



Chisholm Health Ethics Bulletin

Drawing on thorough research, the best of human insight and the strengths of Catholic teaching, we offer an ethical vision to inform modern health care. We strive to guide our readers to greater knowledge and deeper understanding about issues in health care, and to assist all people in their search for insight and wisdom.

In this issue

Reflections After a Lifetime of
Contribution

Cormac Nagle OFM

Medicine as Ministry: A case for truly
theological bioethics

Joseph Parkinson

An Appointment with 'Doctor Google':
Benefits and limitations of using
Internet-based health information

Emanuel Nicolas Cortes Simonet

Zika Virus

Dilinie Herbert

In this issue

Welcome to the *Chisholm Health Ethics Bulletin*. There are four articles in this Bulletin.

The first article is by Fr Cormac Nagle OFM. At the 2015 Catholic Health Australia (CHA) national conference, Fr Cormac received CHA's highest honour, the Maria Cunningham Lifetime Contribution Award. After receiving that award, in this article he reflects on his years of ministry. He insists that Catholic ethical standards should always be interpreted so that they reveal rather than obscure the Good News which Christianity proclaims. He also calls for holistic care which attends not just to our physical health, but also to our emotional, social and spiritual needs.

The next article is by Centre researcher Emanuel Nicolas Cortes Simonet. Many people nowadays seek health information from the internet. Nicolas cautions against using the internet to self-diagnose, for attempts to do so are notoriously inaccurate and unreliable. On the other hand, using the internet to learn more about our health conditions can enhance the therapeutic relationship with our health professionals and improve our health outcomes. Health professionals have a new role to direct their patients to reliable internet sources, and to assist them in understanding and interpreting web-based health information.

The third article is by Fr Joseph Parkinson from the L. J. Goody Bioethics Centre in Perth. Fr Joe reviews a very fine book, *Medicine as Ministry* by ethicist and medical doctor

Margaret E. Mohrmann. Both Mohrmann's book and Joe's article call for a bioethics which is truly theological. This cannot deal merely with philosophical abstractions: instead, it must engage (as God does) respectfully, thoughtfully and lovingly with each unique individual person. Its purpose is less to guide them in making right decisions about their healthcare, and much more to assist them as they search for meaning in the face of suffering.

The final article in this Bulletin is by Centre researcher Dr Dilinie Herbert, who reports on the Zika virus. Dilinie explores the spread of the Zika virus, and the mounting but still inconclusive evidence that it is related to both increased fetal deaths and increased birth defects including microcephaly and eye problems. Dilinie also analyses recommendations for managing the Zika virus. These include public health measures to contain the spread of the virus, and guidelines for the management of pregnancies when there may have been Zika infection.

The Centre's 2016 one-day conference addresses 'The Challenges of Dementia.' Above all, it will explore how we are meeting the challenges of creating dementia-friendly communities, and providing better services for people with dementia in hospitals, community care, and residential aged care. It will be held on Wednesday 14 September 2016 at the Catholic Leadership Centre in East Melbourne. Please mark this date in your diary.

Kevin McGovern ✕

About the Caroline Chisholm Centre for Health Ethics

The Caroline Chisholm Centre for Health Ethics is a Catholic bioethics centre:

- We research and publish about health care issues.
- We provide education and training about health ethics to health professionals and the general community.
- Over the phone or face to face, we assist without discrimination any person who seeks help in making decisions about health care.
- We contribute to community discussion and debate by making public comments about important matters related to health care.
- We also assist health care institutions in the development of policies, protocols and procedures, particular in areas which might be ethically contentious.

Catholic bioethics is based upon both faith and reason. "Faith and reason," Pope John Paul II once wrote, "are like two wings on which the human spirit rises to the contemplation of truth." (John Paul II, *Fides et Ratio*) Thus, the long Catholic tradition contains much reasoned reflection on human experience – reflection which has discerned a natural ethic which is sometimes called the natural law. However, the Catholic tradition also contains much reflection on the wisdom which is found in what the Church recognises as divine revelation. This includes the Bible and above all the example of Jesus

Christ. Noting that Jesus healed the sick, for example, many Catholic health and aged care services proudly proclaim that they are continuing the healing mission of Jesus.

Above all, faith and reason reveal the inherent dignity of each and every human being, no matter how sick, aged, frail or disabled we may be. In the Bible, the book of Genesis records that God created human beings "in the image of God." (Gen 1:27) In the Catholic tradition, it is this *imago Dei* – the image of God which is present in every human being – which is the ultimate foundation of human dignity.

From this starting point, Catholic bioethics contributes to moral discourse in every stage of the life continuum from conception to natural death. This Catholic perspective strives to be holistic and to take into consideration all the needs of the individual – physical, emotional, psychological, social, and spiritual. The Catholic approach to care is marked by great emphasis on the importance of pastoral and spiritual care.

Catholic bioethics makes a significant contribution to the moral debates in our society that are critical in this age of advancing technology. It reminds us of our meaning and purpose in life, and guides us towards its fulfilment, not just as individuals but as people in community.

Reflections After a Lifetime of Contribution

At the 2015 national conference of Catholic Health Australia (CHA), Fr Cormac Nagle OFM was awarded CHA's highest honour, the Maria Cunningham Lifetime Contribution Award. After receiving this award, Fr Cormac reflected on his years of ministry at the Chisholm Centre's 2015 Annual General Meeting. We are pleased to present a slightly edited version of his speech here. Fr Cormac reminds us that Catholic health and aged care follows in the footsteps of Jesus Christ, and that both our service and our ethics are based on a profound respect for human dignity. He advises how our ethical standards should always be interpreted so that they reveal rather than obscure the Good News which Christianity proclaims. Fr Cormac also highlights the need for a holistic and multidisciplinary approach to healthcare. Rather than treating only physical or medical problems, this holistic approach cares for the whole person and also attends to their emotional, social and spiritual needs.

Thank you for the invitation. It is good to catch up with the Caroline Chisholm Centre again, and with many of the people I worked with on the Centre's Board where I was a Member for a number of years. It's good to be back.

Many people now quote Pope Francis. What he says is often most relevant. When Pope Francis was in Cuba, he said to the people, "Love and service, not ideology, are the keys to happiness."¹

I have been asked to reflect on three topics:

- i. my experience in Catholic health and aged care;
- ii. changes which I have observed over my years of ministry; and
- iii. my advice to those who now have responsibility for Catholic health and aged care.

My experience in Catholic health and aged care

My experience goes back a long way. When I was teaching at Padua College in Brisbane in my early years of ordination, I would serve as chaplain on the weekends at the Mater Hospital, a very big hospital looking after everyone from children to aged care and the end of life. In those days, the sisters in charge of the wards were Sisters of Mercy, and the nurses working on the wards were also Sisters of Mercy. You can imagine that I didn't have much rest. When someone was very sick, I was called straightaway. And whether the sick person really realised what was going on or not, I was told to anoint this one, and anoint that one, and so on. No one escaped the administration of the sacraments!

