# Bioethics Outlook

## Plunkett Centre for Ethics

**Australian Catholic University,**
**St Vincent's Health Network & Calvary Healthcare**

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## Statement from Pro-Life Catholic Scholars on the Moral Acceptability of Receiving COVID-19 Vaccines

*The Ethics and Public Policy Center, located in Washington, D.C, dedicated to applying the Judeo-Christian moral tradition to* critical issues of public policy, *has organized the following statement from leading pro-life Catholic scholars, including Ryan T. Anderson, Robert P. George, and O. Carter Snead, along with two professors at pontifical universities in Rome and other U.S.-based scholars, to explain why it is morally acceptable for pro-life citizens to receive any of the COVID-19 vaccines currently available. The statement will be of interest to Australians.*

The past year of suffering under the onslaught of COVID-19 has brought with it numerous ethical questions, and the advent of effective vaccines for COVID is no different. Foremost among the questions for those of us who are committed to defending the intrinsic equal dignity of all human beings from conception to natural death are these: in accepting any of the vaccines on offer, is one in any way endorsing or contributing to the practice of abortion, or is one in any way showing disrespect for the remains of an unborn human being? As to the vaccines currently or soon available in the United States, we agree with Bishop Kevin Rhoades, Chairman of the United States Conference of Catholic Bishops' (USCCB) Committee on Doctrine, that the answer is no. While there is a technical causal linkage between each of the current vaccines and prior abortions of human persons, we are all agreed, that connection does not mean that vaccine use contributes to the evil of abortion or shows disrespect

**In this Issue:** *The clear statement above of the desirability of being vaccinated against Covid-19 is followed by the text of a submission to government about its proposed legalization of mitochondrial donation. We finish with an advice about how best to be responsive to the ethical issues in vaccinating people who are elderly.*

for the remains of unborn human beings. Accordingly, Catholics, and indeed, all persons of good will who embrace a culture of life for the whole human family, born and unborn, can use these vaccines without fear of moral culpability.

Common to the four major vaccines, produced by Moderna, Pfizer, Johnson & Johnson, and AstraZeneca is some use of "immortalized" human cell lines. Ordinarily, cells taken from a body have a limited life span, undergoing only a fixed number of cell divisions before they arrest and die. For ongoing research, scientists prefer to use a "cell line," or a population of cells derived from a single source that has been modified (typically by some form of genetic mutation) to divide indefinitely in culture. Such "immortalized" cell lines allow scientists to conduct many experiments on cells that are both genetically identical and routinely available in the laboratory.

HEK293 is one such commonly used line.[1] The name "HEK" stands for "human embryonic kidney," and "293" refers to the 293rd experiment conducted by the scientist who produced the cell line. The embryonic kidney cells were originally obtained from the remains of a deceased unborn child following what appears to be an elective abortion that took place in the Netherlands during the early 1970s. The exact circumstances of the abortion are not known, but the scientists producing the cell line were not directly involved and, crucially, the abortion *was not* performed for the sake of providing biological materials to researchers.

HEK293 cells are particularly susceptible to the introduction of foreign DNA, and they rapidly became a standard scientific workhorse, that is widely used by both basic scientists and by industry. Although there are currently many modified versions of HEK293s that optimize these cells for specific purposes, *all* of the HEK293 cells available around the world today were derived from the remains of a single unborn child that was aborted a half a century ago. Importantly, there is no *ongoing* use of aborted tissue to generate HEK293 cells, to modify these cells, or to maintain them in the laboratory. Thus, the use of HEK293 (and similar immortalized lines) does not create future incentives for more abortions.

How widely used are HEK293 cells? They are commonly used for testing processed foods produced by companies such as Kraft, Nestlé, Cadbury and others. Indeed, the great majority of processed/packaged food products available for sale in the United States are likely to contain ingredients produced or tested in HEK293 cells.

They are also used as an alternative to animal testing in the cosmetic and pharmaceutical industry. And their use in biomedical research is ubiquitous and has contributed to an enormous number of new medications and medical procedures developed over the last several decades. It thus seems fair to say that in addition to the use of HEK293 cells by the scientific community, nearly every person in the modern world has consumed food products,

[1] We believe that the same analysis applies to the use of the immortalized cell line "PER.C6", used in the Johnson & Johnson vaccine, derived thirty-one years ago using the remains of an unborn baby following an elective abortion obtained for reasons entirely disconnected to the creation of the line.

taken medications or used cosmetics/personal care products that were developed through the use of HEK293 cells in the food, biomedical and cosmetic industries.

The various vaccines have made different uses of the HEK293 cell line, with Johnson & Johnson and AstraZeneca using them for manufacture, Pfizer and Moderna for testing only. But these differences are irrelevant to the following questions:

- Do any of the vaccines make more use than others of the mortal remains of unborn children from whom the cell lines were derived? The answer is no; as a matter of scientific fact, *no fetal "body parts" are present in these immortal cell lines*. The immortal cell lines are artifacts—biological products that have been modified and reproduced many times over, and they do not retain the natural function of the tissue from which they were derived. They are not "body parts" in any meaningful or morally relevant sense.
- Does the production and use of any of the vaccines contribute to, cooperate with, or promote any abortion? Again, the answer is no, for *the abortions from which cell lines such as HEK293 were derived happened decades ago, and no further foetal tissue is used or needed for the maintenance of these lines*.

