depend on a genetic predisposition even to have taste buds at all. We are adaptive creatures. We can find joy and sorrow in any experience, or so the great mystics and poets teach us. Aesthetic judgments are value judgments of experience, and how these judgments create in us an encounter with pleasure or awe or power or disgust. These are not genetic adaptations; they are social and spiritual processes of making a meaningful life out of whatever you were given—or whatever you have life left.

This failure to understand the relationship between aesthetics and genetics may also provide a key to understanding why Liao misses the importance of accepting the unborn life that may have a disability. Aesthetic judgments involve highly subjective value judgments on the surface of things, but, on a deeper level, we judge sensuous experience according to our ability to feel connected to God, to nature, and to other people. This is why sometimes a wine can taste finer when it is tasted in better company. I contend that it is our capacity for relationship that makes us human, not our ability to see or hear or taste the material world.


Paul Scherz, Ph.D., moral theologian and geneticist from The Catholic University of America, provides a helpful explanation of the CRISPR/Cas9 gene editing technology with a subsequent thorough analysis of various uses of the technology according to the integral parts of the moral act according to the Catholic tradition and church documents on germline gene editing. The moral reasoning is precise, unbiased, and careful. Scherz admits uses of CRISPR/Cas9 that effectively treat and prevent diseases for in vivo humans are morally good, but he expresses a great deal of concern around its practical use because it has thus far depended heavily on in vitro fertilization. Also, the actual effects of the alteration are sometimes unpredictable and may lead to unintended mutations.

After presenting proper functioning of the technology and its potential problems, Scherz outlines three ethical questions to consider as CRISPR/Cas9 develops. These are, “How much risk from off-target effects is acceptable in therapeutic uses?” How much power should humans exert over the next generation and, of course, how should technology engage human sexuality without reducing it or instrumentalizing it? An additional question to consider is how “gene drives crystallize new concerns about humans’ relationship with the environment.” The new technology exists within a delicate ecosystem that we know is
already suffering a great deal of change that profoundly affects vulnerable human life.

Scherz expresses a very cautious view toward advancement in use of CRISPR/Cas9 without vilifying it as an intrinsically evil technology that has no potential for good uses. As a highly trustworthy source on Catholic moral teaching and careful analyst of biotechnologies, Scherz’s article is extremely helpful.

CONCLUDING OBSERVATIONS

While many writers want to pause the development of gene editing technologies to ask important questions, most accept that such a pause will not occur. Many ethicists are considering what these technologies actually do, what promises their developers make, and what new capacities for potential domination may occur. In light of those considerations, ethicists must be extra vigilant in returning to the question of what is essentially human. Guidance is helpful, and our religious traditions continue to provide some resources for answering these questions. The greatest risk in these conversations is forgetting that genetics only accounts for so much. Although modified genes could enter into the germline and change nature, we are not yet at great risk of this. For all we know, gene-edited humans could be sterile. Perhaps we should view the fury around this technology as a sign that maybe we haven’t become complacent. If genetic editing is the looming change it seems to be, let us ask how it can be used to protect people from actual molecular threats while also respecting the boundaries we, as a society and as a people of God, have placed around human life, which is a good. Let us also ask if its costs outweigh the benefits of methods which may be more effective in addressing environmental factors in well-being.

Andrea Thornton is a Ph.D. student in theology and health care ethics at the Albert Gnagei Center for Health Care Ethics at Saint Louis University. She is also a Board Certified Chaplain.
Sex and Senior Living: Ethical Questions for Catholic Housing and Long-Term Care – Some Second Thoughts

John A. Gallagher, Ph.D.

In the winter 2019 edition of *Health Care Ethics USA*, Fr. Bouchard, O.P. addressed a number of questions pertaining to sexual morality that arise on a regular basis in Catholic long-term care facilities. The purpose of the essay, he informs his readers, is “to open a discussion about responding to basic human needs in a rapidly changing society.”

This essay intends to further the discussion initiated by Fr. Bouchard and, perhaps, to broaden the context in which issues of human sexuality and intimacy among residents of long-term care facilities might be appropriately construed.

