UGANDA EPISCOPAL CONFERENCE
HEALTH COMMISSION
UGANDA CATHOLIC MEDICAL BUREAU

NOTES ON SOME EMERGING ETHICAL ISSUES

June 2003

Preamble

Some ethical issues have emerged or re-emerged in recent times on which the Bureau has been solicited to provide guidance. The existing documents are the "Ethical Code Guidelines for Hospitals and Health units - 1996" and the "Code of Conduct – 2002". The second document is new and mainly addresses issues of personal behaviour of office holders. The first has been due for revision for some time. The Health Commission had already mandated the Bureau to undertake this task. In the understanding that the need was mainly for a more practical guidance, the Bureau has opted to provide all RCC health stakeholders with a set of notes, meant to complement and update the 1996 Code. Other notes can and will be provided in future on a need to basis or on request of stakeholders.

In these notes the Bureau wishes to tackle matters in a way that provides also the reasons why the Church adopts a stand or position that differs from other agencies and organisations. This necessitates a summary exposition of some general premises. They may appear difficult to understand but it is necessary to understand them if we want to ***"Always be prepared to make a defense to any one who calls you to account for the hope that is in you." (1Pt 3:15)***. Otherwise all stands will appear as unjustified impositions and will not be presented with the ***"gentleness and reverence"*** the Apostle wishes to accompany the account we are giving. After the general premises specific issues will be exposed in the second section: many of the questions and disagreements with the position of the Catholic Church stem from issues pertaining to the beginning and the end of life. This is not surprising, because both the beginning and the end of life are strictly related to the origin: this is why these notes will concentrate on few selected issues related to reproduction.

In the third section a summary exposition of the "principle of double effect" will be given as background to further discernment. The fourth section will clarify some semantic issues, while the fifth section will indicate the desired action by all those concerned. In the sixth section indications for the way forward will be proposed.

This document is circulated to all Bishops and Major Religious Superiors of Congregations involved in health care, and to Hospital Boards and Managements and Diocesan Health Boards and Co-ordinations for follow-up.

1. General premises

The premises presented here develop the knowledge derived from natural law and apply it to human beings. In other words we are dealing here with **"Christian anthropological premises".** By "Christian anthropology" we mean the understanding Christians have developed about the human person[1]. The use of the adjective Christian does not mean that it applies exclusively to Christians. This understanding of the natural law is made possible, easier and more complete by Christ's Revelation but, in its essence, other religious persons share in the same understanding. Only atheists, supposing they really existed, would not be ready to subscribe to this anthropology: otherwise this is the anthropology common to the majority of people recognising the existence of God, regardless of the name they use to indicate Him. In a nutshell, this anthropology recognises that:

- **Man[2] is created by God**: in experiential terms it means that man recognises that he had nothing to do with the fact that he exists. Man just finds himself in existence. The same happened to his mother and father and to his ancestors. Hence he has been made by Another, whom he calls "God".
- This "Other" who made man left an imprint in what we call "**his heart**". This imprint is experienced through the **desire for happiness**. There is no man on earth that can deny that he desires to be happy. Happiness is the most fundamental of human desires, what distinguishes man from all other creatures. Only God, who represents the ultimate destiny of man, can fully satisfy this desire.
- The desire for happiness expresses itself under the form of the many human needs and desires, from the most basic and fundamental (e.g. food, pleasure, well being…) to those we consider higher (e.g. love, good, beauty…). In essence, **there is no real difference between needs and desires: they all have the same origin**. For this reason it is important that all **needs and desires never be considered in isolation: they are effectively linked.** This is why, for example, we underline the importance of a holistic approach to health.
- Man is unique also because he is endowed with a tool that allows him to recognise his fundamental desire and the link existing between all needs and desires. In the same way this tool allows him to recognise the intrinsic link existing between all factors of which reality is composed. This tool is called **Reason**.
- Man is not only endowed with reason. He is also **free**: capable to adhere to what constitutes the source of and the way to his happiness. In experiential terms man experiences freedom, i.e. feels free, only when he is satisfied.
- The fact of being a creature, with God's imprint in his heart, endowed with reason and freedom, and desiring happiness, **makes all human relationships possible, and sets the conditions for all human relationships**. The **disrespect of these conditions hampers human**

[1] In no way this means that this anthropology is valid only for Christians. The use of the adjective Christian here means simply that we are dealing with a science whose development the Christian revelation has made easier and more complete.

