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## Ethically Compromised Vaccines and Catholic Teaching

*Some vaccines are produced using cell lines which were originally developed from tissue from an aborted foetus. Vaccines are ethically compromised by this connection to abortion. Within the Catholic Church, the Pontifical Academy for Life has called for research and development of alternative vaccines which are ethically acceptable. Until alternative vaccines are developed, it has also accepted the use even of these ethically compromised vaccines in order to protect children, pregnant women and the population as a whole from the risk of contracting serious disease. This article explores all these issues from an Australian perspective.*

This article begins with a detailed account of vaccination. It explores the history of vaccination, what vaccines do, and how they are produced. It explains why some vaccines are ethically compromised, and what ethically compromised vaccines are available in Australia. Drawing particularly on a statement by the Pontifical Academy for Life, this article then considers the ethical issues raised by these ethically compromised vaccines. Because the Pontifical Academy's statement draws particularly upon the Principle of Cooperation in Wrongdoing, this discussion begins with an explanation of this important Catholic moral principle. It continues by summarising and expounding the statement from the Pontifical Academy for Life. After a brief comment on the Principle of Double Effect, it finally considers the phenomenon of herd immunity and both the ethical and practical implications of this.

### A Brief History of Vaccination

Edward Jenner is often thought of as the father of vaccination. He amongst others in eighteenth century England observed that milkmaids were never touched by the ravages of smallpox. This led him to a hypothesis that the milkmaids' constant contact with cowpox on the udders of cows provided them with protection against smallpox. To test his hypothesis, in 1796 Jenner inoculated a young boy with the pus from the cowpox nodules of a milkmaid. Jenner later inoculated smallpox into the boy and he did not develop smallpox.<sup>1</sup> By 1800, with fresh memories of the consequences of the disease, vaccination spread rapidly in England and throughout Europe to become a common practice. However, as the disease became less prevalent, resistance began to develop to the practice of vaccination. In response, towards the middle of the nineteenth century, the United Kingdom and some American states passed laws authorising compulsory vaccination programs.<sup>2</sup> In 1898, compulsory vaccination was rejected in England by a new *Vaccination Act*, which recognised conscientious objection to vaccination.<sup>3</sup>

### Vaccination and the Catholic Church

In 1823, on the death of Pope Pius VII, the *zelanti*<sup>4</sup> proposed a man who followed their precepts so that Ercole Consalvi, the Secretary of the Papal States, known as a moderate and wise policy maker, would not become the next pope. Cardinal della Genga became Leo XII (1823-29), as a compromise choice for the papacy.<sup>5</sup>

Pope Leo XII sacked Consalvi and began to undo a number of the reforms which Consalvi had initiated. Believing in the need for greater morality, Leo XII limited the sale of alcohol in Rome, and banned both the waltz and the playing of games on Sundays and feast days. It is alleged that Pope Leo XII stated, "Whoever allows himself to be vaccinated ceases to be a child of God. Smallpox is a judgement of God, the vaccination is a challenge toward heaven."<sup>6</sup> While this text is often attributed to Leo XII, there is no official record of the comment. It could have been attributed to the then-Cardinal della Genga and at most may represent his thoughts. An article by Keefe has attempted to track the origin of the statement. It concludes that it should not be attributed to Pope Leo XII.<sup>7</sup>

Since this time there have been many affirmations from the Vatican supporting vaccination and the development of new vaccines to combat the consequences suffered from many infectious diseases. In 2007, for example, Pope

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Benedict XVI addressed an international group whose purpose was to develop new vaccines and make them available in developing countries. He stated, “ I wholeheartedly encourage your efforts...Such vaccines are urgently needed to prevent millions of human beings, including countless children, from dying each year of infectious diseases...I assure you of the Holy See’s full support of this humanitarian project...”<sup>8</sup>

## What are Vaccines?

Advocating preventative means to avoid the onset of disease has become one of the cornerstones of modern medicine. Vaccinations are one of the simplest and most convenient ways to prevent disease. A vaccine provides an individual with immunity against an infectious agent.<sup>9</sup>

The body’s immune system recognises and treats any infectious agent or ‘antigen’ that challenges it as a trespasser. The body combats these antigens by producing substances known as antibodies. Once the antigen has been effectively destroyed by the antibody, the antibody disappears, but the cells involved with the antibody production remain and become the memory cells for that particular infectious agent. If the body is challenged again with the same infectious agent (antigen), the memory cells remember the antigen and destroy it. This can happen many times over and many years later. This is known as the body’s immune response.

Antigens or parts of antigens are found in vaccines. These antigens are either killed or attenuated (a non-virulent form of the infectious agent, developed in a laboratory). When a vaccine is introduced into the body, no disease manifests. However, the same antibody response occurs, thus producing memory cells to provide immunity to that particular antigen. Without experiencing the disease, an individual can therefore acquire immunity to a number of debilitating diseases through vaccination.<sup>10</sup>

## Production of Vaccines

The bacteria utilised in bacterial vaccines are grown on agar. Agar is a phycocolloid extracted from a group of red-purple marine algae.<sup>11</sup> The viruses for some viral vaccines are cultured in yeast cells, e.g. Hepatitis B vaccine and the human papillomavirus vaccine (HPV). The yeast utilised in the manufacture of these vaccines is either baker’s yeast (*Saccharomyces cerevisiae*), or the methylotrophic species *Hansenula polymorpha* and *Pichia pastoris*.<sup>12</sup> Other viruses for viral vaccines can be grown in a selection of cell lines produced from a variety of sources. These can be Vero cells (an adult African green monkey cell line), or MRC5 and WI-38 cells (human diploid cell lines, originally cultured in the 1960s). HelaT cells are from an adenocarcinoma of the cervix originally cultured in 1955; Rd cells are from a rhabdomyosarcoma cancer of muscle from the 1960s. The yolk sac or the allantoic cavity of chicken eggs are also utilised to grow a number of viruses for vaccine production.<sup>13</sup>

The growth requirement for viruses differs from that required for bacteria. Provided the agar on which they are cultured is given the correct conditions (e.g. aerobic,

anaerobic, nutrients), bacteria can replicate and survive without much further support. However, viruses require another cell in which to reproduce. It is ideal if viruses are grown in a cell derived from human tissue, as the cells within these tissues may have a receptor to allow entry of the virus into the cell so the virus can replicate.

Cells spontaneously replicate, providing an ongoing source of cells. For some cells, it can take up to 40-50 doubling replications before senescence (old age) onsets. However, it is not necessary to harvest cells from a new resource with the onset of senescence, as cells can be grown exponentially from the original storage of cells. Small amounts of the cells are individually ampouled and stored. At the onset of senescence, a new ampoule of cells is revived and the process continues. These cell lines which can be subcultured on a continuous basis provide a well-documented source for the growth and production of viruses for the production of vaccines.<sup>14</sup>

## Vaccines Available in Australia

The Therapeutic Goods Administration (TGA) in accordance with the provisions of the Commonwealth *Therapeutic Goods Act 1989* regulates vaccines in Australia. One of the requirements of the *Act* is that any therapeutic products imported into, supplied in, or exported from Australia be included in the Australian Register of Therapeutic Goods (ARTG). The TGA meticulously evaluates the data provided by the vaccine manufacturer to examine the quality, safety and efficacy of any vaccine prior to it being registered on the ARTG.<sup>15</sup>

In 2011, the Australian government provided funding for sixteen different vaccines. The Australian States and Territories are entitled to select vaccines from these sixteen that are most appropriate for their geographic and demographic needs. The vaccines are listed in the *National Health Act 1953* and *Determination 2011* (Immunisation Program – Designated Vaccines).