Years later, when I returned from postgraduate studies in Rome, I was chaplain to the Royal Women's Hospital in Paddington in Sydney. It was a manifestly different experience. The matron who wasn't very friendly might

make you wait for twenty minutes or half an hour before she would let you into a ward to see the Catholic patients. At this hospital, we had to baptise very sick babies. I'd go in with an eye dropper full of sterile water, and I was told always, "Don't touch the baby!" I'd baptise them with the eyedropper of sterile water. One situation I recall very vividly. I was called one morning to the hospital: a baby was dying, and they wanted me to come and baptise the baby. I went to the ward and said, "Well, where is the baby?" "It's here," they said, and they led me to a back room, and just on a bench there was the baby—full term, dying. There was no else around to give the baby comfort. The doctor said, "It's missing some organs or something. They want you to baptise it." It was awful—just on a bench in a back room. It's so different from what we do at Mercy Hospital for Women, at St Vincent's, and other hospitals. That case remains with me. You can't forget such situations.

In the mid-1970s, I was asked to teach medical ethics to the midwives at the new Mercy Maternity Hospital at East Melbourne.² That was my first venture into teaching in a hospital. It was interesting, but it wasn't always easy because just a couple of years earlier the papal encyclical on contraception had come out, and of course we had lots of questions about sterilisation and contraception. There were many difficult questions, also because of the new technologies that were coming in. At that stage, we had a good ethics team. There was Fr Walter Black MSC, Fr Bill Daniel SJ, Mr James Gobbo who became the Governor of Victoria, Dr James Breheny, and Mr Barham who was a surgeon at Mercy Hospital. It was a good team because we had the medical side, the philosophical side, and the religious ethics side. There was a large auditorium at the hospital, and we held sessions there for the staff of the Mercy and also for Catholic health institutions around Victoria. (The Chisholm Centre hadn't come into existence then.) These were good education programmes, but we did get some flak because there are always both sides of the coin, with those who want to stick with what was traditional and what was always done in the past, and those who want to move on and take advantage of new

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thought and new technologies. I was going through some files the other day, and I came across a letter from Archbishop Little who was the archbishop of the time. He was there for one of our bigger conventions, and afterwards he got some flak about what was said at the convention. He wrote to me and said, "I want to thank you for what you and your team are doing." It was good for me to receive this after he had received some negative opinions about what was said. I think we could say that the

Chisholm Centre has taken over that early role in trying to provide instruction, education and formation to Catholic health professionals in Melbourne and Victoria.

In this period, I was also the chaplain of the Catholic Nurses Association of Australia. We had regular ethics meetings where we talked about moral theology and so forth. Again, after one general meeting where Archbishop Little was present, he came up to me afterwards to say, "Keep on doing what you're doing." It was a good positive push to keep moving forward.

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During this time, a group of us from this Association went to Rome for an international conference for Catholic nurses. There were a lot of nurses who went. (We were quite a large group.) During the conference, we decided to go to visit St Peter's. So off we went, and we got to the entry there. One of the younger nurses had a shorter dress than any of the others, and the Swiss Guard said that this wasn't appropriate and that she couldn't go into St Peter's with that short dress. We didn't know what to do, but the guard produced a knife and asked the nurse to cut the stitching on the hem of her dress. And those extra few inches were enough to allow us all to go in!

I was reminded of this about a month ago at a funeral when I saw a woman and said to her, "I know you." She said, "I know you too. I was the nurse!"

Much later, after a postdoctoral sabbatical at Catholic University in Washington, I was appointed to fifteen years in administration. After I finished with administration, I went to Berkeley to do bioethics, because I knew that that's what I'd be doing when I came back to Australia. So I returned to the Mercy in the early 1990s as a member of the ethics and research ethics committees, and then in 1993 as the Mercy ethicist. At that time, St Vincent's asked me to take on two days a week as chaplain. This practical experience was important, I found, for a realistic approach to ethics. I worked at St Vincent's on Fridays and Saturdays. And you can imagine what the emergency department was like on Friday nights and Saturday nights at St Vincent's Hospital.

Another little story from then: I was called up one night to the emergency department; a man from Fitzroy had been stabbed in the neck by his wife. She had done a very good job—she got him in the jugular, and in the operating theatre they couldn't stop the bleeding. So I was sitting in the corner waiting, and the doctors were working trying to stop the bleeding. The one in charge came over and said,

"Father, you'd better come over and do your bit, because we're not getting anywhere here." So I went over and I anointed the man and said the prayers, and then went over to my corner again. The surgeon came back and said, "We don't know what you did, Father, but it worked!"

Sadly, the man died later the next night, and his wife was charged with murder.

My experience of Catholic healthcare over this long period has been a most positive one. In the past, we had some good moralists writing and teaching Catholic medical ethics. However, they were burdened with the approach of those days, which was in general one of mainly explaining and interpreting the Church's decrees and instructions. There wasn't much room for innovation. This is where ethics committees and research ethics committees helped to change the attitude for they were dealing with real situations—sometimes new situations but always real situations. It should be noted here that in general our Catholic institutions are the ones that have ethics committees. Ethics committees are a rarity in other health institutions and in other public hospitals around this city. It is through the imaginative and academic work of the members of these bodies that I believe we have produced an ethical framework that is also respected outside the Church, even though people might have different opinions. The *Code of Ethical Standards* is a good example of this ethical framework. The solid research of the Chisholm Centre, its publications and its public seminars and conferences, along with the work of Catholic Health Australia with its various ethics and education committees and publications have helped to bring Catholic healthcare to a high standard, both of ethics and medical care.

Changes over my years of ministry

A great catalyst for change has been the renewal of Catholic moral theology in general. With the Council of Trent (1545–1563), moral theology became separated from theology in general. A more legalistic attitude took over. Catholic ethics tended to be more a science applying the norms stated by authority, rather than a question of faith seeking understanding. There was little room for creativity, although some of the traditional principles remained in force, such as 'probabilism', which allowed people to follow the less strict opinion provided a good number of reputable theologians held that opinion, and the Church authority had not outlawed it. A change came about— theoretically at least—with the Second Vatican Council, which stated that moral theology was to be thoroughly renewed.³ However, the brakes were kept on until more recently: renewal took place amongst theologians, but not really amongst church bureaucracy.

As mentioned above, theologians and ethicists have continued to study and advance their knowledge of the practice of Catholic clinical ethics. For example, today we have some excellent protocols or guidelines for Advance Care Planning, for Palliative Care, for the withdrawal of

treatment where it is considered extraordinary or disproportionate, for surrogacy, and so on. Our goal is to treat the whole person and not just the disease. The importance of acknowledging and treating the spiritual and psychological needs of the patient is now taken for granted, and certainly accepted as normal in Catholic ethics and the Catholic ethos.

