



the nathaniel report **61**

A Publication of
THE NATHANIEL CENTRE FOR BIOETHICS

in this issue

Guest Editorial: With Choice Comes Responsibility

Lynne Bowyer and Deborah Stevens

Dangerous and Unwise

John Kleinsman

Binding Referendum Question: "Do You Support the End of Life Choice Act Coming into Force?"

Staff of the Nathaniel Centre for Bioethics

Non-Binding Referendum Question: "Do you Support the Proposed Cannabis Legalisation and Control Bill?"

Staff of the Nathaniel Centre for Bioethics

Suffering in Silence: Young Men's Experience of Silence and Suicide Bereavement

Chris Bowden

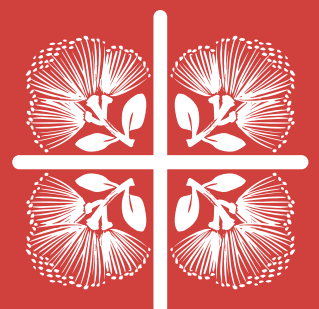
COVID-19 Vaccine – Should Catholics Vaccinate Using an Ethically Compromised Vaccine?

Kevin McGovern and Kerri Anne Brussen

TE KUPENGA
NATHANIEL
CENTRE FOR
BIOETHICS

Nathaniel Centre for Bioethics: PO Box 12243, Wellington 6144, New Zealand.
Telephone: 64 4 4992251 Email: administrator@nathaniel.org.nz

The Nathaniel Centre for Bioethics is formally affiliated with Te Kupenga – Catholic Leadership Institute



The Nathaniel Centre for Bioethics was established in 1999 as an agency of the New Zealand Catholic Bishops' Conference. The key functions of The Nathaniel Centre include:

- developing educational opportunities in bioethics
- acting as an advisory and resource centre for individuals, and professional, educational and community groups
- carrying out research into bioethical issues, and promoting the study and practical resolution of ethical, social, cultural and legal challenges arising out of clinical practice and scientific research
- carrying out research and action to support the Church's pastoral response to bioethical issues taking into account the needs of different cultures and groups in society

Our Philosophy

Rapid advances in science have moral, ethical, and spiritual implications at an individual and societal level. While Catholic bioethics deals with the same realities as secular bioethics we are committed to bringing the light of the Gospel and the wisdom from the Church's moral tradition to the various issues under discussion.

Reason and faith do not exist in isolation; they guide our individual and collective search for truth and they complement each other when they meet in genuine service of those who suffer. In the words of Pope Benedict XVI: "Only in charity, illumined by the light of reason and faith is it possible to pursue development goals that possess a more humane and humanising value." In this way the work of bioethics appears as a practical expression of the reverence we have for the gift of life.

For The Nathaniel Centre the context of bioethics is pastoral, because the ethical issues arising in healthcare and the life sciences reflect the realities of people's lives.

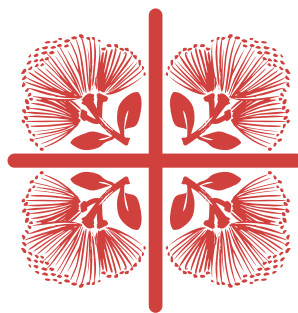
Faith and reason are like two wings on which the human spirit rises to the contemplation of truth...

POPE JOHN PAUL II

... faith consolidates, integrates and illuminates the heritage of truth acquired by human reason.

POPE BENEDICT XVI

Find us on 



IN THIS ISSUE... A NOTE FROM THE EDITOR

This issue comes with a new layout, marking our formal affiliation with **Te Kupenga – Catholic Leadership Institute**. Te Kupenga is the home of three national agencies: the **Catholic Theological College**, responsible for providing approved tertiary qualifications (following an amalgamation between TCI and Good Shepherd College); the **National Centre for Religious Studies**, responsible for supporting religious education in Catholic schools and adult faith formation; and the **Nathaniel Centre for Bioethics**, responsible for research and advocacy on bioethical issues.

In their Guest Editorial *With Choice Comes Responsibility*, **Lynne Bowyer and Deborah Stevens** discuss the upcoming referenda questions on the End of Life Choice Act 2019 and the proposed Cannabis Legalisation and Control Bill. Unpacking and critiquing the neo-liberal narrative that shapes much of our present society, the authors offer an approach to decision-making that centres on the common good and the preferential option for those who are most vulnerable.

In our first article, *Dangerous and Unwise*, **John Kleinsman** highlights the flaws inherent in the final version of End of Life Choice Act 2019 that will be voted on in October; flaws that are now fixed in place and cannot be changed should the Act be approved by a majority vote. He also points out just how far the present Act has deviated from how it was originally 'sold' to the general public – from an Act intended for the few "hard-cases" to an Act that now has the potential to encompass upwards of 25,000 people a year.

Following on from this article, the **Staff of the Nathaniel Centre for Bioethics** offer readers two resources written to assist them with the respective referendums – *Binding Referendum Question: "Do You Support the End of Life Choice Act Coming into Force?"* and *Non-binding Referendum Question: "Do You Support the Proposed Cannabis Legalisation and Control Bill?"*. Each resource provides a background to the referendum question and details key issues and information to consider in deciding how to vote.

In our fourth piece, *Suffering in Silence: Young Men's Experience of Silence and Suicide Bereavement*, **Chris Bowden** shares insights from the in-depth research he carried out with young men bereaved through suicide. Through listening to their experiences in their own words, the author conveys the different kinds of silence the men described on being bereaved, and the different roles these silences played in their grief.

In our final piece, *COVID-19 Vaccine – Should Catholics Vaccinate Using an Ethically Compromised Vaccine?*, **Kevin McGovern and Kerri Anne Brussen** explain the historical origins of vaccines before exploring a critical moral question: How would we respond if the only viable vaccine for COVID-19 was based on a cell line that used cells derived from aborted fetuses?

With Choice Comes Responsibility

Lynne Bowyer & Deborah Stevens

At the October general election voters will be asked to make important choices. Two referenda are being held alongside the general election: one is concerned with the legalisation of cannabis for recreational use; the other is about whether to accept the End of Life Choice Act 2019, which sanctions both euthanasia and physician assisted suicide under certain circumstances. The choices we make in regard to these two issues will shape our cultural landscape and affirm the future trajectory for people in New Zealand. As we move towards making these significant decisions, it is important that we think about the concept of 'choice' and how that concept has been derailed by our current dominant narrative. If we are to make a 'good choice' in the context of the upcoming referenda, we must understand what that requires.

While the world we currently inhabit is multi-layered, the dominant narrative that shapes our institutions and practices is informed by neo-liberal theory. Neo-liberal theory is a political and economic narrative which has constructed a highly regulated, producer-consumer society, driven largely by market forces. Neo-liberalism regards individuals as the basic social unit. In this narrative, isolated and atomistic individuals, who are assumed to be equally situated and empowered, exercise their freedom of choice based on self-interested preference, unimpeded by the choices or actions of others. Interactions with others are largely viewed in transactional terms, undertaken to achieve one's self-interested preferences. Hence, from within this narrative, the concept of choice is predominantly concerned with getting what I think is good for me. Based on such an account, it is sufficient that the choices I make are good for me, and the only justification for this choice is that it was made by me.

