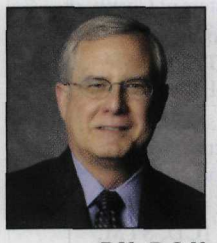
Embryonic Stem Cell Research: Perilous Pursuit?



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Pressures continue to mount to expand embryonic stem cell research (ESCR). On July 18, 2006, the U.S. Senate passed a bill (subsequently vetoed by the president) that would have allowed federal funding of ESCR employing stem cells derived from "left over" frozen embryos from in vitro fertilization. The bill would have undone the restrictions imposed by President Bush in 2001. At least six states—California, Connecticut, Illinois, Maryland, New Jersey, and Ohio—have approved state-funded stem cell research programs, including ESCR, to the tune of nearly $4 billion. At least four other states are debating bills or ballot initiatives to promote stem cell research. Missouri, for example, has an initiative on the November ballot that does not allocate taxpayer money to stem cell research, but does, through a constitutional amendment, guarantee scientists the freedom to conduct such research, including therapeutic cloning now referred to as "somatic cell nuclear transfer" (SCNT). In June 2006, the Harvard Stem Cell Institute announced that it will begin moving ahead with SCNT to obtain stem cells. And the list goes on.

It seems that society is moving inexorably toward a widespread acceptance of ESCR and, by implication, toward adoption of the belief that incipient human life can be sacrificed for *possible* health benefits *for us,* as well as for economic gain (a recurrent theme in the state initiatives). This movement is being fueled solely by promises and hopes, for ESCR has produced no treatments or cures in humans to date. Scientists are still trying to figure out how to manipulate and control ESCs; until they accomplish that, there is no possibility of cures. The scientific challenges are significant. Yet this reality is rarely mentioned by proponents of ESCR. They leave the impression that cures are around the corner. This further fuels the hopes and expectations of the public, as well as our willingness, as a society, to sacrifice the most vulnerable form of human life for our own purposes.

A Test of Moral Character

This is a critical time, if not a watershed moment, for our society. Our moral character is at issue in the choices we make. Surely, our concern for treating and curing diseases that inflict untold suffering on millions is a laudable goal and a display of compassion. But are we justified in doing *anything* to achieve this goal? Are there no limits? Is the relief of disability, disease, and suffering such an important human good that it trumps everything else, including early human life? Are we justified in destroying incipient human life as a means to achieve this good? Do we cross a moral bright line when we use vulnerable human life as a means to our own ends? And if we can justify doing it here, can we justify doing it elsewhere and with other vulnerable forms of human life?

Although what we owe incipient human life is a central consideration in this debate, it is not the only consideration. Also at issue are our beliefs about the place of disability, disease, and suffering in our lives; human finitude; limits; the extent of our obligation to treat disease and relieve suffering; what is understood by human progress; the pursuit of knowledge; the place of science in human life and society; the technological imperative; allocation of societal resources. This is a time not only for ballot casting, but also for careful reflection about what it is we are promoting and deciding about. Unfortunately, the careful reflection may not happen because we are swept away by the promises and the hopes. They tend to limit our vision, and a limited vision on such critical issues can have adverse effects on our moral character as individuals and as a society in the long run.

The growing acceptance of ESCR puts Catholic health care in a difficult position. The ministry is caught between its commitment to human life in all its forms, on one hand, and, on the other, its commitment to healing, the relief of suffering, medical progress, and the pressures of competition and economic stability. The pressure to become involved in ESCR will only increase. Together with these challenges, however, is an

opportunity to witness to some fundamental beliefs—surely about human life, but also about the other beliefs noted above. There is an opportunity here to offer an alternate vision, a different set of priorities in a positive way.

It is also an opportunity to promote moral forms of stem cell research, namely, research using adult stem cells, including those from placenta and cord blood. These stem cells are in fact currently being used to treat a wide variety of medical conditions—Parkinson's, anemia and blood and liver diseases, multiple sclerosis, lupus and other immune diseases, juvenile diabetes and arthritis, and spinal cord injuries—and hold promise for treating many more.

An Initiative in New Jersey

An excellent example of what Catholic health care can do in this regard is occurring in New Jersey. The Catholic HealthCare Partnership of New Jersey (which represents New Jersey's 15 Catholic hospitals) together with the New Jersey Catholic Conference announced in June 2006 their support of adult stem cell research and their commitment to promote umbilical cord and placenta blood donation at all 15 New Jersey Catholic hospitals, in which more than 20,000 births take place annually.

The two organizations will work with the Catholic hospitals to educate pregnant women about umbilical cord and placenta blood donation, provide information about New Jersey's public collection facilities, and encourage donations by expectant mothers at the time of childbirth. Donations will provide more material for stem cell transplants as well as research. (For more information, see *Catholic Health World,* June 15, 2006, or contact Fr. Joseph Kukura, president of the Catholic HealthCare Partnership of New Jersey, at kukuraj@chcpnj.org). Such an excellent initiative and collaboration is worthy of consideration and implementation across the country.

The choices we make today will define us as individuals and as a society and will undoubtedly affect future generations in profound ways. Hopefully, they will be choices we will not one day regret. ■

LETTER to the Editor

A Note on Forgoing Life Support

In a recent article, "End-of-Life Care Revisited" (*Health Progress,* July-August 2006, pp. 50-56), concerning Catholic teaching in regard to the use of assisted hydration and nutrition (AHN) for patients in persistent vegetative state, more fittingly called postcoma unresponsiveness (PCU), Br. Daniel Sulmasy, OFM, MD, PhD, answers some of the erroneous allegations often put forth by those who insist that AHN is ordinary care for patients in this condition.

His analyses of certain issues—whether removing AHN when a patient is not imminently dying constitutes euthanasia, the cost of care for a person in PCU, the nature of human suffering as a reason for removing life support, and the criteria for distinguishing between medical and nonmedical acts—should be looked upon as the gold standard whenever these topics are discussed in the future.

However, in the course of his article, Br. Sulmasy questions the use of the principle of double effect (PDE) when forgoing AHN, or any other method of life support, in the case of a person suffering from a serious pathology. Rather, he focuses upon the moral impossibility as the justifying cause for forgoing life support. Thus, he maintains "when a faithful Catholic withholds or withdraws a life-sustaining treatment, the moral object of the act, the intention-in-acting, is to forgo a treatment that is demanding more than one can reasonably be expected to bear" (p. 51). Because Fr. Benedict M. Ashley, OP, PhD, and I (in *Health Care Ethics,* 4th ed., Georgetown University Press, 1997, p. 425) invoke PDE when explaining the moral decision to forgo life support, it seems a clarification is in order. In our analysis, the PDE does not justify forgoing life support. Rather, foregoing life support must first of all be judged as a morally good act by reason of the moral object (the *finis operis*). Thus, we agree with Br. Sulmasy that the fundamental factor is the moral object of the act.

Hence, when making a judgment that life support either offers no hope of benefit or imposes an excessive burden (cf. directives 56 and 57 of the *Ethical and Religious Directives for Catholic Health Care Services*), the notions of physical or moral impossibility of fulfilling a positive mandate of natural or divine law must be considered, as Br. Sulmasy explains.

But after the decision is made to forgo life support, the death of the patient must be explained. This is where the PDE is utilized. Even though the death of the patient seems to follow from the action by which the moral object is accomplished, it is important to show that death is not the desired effect of the action performed. In this sense, PDE is a reflexive principle, not a justifying principle. In seeking to explain PDE, (Ashley and O'Rourke, p. 191) we posit five conditions. The first is that the act itself must be a good action insofar as its moral object is concerned. The other four conditions simply verify that this is true.

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