One of the most obvious changes in Catholic health institutions today is the almost complete absence of vowed religious. This is so different from when I began in Brisbane so many years ago. Lay people run and serve in our institutions; perhaps 25% are Catholic, at least nominally so. The leaders are normally formed in a business ethic. Therefore, our most important task, I believe, if our institutions are to remain Catholic and imbued with Gospel values, is to educate and form our staff in those same Catholic values.

Many of our staff prefer to work in our institutions because of the moral and Christian atmosphere. They are prepared to follow our rules and norms as they would in any business to which they belonged. These people are also looking for the reasons upon which our teachings are based. Education with open discussion is not only important but, I believe, it's a right that our staff have, and a duty for us to give them that education and formation. It is a great challenge to you who are now the leaders today and will be the leaders tomorrow.

Advice to those who are now responsible for Catholic health and aged care

I don't know whether I should give you advice. Anyhow, I've been asked to give you advice.

The main point is that we need to remember that we are following the footsteps of Jesus Christ and offering what he offered in the Gospels. That is our primary ethical stance (not forgetting of course the best of medical and technical service). This is the reality, and it will influence our attitude and our decisions.

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With the mention of decisions, I think it's important for all of us that once we have made a decision in good faith and conscience, we accept that decision and live with it, knowing that it might not be perfect and that new information may come in the future. But we've made a decision with the best information we have and according to our conscience. We live with that, and we don't regret or live with guilt, knowing that this was the best human decision we could possibly make at this particular time.

Of course, our decisions have to be informed—informed by the Scriptures, by the teaching and tradition of the Church, as well as by culture, our civil society, and science, and guided by the wisdom of the Spirit of God.

There are two extremes. On the one hand there is pure relativism—a no norms, no rules approach, and on the other a legalistic approach. Neither of these—pure relativism or a purely utilitarian approach, nor a strictly legalistic approach—are either wise or worthy of the human person. (It is not necessary for me to dwell here on the utilitarian approach: that is pretty commonly understood.) However, I'd like to speak a little bit about our approach, our ethics, our moral theology.

The laws and rules of the Church ... need to be constantly mediated by ... the rules of interpretation as found in the Church's tradition ... so that the rules do not obscure the basic teaching of the Gospel...

As I mentioned, our moral theology has been much influenced by the legal approach in the period between the Council of Trent and the Second Vatican Council. We have norms and laws, but they need to be interpreted by the wise maxims handed down by Jesus himself. (For example, one of the great maxims of Jesus was, "The Sabbath was made for humankind, and not humankind for the Sabbath."⁴) We must also draw upon the ways of interpretation given to us by the tradition of the Church and by our canon law.

Fundamentally, we base our ethics on the dignity of the human person integrally considered—that is, someone created by God for life with God in his or her physical, moral, emotional, spiritual and psychological being.⁵ The laws and rules of the Church—as interpreted by, say, the *Code of Ethical Standards*—are very important guidelines, but they too need to be constantly mediated by the long tradition of the Church, and the rules of interpretation as found in the Church's tradition and in the canon law of the Church, so that the rules do not obscure the basic teaching of the Gospel.

We get a glimpse of the Church's tradition on interpreting doctrine and law in a Declaration *Mysterium Ecclesiae* (*The Mystery of the Church*) from the Congregation for the Doctrine of the Faith. This declaration states clearly that the meaning of pronouncements depends upon the expressive power of language—sometimes incompletely stated, on the historical period, and on the changeable conceptions of a given epoch and its culture. Often, pronouncements are intended to solve certain questions or correct errors of that particular time. So this Declaration says that we must take all these things into account before we apply a norm or a rule or even a doctrine.⁶

Consider another very wise rule. It's a rule from Roman law originally, but the Church has taken it up in canon law. In Latin, it states: *Summum ius, summa iniuria*. This translates: If you pursue the law to its limits, you will bring about the greatest injury or injustice.

There's also the ancient principle of *epikeia* (in Greek) or *epiky* (in English). This states that no law enunciated in human terms can ever possibly cover every possible human situation.

...make sure that the meetings of various departments in our health institutions ... are multidisciplinary... This ensures that the whole person and their social and psychological and spiritual needs are considered, and not only their medical problem...

Also, the last canon of the *Code of Canon Law* reminds us to observe always "canonical equity" or balance, keeping in mind "the salvation of souls, which must always be the supreme law in the Church."⁷

The Victorian Department of Health and Human Services recently initiated a programme whereby they sent out to health institutions members of their bureaucracy to see what actually happens at the coalface. It was my privilege to mentor one of these staff, and to show her what we did in a Catholic hospital and our ethics and so forth. It was a very good decision of the Department. We need regular interface with the human situations to be able to offer human decisions.

Another important procedure is to make sure that the meetings of various departments in our health institutions (e.g. neonatal intensive care, oncology, and so on) are multidisciplinary, including not only clinical staff but also allied staff, social workers, ethics and pastoral care. This ensures that the whole person and their social and psychological and spiritual needs are considered, and not only their medical problem. Their medical problem will certainly be treated better if we treat them within this fuller context.

Those we work with and those we meet and treat may not accept our religious norms as such, even though they respect them. However, others will respect us and our Catholic ethos if we are authentic ourselves, for people sense who we are at heart. If we believe in ourselves and believe in what we propose, we will do a lot to preserve our precious Catholic approach to healthcare. It's good to remember that there were no general hospitals in the world until the early Christians in Roman times began to look after the poor and the sick. The Romans had hospitals for their wounded soldiers, but there was no one to look after the ordinary people until the early Christians began that. In the same way, the first public hospital in Australia

was St Vincent's in Sydney. We need to remember that our ethos—our Gospel teaching—has done a lot for hospital care for the general people and their health throughout the world and in this country too. In doing this, we answer the call of Pope Francis to love and service. We are authentic so that what people see is what they get. As a Franciscan, I'd like also to quote St Francis of Assisi, who told us that "what you are before God, that you are and no more."

ENDNOTES

¹ Cindy Wooden, "Serve people, not ideology, pope tells Cubans at Havana Mass," 20 September 2015, Catholic News Service, <http://www.catholicnews.com/services/englishnews/2015/serve-people-not-ideology-pope-tells-cubans-at-havana-mass.cfm>. Pope Francis made this point in his homily at the Mass celebrated in the Plaza de la Revolución in Havana on 20 September 2015. He insisted that "service is never ideological, for we do not serve ideas, we serve people." He continued, "Care for and be at the service of the frailty of your brothers and sisters. Do not neglect them for plans which can be seductive, but are unconcerned about the face of the person beside you." For this homily, see Pope Francis, "Homily at the Plaza de la Revolución, Havana," Holy See, http://w2.vatican.va/content/francesco/en/homilies/2015/documents/papa-francesco_20150920_cuba-omelia-la-habana.html.