The choices we make continually affect and shape the world in which we live, and those choices speak of who we are, what we value, and what our lives are about. Although the relentless and insidious narrative of individualism attempts to permeate all aspects of life, the choices we make can challenge this narrative, enabling us to live in ways that are cognisant of our existence as social beings.

As freedom of choice is considered the highest 'good', neo-liberalism is unable to provide any way of deciding on the appropriateness of the choice. Nor is it able to critique the values that underpin that choice. The dominance of the neo-liberal narrative means that other narratives – other ways of living and being – are held at the margins and struggle to have a voice in shaping the world.

Although highly influential and pervasive, it is abundantly clear that the neo-liberal narrative is based on an impoverished

understanding of our human condition that has many shortcomings. Contrary to what its ideology purports, we are not isolated, atomistic individuals, equally situated and empowered. Our existence is complex, interdependent and precarious: we are finite, mortal and fallible, and we do not possess all the skills to go it alone. Placing the emphasis on the unhindered expression of self-interest does not take into account our social embeddedness and the way that relations with others, along with political and economic forces, exert an influence on our lives. The neo-liberal narrative disregards how this matrix of embedded relationships sustains our commitments, obligations, expectations and practices, all of which orient us in a shared world and enable us to make sense of what we do while building compassionate, caring communities.

In other words, the choices we make are not exercised in isolation. They must tie back – from the Latin *re-ligare*, from which we get our word religion – to values that recognise and are responsive to our embedded, interdependent human existence. As any choice we make has ripple out effects that impact others, there is a need to be mindful of our complex interdependencies and the life of the communities of which we are an inescapable part. Therefore, with choice comes enormous responsibility, for others as well as for self. This is something that is often concealed by the current dominant neo-liberal narrative, premised as it is on self-interested individualism.

If we are to live within the truth of our complex, interdependent existence, the concept of 'choice' must include discernment. When we make choices, our fundamentally socially embedded existence requires that we are receptive and attentive to what is salient in a particular situation, so that we respond appropriately. The choices we make continually affect and shape the world in which we live, and those choices speak of who we are, what we value, and what our lives are about. Although the relentless and insidious narrative of individualism attempts to permeate all aspects of life, the choices we make can challenge this narrative, enabling us to live in ways that are cognisant of our existence as social beings.

Therefore, in relation to the proposed law changes around euthanasia and assisted suicide, and the legalisation of cannabis, we need to be sensitive to and discern the ways in which these law changes will impact on our interdependent, human way of life. In order to make good choices when it comes to the referenda, some of the salient questions we need to ask and explore are:

Who will be marginalised by these law changes?

Who will be most negatively affected by these law changes?

Who stands to benefit by these law changes?

How will such law changes affect us as a community? Will it make us more, or less, inclusive?

What effect will these law changes have on our relationships with one another, especially on our relationships with our most vulnerable people?

What narrative am I inhabiting, and does it speak to the full truth of our human existence?

What kind of world do we want to live in, and what kind of people do we want to become?

What kind of world do we want our children and grandchildren to inherit?

Exploring and answering these questions thoughtfully will connect us to the truth of our situation, so that our choices will be a fitting response congruent with our enmeshed human condition.

We must remain alert to the ways in which our concepts exert influence over us, shaping our thinking and hence, our way of life. The neo-liberal distortion of the concept of 'choice', based on a fabricated individualism, is implicit in the current structuring of our healthcare practices, our legal system, our education system, our political system, and the myriad of human interactions that are becoming more and more transactional. It is a conceptual understanding that is in tension with and conceals the relational webs in which we are embedded.

We have better outcomes for all when we pay attention to our concrete reality of interdependent relations and obligations that uphold the common good. Keeping this in mind, what responsible choices will you make in the referenda?

We have seen this tension playing out in regard to Covid-19. On the one hand we have been exhorted to pull together as a "team of five million" for the common good of containing the spread of the virus. Those that go against working together for the common good are deemed "selfish", unable to see that "their actions could have wider negative consequences". On the other hand, once the spread of Covid-19 is contained, it is back to 'business as usual', and the neo-liberal agenda kicks in again. With individualism back at the helm it once again becomes "everyman for himself" (*sic*), along with the continuation of educational, health, wealth and income disparities that neo-liberal ideology creates and sustains. The "wider consequences" of selfish individualism are dismissed as "externalities" of the transactional system.

We have better outcomes for all when we pay attention to our concrete reality of interdependent relations and obligations that uphold the common good. Keeping this in mind, what responsible choices will you make in the referenda?

Dr Lynne Bowyer and Dr Deborah Stevens are co-directors of The New Zealand Centre for Science and Citizenship Trust.

Some Resources on Reasons to Vote No for the End of Life Choice Bill Referendum

Risky Law: www.riskylaw.nz/

"Whatever your views of death and dying, this Act is poor legislation because it does not protect people from being killed against their will."

Vote Safe: www.votesafe.nz/

"LETHAL DOSE: with NO parental knowledge required; with NO assessment for coercion required; with NO mental health support required; with NO attempted treatment required; and with NO physical pain required."

A Fatal Law with Fatal Flaws: <https://carealliance.org.nz/>

The End of Life Choice Act is: "Unsafe – lacks adequate safeguards against wrongful deaths; Unwise – will fundamentally change our societal attitudes towards compassion for the worse; and Unnecessary – we can address end-of-life suffering without using lethal doses of drugs."

Hospice, Euthanasia – Our Opinion:

<https://www.hospice.org.nz/resources/end-of-life-choice-act-our-concerns/euthanasia-our-opinion/>

The End of Life Choice Act 2019: Dangerous and Unwise

John Kleinsman

At the upcoming General Election, voters have an opportunity to express their views on two referendum questions, one a binding referendum on assisted death (assisted suicide and euthanasia) and the other a non-binding question about legalising recreational cannabis.

Importantly, the assisted death referendum question is no longer about the merits or the *idea* of assisted suicide and euthanasia – i.e. whether a case can be made for these practices. Rather, we have to decide, as a country, if we want a *particular* piece of law called the End of Life Choice Act 2019 (EOLC Act); a law that, if passed, cannot be changed or 'fixed'; a law that, in its current state, is regarded by many lawyers, healthcare professionals and others as poorly drafted, dangerous and flawed.

Whatever way one looks at it, any assisted death regime amounts to a form of legalised discrimination, because it both assumes and requires that we make a judgement about a person's worth, and therefore their right to life, by assigning them to one group or the other.

In arguing that the proposed law is dangerous, commentators have highlighted a number of glaring problems with the EOLC Act including: no requirement for a person to talk about their decision with a trusted family member or friend; no mandatory cooling off period as in other countries – a person could be dead less than four days after diagnosis; no need for independent witnesses; a lack of safeguards and process for detecting coercion as well as depression; and no requirement that a person be competent at the time they make the final decision to take the lethal drugs.

It goes without saying that it is unwise to enact any law that is dangerous. Nevertheless, there are also deeper reasons as to why I consider it unwise to vote for the EOLC Act in the referendum.