While there are a number of people who choose not to vaccinate their children or choose not to vaccinate themselves, there is a high level of uptake of vaccinations in Australia.<sup>16</sup> People dissent against vaccination for different reasons. One of the major concerns is vaccine safety. This can be the fear of an adverse event after vaccination, or the concern regarding the exposure to the various components added to the vaccine, e.g. a preservative or growth nutrients added during the manufacture process. The risks do need to be weighed up against the benefits, and the risk of an adverse event is often much smaller than the health risks associated with the disease. With measles the risk of developing acute encephalitis is one in a thousand with natural infection, while it is less than one in a million doses of measles vaccine.<sup>17</sup>

Vegans and vegetarians may choose not to be immunised with vaccines that include animal products during production. Those of Muslim or Jewish faith may avoid products that include a pork derivative. However, Jewish law allows porcine-derived products in the non-edible form, and Shariah law has the principle of

‘transformation’ that changes unclean products to clean and acceptable.<sup>18</sup>

Some Catholics have raised concerns regarding vaccines produced from viruses cultured on cell lines that were derived from fetuses aborted during the 1960s. They are concerned that by using vaccines manufactured from viruses cultured on these cell lines they could be complicit in co-operation with the original abortion from which the cell lines were derived. Of the sixteen vaccines that are part of the Australian immunisation schedule only a small number of vaccines fall into this category. Globally, this varies, as global vaccine producers have different preferences for cell lines in which they grow viruses for vaccines. Different countries also license different vaccines for the same infective agent.

Australia does not have compulsory vaccination but completion of vaccination schedules is now linked to Family tax payments. If the schedule is not completed then payment will be withheld.<sup>19</sup> This is due to an upsurge in the vaccine preventable disease, whooping cough (pertussis). Peter McIntyre et al, suggest that in a pluralistic society compulsory vaccination is not an option. Parental rights are limited by law in cases of abuse or neglect; otherwise, it is thought that parents act in the best interest of the child. Courts may overrule a parental medical decision if it is thought the child requires life saving treatment that is being denied. Vaccines fulfil the ethical criteria of a preventative measure in children. Justice and charity call parents to provide the best possible care for their child.<sup>20</sup>

### Ethically Compromised Vaccines

Australian vaccines that are ethically compromised and therefore of concern are: the rubella (German measles) vaccine which is part of the MMR (mumps, measles and rubella) combined vaccine, and the varicella (chicken pox) vaccine. Other vaccines of concern are Hepatitis A and varicella zoster (shingles). However, although part of the immunisation schedule these two vaccines are only given to particular populations in particular jurisdictions or to travellers. Rabies vaccine is also of concern. It can be given as prophylaxis or treatment for rabies or Australian bat lyssavirus. Since November 2005, the oral polio vaccine has no longer been provided in Australia, but this vaccine would also have been of concern.

MRC-5 (Medical Research Council) is the cell line most commonly utilised, with WI-38 (Wistar Institute) being used mainly for the production of the rubella vaccine.<sup>21</sup> These cell lines are known as human diploid cell strains.

MRC-5 cell line was derived from the normal lung tissue of a fourteen-week-old foetus that was aborted in 1966. This abortion from a twenty-seven-year-old mother was for ‘psychiatric reasons.’<sup>22</sup>

In 1964, Hayflick derived WI-38 from lung tissue from a three month gestation foetus. It is sometimes suggested that this foetus was specifically chosen for the purpose of obtaining foetal tissue.<sup>23</sup> However, the child was not aborted by the parents for the purpose of providing material for tissue culture. The parents, living in

Stockholm, chose to abort the child as they felt that they had too many children.<sup>24</sup>

In 1964, during a rubella epidemic, rubella virus strain RA27/3 was cultured from foetal tissue from a foetus which was aborted after the mother was exposed to rubella during the early stages of pregnancy. This strain of rubella virus is routinely cultured to manufacture rubella vaccine. Although other rubella strains were available, RA 27/3 adapted easily for growth at 30°C. This is an important characteristic, as viruses that grow at this lower temperature attenuate more readily and thus are easily able to be used in a vaccine.<sup>25</sup> Alexander Pruss notes that in this case use was not made of foetal tissue but only of a virus which had invaded the foetus. He argues that the continued use of RA 27/3 is therefore more easy to justify than the continued use of the cell lines derived from foetal tissue. As he observes, “It is not the body that is used, but the body’s enemy.”<sup>26</sup>

The history of the rubella vaccine provides a further insight as to why manufacturers continue to use this particular strain of the rubella virus and persist in culturing the virus in human diploid cells. In 1969 and 1970 when rubella vaccines were first licensed around the world, the USA decided not to license the vaccine developed with RA 27/3, and instead licenced vaccines developed using animal cell lines and other strains of the rubella virus. A number of problems gradually emerged, convincing authorities that the best vaccine was the vaccine developed from RA 27/3 cultured in human diploid cells. Rubella vaccines developed using duck embryo and dog kidney strains caused significant joint reactions, and most regrettably, some of those vaccinated with virus strains other than RA 27/3 manifested a rubella infection after exposure to wild rubella virus. Those vaccinated with strain RA 27/3 did not exhibit symptoms of rubella infection when exposed to wild rubella virus. Europe had licensed the vaccine developed with RA 27/3 and the vaccine showed a respectable safety record. Thus the USA decided that it would be preferable to use the vaccine developed from RA 27/3. Another major factor in favour of using the RA 27/3 rubella vaccine is that through much post vaccination surveillance there had not been any reported teratogenic effects even when the vaccine has been inadvertently given to pregnant women. One of the main reasons that the authorities did not license the vaccine initially was that they were concerned about using a vaccine developed in human cell lines as it potentially could contain contaminants.<sup>27</sup>

### The Vatican Statement on Ethically Compromised Vaccines

In June 2003, the Children of God for Life, a consumer group on the USA wrote to the Vatican asking advice about ethically compromised vaccines. In June 2005, they received a reply from the Pontifical Academy for Life entitled *Moral Reflections on Vaccines Prepared from Cells Derived from Aborted Human Foetuses*.<sup>28</sup> To consider this issue, the statement draws upon a Catholic principle, the Principle of Cooperation in Wrongdoing. In order to understand this statement, therefore, we must

first consider this important ethical principle:

## The Principle of Cooperation in Wrongdoing

The Principle of Cooperation in Wrongdoing is also known as the Principle of Licit Cooperation in Evil or simply the Principle of Cooperation. When another person is engaged in wrongdoing, this principle provides moral guidance to help us discern if we might without moral fault become involved to some extent in this wrongdoing, or when we should not become involved in any way. It was refined into basically its current form by St Alphonsus Ligouri (1696-1787), who is both the Patron Saint of Confessors and Moral Theologians, and one of only thirty-three Doctors of the Catholic Church.<sup>29</sup> Fr Bernard Häring, an important Catholic moral theologian of the twentieth century, once observed that without this principle, the “exercise of the lay apostolate” becomes “totally impossible.”<sup>30</sup> Indeed, we might add that without this principle simply living in the modern world also becomes totally impossible, for it is not always possible to identify or avoid clothing made in sweatshops, food produced by animals like battery hens, or companies who are engaged in wrongdoing somewhere in their corporate structure. When wrong is being done either by an individual or by an organisation, should we to some extent become involved, perhaps in the hope that our involvement will reduce either the wrongdoing or the harm which it causes? Or should we refuse to become involved? In real life, these are some of the most difficult moral decisions which we have to make.

The Principle of Cooperation introduces a number of distinctions so we can define the type of cooperation more precisely:

Cooperation in wrongdoing can be either **formal** or **material**. Formal cooperation occurs when someone intends precisely to contribute to another person’s wrongdoing or shares in their ‘bad will’ in any other way. For example, a nurse who approves of abortion and who assists doctors in performing abortions is engaged in formal cooperation. Such formal cooperation in wrongdoing is never morally permissible.

Material cooperation occurs when someone does not approve of another’s wrongdoing, but nonetheless is involved in some way in the wrongful action. Examples of material cooperation include another nurse who is opposed to abortion but who on rare occasions is compelled to assist at an abortion, and the manufacturer of surgical instruments who also opposes abortion but who knows that these instruments are sometimes used (among many other purposes) for surgical abortion. Depending on circumstances, material cooperation in wrongdoing may or may not be morally wrong.