A number of years ago, I attended a meeting of an ethics committee in a long-term care facility. The topic of discussion on that day, as it had been for several prior meetings, was how to encourage residents to complete advance directives so that their family members and the facility would know their preferences for end-of-life care. As the meeting proceeded, a member of the committee and a resident of the facility, claimed the floor and made a bold statement that galvanized the attention of everyone around the table. And here I paraphrase, but the substance of his comment was that residents come into long-term care to live, to enjoy and relish the years of active life that remain for them. They do not come to focus on death and end-of-life issues. Residents want to continue to live the ordinary human lives that they have lived for the past sixty or seventy years. They want the warmth and comfort of a safe place to sleep, they want nutritious and tasty food, and, in many instances, would like a drink before dinner. But they also want friendship, intimacy and appropriate levels of sexual expression. All of these things are integral components of the ordinary lives of contemporary women and men. They are not extraordinary elements of human life and well-being, but ordinary, regularly recurring aspects of the lives of contemporary Americans. They are essential elements of the common good, of integral and authentic human well-being.

I doubt that Fr. Bouchard would disagree with any of these comments regarding ordinary life and their relevance to the well-being of long-term care residents. Towards the end of his article he writes: “Providing a safe, welcoming
place for them (the elderly) enables them to flourish and to experience God’s grace in old age.” Where we may differ is in the use of ethical categories such as “cooperation” and “scandal” in appraising sexual behavior within Catholic long-term care facilities.

Let me begin with a comparison. The focus of Fr. Bouchard’s essay is with the moral obligations of a Catholic facility regarding sexual acts that may occur within space rented to residents. His essay accepts the traditional teaching of the church regarding fornication and adultery, divorced Catholics remarried outside the church, and couples who are not married according to the requirements of canon law. Thus, the focus of the essay is whether a Catholic residential facility illicitly cooperates in these moral evils and whether its toleration of them constitutes a risk of scandal.

But why this exclusive focus on Catholic long-term care organizations? Could not questions of cooperation and scandal be raised regarding dormitory space rented by Catholic colleges and universities to their students? Is it impossible to conjure up the possibility that at least some of these dorm rooms are used on occasion for sexually illicit acts contrary to church teaching? Why this difference? Are Catholic colleges less Catholic than Catholic health care? Does the principle of cooperation have less applicability to Catholic colleges than Catholic health care? Are Catholic colleges immune from accusations of condoning scandal?

The difference lies, I suspect, not in the relevancy of the church’s moral teaching nor in the applicability of the principle of cooperation or the significance of scandal. College students are deemed competent, they are adults with the psychological and moral capacity to think and act on their own. The college no longer functions in loco parentis. Residents in long-term care, be they situated in independent living or dependent living are culturally perceived to possess questionable levels of cognitive capacity. Among the elderly, cognitive status covers a broad spectrum. Patients in independent living are competent to make their own decisions, decisions regarding their finances, their health care needs and expressions of sexuality and intimacy. Residents who experience dementia are clearly individuals with diminished capacity. And there are many elderly who fall somewhere in between these two groups. Only professional evaluations that can document diminished competency can justify restricting the decision-making of individual residents. Any lesser standard would violate the human dignity and privacy rights of residents.

The point I am trying to get at is that the primary issues for Catholic long-term care are neither cooperation nor scandal. Catholic residents of long-term care have lived for years with divorced and remarried Catholics, with couples living together who are not married as well as members of the LGBTQ communities. These various constituencies are part of the adult world. It would be a rare and unusual resident who would raise issues of scandal or cooperation because these are terms of “church speech” not public discourse.

But posing issues of cooperation and scandal can provide a cloak to cover the complex issue of assessing the cognitive status of residents. Because certain sexual acts and intimacy relationships are deemed intrinsically evil, therefore they ought to be prohibited in a Catholic facility. The problems associated with sex and senior living are not appropriately
resolved by applying the notions of cooperation and scandal, but rather the resolution of these problems ought to focus on issues such as the cognitive status of individual residents and the roles of sexuality and intimacy within the ordinary lives of the elderly.

The central question should be: How do Catholic long-term care facilities nourish the human dignity of residents and their capacity to enjoy the elements of ordinary life? To engage questions such as these would bring theological reflection within Catholic long-term care into alignment with the contemporary mission of the church to the modern world - prophetic evangelization.