Crossing a Rubicon

The fundamental danger associated with legalising euthanasia and assisted suicide in New Zealand is that we would cross a rubicon – a line of no-return – by creating, in law as well as in people's minds, a class of people – those with a terminal illness – who are set apart; a group whose lives are deemed no longer worth protecting in the way we protect other lives; a group for whom it is not just understandable, but *logical* that they might want to end their lives prematurely; a group for whom assisted death is sanctioned and will be facilitated by the State and, more specifically, by the State's own publicly funded health system – ironically, the same under-pressure health system charged with simultaneously funding and providing care for people with a terminal illness.

Whatever way one looks at it, any assisted death regime amounts to a form of legalised discrimination, because it both assumes and requires that we make a judgement about a person's worth, and therefore their right to life, by assigning them to one group or the other. In our current culture, the rationale for such discrimination draws, largely sub-consciously, from a deep well of discriminatory ageist and ableist thinking. This is evidenced by comments made by MP Louisa Wall in the recent parliamentary debate when she stated that not being able to care for oneself, not being able to go to the toilet, and needing to be looked after were "degrading" and amounted to a loss of respect and dignity that was sufficient to justify being dead. Attitudes such as this, and they are commonplace, illustrate clearly why it is impossible to draw a hard and fast line between discrimination towards disability and assisted death. Hence, many disability advocates argue that it is above all the fear of being disabled, combined with ignorance of living with a disability, that drives many people to support the concept of assisted death.

Making assisted death part of the culture of care at the end of life will further change the way we think about people who are ill and disabled, because it will embed the idea that some lives are unworthy of life, an idea with no defined perimeters. Laws are not simply regulatory instruments because they embody and reinforce societal attitudes. Once assisted death becomes embedded in our practices of care, what is permissible and perceived as reasonable will, all too quickly, be seen as desirable and, ultimately, to be encouraged, especially in a society biased towards the young, the strong, the healthy and the able. Is this the sort of society we really want?

The original intentions for assisted death are misrepresented in the EOLC Act

The original premise of introducing assisted suicide and euthanasia into New Zealand was that there are a very small number of people (the so-called 'hard cases') whose pain / suffering is so terrible that the most humane thing to do is to allow them to access a premature death. Whatever one thinks of this premise, the EOLC Act we are being asked to vote on is totally out of step with this premise on at least four counts:

- **The scope of the EOLC Act proves it is not designed for a small number of people.** It encompasses anyone with a life-limiting illness who has a prognosis of 6 months or less to live, **upwards of 25,000 people a year**, most of whom would be well served by palliative care. Were we to introduce a law for the 'hard cases', it would apply to a much smaller group. It would ideally be part of the justice system with its many powers to investigate the issues around competency and coercion. The precedent for a justice-based system already exists as evidenced by those

who, from time to time, petition the courts about ethically challenging healthcare decisions. In such a system, the 'gate-keeping' would occur outside of the healthcare system which, by definition, should be focused on providing therapeutic interventions or otherwise allowing a natural and pain free death.

- **The EOLC Act is not an act of 'last resort' because it does not require patients to first access treatment options, even if effective treatments are available.** If the Act were designed as a measure of last resort, it would only be accessible to people for whom standard treatment was not 'effective'. If it were a measure of last resort, it would also only be accessible to people in extreme circumstances who had ready access to quality palliative care.
- **A person does not need to be in pain to access the EOLC Act.** Yet, when the Act was being debated in parliament, many proponents of the EOLC Act offered personal anecdotes of people dying in terrible pain as the key reason for a law change. **Overseas research shows that the demand for assisted death is not driven by pain or fear of pain but by a range of personal and social reasons, including the fear of being a burden, the fear of being disabled and loneliness.** Likewise, the EOLC Act will allow a premature death for personal and social reasons – in the latest annual report on assisted death from Canada, 13.7% cited isolation or loneliness as a factor; 34% cited feelings of 'being a burden' and 53.3% 'loss of dignity'. In a poll carried out by Curia Market Research in May 2019, only 20% indicated support for a New Zealand law that would be accessed by people not in pain. People's pain and suffering can already be tended to and managed well. The current law already allows people to say 'no' to any treatments and to receive whatever level of pain relief they need, even to the point of being sedated if necessary. It is totally unacceptable for people to die in pain these days and, if quality palliative care is available, no one needs to die in physical pain. The solution to bad deaths is better access to palliative care which effectively addresses peoples physical, as well as psychological, emotional, familial, cultural, and spiritual, needs.

...the right to choose creates an additional burden on those who do not want to avail themselves of a premature death, because they will need to 'justify' their decision not to die and will be increasingly perceived as swallowing up increasingly scarce resources.

- Ironically, many of the 'hard cases' that were highlighted by MPs and others in the parliamentary debate as a reason for introducing the EOLC Act will not be eligible under the proposed law because their deaths are not imminent. In countries that began with a similar law to the EOLC Act, eligibility changes occurred in a relatively short time because it was judged **discriminatory to exclude people who have serious life-limiting illnesses but whose death is otherwise not imminent.** Clauses that were initially promoted as necessary safeguards were quickly labelled

as 'obstacles to free choice', leading to the inclusion of people with 'grievous and irremediable suffering', children, disabled people, those with mental illness (including dementia), and people with progressive neurological conditions. Many proponents of a law change have already expressed the view that the EOLC Act 2019 is too restrictive. The EOLC Act contains within itself the seeds of its own expansion and expansion here would be inevitable.

Unintended consequences of the EOLC Act

There are further reasons why I think it unwise to make assisted death legal in New Zealand:

- In jurisdictions with assisted death, such as Belgium and the Netherlands, there is a continuing and exponential growth in the numbers of people accessing euthanasia which indicates that, **in a relatively short period of time, the practice shifts from an act of last resort for terminal illness to becoming the default way to die.** In certain Dutch postcode areas, euthanasia now accounts for up to 15% of all deaths and approximately 30% of all *foreseen* deaths.
- Those who support the introduction of the EOLC Act acknowledge that there will be wrongful deaths; that there will be some people who will be coerced and others who will choose assisted death because of a wrong diagnosis and/or an inaccurate prognosis. However, proponents generally maintain that this is an acceptable price to pay for offering the choice to die to what they maintain will be a minority of the population. Yet, in the 1960s, New Zealand politicians outlawed capital punishment because they believed that even one wrongful death was unacceptable.
- Proponents of the End of Life Choice Act claim it is a robust law when in fact, as noted above, it is less robust than other assisted death laws overseas. However, even putting such claims aside, the robustness of a law and its ability to keep people safe are two very different issues. Elder abuse in New Zealand is a significant issue, with estimates that 10% of our elders are abused – this despite a robust law and zero tolerance of abuse. It is at best naive to believe that the EOLC Act will be any more effective in preventing abuse than our laws against elder abuse. Clearly, the largest group to be affected by an assisted death law will be our elders.

Legalising the End of Life Choice Act is unwise because: it is at odds with the original intentions of those who seek to introduce it; it will change our perception of what is a 'good' and 'normal' way to die; and, in practice, it will not protect some of our most vulnerable people at a time when they are most susceptible to the message that they are 'better off dead'. In addition, the right to choose creates an additional burden on those who do not want to avail themselves of a premature death, because they will need to 'justify' their decision not to die and will be increasingly perceived as swallowing up increasingly scarce resources. Ultimately, however, it remains unwise because the law itself lacks critical safeguards, safeguards that our MPs chose not to include.