[2] The use of the substantive "man" does not bear any gender connotation. In this context "man" means the human person, of male or female sex.

relationship, and makes the pursuit of happiness impossible. When we speak of **person**, we mean exactly the human being in the context of human relationship (not as isolated entity).

- In this same line, all actions and relationships of man are geared to achieving happiness. Exactly for this reason they must be assessed and judged according to their ultimate end. **Ethics is nothing else than the assessment of the value actions and relationships have with respect to their ultimate end (man's fulfilment and happiness)**. In other words it is an assessment of whether an action or relationship – in the context in which they occur -bring man closer to his ultimate end or not.
- **In this assessment <u>all of the factors</u> concurring to the definition of the end of an action or relationship are kept into account**. This means, for example, that sexual activity and reproduction are intrinsically joined in the order of nature and that, at least potentially, these two factors cannot be disjointed.

All of the ethical stands of the Catholic Church repose on these few fundamental premises and do not contradict them. Asking, as many do, the Church to revise her stand on a certain issue often means asking what is impossible. It is like asking the Church to alter the order of nature. For this reason the teaching of Church stands for all men and women, regardless of their religious belonging. Their conscience is asked to consider what the Church teaches and judge whether or not their tradition, freedom and reason leads them to the same conclusions, and act accordingly. It is surprising anyhow to see how different religious denominations basically concur with the anthropology here summarised.
The clarification of the above points should allow us to understand the rationality and consistency of the stand of the Church on the issues presented below.

2. Specific issues

In this section issues regarding **contraception, fertility regulation, prophylactic use of condoms and abortion** will be exposed. A distinction is made between information about and practice of different topics, including also some contextual notes. This should help in understanding why a certain practice or action is acceptable or not from the anthropology exposed and natural law point of departure. The conclusions drawn are binding for all consciences. In any case the final stand of the Church on the specific issue is also presented and is binding for all Catholics, and their disregard leads to moral sanction. The Church is clear: she wants to provide guidance to all men and women of goodwill: she reserves her remedial actions (sanctions) to her children.

2.a) Ethical assessment of contraception

i) Artificial contraception

In very simplified terms, sexual activity pursues **three aims (three "goods"): physical and affective satisfaction on one side, generation of life on the other**. This is the "datum" of nature we are asked to recognise and respect. Taking into account the intrinsic link existing between all factors of which reality is composed *(see general premises)* means exactly that none of the single factors can be separated (or over-emphasised) from the others without introducing a disorder that hampers the pursuit of happiness[3].

Artificial contraception is the use of mechanical, physical or chemical means that make the sexual act possible without a resulting conception. It actually separates the two ends of sexual activity, by positively and finally excluding the end of reproduction from the action.

This is the reason why Catholic ethics does not accept artificial contraception.

Examples of such methods are the pill, condom, creams, spermicides, depot injections, sub-dermal implants of slow releasing hormones etc…

Nota Bene:

- **Tubal ligation and vasectomy**
  These two methods are classified as contraceptive, but as matter of fact they cause permanent sterility. The finality of these measures makes them particularly unacceptable.
- **Emergency contraceptive pills and IUDs**. These methods cannot be considered contraceptives: they do not prevent conception but hamper the implantation of the fertilized egg in the uterine mucosa. In this sense they are to be classified as abortive. They are currently classified as contraceptives, but we need to be aware that they are abortive. They are totally unacceptable.