² The building at 150 Clarendon Street, East Melbourne is now an apartment complex. This speech was delivered at a restaurant in this complex.

³ Vatican Council II, *Optatam Totius*, Decree on the Training of Priests, 28 October 1965, n. 16, Holy See, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decree_19651028_optatam-totius_en.html.

⁴ Mark 2:27(New Revised Standard Version); cf Matthew 12:1-8, Luke 6:1-5.

⁵ Moving away from the natural law approach of the manuals of moral theology, the Second Vatican Council insisted that the determination of matters of morality should be "based on the nature of the human person and his (sic) acts." Drawing on both this and the official commentary about it, Louis Janssens stated that the basis of Catholic morality must be "the human person integrally and adequately considered." The Second Vatican Council also stated, "[I]t remains each man's [sic] duty to retain an understanding of the whole human person in which the values of intellect, will, conscience, and fraternity are pre-eminent. These values are all rooted in God the Creator and have been wonderfully restored and elevated in Christ." For these, see Vatican Council II, *Gaudium et Spes*, Pastoral Constitution on the Church in the Modern World, 7 December 1965, nos. 51, 61; Louis Janssens, "Artificial Insemination: Ethical Considerations," *Louvain Studies* 8 (1980): 3-29; cf Benedict XVI, *Deus Caritas Est*, Encyclical Letter (25 December 2005), nos. 4-5.

⁶ Congregation for the Doctrine of the Faith, *Mysterium Ecclesiae*, Declaration, 24 June 1973, n. 5, Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19730705_mysterium-ecclesiae_en.html. The Declaration states that "the meaning of the pronouncements of faith depends partly upon the expressive power of the language used at a certain point in time and in particular circumstances." It also notes that "it sometimes happens that some dogmatic truth is first expressed incompletely (but not falsely)." It adds that "when the Church makes new pronouncements... she usually has the intention of solving certain questions or removing certain errors." "Finally, even though the truths which the Church intends to teach through her dogmatic formulas are distinct from the changeable conceptions of a given epoch and can be expressed without them, nevertheless it can sometimes happen that these truths may be enunciated by the Sacred Magisterium in terms that bear traces of such conceptions." The Declaration therefore advises that "all these things have to be taken into account in order that these pronouncements may be properly interpreted."

⁷ *Code of Canon Law*, English translation, 1983, n. 1752, Holy See, http://www.vatican.va/archive/ENG1104/_INDEX.HTM.

All online material accessed 15 January 2016.

Cormac Nagle OFM ✘

An appointment with ‘Dr Google’: Benefits and limitations of using internet-based health information

The internet has made seeking for health information easy and convenient. This information provides medical knowledge which has the potential to empower both patients and health professionals. However, it is concerning that patients may attempt to use this type of information for self-diagnostic purposes, particularly those who are unfamiliar with medical terminology. Understanding web-based information effectively is most important to enable appropriate and informed healthcare decisions. Consequently, a new role for health professionals is indicated, requiring them to become familiar with the health information available on the internet, to direct patients to reliable sources, and to assist them in understanding and interpreting web-based health information.

The internet has made seeking information much easier for many more people all around the world. In 2012–2013, approximately 83% of Australians were internet users.¹ The use of the internet as a source for researching health-related information is wide-spread, with Google – currently the most popular search engine used² – estimating that 1 in 20 of its 100 billion searches each month are for health and medical information.³ In the 12 months prior to 28 October 2015, 78% of Australians used the internet to obtain health or medical information.⁴

Using the internet for health information is a growing global trend due to its availability and convenience. Searching for health information on the internet can assist people without medical expertise to better understand health and illness, and to search for potentially embarrassing medical concerns in the comfort and privacy of their own homes. Similarly, health and medical information found on the internet can be a powerful clinical tool for health professionals who are diagnosing complex medical cases.⁵

Whilst both patients and health professionals alike utilise the internet to search for health-related information, concerns have been raised in the literature in regards to utilising the retrieved information effectively for healthcare-based decisions. These concerns relate to the vast amount of health information available on the internet, the accuracy of this information, how persons appraise and use this information, and how it impacts upon the doctor–patient relationship. This article seeks to explore these concerns, as well as highlighting how information on the

internet, when applied effectively, is beneficial in healthcare.

Concerns about using Dr Google

There are concerns amongst health professionals about patients using the internet to access and research all kinds of symptoms and diseases. The internet allows access to a wide range of often complex health and medical information which can be overwhelming. This is of concern as research has shown that exposing persons with limited medical knowledge to complex medical language and information may cause unnecessary anxiety.⁶ This may be the result of over-searching for health information and worrying that common symptoms reveal serious health conditions. In the literature, this has been termed ‘cyberchondria’.⁷

There is also potential for harm from using internet-based information due to the presence of information which may be of questionable quality or which may even be simply inaccurate and misleading.⁸ More so, readability and understandability of the information is of great importance, as health information may be impractical or ineffective if it is beyond the reading ability of the reader.⁹ This is of particular concern to our population as the readability of Australian health websites is above the average Australian level of reading ability.¹⁰

Health literacy and appraising health information online

In appraising health information on the internet, there are aspects which need to be considered. A persons’ health literacy, that is, the cognitive and social skills needed to “obtain, understand and utilise information to promote health”¹¹ becomes paramount. It is also important to be competent in being able to search for and navigate around a particular search engine or website.

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Qualitative research using focus groups has shown that whilst participants state that they use appropriate criteria to assess online health information, when observed using the internet, they often fail to check the credibility of a website or who wrote it.¹² More so, when using search engines, persons only tend to explore the first few links when seeking health information.¹³ Research such as this raises concerns that persons seeking health information may misinterpret it and undertake inappropriate healthcare decisions,¹⁴ including self-diagnosing.¹⁵

Self-diagnosis

An international study in 2010 found that over 45% of Australians use health information found on the internet to

self-diagnose.¹⁶ Similarly, qualitative research undertaken by the Pew Research Centre has found that 35% of U.S. adults used the internet for self-diagnostic purposes.¹⁷ The concerns associated with self-diagnosis as highlighted in the literature stem from the source by which the information is accessed, namely the search engines used and the links retrieved from search results. Research into the algorithmic structure of search engines highlights that they are not reliable in diagnosing medical conditions.¹⁸ For example, a study on search engines has found that searching for a description of symptoms, rather than using specific medical terms, generates poor results, with only 3 out of 10 links on the first page of results useful for self-diagnostic purposes.¹⁹

...a new role for health professionals is called for ... to provide [patients] with... internet resources which are reliable and accurate...

Whilst accurate and reliable health information can be found on the internet, the significant problem with using 'Dr Google' arises from patients using information to self-diagnose without a physical examination, and using information which does not take into account their medical history. This in turn affects their ability to make informed decisions when it comes to engaging with a health professional or seeking treatment.