Dr John Kleinsman is director of the Nathaniel Centre for Bioethics.

BINDING REFERENDUM QUESTION:

“Do you Support the End of Life Choice Act 2019 coming into force?”



What is the End of Life Choice Act 2019 Referendum about?

If passed, the End of Life Choice Act 2019 (EOLC Act) will make assisted suicide or euthanasia available to competent people with a terminal illness who are 18 or over, *and* are thought to have six months or less to live, *and* are in an advanced state of irreversible decline, and experience “unbearable suffering that cannot be relieved *in a way the person considers tolerable*”.

The group most at risk if we legalise euthanasia and assisted suicide are those vulnerable to the suggestion they would be ‘better off dead’ – our elders, disabled people, and people with depression and mental illness who find themselves fitting the eligibility criteria.

The specific wording of the referendum question is important. **We are not being asked to vote on the idea or desirability of euthanasia.** Rather, we are being asked to vote on the robustness of a specific law, one that differs in the quality of its processes and safeguards from assisted death laws overseas.

A group of more than 200 lawyers, some of whom support euthanasia, are opposed to the proposed EOLC Act because it is a badly drafted, dangerous law that is broader in its scope and riskier than comparable laws overseas – see www.lvnz.org. **The Act cannot now be changed.** If a simple majority of voters support the Act, it will be enacted in its current form without the opportunity to implement changes to make it safer.

What is “Assisted Dying”?

The term ‘assisted dying’ is the preferred language used by the Act. It is a generic term that can refer to either assisted suicide or to euthanasia or to both. The proposed EOLC Act would allow both.

What is “Assisted Suicide”?

Assisted suicide occurs when lethal drugs are prescribed to a person at their request but taken by the patient *themselves* to end their life.

What is “Euthanasia”?

Euthanasia occurs when a third party ends the life of a person by administering a lethal drug, either orally or by injection. The EOLC Act delegates this task to doctors or nurse practitioners.

What is “Palliative Care”?

Palliative care is a relatively new and specialised branch of medicine that provides relief for physical pain and also addresses psychological, spiritual and emotional suffering. Recent advances make it highly effective in dealing with extreme pain. Euthanasia is not required to ensure people experience a dignified, comfortable, compassionate death, provided that quality palliative care can be accessed by those needing it. Quality care needs to be available to all, not just the privileged.

Why are people voting ‘NO’ to the End of Life Choice Act?

- The EOLC Act is broader than a law recently passed in Victoria, Australia, as well as laws in the USA.
- The Act is not designed to be an option of ‘last resort’ – it will not just apply for the ‘exceptionally difficult cases’ because it does not require that a person first make use of available treatments, nor that they first receive palliative care.
- Quality palliative care is effective, but there is no corresponding legal right in New Zealand to access palliative care. Overseas, in places such as Canada, people are choosing assisted death because of a lack of other choices. There is a risk this will also happen in New Zealand because quality palliative care is not universally available to all who need it.
- Any prognosis is a guess. Doctors cannot predict with accuracy how long a person with a life-limiting illness might live. Many people with a prognosis of less than six months go on to live full lives for years.

- Overseas research shows that the choice of euthanasia is not driven by pain but by a range of personal reasons, including the fear of being a burden. Under the EOLC Act, a person with a terminal illness could choose assisted dying out of a misguided sense of duty based on their impression that they are a burden to their families or society.
- The current law already allows people to say 'no' to treatments and to receive whatever level of pain relief they need, even to the point of being sedated if need be. These days, no-one need die in pain.

How is the End of Life Choice Act 2019 different from what is already legal in New Zealand?

Research shows many people are confused about what is already legal in New Zealand and what the Act will allow. The following things are *already legal* in New Zealand and are *not euthanasia*:

- Turning off life support.
- Refusing treatment.
- Acting on 'Do not resuscitate' orders, where patients can request in advance not to be resuscitated if this becomes necessary to keep them alive.
- Administering high doses of medication with the intention of relieving pain – to the point of sedating a person if required – even if it might unintentionally shorten a person's life.

The End of Life Choice Act is legalising something *totally new* in NZ law: doctors intentionally ending the lives of eligible people.

- There is no mandatory stand-down or cooling off period in the EOLC Act as there is in other countries - under the proposed NZ law, a person could be dead less than 4 days after diagnosis.
- Approximately 10% of our elders are the victims of abuse, mostly from their own families. Elder abuse laws are not able to protect our elders. It is naive to expect that the EOLC Act can keep people safe.
- Key medical groups, including the New Zealand Medical Association, Hospice New Zealand, Palliative Care Nurses and Palliative Medicine Doctors all oppose the EOLC Act as unsafe.
- Medical groups have stated that it will be impossible for doctors to detect if people are being pressured or coerced. The EOLC Act only requires a doctor to "do their best to ensure that the person expresses their wish free from pressure." The Act fails to regulate for a process to ensure this happens. It also fails to recognise that doctors are not trained for this and do not possess the powers and means of the courts to make such a determination.
- Requests for an assisted death can often be motivated by depression, something that is extremely difficult to detect. The EOLC Act does not provide for people to be screened for depression.
- The EOLC Act does not require a patient to talk about a decision to end their life with a family member or other significant person.
- Unlike overseas laws, the EOLC Act does not require independent witnesses in the decision process.
- Unlike overseas laws, the person requesting an assisted death does not need to be competent at the time they make the final decision to end their life or have it ended for them.
- While the research is not conclusive, statistical evidence from overseas indicates that, over time, as the rates of assisted dying increase, there is a corresponding increase in suicide rates. An increase in the non-assisted suicide rates in New Zealand cannot be ruled out.
- In the Netherlands and Belgium, it was not originally envisaged that disabled people or people who are mentally ill would be eligible. However, assisted death is now offered to people with mental illnesses and dementia and to disabled people. The same changes will likely happen here.

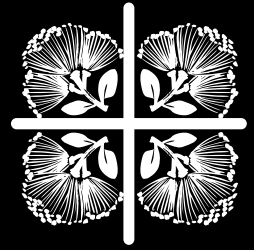
Conclusion: The EOLC Act is badly drafted and seriously flawed. It will expose many New Zealanders to the risk of a premature death at a time when they are most vulnerable. **Whatever one's views about the idea of euthanasia, it is not compassion to vote for a dangerous law.**

For more information see: www.riskylaw.nz or www.votesafe.nz or www.carealliance.org.nz

Authorised by John Kleinsman, the Nathaniel Centre for Bioethics, 15 Guildford Terrace, Wellington 5028

NON-BINDING REFERENDUM QUESTION:

“Do you support the proposed Cannabis Legalisation and Control Bill?”



What is the Cannabis Referendum about?

The Cannabis Referendum is to decide whether to **legalise recreational cannabis**. **The referendum is not about medicinal cannabis**. Being non-binding means that if a majority vote yes, the proposed Bill will be put through the normal parliamentary process and the ultimate decision will rest with the incoming government.

There are three ways of approaching recreational cannabis: **1**: make it illegal and a criminal offence; **2**: decriminalise it – retain its illegal status, but remove criminal sanctions and apply penalties and/or health-based interventions (such as addiction therapy) to those who use, grow and/or supply it; **3**: legalise it.