[3] Our line of reasoning is: in the datum of nature, the sexual activity of human beings aims at procuring physical pleasure, at expressing affection and love and at generating life. These are three factors: two subjective and one objective. If one or more of the three is positively excluded from the act, this latter is demeaned, no longer worthy of the human dignity. We call a wilfully pursued debasement of the act "sin".

ii) Natural regulation of fertility
Natural regulation of fertility banks on the natural rhythm of fertility cycle to guide sexual activity. Reproduction is never artificially excluded. When and if it is excluded, it so occurs within the order established by nature. The Church accepts the use of natural methods for fertility regulation exactly because they do not subvert the natural order of things and do not artificially separate the two ends of the sexual activity.
Example of such methods are the rhythm method, the basal temperature method, the mucus method, the lactational amenorrhoea method (or combination of these).

iii) Responsible parenthood and natural family planning
Natural family planning is the use of methods of natural regulation of fertility in the context of responsible parenthood (i.e.: parents should determine the number of children and their spacing for the good of the whole family -individual members and as a whole).
It goes by itself that natural regulation of fertility used to absolutely exclude conception (never to have children) is morally unacceptable. Natural family planning, an acceptable method of fertility regulation, becomes "immoral" if the fundamental choice is never to have children.

2.b) Practical application to a context of Teaching

(e.g. Nurses'and Midwifery Training Schools)
i) Teaching
The correct and complete knowledge about existing contraceptive means and their mechanisms of action is necessary. No Catholic School should exclude from the curriculum of Nursing and Midwifery Training parts related to artificial contraception, and must accompany it with a clear and complete exposition of the rationale and the moral judgement of the Catholic Church. At the same time all Schools should ensure that the teaching of Natural regulation of fertility is ensured.

ii) Practice
- Practice of Information, Communication, Education (ICE) skills on artificial contraception methods in Catholic Nurses' and Midwifery Schools.

ICE skills are part of the curriculum. These skills may be applied to information and communication about artificial contraception. The student has to prove that s/he is able to explain the merits and demerits of each method. We do not object to this practice as long as it includes clear and complete exposition of the rationale and the moral judgement of the Catholic Church on the method.

- Practice of artificial contraception: the actual practice of artificial contraception (e.g. insertion of IUDs, implants etc...) is not acceptable.

2.c) Practical application to a context of health care provision

i) Information

When patients and users wishing to regulate fertility approach a Catholic Unit, they need to be informed about the variety of methods offered by modern medicine with their merits and demerits, advantages and disadvantages, without distorting the evidence that experience has provided, and positively including the moral evaluation of the Catholic Church. We have an obligation not only to provide information availed to us by the medical and biological sciences, but also to share the knowledge availed to us by ethical sciences. In this way we also discharge our duty as individual Christians and as Institutions of the Church to inform consciences. The ultimate choice, when the duty of information and proposal has been discharged, lies on the individual consciences. Catholic Units will in any case propose and provide for the use of Natural methods of fertility regulation[4].

ii) Dispensing and practice

Dispensing and practice of methods disapproved by the Catholic Church cannot be pursued. This means that the dispensing of pills, condoms, creams etc… and insertion of IUDs, subdermal implants, tubal ligation/vasectomy cannot take place in catholic health services. The same moral restriction applies also to catholic health professionals acting in their personal capacity.
Doing so equates to being actual accessories (as organisation and /or as individual) to a disorderly action, and morally co-responsible of such action.

2.d) Condoms as prophylactic measure

A lot of emphasis has been placed on the use of condoms as prophylactic measure against the spread of STIs and HIV/AIDS.
While nobody seriously doubts that condoms offer partial protection against transmission of STIs, it is also clear that this protection is not absolute, nor that it can be presented as such. There is a degree of risk that remains even with the use of condoms. The use of "safe sex" to define an intercourse protected by condoms is improper and scientifically inaccurate.

i) Information

At level of information, also in this case information must be fair, complete, accurate, inclusive of the Catholic stand; therefore it:

- must not deny that condoms decreases the level of risk
- must not create a false sense of safety that is not supported by scientific evidence

[4] The proposal and provision of knowledge in Natural Fertility Regulation in the context of Responsible Parenthood is an obligation of all Catholic Health Units. The provision of the Minimum Health Care Package cannot exclude this element and all units that do not provide it have to plan so that it can be introduced as soon as possible. Reports need also to be included in the HMIS.