ENDNOTES
2 Ibid.
Legal Lens

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, associate director, supervised the contributions of Brandon Hall (J.D. anticipated 2019) and Valerie De Wandel (J.D./Ph.D. expected 2020).

**COVERAGE AT WORK: THE SHARE OF NONELDERLY AMERICANS WITH EMPLOYER-BASED INSURANCE ROSE MODESTLY IN RECENT YEARS, BUT HAS DECLINED MARKEDLY OVER THE LONG TERM**

National Health Interview Survey data shows that the share of workplace plan coverage for nonelderly individuals rose from 56.3 percent in 2013 to 58.4 percent in 2017. Over the last two decades, the share has declined even more, with the greatest reductions occurring among those with incomes under 400 percent of poverty. Factors including the improvement of the economy since the 2008-09 recession, and the ACA’s “individual mandate” requirement are two causes that may have encouraged more Americans to enroll in employer coverage, with the law’s employer mandate possibly boosting the availability of coverage for lower-wage workers. On the other hand, the availability of subsidies in the ACA marketplaces may have encouraged small employers to stop offering coverage, as they may not be subject to the law’s employer mandate. Nevertheless, rising premiums have helped allocate a decline in individual market enrollment. Although an improving economy and individual mandate may have increased enrollment of job-based health insurance, it is foreseeable that a decrease in such enrollment will continue in the long-run. Chris Lee, Henry J. Kaiser Family Foundation, February 1, 2019. [https://www.kff.org/health-reform/press-release/coverage-at-work-the-share-of-nonelderly-americans-with-employer-based-insurance-rose-modestly-in-recent-years-but-has-declined-markedly-over-the-long-term/](https://www.kff.org/health-reform/press-release/coverage-at-work-the-share-of-nonelderly-americans-with-employer-based-insurance-rose-modestly-in-recent-years-but-has-declined-markedly-over-the-long-term/)

**WHAT CALIFORNIA’S 2015 MEASLES OUTBREAK CAN TEACH US ABOUT VACCINE POLICY**

Over the last few years, measles occurrences have been rising, with 70 documented cases in the Pacific Northwest in late February 2019. In 2015, the county in California where the outbreak occurred, was a location noted for high rates of non-medical exemptions for vaccination. In the recent Washington state outbreak, Clark County had an overall measles mumps-rubella (MMR) vaccination rate of just 83 percent in 2017 according to the state health department. More than two-thirds of the schools that reported had a coverage rate that was less than the necessary herd immunity level. California’s new immunization policy has raised public policy and public health concerns for all states. One concern is that parental substitution of medical and non-medical exemptions and distribution of medical waivers should be monitored more closely to ensure they are allocated to those with priority. Additionally, as unvaccinated children seem to
be located mostly in areas of high rates of exemption, the concentration of exemptions should be monitored as well. Such supervision of the exemption process is necessary to maintain coverage and protect public health. Policies for Action, February 28, 2019. https://www.policiesforaction.org/blog/what-california%E2%80%99s-2015-measles-outbreak-can-teach-us-about-vaccine-policy

IS YOUR SLEEP APNEA MACHINE SNITCHING TO YOUR INSURER?

A loophole in the health data privacy law may allow doctor-ordered data of patients to be shared with insurers and other health companies. Manufacturers of heart monitors, glucose meters, and continuous positive airway pressure sleep machines were reported to have shared data to external companies without the consent of the user. While this may seem controversial, this data sharing was completely legal because those companies are not covered by HIPAA. According to Jordan T. Cohen, an associate with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo P.C., “When an organization that is not regulated by HIPAA obtains health information, they do not have to comply with HIPAA’s privacy protections that prohibit use and disclosure of the data.” Due to this, patients are being encouraged to investigate the privacy policies of their medical devices before providing information to an entity not liable under HIPAA privacy law. Ayanna Alexander, Bloomberg News, March 20, 2019. https://www.bna.com/sleep-apnea-machine-n57982097106/