Up to 2019, the law treated cannabis as a criminal issue. However, in 2019 the Misuse of Drugs Act was amended so that possession offences could be treated as health issues instead of criminal, except where there is a clear public good to be gained from prosecution. Thus, while cannabis remains illegal, the police can use discretion in deciding how to respond to those who use, grow and/or supply it; whether to charge a person or steer them towards a health-based intervention. **In reality, we have a form of ‘de-facto’ decriminalisation.**

There are good arguments to be made that the current laws and regulations around the possession and use of recreational cannabis are not working well:

- The diversion of people to the health system based on police discretion is problematic: rangatahi Māori (Māori youth) are three times more likely to be convicted for cannabis-related offences than their non-Māori peers, indicating systemic racial bias in the current application of the law.
- The current law does not deter people using recreational cannabis – 95% continue to use it after arrest. Decriminalisation offers an alternative path for reforming our laws around recreational cannabis use; for moving from a criminal-based approach to a health-based one focused on addiction and reducing demand. **The current referendum does not provide for a decriminalisation option not based on police discretion.**

The Effects of Cannabis When Used as a Recreational Drug and Rates of Use in New Zealand

The scientific consensus is that recreational cannabis is not benign. When smoked, it can be harmful to the lungs and it can cause symptoms such as bronchitis. It can result in lung disease in those who use it heavily. Cannabis also impairs driving ability: drivers under its influence are more likely to die than sober drivers. Cannabis can be implicated in poor psychological health, including psychosis and possibly depression. Some people are genetically predisposed to a severe psychiatric reaction to it. Cannabis use can cause impairments in cognitive capacity and memory, and early, regular use can compromise a person’s ability to learn. Research focused on adolescents suggests that brain changes can emerge after using the drug.

Today’s cannabis is different to that from the 1960s-80s because it has been genetically modified to have higher levels of THC (the potentially addictive ingredient that causes a high) and lower levels of CBD (the ingredient that counteracts the effects of THC). The long-term effects of today’s cannabis are unknown, because most research has been based on cannabis with lower levels of THC and higher levels of CBD.

Cannabis is the most commonly used illicit drug in New Zealand. It is estimated that 80% of young people use it on at least one occasion. Of this 80%, it is estimated that 10% develop a pattern of heavy, dependent use.

The Proposed Law

The purpose of the proposed *Cannabis Legalisation and Control Bill* is to regulate and control the manufacture, use and sale of cannabis. The intention of the Bill is to reduce the harms caused by recreational cannabis to individuals, whānau, families, and communities by: 1) controlling the potency and quality of cannabis products; 2) shifting users from the black market to legal supply outlets; 3) using the proceeds from these sales to fund health interventions to help those living with cannabis addiction; 4) reducing the demand for cannabis; 5) imposing a minimum-use age of 20 years; 6) ensuring that health warnings accompany the purchase of all legal cannabis products. **A key question is whether the proposed law will be able to deliver what it promises.**

Which Groups are Likely to be Most Negatively Affected by the Proposed Law?

Research shows the **three most vulnerable demographics** in our society in terms of recreational cannabis are:

- rangatahi Māori, because they are three times more likely to be arrested/convicted for cannabis-related offences than their non-Māori peers, indicating systemic racial bias in the current application of the law;
- young people as a whole because of the effect cannabis can have on the developing brain;
- people of all ages (including youth) who are genetically predisposed to a severe psychiatric reaction to cannabis.

Some Factors and Questions to Consider in Deciding How to Vote

- What effect will the proposed changes have on young people, taking particular account of the lack of knowledge of the short-term and long-term side-effects of today's much stronger cannabis?
- Will legalisation help us to better understand and respond to the complex constellation of social, economic, historical, political, and physical factors, including racism, that are at the root of drug use/addiction?
- Our rangatahi (youth) may be uniquely susceptible to lasting damage from cannabis use into their early or mid-20s, while the brain is still developing. Studies have found evidence of brain changes in teens and young adults who smoke cannabis.
- The belief that making cannabis more easily available while expecting that prohibition will restrict its availability and reduce demand among rangatahi is counter-intuitive – young people will access it more easily, in the same way they currently access alcohol and tobacco through friends and family, not retailers.
- Overseas, the legalisation of cannabis has not ended the black-market supply, primarily because regulated cannabis costs more by being subject to testing and taxes, and has lower levels of the active ingredient, THC.
- When cannabis is combined with alcohol, the risk of a fatal driving accident increases. That risk is present with moderate levels of cannabis and blood alcohol under the drink-driving limit.
- Research shows that while there is minimal change in the number of people who consume cannabis after it is legalised, those who do consume appear to increase their use considerably.
- Globally, cannabis is emerging as big business, worth billions of dollars. As with the tobacco business and the alcohol business, these companies are powerful and have a vested interest in driving up demand.
- How does this Bill intersect with other Bills – e.g. the 2019 Mental Health and Wellbeing Commission Bill and how will it intersect with the aim to be Smoke Free by 2025?

Conclusion: Cannabis is a complex, nuanced issue. The current laws are not preventing harm despite it being illegal. Decriminalisation and legalisation of recreational cannabis around the world are a relatively recent change in approach and the long-term effects – physical, social, economic – whether positive or negative or neutral, are not fully known yet and may not be known for some years. The key questions are: 1) how do we best respond to the current ineffectualness of the law? 2) how do we best attend to the harm that is happening, especially to our rangatahi? and 3) how do we best prevent future harm?

For more information, see: <https://dunedinstudy.otago.ac.nz/publications?category=1> and <https://www.pmcsa.ac.nz/topics/cannabis/>, as well *The Nathaniel Report* (Issues 57, 58 and 60).

Authorised by John Kleinsman, the Nathaniel Centre for Bioethics, 15 Guildford Terrace, Wellington 5028

Suffering in Silence: Young Men's Experiences of Silence and Suicide Bereavement

Chris Bowden

Between 2018-2019 there were an estimated 685 suicides in Aotearoa/New Zealand. The majority of these (n=498, 73%) were men. Suicide in men has been described as a "silent epidemic" because of its high incidence, a lack of public awareness, and a lack of targeted gender-specific prevention and intervention strategies¹. The highest rates of suicide occur in the following age ranges: young men 20-24 years of age (n=64, 36.4 per 100,000 population), 25-29 year olds (n=57, 31.57 per 100,000), 50-54 year olds (n=46, 30.51 per 100,000), and 15-19 year olds (n=48, 29.69 per 100,000)². As a suicide-loss survivor and someone who works in suicide postvention, I wanted to research and better understand the experiences of young men who lose close friends to suicide. Few studies have focused on men's experiences of grief and suicide bereavement. Men's grief is often marginalised and invisible, and few support services are male-friendly and gender-responsive.

All the men experienced silence after suicide. It was all around them, and it was ubiquitous. When they found out their friend/s had taken their lives, they struggled to find the words to describe how they felt to others; they were shocked and voiceless.