Material cooperation can be either **immediate** or **mediate**. Material cooperation is immediate when someone cooperates in the performance of the wrongdoing itself, whereas it is mediate when someone facilitates wrongdoing either by providing something

which is needed for the wrongdoing or by removing obstacles which would otherwise prevent the wrongdoing. Thus, for example, the nurse who is opposed to abortion but who still on rare occasions is compelled to assist at an abortion is engaged in immediate material cooperation; whereas the manufacturer of surgical instruments who also opposes abortion but who knows that these instruments are sometimes used in abortion, is engaged in mediate material cooperation. Immediate material cooperation in grave attacks on human life is always morally wrong.<sup>31</sup>

Material cooperation can also be more **proximate** or more **remote**, depending on its ‘distance’ from the wrongdoing. Immediate material cooperation such as that of the nurse assisting in an abortion is always proximate. On the other hand, the material cooperation of the nurse who sterilises surgical instruments which might be used for abortion (among many other purposes) is more remote. And the material cooperation of the instrument maker is even more remote.

Material cooperation in wrongdoing can also be either **necessary** or **contingent**. It is necessary if the wrongful action cannot occur without it, whereas it is contingent if without it the wrongful act will still occur anyway. For example, if only one anaesthetist was available, her involvement would be necessary cooperation. On the other hand, if other anaesthetists were available and willing, her involvement would simply be contingent.

Material cooperation can also be either **active** or **passive**. It is active when someone is connected in some way with the performing of the wrongdoing. It is passive when someone who has a duty to oppose the wrongdoing, fails in this responsibility. All the examples above are of active cooperation. On the other hand, in a jurisdiction where abortion was illegal, the chief administrator of a hospital who knew that illegal abortions were being performed there but who did nothing about this, would be engaged in passive cooperation.

All things considered, some material cooperation might be morally justified. The *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* states that we should “only choose to provide material cooperation when the legitimate benefits and prospective harms of cooperation are to be preferred to the legitimate benefits and prospective harms of non-cooperation.” To make this determination, we should consider:

how important is the good one is pursuing and whether there are other ways of pursuing it; how serious are the evils to which one’s cooperation would contribute, and the necessity and proximity of one’s contribution to the success of the other’s action; the foreseeable benefits and harms that would result from cooperating and from not cooperating, including any injustice one’s cooperation would occasion.<sup>32</sup>

We should also strive to minimise the harm which our

material cooperation causes.<sup>33</sup>

One possible harm of material cooperation is **scandal**. Scandal is the distress which other people may feel because of our connection with wrongdoing or – more seriously – the danger that our connection with wrongdoing may lead other people into wrongdoing and sin. As the *Code* notes, we minimise the risk of scandal by “explaining clearly... the reasons for one’s cooperation and why the... cooperation is permissible according to Catholic principles.”<sup>34</sup>

*... it is morally licit to use these ethically compromised vaccines ... “to avoid a serious risk not only for one’s own children but also, and perhaps more significantly, for the health conditions of the population as a whole – especially for pregnant women.”*

Obviously, immediate cooperation is harder to justify than mediate cooperation, and the more remote forms of material cooperation are easier to justify than proximate cooperation. Necessary cooperation is much harder to justify than contingent cooperation, whereas passive cooperation is easier to justify than active cooperation. Justification for material cooperation is sometimes referred to as either **sufficient reason** or **proportional reason**.

A moral theologian named Charles McFadden once considered what might be proportional reason for various forms of material cooperation with abortion. He insisted that “both doctors and nurses who work in an institution wherein they are periodically asked to assist in immoral operations should look for another position.”<sup>35</sup> McFadden believed that even in a one-off situation reasonably proximate material cooperation such as that of the nurse who hands the surgical instruments to the doctor might be justified “only if a refusal to assist would inflict a *very grave loss* on oneself or on some other person.” This might be “a risk to one’s own life,” “possible loss of life to the patient,” or loss of employment for “a nurse who was the sole support of aged parents... in a period of severe economic depression, when there was no reasonable expectation of getting another position.”<sup>36</sup> On the other hand, remote material assistance such as sterilising and setting out the surgical instruments might be justified by the threat of serious penalty such as “suspension for a week, with consequent loss of salary, or some equivalent loss.”<sup>37</sup>

The above are only one theologian’s conclusions, and some may disagree with them. Three observations should be made. Firstly, the above examples are set in a situation in which health professionals are compelled against their will to participate in abortion. Such compulsion is morally unacceptable. To the contrary, the Church insists that “the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-

care personnel, and directors of hospitals, clinics and convalescent facilities. Those who have recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane.”<sup>38</sup> Secondly, however, in the unjust situations in which such compulsion does occur, the Principle of Cooperation sets reasonable limits on what is morally acceptable. For the more proximate forms of material cooperation, the requirements for proportional reason are very high indeed. On the other hand, for the more remote forms of material cooperation, the requirements for proportional reason while still quite high are correspondingly less. If the requirements for proportional reason are satisfied, one may reluctantly cooperate materially and remotely even with abortion without moral fault. Finally, even if the requirements for proportional reason are satisfied, some health professionals will still refuse any involvement with abortion in order to witness to the great value of human life. Their right to do so should be recognised and respected.

### The Principle of Cooperation Applied to Ethically Compromised Vaccines

Applying the Principle of Cooperation to vaccination, the Pontifical Academy for Life provides judgements about three different areas:

The first judgement is that “every form of *formal* cooperation” with the abortions from which cell lines were generated is “morally illicit.”<sup>39</sup> It is therefore morally wrong to approve of these abortions. Further, because of their position, some people may have a moral duty to denounce these abortions. Failing to do so because one secretly approves of the abortions is also morally illicit. The statement recognises this as passive formal cooperation.

Secondly, the “preparation, distribution and marketing of vaccines” connected with these abortions is “as a matter of principle, morally illicit.” It is of particular concern that such activity “could contribute in encouraging the performance of other voluntary abortions, with the purpose of the production of such vaccines.”<sup>40</sup> At the very least, this means that everyone involved in the preparation, distribution and marketing of these vaccines must use the Principle of Cooperation to consider their own position. Some of these workers “have no voice” in the decision to use these cell lines.<sup>41</sup> Like the nurse asked to give remote, material cooperation to abortion, they must decide if they have proportional reason to remain in their current role. Others are in much more senior positions. The Pontifical Academy for Life’s statement suggests that these senior people are morally derelict “if they do not denounce and reject publicly the original immoral act (the voluntary abortion), and if they do not dedicate themselves together to research and promote alternative ways, exempt from moral evil, for the production of vaccines for the same infections.”<sup>42</sup>

Thirdly, the statement considers the “doctors or parents who resort to these vaccines for their children.” It

provides four conclusions:

- (i) “[D]octors and fathers [*sic*] of families have a duty to take recourse to alternative vaccines (if they exist).” Elsewhere, the statement refers to this duty as a “grave responsibility.” However, it also recognises that there might be obstacles to doing this. For example, in footnote 14, it notes that “grave forms of allergy” have occurred with some of the alternative vaccines. If these allergic reactions do indeed raise serious concerns, the duty to use alternative vaccines may cease.<sup>43</sup>
- (ii) Doctors and families also have a duty of “putting pressure on the political authorities and health systems so that other vaccines without moral problems become available.” We should do this “by all means (in writing, through the various associations, mass media, etc.).”<sup>44</sup>
- (iii) As regards those ethically compromised vaccines without an acceptable alternative, “it is right to abstain from using these vaccines if it can be done without causing children, and indirectly the population as a whole, to undergo significant risks to their health.”<sup>45</sup> This might be possible, for example, if a vaccine offered protection only against a not very serious condition. As we shall see below, it is not really possible if a vaccine protects against a serious condition.
- (iv) On the other hand, if a failure to vaccinate exposes children and the general population to “considerable dangers to their health, vaccines with moral problems pertaining to them may also be used on a temporary basis.” The statement explains that the use of such vaccines is “passive material cooperation.” It adds that the “duty to avoid *passive material cooperation* is not obligatory if there is grave inconvenience.” For this reason, it finds “in such a case, a *proportional reason*, in order to accept the use of these vaccines in the presence of the danger of favouring the spread of the pathological agent, due to the lack of vaccination of children.” It adds that this is “particularly true in the case of vaccination against German measles” or rubella.<sup>46</sup>