- must include the presentation of the objections of Catholic Ethics and the information that condoms are not dispensed in Catholic Health Units but can be obtained in any other Government Health Unit.

ii) Dispensing and distribution
The same applies here as for artificial contraception. Dispensing and distribution of condoms cannot occur in the context of Catholic Health Care.

iii) Comments about condoms in the context of the fight against HIV/AIDS.
The key to the Uganda success story in the field of fight against HIV/AIDS is not the use of condom. If ever, Uganda has proven that others are the keys to its success. Condom is but one of the factors of a success that was evident much before its introduction. There are studies that have demonstrated this fact. There is no magic solution to the problem of HIV/AIDS, and no short cut. Abstinence from promiscuous sex and faithfulness to the partner are still the key factors for an effective prevention of STIs transmission. It is clear that, if the choice of an individual is that of being promiscuous, this had better occur with the relative protection of condoms. But woe to a society that banks on avoiding the core of the matter (promiscuity) and concentrates on making promiscuity possible at decreased risk. Promiscuity is dangerous for health: this is the datum of epidemiology, easily understood by reason. The Catholic Church cannot fail to maintain this evidence and provide witness to it. It is a trust paid to the rational nature of the human person, who is capable of understanding what is good and what is bad, and to choose by adhering to what is good. This requires a great work of education, especially of the youth, that should be taken up with much more vigour by all Health Care Institutions, in collaboration with all other organisations that respect the rationality and soundness of the Church approach. It is not enough to say no to condoms or to refuse to distribute them. It is necessary to re-discover the energy that the Church showed at the beginning of the epidemic.

2.e) Abortion

Abortion is the expulsion of the foetus from the womb before it is viable. When it occurs for natural causes it is called **miscarriage**. When it is intentionally caused it is called **induced abortion**.
Induced abortion can be direct or indirect: it is called direct when the death of the foetus is intended, and not accidental (i.e. there is a positive intention and certainty that the death of the foetus will be the inevitable result of the act performed).

i) Induced direct abortion.
Church ethics recognises that **induced direct abortion is one of the most serious evils a man can commit. If committed by a Catholic it is punished with the harshest possible penalty: excommunication**[5] for all who directly

[5] Excommunication means the exclusion from the communion of the faithful. The form of excommunication applicable for abortion is automatic ("latae sententiae": i.e. the act brings it into effect without the need for the Church to pronounce it formally). Only Bishops can re-admit the faithful in the communion of the Church.

take part in the act, actively or passively. The stand of the Church on this matter has never changed and will not change.
The law in Uganda is clear: induced direct abortion is a crime. In this case the law recognises that the death of a foetus induced as an end or a means is a direct killing. Instead legislation in many Countries of the world has now legalised abortion under the assumption that abortion is carried out anyhow, but in very unsafe conditions. Its legalisation would make it safer for the mother. The use of the words "unsafe abortion" and "safe abortion" is becoming more and more frequent also in Uganda.
Regardless of what the future has in store, we need to know that legalisation of induced direct abortion will not change matters. Christian doctrine will maintain that it is a very serious sin against God and His law, which needs to be resisted by all. The right to conscientious objection must be invoked by all health workers. If this right is not recognised in the current legislation, we shall have to make sure that it will recognised before any change in the current legislation on abortion. It goes by itself that no direct induced abortions can be carried out in Catholic Health Units, ever.