I conducted a study which involved in-depth interviews with young men 18-25 years of age who had lost a close friend/s to suicide³. My analysis identified a number of key themes in the men's experience of suicide bereavement. However, the key unvarying aspect or "essence" of their experience was silence. All the men experienced silence after suicide. It was all around them, and it was ubiquitous. When they found out their friend/s had taken their lives, they struggled to find the words to describe how they felt to others; they were shocked and voiceless. The men experienced disbelief and withdrew from others and maintained their silence; they struggled with unanswered questions and felt powerless. In the days and weeks after the suicide, they tried to remain stoic and silence their grief and feelings. They chose to keep quiet and restrained their emotions because they feared judgment and looking weak and vulnerable. They suppressed their grief, sadness, depression and, in some cases, suicidal thoughts. They did this by keeping busy and distracting themselves. When they grieved at funerals and in private, they chose to do so in silence. They realised their loss when they were confronted with the reality of their friend's death, when they watched the coffin being lowered, and when others broke their silence and reminded them of their friend's death.

At times the men were silenced by others. This happened when the suicide of their friend was not acknowledged, when they

were excluded or shut out from rituals and/or decision-making about ways to honor their friend/s. They broke their silence and expressed their grief when they found friends and family/whānau who understood or had similar lived experience. They shared their grief with others who wanted to talk about their friend – the person – and not the way they died. They broke their silence with professionals and supporters when they were provided with a safe, respectful space to vent, learn and receive help.

The men also sought out quiet spaces where they could reflect/make sense of their experience, remember, reconnect with their friend. Sometimes they experienced the therapeutic presence of others who were "just there" for them in silence. They sought out quiet spaces where they could think, contemplate their loss, consider how their relationships, self and world had changed. It was in these spaces and times that they realised their perspective on life had changed, they came to accept their loss, and that they need to move forward in ways that honored their friend/s.

This study showed the young men experienced four different kinds of silence: personal, private, social and analytic. *Personal silence* relates to the inability of the young men to understand or describe for others how they felt. They withdrew or detached into a world of silence because they were shocked, traumatised, thrown off balance, and didn't know what to say or do. The young men experienced *private silence* when they chose to be stoical, showed emotional restraint, and kept their thoughts and feelings private and hidden from others. Some did this to protect themselves from being judged, looking weak and vulnerable, and from being overwhelmed. Others avoided situations and kept quiet to protect others from experiencing greater sadness, pain and despair, and to stop them worrying. They kept busy, sought cognitive distractions and maintained normal routines to "dial down", "turn off" or "fight through" and keep their grief private.

The men encountered *social silence* when others silenced them and when they broke their silence with those they trusted. It was important for the men to be involved and invited in funeral rites and rituals, to have a voice and to be given space to grieve alongside others in their own way. They experienced social silence when others said or did things that put pressure on them to move on or get over their grief, minimised their grief and loss, or when others disrespected their friend (saying suicide was cowardly act or a sin). They chose to break their silence and share socially when they encountered a "compassionate witness" who was non-judgmental, shared their own vulnerability, validated their suffering, patiently waited for disclosure, assured them of confidentiality, provided them

with meaningful support, and helped them find solutions and practical strategies for managing their grief.

The experience of losing a close friend to suicide led to changes in perceptions about self and the world. The men used the quiet to develop a deeper sense of spiritual awareness and a more complete understanding of life and death.

Quiet physical and mental spaces enabled the men to reflect, remember and reconnect. It was in these spaces they experienced *analytic silence*. Spending time alone, viewing pictures and posts on social media, visiting the grave or important locations helped the men do their private “grief work”, make meaning, take stock, reflect on the change and adjustments they had made and integrate their loss. In these spaces they reflected on the emptiness, the hole in their lives, they talked to the deceased, and thought about how they could keep their connection with their friend. Quiet and reflective spaces helped the men to analyse, look inward critically at their lives, identify their needs for self-care, appreciate life, identify new or existing values and priorities, and develop more empathy and care for those who had experienced similar suffering and loss. The experience of losing a close friend to suicide led to changes in perceptions about self and the world. The men used the quiet to develop a deeper sense of spiritual awareness and a more complete understanding of life and death. They realised that survivors learn to live with suffering, rather than recover from or get over it.

What this study showed was that silence was an important aspect of these young men’s experiences of suffering and suicide bereavement. They suffered, grieved, lived through, and transformed their loss experience in silence. We need to see, listen to, respect and join with the silence of men in order to better understand their experience and needs for care, companionship and support.

Dr Chris Bowden is a lecturer in Te Puna Akopai/The School of Education at Victoria University of Wellington. His research focuses on suicide bereavement, male suicide-loss survivors and male sexual abuse survivors. Chris has been working in the area of suicide prevention and postvention for many years and was a recipient of a Life Keepers National Suicide Prevention Award in 2018.

Endnotes

- 1 Bilsker, D. & White, J. (2011). The silent epidemic of male suicide. *British Columbia Medical Journal*, 53(10), 529-534.
- 2 Coronial Services of New Zealand (2019). *Annual suicide statistics since 2011*. Ministry of Justice, New Zealand. <https://coronialservices.justice.govt.nz/suicide/annual-suicide-statistics-since-2011/>
- 3 Bowden, C.J. (2017). *Silence after suicide: A phenomenological study of young men's experience of losing a close male friend*. A thesis submitted in fulfilment of the degree of Doctorate of Philosophy in Health. Victoria University of Wellington. <http://researcharchive.vuw.ac.nz/handle/10063/6662>

Need to talk? Free call or text 1737 any time for support from a trained counsellor.

Lifeline – 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)

Youthline – 0800 376 633, free text 234, email talk@youthline.co.nz or www.youthline.co.nz/web-chat-counselling.html

Samaritans – 0800 726 666

Shine (domestic violence) – 0508 744 633

Women’s Refuge – 0800 733 843 (0800 REFUGE)

Alcohol and Drug Helpline – 0800 787 797 or <https://alcoholdrughelp.org.nz/contact/>

Are You OK (family violence helpline) – 0800 456 450

Rape Crisis – 0800 883 300 (for support after rape or sexual assault)

COVID-19 Vaccine – Should Catholics Vaccinate Using an Ethically Compromised Vaccine?

Kevin McGovern & Kerri Anne Brussen

The History of Vaccines

Edward Jenner is considered the father of vaccinology. He pioneered the world's first vaccine, which was for smallpox. Caused by a virus, smallpox was a serious disease which killed about three in ten of the people who contracted it and left many others with severe scars. Smallpox was mainly spread by direct, lengthy face-to-face contact between people. Virus from an infected person spread to another when they coughed or sneezed. Over the centuries, smallpox killed literally millions of people. Jenner observed that milkmaids who became infected with cowpox did not subsequently contract smallpox. In 1796, Jenner inoculated a young child with cowpox, and demonstrated that the child had developed immunity against smallpox. It is said that through this discovery, Jenner saved more lives than anyone else has ever done. Through ongoing vaccination programmes, smallpox was eradicated in 1979. Vaccination has also greatly reduced the risk of infection for many other diseases for much of the world's population, including rubella, polio, whooping cough, diphtheria, mumps, chicken pox, measles, and tuberculosis. Although these diseases are still present in some parts of the world, many parents today have the great gift of not worrying when the next outbreak might ravage their local neighbourhood and their children.