As the statement notes, rubella is a highly contagious disease with transmission between people occurring through respiratory secretions. In developed countries the average number of transmissions from a single case of rubella is between three and eight. Because of the ready transmission of this disease it is very difficult to avoid the infection of pregnant women. Further if a pregnant woman is infected, the risk of infection of her unborn baby is very high (about 95%). For example, in a rubella outbreak in Philadelphia in the 1960s it was calculated at the peak of the epidemic that 1% of all births were affected by rubella infections. Congenital rubella syndrome involves serious consequences for the unborn child, including congenital heart disease, cataracts and deafness, along with other problems.<sup>47</sup>

In footnote 16, the statement again notes that this

syndrome causes “grave congenital malformations in the foetus, when a pregnant woman enters into contact, even if it is brief, with children who have not been immunized and are carriers of the virus.” It makes the chilling observation that “in this case, the parents who did not accept the vaccination of their own children become responsible for the malformations in question.”<sup>48</sup> Given the seriousness of rubella infection, it is difficult to see how any parent could ever think that they have proportional reason to refuse to vaccinate their children against rubella.

In the same footnote, the Pontifical Academy for Life also states that “parents who did not accept vaccination for their own children” are also responsible for “the subsequent abortion of foetuses, when they have been discovered to be malformed.”<sup>49</sup> In these tragic circumstances, those who did not vaccinate their children against rubella are obviously directly responsible for the affliction of an unborn child, and less directly responsible for the abortion which follows from someone else’s decision after their unborn child was afflicted. Even so, it cannot be denied that this sort of abortion is a foreseeable risk of not vaccinating one’s children. When one does not vaccinate, there is a foreseeable risk that unborn children will be infected, and a further foreseeable risk that in these circumstances some parents will opt for abortion. If therefore we are truly pro-life and anti-abortion, perhaps it is better that we focus not on an abortion from over forty years ago which cannot be undone, but instead on taking steps to vaccinate to prevent the tragic circumstances which could lead to more abortions in the future. All things considered, even allowing for the current need to use an ethically compromised vaccine, perhaps vaccination against rubella is truly the more pro-life decision.

Later in the statement, the Pontifical Academy adds that as we communicate our concerns about ethically compromised vaccines, we should also state that until ethical alternatives are available it is morally licit to use these ethically compromised vaccines “insomuch as it is necessary in order to avoid a serious risk not only for one’s own children but also, and perhaps more significantly, for the health conditions of the population as a whole – especially for pregnant women.”<sup>50</sup>

Finally, we should note that this teaching is repeated in the Congregation for the Doctrine of the Faith’s most recent statement on bioethics. There, the Congregation states that “danger to the health of children could permit parents to use a vaccine which was developed using cells of illicit origin, while keeping in mind that everyone has a duty to make known their disagreement and to ask that their healthcare system make other types of vaccine available.”<sup>51</sup>

## The Principle of Double Effect

John Grabenstein makes the interesting suggestion that the use of ethically compromised vaccines can also be examined using the Principle of Double Effect. Originating in the work of one of the church’s greatest theologians, Doctor of the Church St Thomas Aquinas

(1225-1274), this principle was first articulated in its current form in Jean-Pierre Gury's very influential *Compendium Theologiae Moralis* (1850).<sup>52</sup> The Principle of Double Effect is invoked when a single action has at least two effects, one of which is good and the other of which is bad. It sets out four conditions which must all be satisfied before the action can be recognised as morally licit. Thus, Grabenstein suggests that the use of ethically compromised vaccines does indeed have good and bad effects: "the good effect is disease prevention and the bad effect is the potential for encouraging future abortions" so as to develop new cell lines for use in the production of vaccines. The first condition of this principle is that the action itself must be good or indifferent, not intrinsically evil. Vaccination is indeed a good action. Vaccination is good because it prevents disease. The second condition is that the bad effect though foreseen is not directly intended. This condition is also satisfied: those who vaccinate need not and generally do not intend to encourage additional abortions. The third condition is that the good effect is not produced by the bad effect. Again this condition is satisfied: the good effect of vaccination is not in any way caused by the possible bad effect of encouraging future abortions. The final condition is that the good effect is at least as significant as the bad effect and therefore that there is a proportional reason for causing or tolerating the bad effect. This condition too is satisfied: the immediate and certain good of disease prevention outweighs the remote and merely possible bad effect of perhaps promoting future abortions. Like the Principle of Cooperation, then, the Principle of Double Effect also confirms that it is morally licit to use ethically compromised vaccines to protect against serious disease.<sup>53</sup>

## Herd Immunity

When a significant proportion of a population (or 'herd') are vaccinated, their presence provides a measure of protection for individuals who are not vaccinated or who have not developed immunity, even after vaccination or exposure to natural infection. This phenomenon is known as community immunity or, more commonly, as herd immunity. Quite simply, the presence of so many disease-resistant people reduces the possibility of contact between an infectious individual and a susceptible individual. In other words, the vaccinated population acts as a firebreak or firewall which restricts the spread of infectious disease. Based on such variables as the virulence of the disease, scientists have calculated herd immunity thresholds for various diseases. This is the proportion of the population who must be disease-resistant in order to effectively prevent the persistence of that disease within that population. For example, rubella cannot persist within a community in which 80-85% of the population are disease-resistant. By contrast, pertussis or whooping cough is more infectious, and its herd immunity threshold is 92-94%. Herd immunity is important because some individuals such as infants who are too young cannot be vaccinated. Further, pregnant women, immunocompromised individuals and other people with various medical conditions cannot always be

vaccinated. All these people will receive some measure of protection through herd immunity.<sup>54</sup>

Because of herd immunity, vaccination is not simply a benefit for the individual. Because it contributes to herd immunity, the decision to vaccinate is also a contribution to the common good of society. Vaccination benefits society as a whole and particularly benefits those vulnerable individuals who must rely on herd immunity for some measure of protection against disease.

It follows that society has an interest in promoting and encouraging vaccination. It is therefore reasonable for governments to offer some benefits to those who vaccinate their children, and to deny some benefits to those who do not. Because we all benefit from vaccination, it is also reasonable for society to offer benefits to those who suffer adverse consequences after vaccination. Harmful long-term consequences of vaccination are in fact extremely rare. In Australia, 5,128 adverse events after vaccination were reported to the Australian Adverse Drug Reactions Unit of the TGA between 2000 and 2004, but only seven of these persisted and resulted in sequelae. (The reporting of an adverse event at the time of vaccination establishes a timing association but not necessarily a causal connection.)<sup>55</sup> In the rare event of harmful long-term sequelae of vaccination, however, it is reasonable for society to offer compensation. Thus, for example, the 1986 US *National Childhood Vaccination Act* offers compensation to anyone who suffers long-term harm from federally-approved vaccines.<sup>56</sup> While such a system does not currently exist in Australia, it has been argued that Australia should have a compensation system.<sup>57</sup> It is to be hoped that some benefit will be offered to those who experience ongoing sequelae after vaccination through Australia's proposed National Disability Insurance Scheme.

... The Catholic Church ... calls for research and development of alternative, ethically acceptable vaccines.