The internet and the doctor–patient relationship

The dynamics between patients and health professionals have changed. Where traditionally the health professional was the main provider of health information and treatment options to patients,²⁰ the paradigm shift into a patient-centred approach has encouraged patients to take a more active role in their healthcare.²¹ Concerns have been raised in light of this paradigm shift as the internet has changed the way in which health professionals and patients engage in the therapeutic relationship.

The literature reports both health professionals' perspectives and patients' perspectives on the use of internet-based health information. Some research shows that health professionals are not concerned about patients accessing health information on the internet,²² whilst other research does find some concerns.²³ Some health professionals may experience anxiety when confronted with patients bringing in health information from the internet.²⁴ This anxiety may stem from a fear of being perceived as incompetent, or having their expertise questioned, or feeling challenged by the patient.²⁵

From the patient perspective, patients trust and value their relationship with their health professional much more than the health information found on the internet.²⁶ Information obtained from the internet supports the therapeutic relationship between patients and health professionals, and allows for improved communication and rapport.

Additionally, patients who search for internet health information are likely to pay more visits to health professionals.²⁷ In light of this, health professionals should not feel intimidated when a patient brings in health information from the internet; rather, it should demonstrate that patients are attempting to collaborate and participate alongside their health professional, and reaching for better healthcare outcomes.²⁸

A new role for health professionals

With the internet contributing to the changing dynamic between patients and health professionals, a new role for health professionals is called for to embrace this change whilst also providing quality healthcare. This can be achieved by health professionals being more educational and supportive with their patients. Supporting patients in making sound healthcare decisions, managing patient uncertainty with diagnosis, and providing effective guidance about treatment options build trust and respect of the health professional. In order to undertake this role effectively, health professionals require critical appraisal skills to determine whether information found by the patient is relevant to them and their medical history.²⁹ This is important as patients with poor health literacy may find it difficult to understand the available health information on the internet, and thus require guidance into searching for information which is suitable to their needs.³⁰

In clarifying the confusion and enhancing communication, it is important for the health professional to discuss the information offered by the patient, and to provide them with alternative internet resources which are reliable and accurate. Interpreting the health information obtained by patients and guiding them in their treatment decision-making process effectively enables the patient to feel empowered in their decision-making and positively impacts on the doctor–patient relationship.

During a recent talk in Melbourne, Professor Jeremy Sugarman noted in passing that he has challenged himself to engage in this new role in his own clinical practice. Professor Sugarman is an internationally recognised leader in biomedical ethics, and the Deputy Director for Medicine at the John Hopkins Berman Institute of Bioethics in Baltimore, Maryland. In his talk, he reported that he now asks his patients what they know, and where they have looked for information. He also tries to direct them to reputable sources of information, including those available on the internet.³¹

Conclusion

The internet has vastly changed the way in which we access information and particularly information which is health-related. This has given people greater autonomy and has broadened their choices in health-related decision-making. The efficiency of retrieving useful information is dependent upon a few variables such as the searcher's knowledge, their health literacy base, as well as the accuracy and reliability of the retrieved information. It is important to

note that search engines such as Google are not effective in self-diagnosis when searching with a description of common symptoms.

The overwhelming volume of health related information available online is likely to confuse patients who lack medical expertise. The paradigm shift in healthcare leads us to now view the healthcare professional as more of an interpreter of health information rather than the conventional, paternalistic expert. Whilst this changing role impacts upon the doctor–patient relationship, it brings about a new way to collaborate, enhance communication and provide treatment. It is important to balance the risks and benefits of relying on health information found on Google or other search engines, but ultimately, it cannot replace the supportive, caring and compassionate human dimension needed particularly in times of serious health concerns.

ENDNOTES

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Medicine as Ministry: A case for truly theological bioethics

Bioethics at the bedside looks different from bioethics in the classroom, because the patient in the bed is a person with their own particular history, a unique experience of illness, and an unrepeatable future. In the context of Christian faith, bioethics must include far more than mere clinical data and academic prowess: there must be a central role for the God who is mystery. This article reflects on the rich perspective of leading American paediatrician and ethicist,

Margaret E. Mohrmann.

Bioethics has never been an exact science. Even when it strives for absolute objectivity by the application of the most rigorous philosophical discipline, clinical situations often escape our capacity to arrive at certain judgement. This should not surprise us, of course, since clinical situations are often extremely complex human dramas, and in such matters, as Aristotle reminds us, we should never expect greater certainty than our subject matter allows.¹

The natural limitations of bioethics are nowhere more evident than in the experience of dying. Whether in the academic setting or by the bedside, when bioethics attempts to deal with matters around the end of life, its inherent fallibility becomes clear to all. Many factors contribute to the uncertainty, the most obvious culprits being the natural limits of clinical knowledge, and differing points of view and communication difficulties between key players (doctor, patient, family, nurses). However there is often another layer of complexity which remains totally outside the reach of bioethics, but which is no less important to the resolution of the human drama which unfolds: the patient's (or their family's) unique appreciation of the meaning of the illness or trauma they are suffering. Until we grasp the effect and meaning of this solipsistic truth – which is indeed *truth* – we cannot fully comprehend the meaning of the tragedy and so cannot effectively address all of its human dimensions.

Doctors understand this. They confront it daily, and it is an enormous privilege to be granted access to the complex world that doctors inhabit via a short book that should be on the 'required reading' list for anyone seriously engaged in clinical ethics.

Medicine as Ministry is a short (120 pages) but profound reflection on suffering, dying and hope from Dr Margaret E. Mohrmann, MD.² Dr Mohrmann has the distinction of holding doctoral degrees in both medicine and religious ethics, and currently fills senior academic roles at the University of Virginia (USA) in both the School of Medicine and the College of Arts and Sciences. The book brings together her expertise in paediatric medicine, ethics and religion, weaving a single profoundly pastoral vision from the stuff of all three endeavours. Its origins lie in a series of papers presented in 1991 at a conference in North Carolina on *Medicine and Ministry of the Whole Person*.

Critique of biomedical ethics

In keeping with her pastoral intent, Mohrmann adopts very broad definitions of 'healer' and 'patient', meaning by them respectively anyone and everyone engaged in caring for the sick, and anyone who suffers in any way. Care, in her view, is always *care*: whether medical, pastoral, social or religious, genuine care is marked by the same characteristics of presence, consolation and healing. Her view of ethics is overtly theological rather than biomedical, and she insists that the latter is simply incapable of

comprehending an adequate understanding of the human person in relation to the 'things that matter most' to them, including especially God: "I hold that biomedical ethics, as it

I hold that biomedical ethics, as it is currently conceived and practiced, is an insufficient base for ... ethical ministry...

is currently conceived and practiced, is an insufficient base for the sort of ethical ministry compelled by the suffering of those who seek medical care."³

Dr Mohrmann argues her case in a searing critique of academic bioethics. In the first place, biomedical ethics relies too much on clinical information which is always insufficient for reaching moral conclusions: "Clinical information alone cannot lead us to moral conclusions. For moral conclusions, we need another sort of information in addition to the clinical. We need to know who [the patient] is, what her life has been like, and what she wants her dying to be like."⁴ She calls us to look patients in the eye, to recognise and honour each one as the unique individual they are, each with their own unrepeatably and irreplaceable story which provides context to their illness and suffering, and to that extent contributes meaning to their life and therefore to their illness, to its appropriate treatment, and to our attempts to care.