ii) Induced indirect abortion
In this case the death of the foetus is permitted but not willed as means or end. It occurs in the case of serious illness of the mother when the only workable treatment, whether medical or surgical, will have two effects: the cure of the mother and the death of the foetus. In this case the moral **principle of double effect** applies (*see below*). The foetus is not directly attacked and its death, even if certain to follow, is an incidental and unavoidable by-product in the performance of an otherwise legitimate act. **Induced indirect abortion is not a moral evil**. In practice induced indirect abortion is very rare nowadays.
The principle of double effect is exposed separately and deserves to be well known by all doctors. It is often mentioned, but rarely correctly applied.

iii) Abortion in the early stages of pregnancy.
Some controversy may occur in the interpretation of the word "pregnancy". **Pregnancy starts with conception and ends with the expulsion of the foetus from the uterus of the mother**. Distinctions are made between "fertilized egg", "embryo" and "foetus" for the purpose of distinguishing different phases of the same process. There is not substantial difference either between the fertilised egg before its implantation in the uterine mucosa and after. Conception occurs when a spermatozoon enters the wall of an egg and genetic materials from the father and the mother join. **From then on, a totally new life begins, distinct from that of the father and the mother**. It is this new life that progresses to stages of development, exactly as happens to a child who becomes an adolescent and then develops into an adult human being. Therefore it is never licit to decide arbitrarily that the human being has different values in his /her different stages of development after fertilization has occurred. The so called "ECP" (emergency contraceptive pill) prevents the nidation of the fertilised egg in the uterine mucosa. This would, in the understanding of some, qualify this pill as contraceptive. As matter of fact what ECP causes, when conception has occurred, is a direct induced abortion.

3. The principle of double effect[6]

This is one of the most important principles in ethics, because it allows us to solve some of the difficult discernments that may become necessary in our life. It helps solving the dilemma of the "Indirect voluntary". Something is called "**indirectly voluntary**" when it represents the unintended but foreseen consequence of something else that is "**directly voluntary"**.

The premise for the application of the principle of double effect is that we are dealing with an indirect voluntary: **no evil must ever be willed for its own sake either as goal or as end** (because we fall here in the directly voluntary).

Given this clarifying premise, which are the conditions that make the principle of double effect applicable (and therefore morally justifies something evil)?.

1. The action done must be good in itself or at least indifferent.
2. The good intended must not be obtained by means of the evil effect (the evil effect must be only an incidental by-product).
3. The evil effect must not be intended for itself but only permitted.
4. There must be a proportionally grave reason for permitting the evil effect.

[6] For more insights look at "M.A. Gonsalves, Fagothey's Right and Reason – Ethics in Theory and Practice – 9th Edition, Prentice-Hall Inc.".

4. Additional note on Semantics

Communication is very important in all the matters we have covered here. Language is the main vehicle we use for communication. Semantics is the science that studies language. At the same time health and the practice of medicine have a first and most important premise: the first thing we must abstain from or avoid is to harm (**Primum non nocere**). Safety of medical and health procedures is the most important concern we must have when we act.

Semantics is never neutral. In the field of Reproductive Health recourse to the adjective **"safe"** has been noted and is receiving particular emphasis in two cases: **"safe sex"** to define sexual activity "protected" by the use of condoms, and **"safe abortion"** to define abortions carried out by professionals in an authorised medical environment. In both cases the use of the adjective "safe" is unjustified, and we should not yield to adopting such definitions.

In the first case because there remain a proportion of risk – not very small according to recent studies[7] – that would suggest the use of a more prudent definition.

In the second case because, even if we wanted to forget that abortion is not safe at all for the foetus, who is actually killed, it remains a procedure entailing a certain degree of risk also for the mother: less than the risk entailed by other abortive practices, but nonetheless present.

This footnote is provided to caution all about the ease with which we absorb from the surrounding environment terms and ways of speaking that do not correspond to the datum provided by reality and evidence. As health workers we have a pride in proceeding with the support of the scientific datum to all that we do: we should do the same with the use of words. In both cases at least the comparative **"safer"** should, if necessary, be used in our language.