In contrast to those who contribute to the common good through vaccination, those who do not vaccinate benefit from herd immunity without contributing to it. John Grabenstein reports that for this reason sociologists refer to those who do not vaccinate as "free-riders" or "free-loaders." He adds that "such behavior" is "inequitable and uncharitable." Further, "if enough people 'free-load,' then the community's collective immunity dissipates and disease outbreaks resume."<sup>58</sup>

There are limits to herd immunity. As we have noted above, overall herd immunity is weakened as the numbers of those who do not vaccinate grow. A further problem is the 'Clustering of exemptions.' This means that those who do not vaccinate often congregate together in the same reasonably small geographic area. As so many have not vaccinated in a small area, herd immunity

**N** will be particularly compromised in this region.

**F** The smallpox outbreak in Montreal in 1885 provides a particularly poignant historical example. During this outbreak of disease, three thousand of Montreal's inhabitants were killed in less than four months, and the city was quarantined from the rest of North America. Most of those who died, however, were Catholic French Canadians. Their co-religionists who were Irish Catholics who were not affected to the same degree, as these Irish were mostly accepting of vaccination. By contrast, there were at least three reasons why these French Canadians did not vaccinate. One was that vaccination was not a tradition within their French culture. A second was that this group were greatly influenced by a peculiar form of piety which tended to regard outbreaks of disease as the will of God and which therefore disapproved of efforts to control or prevent disease. A third cause was that these French Canadians rejected vaccination as a particularly English notion. In other words, their Anglophobia became vaccinophobia. While perhaps hesitant at first, Catholic clergy eventually began to advise their congregations to vaccinate. When the epidemic concluded in 1886, far too many innocent French Canadian children had died because of their parent's rejection of vaccination and because of the clustering of those who refused to vaccinate.<sup>59</sup>

More recent examples can also be offered. In the USA in 1994, a measles outbreak occurred in two Christian Science communities which did not routinely accept vaccination. One hundred and ninety students were infected. In 1978 and again in 1993, there were outbreaks of poliomyelitis in the Netherlands, with a further outbreak detected in a population which held similar beliefs in Canada. In 1991, there were 31 case of congenital rubella in the USA. However, whereas the risk of congenital rubella for the general US population was 0.006 per 1,000 births, it was 14 per thousand births amongst the Amish population which rejected vaccination.<sup>60</sup> Even when the issue is not religious beliefs, it can still be shown that low levels of immunisation increase the population's risk of disease. In the former Soviet Union from 1989 to 1994, as vaccination levels declined there was an increase in cases of diphtheria from 839 cases in 1989 to almost 50,000 cases and 1,700 deaths in 1994.<sup>61</sup>

Infectious agents do not respect borders, as can be seen by the importations of cases of polio into countries declared polio free. Further, just as an infectious agent can cross borders so too do individuals who are not vaccinated. While individuals are protected in Australia from many infectious diseases because of the high herd immunity, when these unvaccinated individuals travel this same protection cannot be guaranteed in many developing countries and even in some developed ones. Diseases which are now uncommon in Australia are still common in many other countries. Thus, children who were not vaccinated because of their parents' decision need to be informed of the choice that was made for them. Particularly if they travel overseas, they may be well advised to think again about vaccination.

## Conclusion

The Catholic Church does not dismiss the problem of ethically compromised vaccines. To the contrary, it calls for research and development of alternative, ethically acceptable vaccines. It also exhorts all people including parents to join in this call. However, until alternative vaccines are developed, it also accepts the use even of these ethically compromised vaccines in order to protect children, pregnant women, and the population as a whole from the risk of contracting serious disease. The teaching of the Catholic Church provides no support for the refusal of vaccination against serious disease, even if the only available vaccines are ethically compromised.

## ENDNOTES

<sup>1</sup> Seth Mnookin, *The Panic Virus: Fear, Myth and the Vaccination Debate* (Collingwood, Australia: Black Inc, 2011), 31-2. Prior to Jenner, variolation was practised as a means of inducing immunity to smallpox in those who had not suffered from the disease. Variolation consisted of a person being inoculated with the pus from a smallpox pock in the hope that the person would experience a mild form of smallpox and thus develop immunity to the disease. Lady Montagu brought this method from Turkey to England in 1721. It was adopted in Europe during the eighteenth century mainly by the aristocracy. However, variolation was dangerous. There was a 2%-3% death rate, and the occasional outbreak or transmission of other infections such as syphilis. The practice however became prevalent because its mortality rate was ten times lower than that experienced in naturally occurring cases of smallpox. For more on this, see Stefan Riedel, "Edward Jenner and the history of smallpox and vaccination," *Baylor University Medical Center Proceedings* 18 (2005): 21-23.

<sup>2</sup> *Ibid.*, 31-3.

<sup>3</sup> Peter B. McIntyre, Alison H. Williams, and Julie E. Leask, "Refusal of parents to vaccinate: dereliction of duty or legitimate personal choice?" *Medical Journal of Australia* 178, no. 4 (2003): 150-151.

<sup>4</sup> At the time of Pius VII's death, the *Zelanti* were conservative and rigid clerical defenders of Church orthodoxy who made up the majority of the then-Extraordinary Congregation for the Ecclesiastical Affairs of the Catholic World. In 1827, this Congregation reassumed its former name as the Congregation for Extraordinary Ecclesiastical Affairs. Its functions are now fulfilled by the Section for Relations with States within the Vatican Secretariat of State. For more on this, see "Roman Congregations," *New Advent*, <http://www.newadvent.org/cathen/13136a.htm>; and "The Secretariat of State," Holy See, [http://www.vatican.va/roman\\_curia/secretariat\\_state/documents/rc\\_seg-st\\_12101998\\_profile\\_en.html](http://www.vatican.va/roman_curia/secretariat_state/documents/rc_seg-st_12101998_profile_en.html)

<sup>5</sup> Nicholas Atkin and Frank Tallett, *Priests, Prelates & People: A History of European Catholicism since 1750* (New York: I.B. Tauris & Co., 2003), 86, 102.

<sup>6</sup> Richard A. McCormick, *Health and Medicine in the Catholic Tradition* (New York: Crossroad, 1987), 17.

<sup>7</sup> Donald J. Keefe, "Tracking a Footnote," *Fellowship of Catholic Scholars* 9, no. 4 (1986): 6-7 at 7. Keefe's article details how an unsourced footnote and unsubstantiated comments can lead to inaccuracies in the historical record. Atkin and Tallett suggest that Pope Leo XII left vaccination as an optional practice, and that some priests at the time did see it as interfering with the natural processes of the body. For this, see Atkin and Tallett, 103.

<sup>8</sup> Benedict XVI, "Address to a Group of Finance Ministers and International Leaders on the Occasion of the Launch of the Advance Market Commitment Initiative," 9 February 2007, Holy See, [http://www.vatican.va/holy\\_father/benedict\\_xvi/speeches/2007/february/documents/hf\\_ben-xvi\\_spe\\_20070209\\_advance-market\\_en.html](http://www.vatican.va/holy_father/benedict_xvi/speeches/2007/february/documents/hf_ben-xvi_spe_20070209_advance-market_en.html)

<sup>9</sup> Infectious agents can be viruses, bacteria, parasites, rickettsia, fungi, and prions (misfolded proteins which cause other proteins to become misfolded and thus cause disease). Not every individual is born with a fully functional immune system, so some individuals are more susceptible to an infectious disease than others and may also suffer more severe consequences.



<sup>10</sup> Centres for Disease Control and Prevention (CDCP), "How Vaccines Prevent Disease," CDCP, <http://www.cdc.gov/vaccines/vac-gen/howvpd.htm>

<sup>11</sup> Phycocolloid is a gelatinous substance produced by seaweed. It is not degraded by bacteria, unlike gelatine utilised in jelly. Voigt Global Distribution Inc, Section III, Agars, <http://www.vgdusa.com/Spreadsheets/bacto-agar.pdf>

<sup>12</sup> Georg Melmer, Gotthard Kunze, and Gerd Gellissen, "Recombinant Vaccine Production in Yeast," *BioPharm International* January 2008.