The COVID-19 pandemic

This year, 2020, on March 11, a pandemic was declared by the World Health Organisation. There has not been such a world pandemic since the Spanish Flu just over one hundred years ago. Coronavirus 19 or COVID-19 has caused havoc across the world. Infections and deaths are occurring at a disturbing rate.

COVID-19 belongs to a family of viruses which includes the severe acute respiratory syndrome (SARS) virus (as well as several bat coronaviruses). The Middle East respiratory syndrome (MERS) virus, another coronavirus, appears more distantly related.¹ In the seventeen years since the SARS outbreak of 2003, no vaccine has become available.²

COVID-19 is a highly infectious virus spreading between people when an infected person is in close contact with others. Transmission can occur through saliva, respiratory secretions or secretion droplets, which can be released from the mouth or nose when an infected person coughs, sneezes, speaks, or sings. Uninfected people who are in close contact (within 1 metre) with an infected person can be infected with COVID-19 when those infectious droplets get into their mouth, nose or eyes. Transmission can also occur through touching objects or surfaces contaminated with COVID-19.³

The COVID-19 pandemic now poses a significant threat to global public health, economic stability and growth, food security and environmental issues. As seen so far, the pandemic has claimed hundreds of thousands of lives with the potential to claim many more. It is placing, and will continue to place, an enormous strain on global health care systems. Social distancing and different levels of lockdown can help to reduce the spread of COVID-19. However, these measures come at enormous social and economic costs to all aspects of society.

Human cell lines are one type of cell line that supports the growth of COVID-19. One of the sources used for these cell cultures is tissue from deliberately aborted fetuses. This can pose a significant moral quandary for Catholics and others. Catholic teaching upholds the principle of the inviolability of human life and forbids direct abortion.

Some of the major challenges of this pandemic are the lack of a safe and effective vaccine and a lack of treatments in lieu of a vaccine. Scientific knowledge is growing daily to understand more fully the transmission of infection, including the potential for transmission by asymptomatic infected people, the disease trajectory, who is more susceptible to infection, and the longer-term health implications of a COVID-19 infection. The long-term protection provided by the immune response either from a COVID-19 infection or potential vaccine is still unknown. The requirement for boosters if a vaccine is developed is yet to be determined.

Vaccination is considered one of the best exit strategies for fighting the COVID-19 pandemic, and a race has begun to develop an effective vaccine. As of 10th August 2020, there are 28 candidate vaccines in clinical evaluation, and 139 in pre-clinical development.⁴

The origin and development of vaccines

Vaccines can be produced by growing the virus in a cell line or another substrate. They can also be developed through replicating viral vectors, subunit vaccines, mRNA and DNA techniques, as well as through production of a non-replicating viral vector. Companies in the race to develop a vaccine are utilising one or more of these techniques. (It should be noted that no commercial vaccine has yet been licensed utilising mRNA, DNA or non-replicating viral vector techniques.⁵ COVID-19 may be the first.)

Human cell lines are one type of cell line that supports the growth of COVID-19. One of the sources used for these cell

cultures is tissue from deliberately aborted fetuses. This can pose a significant moral quandary for Catholics and others. Catholic teaching upholds the principle of the inviolability of human life and forbids direct abortion. What is more, Catholic teaching opposes the use of tissue from deliberately aborted fetuses.⁶ On this matter, it is also worth noting that the use in medical research of human foetal tissue from elective abortions was restricted in the United States last year.⁷ Vaccines which have been produced using cell lines from deliberately aborted fetuses are often known as ethically compromised vaccines.

...someone who refused an ethically compromised COVID-19 vaccine could catch the virus, have the potential to be asymptomatic, and infect others, who could become seriously ill with the possibility that they may die. By refusing a vaccine when available, one could therefore perhaps be directly responsible for the death of another.

Two cell lines derived from elective abortions are PER.C6 and HEK-293. Both these cell lines are being utilised by a small number of research facilities who are in the process of developing a COVID-19 vaccine. HEK-293 is a kidney cell line widely used in research and industry. The foetus was aborted in about 1972. PER.C6 was developed from retinal cells from an 18-week-old foetus aborted in 1985.⁸ The cells used today in the potential vaccine manufacture are cells that are descended from the cells that were originally sourced from the foetal material. Thus, while their lineage can be traced back to the fetuses, the cells in use today are not the cells from the aborted foetus.⁹ Further, if a COVID-19 vaccine is produced through the use of these cell lines, the vaccine will not contain cells or DNA pieces that are recognisably human. The cells are killed as the virus grows in them, usually bursting the cell membrane. The process of vaccine purification removes cell debris as well as any growth reagents.¹⁰

Catholic teaching and ethically compromised vaccines

The Vatican has issued a number of documents to guide Catholics in their response to ethically compromised vaccines. In 2005, the Pontifical Academy for Life issued *Moral reflections on vaccines prepared from cells derived from aborted human fetuses*. The issue of ethically compromised cells is also considered in the Congregation for the Doctrine of the Faith's 2008 *Instruction Dignitas Personae on certain bioethical questions*. The Pontifical Academy for Life dealt with this issue again in its 2017 *Note on Italian vaccine issue*. All these documents apply a Catholic principle called the principle of cooperation to the issue of the production and utilisation of ethically compromised vaccines.

The Catholic Church is not dismissive of the problem of ethically compromised vaccines. To the contrary, the Church has a clear and consistent position which includes three important points:

- First, when a choice exists between an ethically compromised vaccine and another vaccine which is not

ethically compromised, we have a grave responsibility (all other things being equal) to use the latter vaccine.

- Second, when only ethically compromised vaccines are available, we should make known our moral objection to these vaccines, lobbying governments and healthcare systems to prepare and make available vaccines that are not ethically compromised.
- Third, until ethically uncompromised vaccines are developed, we can and should use ethically compromised vaccines to prevent serious health risks both for ourselves and for everyone. The Pontifical Academy for Life stated this third point very clearly in 2017. It said that "we believe all clinically recommended vaccinations can be used with a clear conscience ... the moral responsibility to vaccinate is reiterated in order to avoid serious health risks for children and the general population."¹¹

The 2005 document from the Pontifical Academy for Life contained a noteworthy footnote. It noted that rubella can cause "grave congenital malformations in the foetus when a pregnant woman enters into contact, even if it is brief, with children who have not been immunised and are carriers of the virus. In this case, the parents who did not accept the vaccination of their children become responsible for the malformations in question, and for the subsequent abortion of fetuses, when they are discovered to be malformed."¹² Parents in this situation are of course only indirectly responsible for these abortions.

Ethically compromised COVID-19 vaccines and moral responsibility

However, someone who refused an ethically compromised COVID-19 vaccine could catch the virus, have the potential to be asymptomatic, and infect others, who could become seriously ill with the possibility that they may die. By refusing a vaccine when available, one could therefore perhaps be directly responsible for the death of another. If only an ethically compromised vaccine is available, the truly pro-life decision is to vaccinate with that vaccine, not infect others, and save lives.

The World Health Organisation in 2019 listed "Vaccine Hesitancy" as one of the ten major global threats.