[7] A new UNAIDS study has found that even when used consistently, condoms fail to protect against HIV transmission approximately one in 10 times. In previous reports, condom effectiveness against HIV was widely estimated at between 46 and 100 percent. The report's main author, Norman Hearst, a University of California professor, drew on two decades of scientific research on condoms. While these findings could likely add fuel to a global debate on the efficacy of condoms in tackling HIV/AIDS in the developing world, UNAIDS said the aim was not only to clear up confusion over condom effectiveness, but also to help educate people worldwide on proper condom use. The study "makes a cogent argument that we should be talking about safer sex, not safe sex, with condoms," UNAIDS chief scientific adviser, Catherine Hankins, told the UN news service PlusNews. Hankins said the final version of the report was due for release by the end of June 2003.

5. Summary and conclusion

In the previous sections we have tried to expose the general principles informing Catholic ethics and illustrate some practical application of these principles to issues and contexts we are often confronted with.
Nobody can deny that fertility regulation, responsible parenthood, and the field of reproductive health in general, represent a challenge. The challenge posed by HIV/AIDS and STIs in general does not need to be emphasised further: it is clear.
In these notes we have put an emphasis on ethics. We have done so because we thought it necessary also in consideration that new practices have appeared in our institutions that the church does not approve, while other practices that the Church approves of have been abandoned.
As general comment we would like to see that, after this clarification, a new commitment is found in adhering to the stand of the Catholic Church on these issues.
There is need to ensure that these notes are read, understood, discussed in all catholic health institutions, from boards to managements to ethical committees. They need to be attached as complement to the "Ethical Code Guidelines for hospitals and health units" and brought to the attention to all new employees before they accept employment in our units.
Therefore, on matters here exposed, where the discernment has already been made in accordance with the tradition of the Church, we ask the Boards to exercise their function of custodians of the Mission Statement and promote the necessary actions aiming at ensuring the due guidance.
For other matters or specific issues not mentioned here, it is our hope that this contribution may offer guidance to the practical discernment and decision making. We shall also endeavour to answer new questions emerging whenever they are presented.

6. The way forward

But this would not be enough and it is not enough. We cannot limit ourselves to abstaining: challenges demand a pro-active approach and the proposal of alternatives: we would like to see our institutions doing much more and much better what the Church approves of, particularly in promoting the vision of man presented in the general premise.

i) Promotion of alternative approaches
In this sense we would like to see our health care institutions more committed to doing and documenting:

- Education to Natural Fertility Regulation (Natural family Planning and Family Life education Programmes)
- Behaviour change programmes for adolescents and youth
- Adolescent health programmes.

Several Programmes and Projects have made, are making, and will make resources available for scaling up of these activities. We just need to state what we intend to do, shape it in a project frame, look for the funding avenues. We shall not fail to keep all informed of what is emerging.

ii) Increased access to essential services
On the other hand we cannot forget other traditional reproductive health related activities for which we need to scale up access:

- access to prenatal care
- access to Emergency obstetrics
- access to post natal care and to mother and child care in general
- access to Natural Family Planning.

For these we just need to be more focused on objectives we wish to reach, rather than merely responding to the demand for service.

iii) Introduction of new services
New activities are emerging in the field of reproductive health, such as PMTCT (prevention Mother to Child Transmission of HIV/AIDS), VCT (Voluntary Counselling and testing) and others. Somewhere down the line there is also access to HAART (Highly active anti retro viral therapy -ARVs). At one point or the other we have presented (or we shall present) these services in the Bulletin. We know that funds are available also for scaling up these new interventions, that need to be tapped. The creativity and inventiveness of the management of hospitals and diocesan health co-ordinations are critical for this purpose.

There is no better way for Church health institutions to be respected in their sometimes unpopular stands than doing what we are already doing or wish to do in the best possible way, and giving proper documentation and account for it.