It is these stories, secondly, that enable us to resist the temptation of biomedical ethics and its "abstraction of unique stories into paradigmatic cases,"⁵ preferring instead to keep focus on the real person of this particular patient. Thus Mohrmann reminds us that "[p]atients are persons who have names and faces; they have unique lives and unique deaths. To think that appropriate ethical answers can be found by abstracting those real persons out of their grounded, embodied, one-of-a-kind stories is to make a fundamental error in ethical reasoning."⁶

Finally, and perhaps most tellingly for most of us engaged in bioethics these days, Mohrmann critiques the tendency of biomedical ethics to profess a capacity to deliver 'the right answer,' as though by simple application of principles these come pre-packaged and independent of the unique truth of each patient.

For one who has been engaged in bioethics for over twenty-five years, this particular view is both deeply shocking and almost self-evidently true. Our Catholic dependence on 'top-down' ethics (as can occur if we too mechanically apply our *Code of Ethical Standards*) tends to create an expectation that simple application of the principles will deliver ethically certain and pastorally appropriate 'answers' in every case. Yet upon reflection my clinical experience is very different: particularly in the paediatric setting, a clinical ethics consultation often exposes the

infinite significance of the parents' deep attachment to their child and the profound meaning of his or her life in the context of their own. This knowledge is certainly true, and it is absolutely critical to managing the particular 'case,' yet it utterly eludes the kind of empirical certainty we commonly rely upon in medicine. In truth, the search in clinical ethics is not for the 'right' answer; it is a search for meaning in the face of suffering which contradicts and erodes everything that, until that moment, has provided structure and coherence to our lives. This is not the stuff of traditional clinically-focused biomedical ethics, nor is it nourished on the intellectual rigour of the strict philosophic discipline to which we have become accustomed. It is rather a more necessary and worthy exercise in pastoral care, fed by the individual healer's capacity for compassion.

Theological ethics

Thus Mohrmann urges a truly theological ethics, which is "the study of the moral implications of theological statements and beliefs, of the way that God and our convictions about God do or should determine our character and our conduct, as individuals and as a society. . . . It is about how to understand what happens to us and what we do about it in the light of our existence as persons created to live and flourish within the universe embraced and sustained by God."⁷ Its grounding in this universe of human experience places theological ethics as an expression of natural law: if we proceed carefully and with due consideration for the unique individual, we can and will reach morally right conclusions about caring actions based as nearly as we can upon a framework of meaning in harmony with God's will for the particular individual.

Mohrmann's position unfolds naturally, greatly enriched by her profoundly moving use of story. Theologically it develops very simply: since God is One, everything else in life – including life itself – comes second. This allows us to accept the reality of death with equanimity. It frees us from the tyranny of vitalism, from a sense that only physical life matters. It restores the spiritual to its central place in our understanding of human life and, indeed, of the universe. It contradicts the kind of dualism which overly medicalised, technologised, overly interventional care can imply. As Mohrmann reminds us, "the question is not 'What can I do to live longer?' The question is, 'How shall I live the life I have?'"⁸ What rescues this approach from the errors of situation ethics is its sheer realism: Christian theological ethics of this kind accepts the reality not only of pain and suffering but also of our inability at times to provide relief without seeming to offend other equally valuable moral principles. In modern biomedical ethics, for example, a dilemma between relieving pain and shortening life is routinely resolved by application of the principle of double effect, a reasonably neat intellectual construct which, by guiding us to morally acceptable explanations of our actions, sometimes absolves us from entering their real moral depth. In the theological ethics espoused by Mohrmann, however, embracing the option to relieve pain

does not absolve us from the need to grieve the shortening of the patient's life. Theological ethics affirms constantly both imperatives (relieve pain, and respect life), and deep entry into the reality of such dilemmas elicits both genuine reluctance to choose one and true grief at bringing about the other.

Of course, God is also Three, which creates a relational framework for both the giving and receiving of care. Mohrmann reminds the healer to draw energy and inspiration from those we care for: that the patient, or their family, can often pour back into our being as much or more richness than we pour into theirs. This too is a reflection of our common nature as beings created in the image of God:

This is ... not the argument that we may be entertaining angels unaware, that we need to be open to healing from those we serve because one of them may have something important to give us. It is, rather, the argument that we are always entertaining angels unaware. God and God's love, the love that can replace drop for drop all the love and mercy we expend, comes to us through the mediation of each person God presents us with as an object of our love and service. It works that way because our nature, like God's, is relational.⁹

Theological ethics aimed at the good of the unique individual person must necessarily draw us to see, to hear, to recognise the one who suffers, and to pay attention to their experience. The most important step is to listen to their stories, to their experience of suffering: what this disease or disability means to this individual. It is one thing to know the etiology and treatment of (for example) lupus; as Mohrmann graphically illustrates, it is another thing altogether to grasp the meaning of Flannery O'Connor's experience of lupus: "The wolf, I'm afraid, is inside tearing up the place."¹⁰ Likewise, it is one thing to know how to treat psoriasis, but another altogether to grasp its meaning to the sufferer: "I am silvery, scaly. Puddles of flesh form wherever I rest my flesh. Each morning I vacuum my bed. . . . The name of the disease, spiritually speaking, is Humiliation."¹¹ If we miss this name, this experience of

In truth, the search in clinical ethics is not for the 'right' answer; it is a search for meaning in the face of suffering ...

humiliation that psoriasis inflicts upon this patient, we miss its true meaning. Mohrmann employs the metaphor of weaving to explain the caregiver's role: it is both to help the patient understand the warp and weft of their life up to now, and to assist the patient to weave into it the new thread of illness or tragedy in such a way that life into the future has some meaning – even if that life will be very short. Only the patient can weave: the caregiver may contribute form but not content. The meaning of the

patient's suffering is for that patient alone to construct out of the interrupted story of their life.