FEDERAL JUDGE AGAIN BLOCKS MEDICAID WORK REQUIREMENTS

For a second time in under a year, a federal judge has struck down the Trump administration’s requirement that some Medicaid recipients work to obtain or maintain benefits. In the ruling, Judge James Boasberg held that the Department of Health and Human Services (HHS) acted arbitrarily and capriciously in approving the work requirements because HHS did not demonstrate how the imposed work requirements furthered a “core objective” of Medicaid. That core objective, Judge Boasberg ruled, is to provide “medical coverage to the needy.” In two separate opinions, Judge Boasberg struck down Kentucky’s and Arkansas’ work requirements. Kentucky’s requirements were set to take place just before the decision was made, and Arkansas had already implemented its work requirements, resulting in the loss of access to healthcare coverage for 18,000 enrollees. Further, the decision could have a ripple effect nationally. Currently, eight other states have passed Medicaid work requirement laws, and another seven are waiting on approval from HHS. However, those states, and HHS seem to be undeterred by the ruling, vowing to move forward with approval and implementation. Both states have also pledged to appeal the ruling. Phil Galewitz, Kaiser Health News, March 27, 2019. https://khn.org/news/federal-judge-again-blocks-medicaid-work-requirements/
FRANCISCAN ALLIANCE MUST DEFEND $320M PENSION LAWSUIT

A federal district court judge in Indiana hit on two hot button issues with one opinion. The first issue is whether pension plan participants have standing to sue over plan mismanagement that does not result in reduction or denial of promised benefits. A circuit split currently exists, with the Third, Fourth, and Fifth circuits denying standing to pension participants who allege mismanagement without corresponding benefit cuts. The Second circuit, has ruled the opposite. Judge Robert J. Miller, of the U.S. District Court for the Northern District of Indiana ruled that the Franciscan workers have standing because of alleged underfunding of Franciscan Alliance health system (Franciscan), and Franciscan’s failure to obtain insurance against insolvency from the Pension Benefit Guaranty Corporation. Addressing the second significant issue in the opinion, Judge Miller ruled against dismissing a claim that Franciscan was exempt from the Employee Retirement Income Security Act of 1974 (ERISA) under the church plan exemption. Franciscan is one of many religiously-affiliated hospitals that have been accused of misusing ERISA’s church plan exemption in order to underfund pension plans, in some cases, by hundreds of millions of dollars. A 2017 U.S. Supreme Court case broadening the scope of ERISA’s church plan exemption left several remaining questions to be decided. In the case of Franciscan, Judge Miller opted not to rule in the health system’s favor, instead, moving forward with claims of breach of ERISA’s fiduciary duty requirements, as well as state breach of contract claims. Jacklyn Wille, BNA, March 28, 2019. https://www.bloomberglaw.com/document/X9K1HEBC000000?bna_news_filter=employee-

ASSOCIATION HEALTH PLAN RULING COULD RESULT IN THOUSANDS LOSING COVERAGE

A recent U.S. district court decision has invalidated a 2018 Department of Labor (DOL) rule (the Rule) permitting association health plans (AHPs), effective immediately, holding that the Rule ran afoul of both the Affordable Care Act (ACA) and the Employee Retirement Income Security Act of 1974 (ERISA). Under the Rule, associations and employers were permitted to band together to create AHPs. While there is some debate about whether the rule violates the ACA, there seems to be little debate that the Rule runs afoul of ERISA. In his holding, the district court judge held the Rule ignores the language and the purpose of both the ACA and ERISA. Further, the judge found the Rule “does violence to ERISA,” and runs counter to “Congress’s clear intent that ERISA cover benefits arising out of employment relationships.” The decision is likely to disrupt the healthcare coverage of thousands, due to the existence of some 30-plus AHPs which are already providing coverage. However, it is not yet clear whether the Trump administration will appeal the decision, or what the next step(s) will be for those who relied on the AHPs, given the immediate effect of the judge’s decision. Shelby Livingston, Modern Healthcare, March 30, 2019. https://www.modernhealthcare.com/insurance/association-health-plan-ruling-could-result-thousands-losing-coverage
SDNY HANDS SELF-INSURED HEALTH PLANS A TOTAL WIN