Common to all pro-life witness is recognition that the apparent elective abortion that led to the derivation of the HEK293 cell line was morally impermissible and involved the unjust taking of a human life. But to repeat, the HEK293 cell line currently used around the globe in scientific research and those like it do not contain the remains of any human being and so its use does not show disrespect for human remains, any more than the contemporary use of products, such as roads or train lines, that were constructed by unjustly enslaved human beings, or use of land unjustly taken, shows disrespect for those victims in the distant past.

As a descriptive matter, some pro-life advocates may prefer to use one vaccine rather than another in order to witness against the evil of abortion, or to signal special respect for the unborn babies whose lives were lost. Again, we agree with Bishop Rhoades that such a choice is a matter for their conscience. But we think it a mistake to say both that these vaccines are morally permissible to use and yet that some *ought* to be preferred to others. There appears to us to be no real distinction between the vaccines in terms of their connection to an abortion many decades ago, and thus the moral starting point is one of equivalence.

Moreover, there might be good reasons for some persons to prefer or to promote the vaccines, such as Johnson & Johnson, that use HEK293 (and PER.C6) for manufacture rather than testing, namely, that the J&J vaccine requires only one dose, does not require storage at extremely low temperature, and thus may be more useful in reaching remote or otherwise underserved populations. Those who have special reasons to take the J&J vaccine should not, we believe, be led to think that they are choosing something that in other ways is more morally tainted than the Pfizer or Moderna vaccines.

Persons with access to these vaccines have strong moral reasons to take them: in doing so, they build up the herd immunity that will provide the greatest possible protection for the

most vulnerable among us, including the elderly, those with pre-existing conditions, some minority populations, and the many other seemingly random victims of severe COVID-19. To be perfectly clear, we are not saying that people are justified in using and promoting these vaccines because the great goods they provide offset the evil of appropriating a prior wicked action. Rather, we believe that there is no such impermissible cooperation or appropriation here. The attenuated and remote connection to abortions performed decades ago and the absence of any incentive for future abortions offer little if any moral reasons against accepting this welcome advance of science.

**Postscript** *(added March 11, 2021)*

This brief postscript is to underscore what is already stated explicitly above and to avoid any confusion. By way of background, the statement was meant to offer a comparative ethical analysis of the use of the different COVID vaccines available in light of variations in their production (i.e., using immortalized cell lines in testing versus manufacture). After analyzing the question, we concluded (along with the USCCB and the Congregation for the Doctrine of the Faith (CDF)) that one may choose any of these vaccines to protect oneself or one's community from transmission of the virus without (1) endorsing the abortion that preceded the development of the cell line (performed for reasons separate and independent such development), (2) incentivizing future abortions, or (3) disrespecting the memory or mortal remains of the baby whose cadaveric tissue was used and modified to create the cell line.[2] Moreover, we concluded that there are not reasons rooted in concerns of moral culpability to choose one vaccine over another based on differences in production.

At the same time, we noted that there are those who share our pro-life commitments who might wish to choose one vaccine over another in order to express their prophetic witness in favour of a culture of life, to show special respect for the lives and memories of unborn children unjustly killed in abortion, and to avoid a coarsening of the moral sense in this context. We observed (with the United States Conference of Catholic Bishops) that such people should be free to make such choices as their consciences dictate. However, we were also clear that one is not morally required to make such a choice, and those who do not are not morally culpable.

On the other hand, our statement did not assert that there is a binding moral duty to take any of the vaccines. It did, however, explain why, in our judgment, there are strong moral reasons to do so, given the apparent benefits for vulnerable individuals and communities, and the absence of immoral cooperation or appropriation. The statement did not address the matter

[2] "It must therefore be considered that, in such a case, all vaccinations recognized as clinically safe and effective can be used in good conscience with *the certain knowledge that the use of such vaccines does not constitute formal cooperation with the abortion* from which the cells used in production of the vaccines derive. It should be emphasized, however, that the morally licit use of these types of vaccines, in the particular conditions that make it so, does not in itself constitute a legitimation, even indirect, of the practice of abortion, and necessarily assumes the opposition to this practice by those who make use of these vaccines." Congregation for the Doctrine of the Faith, "Note on the Morality of Using Some Anti-Covid 19 Vaccines" (December 2020).

of those who wish to express prophetic witness for a culture of life and signal special respect for the unborn by entirely avoiding the vaccine. We would note that the Congregation for the Doctrine of the Faith's December 2020 statement speaks to this matter directly in paragraph 5:

At the same time, practical reason makes evident that vaccination is not, as a rule, a moral obligation and that, therefore, it must be voluntary. In any case, from the ethical point of view*, the morality of vaccination depends not only on the duty to protect one's own health, but also on the duty to pursue the common good.* In the absence of other means to stop or even prevent the epidemic, the common good may recommend vaccination, especially to protect the weakest and most exposed. Those who, however, for reasons of conscience, refuse vaccines produced with cell lines from aborted fetuses, must do their utmost to avoid, by other prophylactic means and appropriate behaviour, becoming vehicles for the transmission of the infectious agent. In particular, they must avoid any risk to the health of those who cannot be vaccinated for medical or other reasons, and who are the most vulnerable.