Theological ethics resists the temptation to deliver precast answers and meanings to every unique patient. Rather, just as God attends to the uniqueness of each individual, a truly theological bioethics brings the unchanging truths of the Gospel command to love into intimate contact with the

the caregiver's role: ... is both to help the patient understand the warp and weft of their life up to now, and to assist the patient to weave into it the new thread of illness or tragedy in such a way that life into the future has some meaning – even if that life will be very short...

mystery of the individual. The outcome depends not on the fixed clinical data alone, nor on the philosophic discipline of ethics alone, but on the intersection of human lives, the caregiver and the patient, which is always an interaction with mystery. In this way theological ethics demands that the ethicist must leave room for the action of the divine, leave room for mystery, and must resist the temptation of infallible omnipotence that is sometimes expected of them – whether by the patient, the clinician or the Church. Bioethics can only be truly theological, and only truly Catholic, if it resists the temptation of infallibility and truly honours the mystery of the divine in every patient and every clinical situation.

ENDNOTES

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Zika Virus

The Zika virus has dominated the news media and captured the attention of the international community. Epidemic disease has become the mainstay of public health emergencies in our recent past with Ebola virus in West Africa and now Zika virus in Latin America. An unexpected and troubling feature of this current outbreak is the high incidence of birth defects and neurological health complications. As scientists investigate a possible causal link, health authorities as well as Catholic Church leaders are involved in communicating how women and the wider

community should make decisions about their health, reproduction and pregnancy. A morally appropriate, culturally sensitive and socially inclusive approach to managing the immanent risk should be the priority.

What is Zika virus?

Experts in epidemiology warn that widespread epidemics are a reality and, indeed, that it is 'not a matter of *if*, but *when*'. The last five years has been a challenging time as the global community struggled to contain Ebola in West Africa, and now must manage the complications caused by Zika virus in South and Central America. There are serious concerns about epidemics both because of the devastation that they can cause in any region, and the risk that they may spread to the rest of the world. Zika virus is the most recent of these outbreaks that is not only paralysing health infrastructure but also threatening the health of a generation of people in the affected regions. Unlike Ebola, Zika virus is not fatal and its symptoms in infected adults are manageable but it is the complications that are caused during pregnancy which are most concerning. Therefore, like Ebola—and perhaps in a more timely fashion—the

... widespread epidemics are a reality ... it is 'not a matter of if, but when'...

World Health Organisation has declared this outbreak a public health emergency of international concern.

Zika virus was found in rhesus monkeys in the Zika forests of Uganda in 1947. A mosquito-borne flavivirus,¹ it has caused mild, sporadic infection in people living in some African and Asian countries. Confirmed cases of Zika virus are only discovered after serological investigation since symptoms are non-specific and similar to those of other flaviviruses such as Dengue, West Nile and Chikungunya. The first person to contract the disease outside Africa and Asia was living on Yap Island in the Federated States of Micronesia in the North Pacific. She contracted the disease in 2007, and was initially incorrectly diagnosed as having Dengue. A similar misdiagnosis occurred in 2013 when a family in French Polynesia was infected with Zika. This became what was then the largest known outbreak, which affected an estimated 19,000 persons. It also expedited serological testing in order to map the virus genome.² Since then, the incidence and spread of Zika virus has grown dramatically. At the start of 2016, outbreaks were reported in Central and South America—specifically in Columbia, El Salvador, Guatemala, Mexico, Paraguay, Puerto Rico, and Venezuela.³

As the number of cases of Zika virus infection grew in these areas, there emerged an unprecedented increase in Guillain-Barré syndrome and other neurological and auto-immune problems, in miscarriages and stillbirths, and in the number of babies born with eye problems and a congenital microcephaly which can signal underlying brain damage.⁴ This raised significant concerns and distress in the worst

affected areas, especially for women during pregnancy. It also raised questions about the capacity of the health infrastructure to care for families and children with disabilities. This article will seek to provide an overview of the current knowledge about Zika virus, and the public health measures that are being instigated to manage community risk. Scientific and epidemiological research is showing some concerning results, and health authorities are confronted with the task of identifying the best cause of action to avoid long-term health complications. Because of the large and often devout Catholic population in Central and South America, Catholic Church leaders are also central in this discussion. There is intense and ongoing debate about how to respond to the imminent risk to communities living in these affected areas and especially for women considering pregnancy.

Zika virus and birth defects

As this article goes to print, the evidence for Zika virus as the causal agent of birth defects is not substantiated. The *New England Journal of Medicine* published a brief report on the association between Zika virus and microcephaly.⁵ The report is based on a woman who was living in Brazil during the current outbreak of Zika virus. She became pregnant and, perhaps due to the disquiet about birth defects during pregnancy in Brazil where Zika virus was most severe, she returned to Slovenia for urgent medical attention. Sometime after becoming pregnant, she experienced symptoms common in people infected with Zika virus – fever, rash, itching and pain.⁶ The region where she was living at the time did not have diagnostic testing for Zika virus, but fetal ultrasound did reveal normal development at 20 weeks gestation. When she returned to Slovenia, another ultrasound was performed at 29 weeks, and there appeared to be serious fetal abnormality – the most obvious being a smaller head circumference. Doctors involved in the case became increasingly concerned about the possible link between the virus and microcephaly. After being told about possible health complications and mortality for the child, the woman chose to terminate the pregnancy.

An autopsy was performed, and vital organs including the fetal brain were analysed for presence of the Zika virus. The results were most worrying as it showed the presence of a complete Zika virus genome in the brain tissue, which indicated vertical transmission of the virus from mother to child. The brain and eyes were the organs where the virus was most apparent. Perhaps the most worrying finding from this case study was that the concentration of virus in the fetal brain tissue, though consistent with the amount present in semen samples, was higher than that found in the mother. In a separate case where a fetal abnormality had been detected, tests on the amniotic fluid also supported intrauterine transmission of the virus.⁷

Reproduction and health

The impact of Zika virus is not limited to the risks of birth defects, but has health implications broadly for families and

the community at large. In light of the as yet inconclusive link between vertical, intrauterine or sexual transmission of the virus, there is also no consensus amongst community leaders and health authorities on negotiating the risks to and management of pregnancy. Adding to this complex debate is the fact that Latin America, which includes Central and South America, has a very large population of Roman Catholic Christians. Indeed, 425 million Catholics – nearly 40% of the world's Catholic population – live in Latin America.⁸ Brazil with about 126 million Catholics has the largest Catholic population in the world; Mexico with 96 million has the second largest Catholic population.⁹ These are important aspects to consider when addressing the challenges that Zika virus poses immediately for communities in Latin America.

The threat of sexual violence and exploitation of women and adolescent girls in Latin America is an ever-present reality. Due to limited sex education, high incidences of rape, and other factors, 56 percent of all pregnancies are unplanned.¹⁰ Furthermore, many women and their families live in remote and regional areas where there are few healthcare facilities. Health disparity in Latin America is a complex issue that is reflected in the high incidence of communicable diseases and some chronic illnesses.¹¹ The arrival or perhaps the resurgence of Zika virus is yet another burden in a community that is afflicted by poor health, poverty and injustice. The unrelieved struggle of so many people who face so many burdens is poignantly instilled in a community psyche which often does not hope for things to be better and sometimes lives only for the present moment. This can be displayed in risky health behaviours and in the ways that people make decisions about pregnancy and other matters.