<sup>13</sup> Sanofi Pasteur, "Home Page," [http://www.sanofipasteur.com/sanofi-pasteur2/front/index.jsp?siteCode=SP\\_CORP](http://www.sanofipasteur.com/sanofi-pasteur2/front/index.jsp?siteCode=SP_CORP); GlaxoSmithKline, "Home Page," <http://www.gsk.com.au/default.aspx>; American Type Culture Collection, "Home Page," <http://www.atcc.org/>

<sup>14</sup> Barbara E. Eldred et al, "Vaccine components and constituents: responding to consumer concerns," *Medical Journal of Australia* 184, no. 4 (2006): 173. Note that not all cell lines are continuous, but that those used in ethically compromised vaccine production are continuous.

<sup>15</sup> Australian Government, "Overview of Vaccine Regulation and Safety Monitoring and Investigation into Adverse events Following 2010 Seasonal Influenza Vaccination in Young Children," Department of Health and Ageing, Therapeutic Good Administration, (8 October 2010), 3.

<sup>16</sup> Brynley Hull et al, "Immunisation Coverage Annual Report, 2007," *Communicable Diseases Bulletin* 33, no. 2 (2009): 186.

<sup>17</sup> World Health Organisation, Measles Initiative, World Health Organisation, [http://www.measlesinitiative.org/mi-files/Reports/Measles%20&%20Immunization/Measles/Epidemiology%20and%20Prevention%20of%20Vaccine%20Preventable%20Diseases\\_Pink%20Book.pdf](http://www.measlesinitiative.org/mi-files/Reports/Measles%20&%20Immunization/Measles/Epidemiology%20and%20Prevention%20of%20Vaccine%20Preventable%20Diseases_Pink%20Book.pdf), pg 158; World Health Organisation (WHO), Mass Measles Immunisation Campaigns, WHO, [http://www.who.int/immunization\\_safety/publications/aefi/en/AEFI\\_measles\\_campaigns.pdf](http://www.who.int/immunization_safety/publications/aefi/en/AEFI_measles_campaigns.pdf); pg 3.

<sup>18</sup> Eldred et al, 173.

<sup>19</sup> Editorial, *The Age*, 28 November 2011, p. 10.

<sup>20</sup> McIntyre, Williams, and Leask, 150.

<sup>21</sup> The National Institute for Medical Research is located in the United Kingdom. Wistar Institute is located on the campus of the University of Pennsylvania in Philadelphia. Abortion was illegal in the 1960s in America so the foetal tissue was supplied by the Karolinska Institute Medical School in Stockholm.

<sup>22</sup> Pontifical Academy for Life, "Moral Reflections on Vaccines Prepared from Cells Derived from Aborted Human Fetuses," *The National Catholic Bioethics Quarterly* 6, no. 3 (2006): 541-550 at 543. In his cover letter, the then-President of the Pontifical Academy for Life, then-Bishop (now Cardinal) Elio Sgreccia notes that the statement was approved by the Congregation for the Doctrine of the Faith. The statement is also available at Children of God for Life (CGL), <http://www.cogforlife.org/vaticanresponse.pdf>. The two records of the statement differ in that the third footnote in the NCBQ version is missing from the CGL version. As a result, all subsequent footnotes are numbered differently in the two versions of the statement.

<sup>23</sup> Rene Leiva, "A Brief History of Human Diploid Cell Strains," *The National Catholic Bioethic Quarterly* 6, no. 3 (2006): 443-451 at 445.

<sup>24</sup> Pontifical Academy for Life, 542; Leiva, 445.

<sup>25</sup> Stanley A. Plotkin, "The History of Rubella and Rubella Vaccination Leading to Elimination," *Clinical Infectious Diseases* 43, Suppl 3 (2006): S165-6; cf Leiva.

<sup>26</sup> Alexander R. Pruss, "Complicity, Fetal Tissue, and Vaccines," *The National Catholic Bioethics Quarterly* 6, no. 3 (2006): 461-470 at 465.

<sup>27</sup> Plotkin, S165-6.

<sup>28</sup> Pontifical Academy for Life.

<sup>29</sup> Russell E. Smith, "Formal and Material Cooperation," *Ethics & Medics* 20, no. 6 (June 1995): 1-2 at 1.

<sup>30</sup> Bernard Häring, *The Law of Christ*, trans. Edwin G. Kaiser (Cork: Mercier, 1963), 2:494-519 at 500.

<sup>31</sup> Pontifical Academy for Life, 545-546.

<sup>32</sup> Catholic Health Australia (CHA), *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* II.8.12, CHA, <http://www.cha.org.au/site.php?id=223>

<sup>33</sup> Code, II.8.13. <sup>34</sup> Code, II.8.16.

<sup>35</sup> Charles J. McFadden, *Medical Ethics*, 5<sup>th</sup> ed. (London: Burns & Oates, 1961), 336.

<sup>36</sup> *Ibid.*, 331, 334. <sup>37</sup> *Ibid.*, 332.

<sup>38</sup> John Paul II, *The Gospel of Life (Evangelium Vitae)*, #74, Holy See, [http://www.vatican.va/holy\\_father/john\\_paul\\_ii/encyclicals/documents/hf\\_jp-ii\\_enc\\_25031995\\_evangelium-vitae\\_en.html](http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html)

<sup>39</sup> Pontifical Academy for Life, 546. <sup>40</sup> *Ibid.*, 546.

<sup>41</sup> cf Congregation for the Doctrine of the Faith, *Instruction on Certain Bioethical Questions (Dignitas Personae)*, #35, Holy See, [http://www.vatican.va/roman\\_curia/congregations/cfaith/documents/rc\\_con\\_cfaith\\_doc\\_20081208\\_dignitas-personae\\_en.html](http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html)

<sup>42</sup> Pontifical Academy for Life, 547.

<sup>43</sup> *Ibid.*, 547-548. <sup>44</sup> *Ibid.*, 547-548. <sup>45</sup> *Ibid.*, 548.

<sup>46</sup> *Ibid.*, 548. This statement is also discussed in Fr Tad Pacholczyk, "The Morality of Vaccinating Our Children," (US) National Catholic Bioethics Center, <http://www.ncbcenter.org/Page.aspx?pid=251>. Fr Pacholczyk summarises the statement in this way: "[E]ven when a vaccine is made from aborted material, and when no other form of that vaccine exists, parents may indeed vaccinate their children. In fact, in many instances, parents should feel a strong obligation to do so, considering the gravity and severity of the diseases involved... [P]arents and others must vigorously and persistently apply pressure to pharmaceutical companies to reformulate their vaccines in [cell] lines from non-objectionable sources. If such alternatives already exist, parents should request that their doctors use those vaccines instead."

<sup>47</sup> Pontifical Academy for Life, 541-2; Plotkin, S166, S164.

<sup>48</sup> Pontifical Academy for Life, 548.

<sup>49</sup> *Ibid.*, 548. <sup>50</sup> *Ibid.*, 549.

<sup>51</sup> *Dignitatis Personae*, #35. This teaching is cited and explained in Fr John Flader, "Vaccines from abortions," *The Catholic Weekly* (Sydney), 8 May 2008, p. 12. Opus Dei priest Fr Flader concludes that "in this case the need to vaccinate children against potentially life-threatening illnesses would justify the use of vaccines obtained from aborted fetuses if no other vaccine is available." At the same time, however, "parents should tell their doctor or health insurer that they would prefer that the vaccines did not come from aborted fetuses." Corresponding Member of the Pontifical Academy for Life Fr John Fleming also quotes and explains this teaching in *Dignitas Personae Explained* (Ballan, VIC: Modotti Press, 2010), 69-71.

<sup>52</sup> For a thorough analysis of the history of this principle, see Joseph T. Mangan, "An Historical Analysis of the Principle of Double Effect," *Theological Studies* 10 (1949): 41-61.

<sup>53</sup> John D. Grabenstein, "Moral Considerations with Certain Viral Vaccines," *Christianity and Pharmacy* 2, no. 2 (1999): 3-6 at 4.

