



# Your Business Is Our Business

## PEDIATRICS, PUBLIC HEALTH

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BY MARY M. DOYLE ROCHE, Ph.D.

**W**hile many Catholics are familiar with the church's teachings on a number of ethical issues in medicine (abortion, embryonic stem cell research and euthanasia for example), they may be less familiar with the church's moral traditions in terms of health as a common good. Two public health initiatives regarding children have recently received substantial media attention: rising rates of childhood obesity and debates over the safety of childhood vaccinations and immunization schedules. Themes in Catholic social teaching, including the family, the common good, the principle of subsidiarity and the option for the poor and vulnerable can provide insight on how to address these urgent issues.

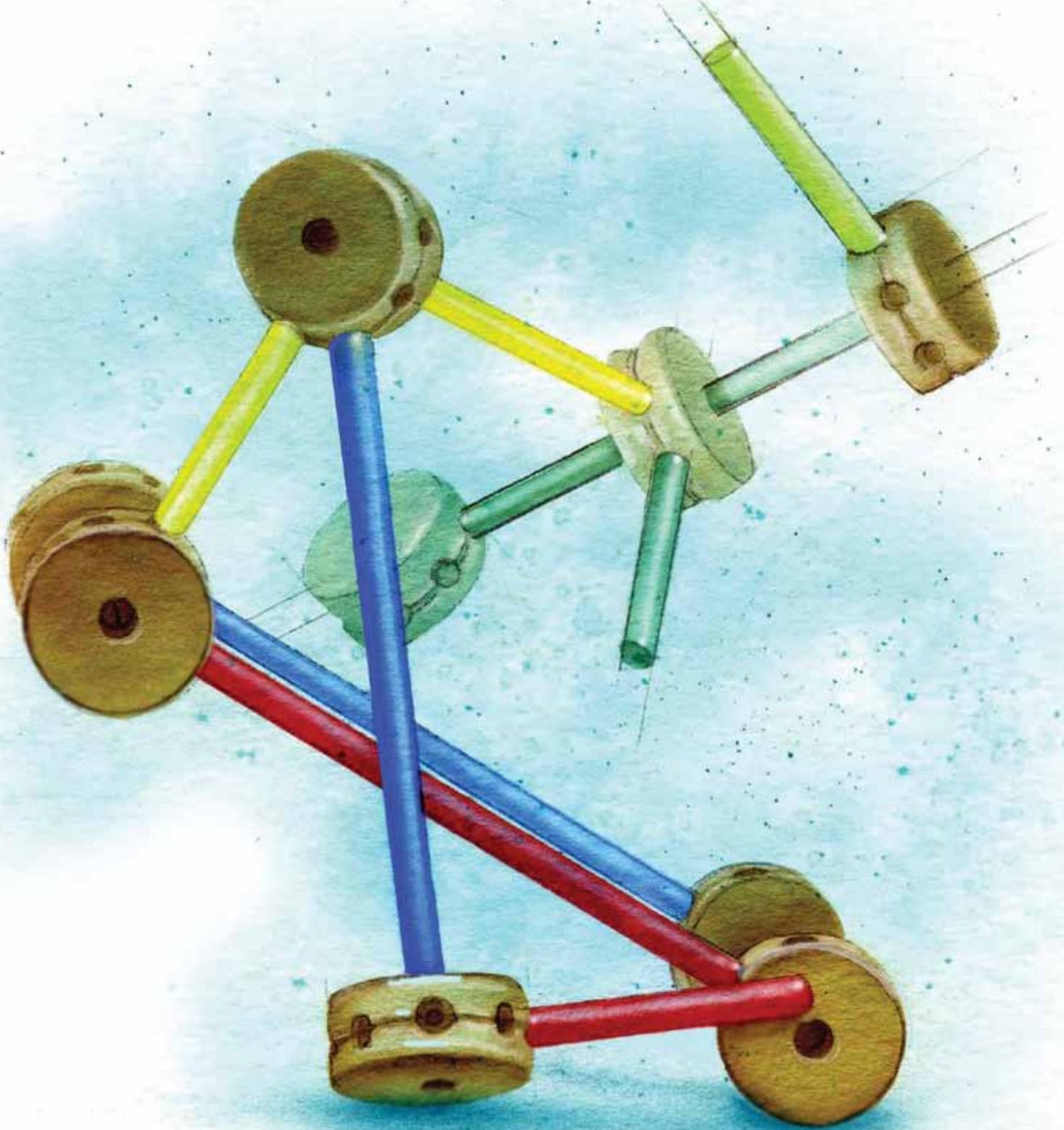
The church has long upheld the unique responsibility of care parents have for their children and of parental authority in making decisions on behalf of their children, decisions that are consistent with the family's values. However, in the context of public health concerns, claims about the importance of parental authority and concern for their own children must be kept in creative tension with the Christian commitment to the common good for all people. The family is not an isolated, autonomous unit. Rather, the family is the most intimate community of civil society, and it is interdependent with other institutions in securing the well-being of all children.