Many recommendations have been made to reduce the risk of Zika infection particularly during pregnancy. These include measures to eliminate the mosquitoes which spread the virus, and personal measures to prevent being bitten by these mosquitoes.¹² They also include measures to reduce the risk of sexual transmission of the virus.¹³

As the number of cases of Zika virus infection grew ... there emerged an unprecedented increase in ... miscarriages and stillbirths, and in the number of babies born with eye problems and ... microcephaly ...

In March 2016, the World Health Organisation (WHO) published interim guidelines for managing pregnancy in the context of the Zika virus. These state that testing for Zika virus infection should not be offered to all pregnant women in Zika-infected areas, but limited to those with a history of symptoms which suggest Zika infection. Ultrasound scans should be considered for all women, ideally in the first trimester, at 18 to 20 weeks, and at 28 to 30 weeks. Where appropriate and feasible, amniocentesis could also be considered. If microcephaly is identified, the woman—and

her partner if she wishes—should be given evidence-based information on the prognosis of identified abnormalities, and assisted with non-directive counselling. Those who choose to continue their pregnancy must receive appropriate care and support.¹⁴

In like vein, the US Centers for Disease Control and Prevention (CDC) also recommend that testing for Zika virus infection should be offered only to those women who report symptoms of possible infection. They also encourage serial ultrasound examinations to monitor fetal growth and anatomy, and referral to specialist care as required. Because of possible complications, they do not recommend amniocentesis before 14 weeks of gestation.¹⁵ Other experts do not recommend amniocentesis before 21 weeks.¹⁶

Australia has also produced its own guidance. The Communicable Diseases Network Australia has produced *Interim recommendations for assessment of pregnant women returning from Zika virus-affected areas*. Healthcare providers, it states, should ask all pregnant women about their travel history. There are detailed instructions about testing for Zika virus infection. Like the WHO and CDC guidelines, this includes Zika virus testing of all symptomatic pregnant women. Going beyond WHO and CDC, however, the Australian guidance recommends more extensive testing, including virus tests for all pregnant women whose potential exposure to the virus occurred more than two weeks previously. Those who test positive should be referred for specialist obstetric advice and management.¹⁷ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has also produced *Care of women with confirmed Zika virus infection during pregnancy in Australia*. Serial ultrasounds at least every 4 weeks are recommended. Amniocentesis should be considered particularly if the fetal ultrasound examination is abnormal.¹⁸

Catholic standards

In secular discourse, two so-called solutions have been proposed for the risk in pregnancy of the Zika virus. One is abortion of any unborn child affected by the virus; the other is contraception to prevent pregnancy while the risk of Zika infection persists.

The Catholic Church has always opposed direct abortion. It rightly recognises this as a violation of the right to life of the unborn child. The Zika crisis has not changed this. For example, Pope Francis was asked about the implications of the Zika virus in an in-flight interview as he returned from Mexico on 17 February 2016. He strongly rejected abortion as a so-called solution. Instead, he insisted that abortion is an “absolute evil,” “an evil in and of itself,” not simply a “religious evil” but truly a “human evil.”¹⁹ Cardinal Odilo Scherer of the Archdiocese of São Paulo in Brazil teased out the positive implications of this. He said that mothers who give birth to babies with microcephaly have a “mission” to care for them, and the right to receive all necessary support to do so.²⁰

The Catholic Church also opposes contraception. It recognises two great values in sexual intercourse within marriage: the expression and deepening of love (sometimes called the unitive good), and the creation of new life (sometimes called the procreative good). What is more, the Church teaches that we cannot act against either of these goods. This excludes contraception, which acts against the procreative good. However, it does not exclude natural family planning which restricts sexual intercourse to the infertile periods, and therefore does not involve any

Vatican spokesman Fr Federico Lombardi confirmed that the pope was indeed speaking ... of “the possibility of a recourse to contraception or condoms in cases of emergency or in special situations” ... the pope “does not say that this recourse can be accepted and used without any discernment, but in fact clearly said that it can be taken into consideration in cases of particular emergency.”

action against the procreative good.²¹

Without rescinding this teaching,²² the Church has recognised a small number of emergency situations during which it might not be wrong to use contraception. In the 1960s, permission was tacitly given for nuns in danger of rape in the Belgian Congo to use contraceptives. In the Bosnian War of the early 1990s, various militias used mass rape as an instrument of terror. An article in *La Civiltà Cattolica* (which is approved by the Vatican before publication) permitted women to use contraceptives in these circumstances too.²³ In 2010, Pope Benedict XVI stated that if there is a risk of HIV infection “when a male prostitute uses a condom... this can be a first step in the direction of a moralisation, a first assumption of responsibility...”²⁴

Does the Zika virus constitute such an emergency situation? When Pope Francis was asked about this during the in-flight interview, he did not give a definitive answer. Even so, his answer suggested some openness to this possibility. For example, he noted that, unlike abortion, “preventing pregnancy is not an absolute evil.” What is more, when asked about this, Vatican spokesman Fr Federico Lombardi confirmed that the pope was indeed speaking about “condoms and contraceptives,” and of “the possibility of a recourse to contraception or condoms in cases of emergency or in special situations, which does not involve the suppression of a human life, but avoiding a pregnancy.” Fr Lombardi added that the pope “does not say that this recourse can be accepted and used without any discernment, but in fact clearly said that it can be taken into consideration in cases of particular emergency.”²⁵

When there is a significant risk that an unborn child could be seriously harmed by the Zika virus, it is reasonable while the risk remains for a couple to postpone pregnancy. One solution would be to abstain entirely from sexual

intercourse. However, given the importance of sexual intercourse within marriage, this might not be appropriate in the long term. Yet another solution would be recourse to the modern and highly effective methods of natural family planning (NFP).²⁶ However, some couples might not have ready access to instruction about NFP, or they may be unable to abstain during the fertile periods, or a woman might be unable to persuade her husband to abstain during these times. In these sorts of situations, while a significant risk remains, couples may have to undertake the discernment which Pope Francis spoke about.

Future direction

Zika virus research is aiming to establish whether or not there is a causal link between infection and birth defects. This is an important step towards better advising and managing risk in the community. Much more knowledge about Zika virus and its various modes of transmission are also needed before efforts to develop an effective vaccine can proceed. In Latin American communities there is ongoing work to eradicate the mosquito and control environmental factors – such as water collecting in and around housing—to reduce the number of people becoming infected in this way. This is a unique outbreak due to the long-term implications for the health of future generations, and particularly for this reason the measures to negotiate risk need to be sensitive to moral, cultural and social factors.

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