<sup>54</sup> For a useful diagrammatic explanation of herd immunity, see (US) National Institute of Allergy and Infectious Diseases (NIAID), "Community Immunity ('Herd' Immunity), NIAID, <http://www.niaid.nih.gov/topics/pages/communityimmunity.aspx>

<sup>55</sup> Nicholas Wood and David Isaacs, "Monitoring vaccine reactions in Australia," *Medical Journal of Australia* 184, no. 4 (2006): 150.

<sup>56</sup> Daniel P. Maher, "Vaccines, Abortion and Moral Coherence," *The National Catholic Bioethics Quarterly* 2, no. 1 (2002): 53.

<sup>57</sup> Heath A Kelly, Clare Looker and David Isaacs, "A no-fault compensation scheme for serious adverse events attributed to vaccination," *Medical Journal of Australia* 195, no. 1 (4 July 2011): 4-5.

<sup>58</sup> John D. Grabenstein, "The Value of Immunization for God's People," *National Catholic Bioethics Quarterly* 6, no. 3 (2006): 433-442 at 436-437.

<sup>59</sup> Michael Bliss, *The Making of Modern Medicine - The Turning Points in the Treatment of Disease* (Chicago: University of Chicago Press, 2011), 22-30.

<sup>60</sup> Morbidity and Mortality Weekly Report, "Rubella and Congenital Rubella Syndrome - United States, January 1, 1991 - May 7, 1994," 43, no.21 (June 03, 1994): 391,397-401, CDC, <http://www.cdc.gov/mmwr/preview/mmwrhtml/00031338.htm>

<sup>61</sup> Centre for Disease Control and Prevention, Basics and Common Questions: Some Common Misconceptions about vaccination and how to respond to them, Centre for Disease Control and Prevention, <http://www.cdc.gov/vaccines/vac-gen/6mishome.htm>

All on-line resources accessed 12 December 2011

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 Kerri Anne Brussen ✱

# Home or Away? A Choice for Catholic Healthcare

*Catholic health and aged care providers seeking new governance structures face a choice of embedding their ministry in either the local Church or the universal Church. This article asks how we view these ministries in the first place: in what sense are they truly 'ministries of the Church'?*

As the Australian Church prepared for the canonisation of St Mary of the Cross MacKillop in 2010, we quite properly reflected on her many virtues and on her achievements in the field of Catholic education. Among other things we discovered that St Mary chose to establish her new religious Order under Pontifical protection rather than succumb to the wishes of several diocesan bishops who would have preferred to exercise more personal and proximate governance of the Sisters' work in schools.

On delving deeper into her decision, two things become apparent. First, it seems it was not disregard for local ecclesial authority that motivated St Mary to plant her Order in the universal rather than the local Church, but a profound desire to keep her fledgling community intact as demand for its ministry grew across the nation.<sup>1</sup> And second, the bishops' desire to control Catholic schools in their dioceses is probably understandable, given that Catholic education is so closely identified with the core mission of the Church. Indeed, the 1983 *Code of Canon Law* recognises it as one of the principal ways in which the Church fulfils its teaching office.<sup>2</sup>

But other areas of ministry such as health and aged care, which are no less important in the mission of the Church, do not seem to enjoy the same clearly defined place.<sup>3</sup>

All Catholic health and aged care providers in Australia today are having to deal with two major factors impacting their ministry: tighter and more regulated corporate operating environments, and new internal governance structures as their former sponsors, usually religious orders, themselves adapt to new configurations. All providers are asking the same fundamental questions: how do we continue the ministry of our founders? where are the areas of need today? what is our mission in the twenty-first century? There is also the identity question, a subject of much study and discussion today and no doubt into the future: what does 'being Catholic' actually mean in practice for a health or aged care organisation in these new environments? And perhaps most difficult of all: how does one measure 'Catholic identity'?<sup>4</sup>

These questions are of immediate practical concern to everyone seeking to promote Catholic health and aged care anywhere in the world. It is now just one year since the Bishop of Phoenix, Arizona (USA), removed the right of St Joseph's Hospital in his diocese to call itself Catholic.<sup>5</sup> That case prompted much discussion about clinical ethical dilemmas in health care, but it also drew attention to a core feature of the present and future life of every Catholic health and aged care facility: its relation with the local Church.

Obviously one cannot speculate about any ministry's 'Catholic identity' without referring to the Church itself,

but which instance of Church should be our primary reference point: the universal Church or the local Church? Should we differentiate at all? This question has great significance for health and aged care ministries negotiating the transition from religious to lay leadership, and in particular to the new lay-led 'public juridical persons' (PJPs) which represent both new challenges and new opportunities for the local Church and bishop.

Religious congregations and the emerging lay-led structures are both PJPs, of course, but the *Code of Canon Law* has much more to say about the former than the latter. The *Code* provides a template for religious orders and congregations and for the ministries managed by them, and the Church as a whole is more familiar with the 'religious order' model in ministry. One characteristic of the 'religious order' model is that the governance, management and conduct of their various ministries may rest in the very same hands. This very flexible arrangement not only allows each congregation continually and quickly to seek the 'best fit' between ministry demand and capacity, it also provides a single point of contact with all levels of the governance structure. That accessibility, and the guidance of the *Code*, gives the local Church and bishop a certain confidence in dealing with 'religious order' ministries and their governance.

The new PJPs are not such familiar territory for the local Church.<sup>6</sup> The governance, management and conduct of lay-led PJP ministries can rest in three very different sets of hands reflecting the demands of the contemporary corporate environment in which they operate. These new structures represent a new challenge for the bishop: with which level of governance or management should he deal? Even more fundamentally, what is his role in these ministries and their governance?

Neil Ormerod notes that while 'lay' leaders today bring a great deal of corporate wisdom and experience to the governance table, they often lack the established ecclesial formation of religious congregational leadership.<sup>7</sup> It is not surprising therefore that lay leaders often work out of a very different 'sense of church' than that of the local bishop who tends to be, by training and definition, a 'church man' bound to canonical ways which, among other things, seek to define precisely the role of the bishop in relation to Catholic structures in his diocese. But the *Code of Canon Law* gives little detail on the bishop's role in relation to the emerging new corporate structures.

For example, in his ecclesial role the bishop is central to many ministry decisions, including those having major financial implications. In these matters his role approximates that of an executive director. But health and

aged care ministries today necessarily operate in a highly regulated civil corporate environment in which the role of an executive director is particularly onerous (as demonstrated in the Federal Court's recent decision which held individual directors responsible for financial governance of the Centro property group).<sup>8</sup> Given the sheer complexity of this model of corporate governance and the potential to expose a diocese to financial risk, it is not surprising that few bishops today are willing to take on a director's role (or its equivalent) in health and aged care.

So what is the local Church and bishop's relationship to the emerging governance models in Catholic health and aged care ministry? An ecclesiological argument grounded in the notion of 'sacrament' suggests some intriguing possibilities.

Every particular Church (such as a diocese) shares in the nature and mission of the universal Church.<sup>9</sup> Because the universal Church is sacramental in nature, the mission of the local Church is to make present and active the love of God made visible in Christ.<sup>10</sup> This mission is shared by all parts of the local Church including parishes, schools, health and aged care facilities and welfare providers, each in ways in keeping with their particular ministry, because all share something of the Church's own character of 'sacrament'.

In the field of health and aged care, the local Church in the past has fulfilled its mission through ministries established and run by religious congregations. But notice a subtle shift in emphasis today. Older ecclesiologies were comfortable with the idea that a hospital was 'a ministry of the religious order' from which the local Church drew benefit. In this 'sacramental ecclesiology,' the hospital is viewed as 'a ministry of the Church' which may originally have been established and run on the Church's behalf by the religious order and is now run, still on the Church's behalf, by a lay-led PJP.

The shift is not in actual legal or canonical ownership, of course, but in what might be called 'psychological ownership': a sense of being responsible for and taking pride in a particular ministry. 'Psychological ownership' of a ministry can extend to individuals who are able to play no active role in that ministry other than to support it indirectly, for example through prayer or by financial contribution. Examples already exist in every parish: Catholic people routinely provide financial support for the work of Catholic organisations such as the St Vincent de Paul Society and Caritas, and such support enables parishioners - including those who are unable to play any direct role in these ministries - to take a sense of pride in and 'ownership' of their work.