If someone chooses not to be vaccinated, they are instead reliant on others to be immunised so that a society can reach a sustainable level of herd immunity through which transmission is interrupted. In this situation, an unimmunised person may be protected against COVID-19 through the acceptance of vaccination by others. However, there are both practical and ethical problems with this. John Grabenstein reported that sociologists refer to those who do not vaccinate as "free-riders" or "free-loaders." He added that such behaviour is "inequitable and uncharitable". Further, "if enough people 'free-load', then the community's collective immunity dissipates and disease outbreaks resume."¹³ To refuse a COVID-19 vaccine would therefore be "a morally wrong act contrary to the common good".¹⁴ The World Health Organisation in 2019 listed "Vaccine Hesitancy" as one of the ten major global threats.¹⁵

Dr Helen Watt, a senior research fellow with the Anscombe Bioethics Centre in Oxford wrote a briefing paper in April 2020.¹⁶ The paper admits that there is “no absolute duty” to boycott a COVID-19 vaccine developed using a cell line derived from an aborted foetus. However, it argues that “some will feel, whether rightly or wrongly, called to a boycott [of such a vaccine] even if no alternative vaccine is available to them.” We believe that this comment is not pro-life and potentially dangerous as it may encourage people not to vaccinate. While Dr Watt may be pressuring vaccine companies to utilise ethical methods for vaccine production, encouraging the boycotting of an ethically compromised COVID-19 vaccine is quite dangerous.

In this pandemic, could Catholic researchers or a Catholic research institution use ethically compromised cell lines for development of a COVID-19 vaccine? There may indeed be proportional reasons for doing so. Some compromised vaccines have been used effectively for many years. Researchers may be very familiar with these cell lines, know the techniques of using them, and know the outcomes which are most likely. In this crisis, they may reasonably decide that they do not have either the time or the financial resources to develop and adequately characterise ethically uncompromised cell lines or to utilise other techniques to develop a vaccine. They may also belong to an international consortium in which they have little influence on the cell line used for vaccine development. They should not forget about the need to develop uncompromised cell lines, but they may reasonably not seek to do so during this time of crisis.

If they do use ethically compromised cell lines, they should recognise the ethical problems with them, and also state their proportional reason for using them during the pandemic. As the *Code of ethical standards for Catholic health and aged care services in Australia* states, we minimise the risk of scandal by “explaining clearly ... the reasons for one’s cooperation [i.e. in this case, the use of a cell line derived from an historical abortion] and why the ... cooperation is permissible according to Catholic principles.”¹⁷

Conclusion

Developing ethically uncompromised cell lines and vaccines is important. In the crisis of this pandemic, developing and using an effective vaccine to save lives is even more important. If a COVID-19 vaccine is developed using a cell line derived from an aborted foetus, the Catholic Church would surely permit the use of this vaccine, and Catholics should not hesitate to use it. Saving lives was just what Edward Jenner set out to do, and saving lives is still very important.

Kevin McGovern is a Catholic priest. He is a former Director of the Caroline Chisholm Centre for Health Ethics in Melbourne, Australia. He is an adjunct lecturer at both Australian Catholic University, and Catholic Theological College within the University of Divinity.

Kerri Anne Brussen has worked as a medical scientist, and is a former Researcher at the Caroline Chisholm Centre for Health Ethics.

Endnotes

- 1 <https://www.uptodate.com/contents/coronavirus-disease-2019-covid-19-epidemiology-virology-and-prevention>.
- 2 <https://theconversation.com/fast-covid-19-vaccine-timelines-are-unrealistic-and-put-the-integrity-of-scientists-at-risk-139824>.
- 3 <https://www.who.int/news-room/q-a-detail/q-a-how-is-covid-19-transmitted>.
- 4 <https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines>.
- 5 <https://www.chop.edu/centers-programs/vaccine-education-center/making-vaccines/prevent-covid>.
- 6 <https://www.cha.org.au/images/resources/Code%20of%20ethics-full%20copy.pdf, II.3.27>.
- 7 <https://www.sciencemag.org/news/2020/06/abortion-opponents-protest-covid-19-vaccines-use-fetal-cells>.
- 8 <https://www.sciencemag.org/news/2020/06/abortion-opponents-protest-covid-19-vaccines-use-fetal-cells>.
- 9 <https://catholicethics.com/forum/dealing-with-the-coronavirus/>.
- 10 <https://www.chop.edu/centers-programs/vaccine-education-center/vaccine-ingredients/fetal-tissues>.
- 11 <http://www.academyforlife.va/content/pav/en/the-academy/activity-academy/note-vaccini.html>.
- 12 <https://www.immunize.org/talking-about-vaccines/vaticandocument.htm>.
- 13 John D. Grabenstein, “The Value of Immunization for God’s People,” *National Catholic Bioethics Quarterly* 6, no. 3 (2006): 433-442 at 436-437.
- 14 <https://catholicethics.com/forum/dealing-with-the-coronavirus/>.
- 15 <https://www.who.int/news-room/feature-stories/ten-threats-to-global-health-in-2019>.
- 16 <http://www.bioethics.org.uk/images/user/covidbriefing2.pdf>.
- 17 <https://www.cha.org.au/images/resources/Code%20of%20ethics-full%20copy.pdf, II.8.6>.

All online resources were accessed on 11 August 2020.



The Nathaniel Centre for Bioethics

THE STORY BEHIND THE NAME

The red flowers of the Pohutukawa appear in December each year. At Cape Reinga on the northern tip of New Zealand there is a lone Pohutukawa, thought to be 800 years old. In Māori tradition the spirits of the dying travel to Cape Reinga where they slip down the roots of the sacred Pohutukawa into the sea, to journey back to their origin in Hawaiki.

Nathaniel Knoef was born on 12 December 1998, as the Pohutukawa flowers were beginning to appear. He died on 2 February 1999 as the same flowers faded, giving way to the seed from which new Pohutukawa would grow. At his birth Nathaniel was diagnosed with incurable health problems and in the few weeks of his life his parents faced many ethical issues associated with his care. Their story clearly highlighted the need ordinary people have for access to support in dealing with the growing number of ethical issues which surround the gift of life.

The naming of New Zealand's national Catholic Bioethics Centre in honour of Nathaniel is a sign of the Centre's commitment to those who are most vulnerable in the complex ethical situations which develop in their lives.

Thanks

The staff of the Nathaniel Centre for Bioethics wish to thank all their benefactors whose support has been instrumental in the establishment and continued work of the Centre. The Nathaniel Centre is supported by the New Zealand Catholic Bishops' Conference and also relies upon fees for its services, and individual donations for its continued operation and growth.

We are grateful to the Bishops' Conference and all who support us through donations. We provide a receipt for all donations received. The receipt states the Charities Commission registration number.

Subscription

THE NATHANIEL REPORT is published three times each year. Subscription is NZ\$50 per annum within New Zealand. Australian and South Pacific subscribers (including air post) NZ\$57.50. Rest of the world (including air post) NZ\$59. To subscribe please send the subscription form included with this issue of The Nathaniel Report.

If you wish to support the ongoing work of the Centre by making a donation or if your circumstances prevent you from helping us now, would you consider making a bequest to the Nathaniel Centre in your will? If you would like information on how to do this please contact:

Nathaniel Centre for Bioethics
PO Box 12243
Wellington 6144
NEW ZEALAND

Telephone: 64 4 4992251

Email: administrator@nathaniel.org.nz

www.nathaniel.org.nz

Find us on 