The following cases illustrate the need for families to make health care decisions in light of the good of their communities and "other people's children," as well as the need that families have for support from many levels of civil society — neighborhoods, schools, houses of worship, gov-

ernments and private industry — in order to be healthy.

### VACCINATION IS A SOCIAL ACT

In 2010, the public affairs TV show "Frontline" aired a piece titled "The Vaccine War." The PBS program chronicled controversies about the safety of vaccines given to infants and young children and reported connections to the rise in diagnoses of autism spectrum disorders. It is a story of legitimate concern for vaccine safety, a painful searching for answers about autism and an unfortunate mix of misinformation, short communal memory, research fraud, hoaxes and hype created by celebrity star power. Actress Jenny McCarthy — mother of an autistic child — and actor Jim Carrey have been prominent figures in the movement against vaccination.<sup>1</sup> The ethics of scientific research and the influences of market capitalism and the media on health care are urgent questions.



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reminds us that the family  
is not an isolated, autonomous unit.**

However, the vaccine controversy reveals deeper questions about our cultural approach to health.

Parents often view the vaccination of their children as a personal protection measure against disease, and vaccination programs have virtually eradicated communicable diseases like polio and smallpox. Though vaccinations benefit individuals, they also are profoundly social in nature. According to the National Institute of Allergy and Infectious Diseases, children whose age or medical condition such as a compromised immune system prevents them from being vaccinated rely on “herd immunity.” That is to say, once a significant number of children are vaccinated against a disease, this immunity benefits all children, including those too vulnerable to be vaccinated.<sup>2</sup>

Clusters of measles outbreaks in recent years bear witness to what happens when that herd immunity begins to break down. All states require children to be immunized against certain infectious diseases before they attend school, but medical exemptions are granted in certain cases. Many states also allow parents or guardians to get their children an exemption based on religious or personal belief. Parents interviewed by “Frontline” give a number of reasons for not vaccinating their children, including fear about the side

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effects, concerns about the vaccination schedule and the safety of preservatives used in vaccines and a belief that we should not intervene in every childhood illness (chicken pox, for example).

What is perhaps most troubling about the interviews is the parents’ apparent inability to connect the health of their children to the health of the community. As they discuss their reasons for not getting their children vaccinated, these parents leave no doubt that they love their children and are committed to their well-being as a first priority. But the parents seemed unable to articulate how this obligation might extend to other children in their neighborhoods and schools.

It is on this point that the Catholic vision of family life can speak meaningfully about the human dignity of all children and the need for families to act in a spirit of solidarity rather than competition or isolation. Families provide the context in which we first learn about faithfulness to those we love and about pursuing justice for all people. It is in the family that Christians also learn

about their special responsibility to the poor and powerless. Interdependence is a good of human community, not a burden.

When families do not cultivate habits of solidarity on the local level, it becomes more difficult to discern global connections and obligations. Concerns that children in some developing nations might be extremely vulnerable to communicable diseases was not linked in any way to what happens in the small, affluent U.S. community featured on “Frontline.” Additionally, rhetoric adopted by both sides of the debate spoke about the threat of disease that comes from those outside of the community that, they reason, would otherwise be immune from the diseases affecting those in other parts of the world.

Other parents interviewed on the program seemed reluctant to admit that their children basically benefit from the vaccines received by other children. Essentially, they are asking other children to bear any risks of vaccination on their own children’s behalf.