Self-insured health plan sponsors scored another big win recently, when the Southern District of New York (SDNY) recently upheld a plan’s prohibition on assignments of benefits under the Employee Retirement Income Security Act of 1974 (ERISA). Courts have overwhelmingly held in favor of upholding the prohibition of assignment of benefit clauses, as reinforcing of ERISA plan language as supreme. The suit was brought by a group of out-of-network providers as a claim for benefits under ERISA 502(a)(1)(B) under the theory that out-of-network providers had derivative standing by obtaining from the patient/participants an assignment of benefits, a designation as authorized representative under ERISA, and a general power of attorney. United’s plan language, however specifically prohibited assignments of benefits. The plaintiffs alleged that despite the plan’s anti-assignment clause, United had waived such prohibition by (1) remitting payments directly to the plaintiff/providers; (2) sending notices of claim denials to the plaintiff/providers, and noting that the providers could appeal such denial if their patients had properly authorized them to do so; and (3) offsetting payments to the plaintiff/providers by overpayments. The SDNY held that none of the actions evidenced a clear manifestation of an intent to waive the anti-assignment clauses, and thus, the plan language was controlling. Thus, because the anti-assignment language was included in the documents and properly drafted, United prevailed. Mark Stember, JD Supra, April 3, 2019.

ECONOMIC RIPPLES: HOSPITAL CLOSURE HURTS A TOWN’S ABILITY TO ATTRACT RETIREEES

The United States is once again facing a surge of rural hospital closures like the crisis of the 1980s. Since 2010, 104 rural hospitals have closed, with some 400 more at risk of insolvency and closure. These closures have obvious adverse impacts on rural populations’ abilities to access health care, but the disastrous economic consequences that follow rural hospital closures have some communities on edge. Rural hospitals are often one of, if not the, largest employer with their communities. Further, rural communities tend to be older. And for retirement communities, such as Celina, Tennessee, a retirement town of about 1,500, the loss of its 25-bed hospital has served as a deterrent for future retirees, who are reluctant to face a 20-mile drive to the next available health care provider. The closure of the hospital means 147 nurses, aides and clerical staff must find new jobs. As the 11th rural hospital to close in Tennessee in recent years, the economic and health care impacts are becoming all too familiar. Blake Farmer, Kaiser Health News, April 10, 2019.
researchers with the University of Wisconsin Health, as Medicare beneficiaries develop more complex diseases, they are more likely to switch from a physician to a hospital-led ACO. Similarly, the Medicare Payment Advisory Commission found that beneficiaries who switched ACOs have higher health care spending than the market average. Last year, an analysis from CMS found that physician-led ACOs get net savings of $182 million but hospital ACOs have net losses of $231 million. Adding further pressure, CMS will implement a redesigned Medicare Shared Savings Program starting July 1, where an ACO must take on more risk or be kicked out of the program. The new program accounts for risk adjustment concerns, allowing a one-time benchmark increase of up to 3 percent to account for unexpected higher use. However, the National Association of ACOs has indicated that the study is the latest evidence that the 3 percent risk adjustment change is not enough and that hospital-led ACOs are potentially facing an insurmountable bias. Robert King, Modern Healthcare, April 15, 2019. https://www.modernhealthcare.com/finance/new-beneficiaries-are-leading-financial-woes-hospital-acos

STRUCTURAL RACISM- A 60-YEAR-OLD BLACK WOMAN WITH BREAST CANCER

As a result of racial disparity in health care, Chicago established the Metropolitan Chicago Breast Cancer Task Force in 2008. Local researchers had discovered an increasing gap between black women and white women in cancer-related mortality. When new breast cancer treatments became available, the breast cancer mortality rate among white women in Chicago decreased but less so for black women. Consequently, the task force sought to identify variation and gaps in the quality and access of breast cancer treatment and screening, rather than biologic differences. The task force noted that black women in Chicago were almost 40 percent less likely than white women to receive care at a highly rated breast cancer imaging center, leaving them more likely to have their cancer missed on screening exams. Kristen Pallok, B.S., Fernando De Maio, Ph.D., and David A. Ansell, M.D., M.P.H, The New England Journal of Medicine, April 18, 2019. https://www.nejm.org/doi/full/10.1056/NEJMp1811499?query=TOC
NEW END-OF-LIFE RESOURCE FROM CHA
BY PROMINENT THEOLOGIAN THOMAS F. O’MEARA, OP

“This book is a roadmap for our journey toward God.”

PETER C. PHAN
Foreword

Resource for Catholic health care leaders, clinicians and pastoral care providers, as well as faculty and students in graduate bioethics, health care mission and leadership programs.