In health and aged care ministries in the past, 'psychological ownership' naturally rested with the religious order which was also the actual canonical 'owner' and operator of those ministries, and it is not difficult to imagine the new lay-led PJPs inheriting both kinds of ownership. But in a sacramental ecclesiology which conceives of ministries in relation to the nature of the Church as sacrament (rather than in relation to the

charism of a particular religious order), a sense of 'psychological ownership' could quite properly be engendered not only in individual Catholics but also in the whole particular Church.

This opens up an intriguing opportunity which strengthens the argument for embedding a PJP in the local rather than the universal Church. It is entirely possible for the canonical ownership of a ministry to rest in one place while psychological ownership rests in another. But how much more meaningful would it be if the ministry is fully grounded in the very same ecclesial community whose members can say, "This health care facility is *our* Church, *our* Catholic community, fulfilling *our* mission in the world."

Every Catholic health or aged care provider today must answer the question, 'why are we in this business in the first place'? Utilitarian answers (such as 'to care for the poor') are helpful but insufficient if they locate the rationale of Catholic health care in outcomes alone; and in any event, if Catholic hospitals were once necessary to provide health care for the poor, Australia's excellent system of universal health cover now meets most of this need. But in addition to outcomes, and indeed prior to them, Catholic health care finds its rationale in the identity of the ecclesial community that provides it. To put it simply: we are engaged in providing health and aged care because it is the very nature of our Catholic Christian community to care for the sick and the ageing. So in *Deus caritas est* Pope Benedict XVI identifies practical love (*caritas*, the service of charity) as "a responsibility for each individual member of the faithful, but it is also a responsibility for the entire ecclesial community at every level: from the local community to the particular Church and to the Church universal. . . . For the Church, charity is not a kind of welfare activity which could equally well be left to others, but is a part of her nature, an indispensable expression of her very being."<sup>11</sup>

The dynamism of health and aged care ministries comes only partly from the needs of those who are sick and ageing. It comes in larger part from our own identity as Church: it is our mission, it is of our very nature and identity, to make the love of God in Christ visible and active in the world. It is not surprising that many Catholic health and aged care providers take as their own the words of St Paul, 'the love of Christ urges us'.<sup>12</sup> It is Christ's love for the sick that we the Church extend to the present day; it is *our* care for the sick and ageing that makes Christ's love visible and effective.

Where in the Church should we embed health and aged care ministries and the PJPs that govern them? This is more than a question of canonical ownership - it is a fundamental question of authenticity. When Catholics say 'this is a ministry of the Church', do we want them to mean 'this is *our* ministry'? If so, how should we arrange things to promote this sense of ownership?

Part of the answer lies in simply helping Catholic people become more aware of the extraordinary work done in our health and aged care facilities, and of the ways in

which every Catholic person can support these ministries. A strategic program of informing parishes and individual Catholics will not only uncover new resources and dynamism for these ministries but also promote a greater sense of pride in them. And both psychologically and ecclesiologically, I suggest, embedding the governance structures of these ministries in the local Catholic community will help to engender a sense of local ownership of them.

What might be required to bring this about? Good will from all parties, health care providers and bishops alike; the patience to create appropriate PJP structures; intentional building of trust between ecclesial and corporate leadership; and measures to help the local Church realise that it is, indeed, fulfilling Christ's command to care for the sick through its health and aged care ministries.

#### ENDNOTES

<sup>1</sup> For an account of the life and work of St Mary MacKillop, see <http://www.marymackillop.org.au/index.cfm>

<sup>2</sup> Book III of the 1983 *Code of Canon Law* ("The Teaching Office of the Church") ranks "Catholic Education" (canons 793-821) alongside "The Ministry of the Divine Word" (canons 756-780), "The Missionary Activity of the Church" (canons 781-792), and "The Profession of Faith" (canon 833). For the *Code*, see *Code of Canon Law*, Holy See, [http://www.vatican.va/archive/ENG1104/\\_INDEX.HTM](http://www.vatican.va/archive/ENG1104/_INDEX.HTM)

<sup>3</sup> I am indebted to Mons. Brian Lucas, General Secretary of the Australian Catholic Bishops Conference, for drawing my attention to this point.

<sup>4</sup> See, for example, Neil Ormerod, "Identity and Mission in Catholic Organisations," *Australasian Catholic Record* 87 (2010): 430-439.

<sup>5</sup> "Phoenix bishop removes hospital's Catholic status," *National Catholic Reporter*, 21 December 2010. Online at <http://ncronline.org/news/phoenix-bishop-removes-hospitals-catholic-status>

<sup>6</sup> For an excellent summary of PJPs, see Ian Waters, "Public juridical persons within the Church," *Church Matters* 2: 6-8; and Bill d'Apice, "Civil law issues in establishing new public juridical persons," *Church Matters* 2: 3-4. Both online at Makinson and d'Apice, <http://>

[www.makdap.com.au/docs/charity/publication/Church%20Matters%20-%20issue%202021.pdf](http://www.makdap.com.au/docs/charity/publication/Church%20Matters%20-%20issue%202021.pdf)

<sup>7</sup> Ormerod, 430.

<sup>8</sup> On the Centro decision, see Leonie Wood, "Centro loses landmark decision," *Sydney Morning Herald* 28 June 2011, <http://www.smh.com.au/business/centro-loses-landmark-decision-20110627-1gnpm.html>; and for commentary "The Centre Case: Directors' Duties for Financial Statement," Finlaysons, [http://www.finlaysons.com.au/news/documents/Alert-201107-The\\_Centro\\_Decision.pdf](http://www.finlaysons.com.au/news/documents/Alert-201107-The_Centro_Decision.pdf)

<sup>9</sup> See Canon 369, *Code of Canon Law*.

<sup>10</sup> See Vatican Council II, *Gaudium et Spes (Pastoral Constitution on the Church in the Modern World)*, #21: "[It] is the function of the Church, led by the Holy Spirit who renews and purifies her ceaselessly, to make God the Father and His incarnate Son present and in a sense visible"; and the *Catechism of the Catholic Church*, #738: "Thus the Church's mission is not an addition to that of Christ and the Holy Spirit, but is its sacrament: in her whole being and in all her members, the Church is sent to announce, bear witness, make present and spread the mystery of the communion of the Holy Trinity." For these documents, see *Gaudium et Spes*, Holy See, [http://www.vatican.va/archive/hist\\_councils/ii\\_vatican\\_council/documents/vat-ii\\_const\\_19651207\\_gaudium-et-spes\\_en.html](http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html); and *Catechism of the Catholic Church*, Holy See, [http://www.vatican.va/archive/ENG0015/\\_INDEX.HTM](http://www.vatican.va/archive/ENG0015/_INDEX.HTM)

<sup>11</sup> Pope Benedict XVI, *Deus Caritas Est (On Christian Love)*, #20 & 25, Holy See, [http://www.vatican.va/holy\\_father/benedict\\_xvi/encyclicals/documents/hf\\_ben-xvi\\_enc\\_20051225\\_deus-caritas-est\\_en.html](http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est_en.html). Benedict recognises that the ministry of charity is as essential to the Church as are proclaiming the Word of God and celebrating the sacraments: "The Church's deepest nature is expressed in her three-fold responsibility: of proclaiming the word of God (*kerygma-martyria*), celebrating the sacraments (*leitourgia*), and exercising the ministry of charity (*diakonia*). These duties presuppose each other and are inseparable." (#25)

<sup>12</sup> II Corinthians 5:14. The phrase 'the love of Christ' (*ἀγάπη του Χριστου*, *agapē tou Christou*) is often taken to mean 'the love we have for Christ,' but an alternative reading possibly sits more comfortably with its context: it is Christ's love for us that drives us on.

All on-line resources accessed 2 December 2011

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