Equally as disturbing is the expressed notion that childhood illnesses are a part of life: getting chicken pox, for example, is seen as a rite of passage. The assumption behind parents allowing their children to get chicken pox rather than get vaccinated is that their children would have access to everything they needed to become well again. This may be true of children with robust immune systems and ready access to high quality health care, but it is certainly not true of all children. On the program, the physicians and ethicists who remember firsthand the impact of diseases like polio and measles, and those who treat children today for complications from chicken pox or pertussis, are much less sanguine about children taking the calculated risk of acquiring such an illness in the expectation they will have an easy, complete recovery.

### **CHILDHOOD OBESITY IS EVERYONE’S PROBLEM**

A second case further illustrates our private, individualistic approach to health care in the lives of children. Childhood obesity and overweight are not communicable diseases in the same sense as measles, mumps and rubella, but they are characterized in our 21st century society by a quality of contagion all their own. According to the Centers for Disease Control and Prevention, obesity rates among children ages 6-11 years were as high as 19.6 percent in 2008.<sup>3</sup> In 2010, a *JAMA* study of children ages 2-19 found one in every three (31.7 percent) was overweight or obese.<sup>4</sup>

The health consequences of obesity include



greater risk for cardiovascular disease, bone and joint problems, sleep apnea and social and psychological problems such as stigmatization and poor self-esteem. Combined with rising rates of obesity among adults, these negative health outcomes will surely put an increasing strain on our health care resources in the coming years.

In a 2010 report, U.S. Surgeon General Regina Benjamin, MD, called for a robust response to this epidemic, including increased access to affordable nutritious foods and opportunities for physical activity.<sup>5</sup> Benjamin wrote, “I envision men, women, and children who are mentally and physically fit to live their lives to the fullest. The real goal is not just a number on a scale, but optimal health for all Americans at every stage of life.”

In a similar vein, the American Academy of Pediatrics joined forces with First Lady Michelle Obama and various government agencies in the “Let’s Move” program, announced in 2010 as an initiative to reduce childhood obesity through more healthful food choices and more activity that is physical.<sup>6</sup>

These initiatives highlight the need for responsible choices among individuals and parents, as well as the need for the kind of social and economic circumstances that make those choices possible in the first place. A “just say no” approach to temptations produced by school vending machines filled with high-caloric snacks and drinks or incessant advertisements for candy and sugared cereals will come up short. It is disingenuous to think that individual parents and children can resist such pervasive enticements without a substantial network of support.

An individualistic culture such as we have in the United States, nearly obsessed with youth, beauty and thinness, stigmatizes obesity to the point of labeling it a personal moral failure. An overweight person is seen as lacking restraint and will power. The burden of change falls squarely on that individual who is expected to lose weight as a personal project (often aided by a miracle pill or some other technological device). For children who often exercise little control over the foods they have available to them, who have little opportunity to play and exercise in a safe environment or who have no context or example for adopting healthy eating practices, the social consequences of obesity can be devastating. It is especially easy to blame poverty-stricken parents for inability or failure to provide a healthy environment for their children. Parents need the support of schools, businesses, health care institutions, governments and churches to resist the pressures that short-

change their own and their children’s health.

#### ENGAGING CATHOLIC SOCIAL THOUGHT

How might practitioners in Catholic health care institutions incorporate themes in Catholic social teaching into the conversation about public health initiatives undertaken on behalf of children?<sup>7</sup> First, Catholic social teaching is grounded in the intrinsic dignity of the human person as one made in the image and likeness of God, or *imago Dei*. All people, including children, possess this dignity regardless of their health status or any

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other physical attribute. Practices that encourage stigma and unjust discrimination violate this basic commitment.

While the culture in the United States often equates dignity with autonomy, self-determination and control (words that rarely characterize children), the teaching of the church highlights the social and interdependent nature of the human person. Interdependence is not only a fact of human life — it is a profound human good. It is good that we need each other and flourish in community.

The common good in Catholic social teaching are those social circumstances that allow individuals and their communities to flourish. We have noted that children require a number of goods for their well-being: healthy food, potable water, access to health services (prevention and treatment measures), clean air, a safe environment, education and a secure family. These are all achieved more readily in communities that are free from the chains of poverty, racism and sexism.

A key component of the common good is participation: Individuals do not merely make claims on the community’s resources; they also have a responsibility for helping to build up those resources in the first place. The rights that we have as individuals are paired with responsibilities to pursue goals like healthy communities that extend beyond our self-interest. This may require that we accept some of the burdens and risks that come with the commitment, so long as these are distributed according to the norms of justice and do not overwhelm the dignity of any one unique individual. No one person or group should be asked to shoulder these burdens repeatedly, and

all people should be able to share in the fruits of common endeavor, including a quality public health care infrastructure.

Related to the social nature of the person is the commitment to human solidarity, justice and the option for the poor and vulnerable. We are called on to stand with one another in the pursuit of justice for all people. In this context, that is to say that all people should share in the good of health and health care. The poor and powerless have the most urgent claim on our resources in this regard, and their basic needs set the priorities for the community. Public health initiatives, including those to prevent communicable diseases among children and those aimed at reducing obesity, need to focus on those who are most vulnerable and who have the least ability to secure their own well-being.

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Parents must pursue the good for the children in their families, but they must also reasonably pursue the well-being of other children whenever possible. Parents need to acknowledge that they benefit from a complex network of social circumstances when they are able to secure a healthy environment for their children; they have not achieved this through mere individual effort. They ought not to place undue blame on other parents or stigmatize those who do not enjoy such networks of support, but rather they should seek to build relationships of solidarity.

Finally, a more technical term from the tradition: subsidiarity. Subsidiarity is the principle that has been used to determine the proper role of government in our common life. The principle respects the autonomy of the most intimate of social networks — the family. Governments ought not to do what parents and families are best able to do. There is a limit to what governments might require of an individual. At the same time, government has a role in protecting the vulnerable when families are unable or unwilling to do so. While parents enjoy a considerable amount of decision-making authority on behalf of their children, that autonomy is also not unlimited.

The principle of subsidiarity recognizes that some tasks facing communities will require the cooperation of many levels of civil society including families, churches and schools as well as local,

state and federal governments. Many crises that we face in global public health will require international forms of collaboration. An insular view of the family is impoverished given the commitments of the church to our rights and responsibilities in light of the common good.

That health and health care access are not only private, individual goods but also are profoundly social and public is a crucial connection between public health initiatives on behalf of children and the commitments of Catholic social teaching. Emphases on prevention that are found in public health programs as well as the multisectoral approaches that characterize them (education, private industry, government, media, etc.) are also potential sites of fruitful conversation. It is true that Catholic theological traditions have steadfastly maintained the vital role that parents play in the lives of children as well as the need for people to claim moral responsibility for their actions in pursuit of a virtuous life. Pediatric issues in public health prompt us to reflect further on other equally important themes in our tradition: the interdependent nature of the human person and the family, the balance between rights and responsibilities, and the Gospel call to seek justice and care for the poorest among us.

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#### **NOTES**

1. To view this “Frontline” episode online, see [www.pbs.org/wgbh/pages/frontline/vaccines/](http://www.pbs.org/wgbh/pages/frontline/vaccines/).
2. For more information on herd immunity, see the National Institute of Allergy and Infectious Diseases of the National Institutes of Health at <http://www.niaid.nih.gov/topics/Pages/communityImmunity.aspx>.
3. Centers for Disease Control and Prevention, [www.cdc.gov/healthyyouth/obesity/index.htm](http://www.cdc.gov/healthyyouth/obesity/index.htm).
4. Cynthia L. Ogden et al., “Prevalence of High Body Mass Index in US Children and Adolescents 2007-2008,” *JAMA* 303, no.3 (2010): 242-249.
5. U.S. Department of Health and Human Services, *The Surgeon General’s Vision for a Healthy and Fit Nation*, Office of the Surgeon General, January 2010.
6. American Academy of Pediatrics, [www.aap.org/healthtopics/overweight.cfm](http://www.aap.org/healthtopics/overweight.cfm).
7. For an explication of the major themes and documents of Catholic social teaching see Thomas Massaro, *Living Justice: Catholic Social Teaching in Action* (Lanham, Md.: Rowman and Littlefield, 2008).

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