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**Ryan T. Anderson**, Ph.D., President of the Ethics and Public Policy Center

**Father Nicanor Pier Giorgio Austriaco**, O.P., Ph.D., S.T.D., Professor of Biology and of Theology, Providence College

**Maureen Condic**, Ph.D., Associate Professor of Neurobiology, University of Utah

**Father Kevin Flannery**, S.J., Ph.D, Emeritus Professor of Philosophy, Pontifical Gregorian University

**Robert P. George**, J.D., D.Phil, D.C.L., D.Litt., McCormick Professor of Jurisprudence, Princeton University

**O. Carter Snead**, J.D., Professor of Law and Director of the de Nicola Center for Ethics and Culture, University of Notre Dame

**Christopher Tollefsen**, Ph.D., Distinguished Professor of Philosophy, University of South Carolina

**Father Thomas Joseph White**, O.P., D.Phil., Professor of Systematic Theology, Pontifical University of St. Thomas Aquinas – Angelicum

# Submission to Government re proposed legalization of mitochondrial donation in Australia


## Bernadette Tobin


*Mitochondrial donation is a form of assisted reproductive technology which can help some parents to avoid transmitting mitochondrial DNA disease to their biological children. Used in conjunction with in-vitro fertilisation (IVF), mitochondrial donation techniques allow for an embryo to be produced using material containing nuclear DNA from a man and woman and the mitochondria in an egg donated by another woman. This approach minimises the risk of transmission of the abnormal mitochondria from the mother to her child. Severe mitochondrial disease can have a devastating effect on families, including the premature death of children, painful debilitating and disabling suffering, long-term ill-health and poor quality of life. Women who carry a mitochondrial genetic defect risk passing on severe mitochondrial disease when they have their own biologically-related child.*

*Introducing mitochondrial donation could prevent some children from suffering from this life threatening disease and reduce the burden of mitochondrial disease into the future. The Australian Government is proposing to legalize the technology. The aim is to allow families to access the technique safely, at a regulated clinic. Ongoing research will also be allowed to increase Australian-based knowledge and expertise. Once the clinic has demonstrated success over a number of years, and the results have been evaluated by experts, there will be an option to allow for licensed clinics across Australia to offer mitochondrial donation. Over the last month, the Commonwealth Government has sought the views of the public on its proposed approach to introducing mitochondrial donation in Australia. The following is the text of a submission made by Bernadette Tobin on behalf of the Plunkett Centre for Ethics*.

We should be looking for ways to help couples who want to avoid passing on mitochondrial disorders to their children. Their desire for healthy children to whom they are biologically related is understandable.[1] The question is whether mitochondrial donation, because it involves creating human life not for its own sake but for the purposes of experimentation, extraction and then destruction is an unethical way of addressing the problem that they face.[2]

[1] That said, and acknowledging their prerogative to make their own decisions in their own circumstances, couples do have the option of availing themselves of less risky techniques such as IVF with donor egg, or adopting or fostering children, or deciding not to have children, etc.

[2] Any procedure for the creation of a child should be consistent with the child's right to a natural biological heritage. Mitochondrial replacement arguably violates this right, the entitlement to be conceived from untampered-with biological origins, from a natural sperm from one, identified, living, adult man and a natural ovum from one, identified, living, adult woman. Somerville, M. Children's Human Rights to Natural Biological Origins and Family Structure, *International Journal of the Jurisprudence of the Family,* Vol 1, 2010.

There are two main methods for mitochondrial donation: *Pronuclear transfer (PNT):* two embryos are created, one with abnormal mitochondria in the egg, the other with a donor egg.

The nuclear DNA is removed from each embryo. The nuclear DNA from the abnormal embryo is then transferred to the healthy embryo. Two embryos are destroyed in the process of creating a third. *Maternal spindle transfer (MST):* the nuclear DNA is removed from the intending mother's unfertilized egg to the donor's egg which has had its nuclear DNA removed. The reconstructed egg is then fertilized to create a human embryo.

In both processes, human embryos will be deliberately destroyed. This is part of the process of PNT and will be part of the research involved in preparing for, and undertaking, MST. In addition, if it is decided to implant only male embryos, because mitochondrial disease follows the maternal line, then female human embryos would also be destroyed.

Over the last ten years the significant advances in therapy development for mitochondrial diseases raise a serious question about why the law should be changed now to permit such an ethically-troubling solution to the problem faced by these couples. The synopsis of one report states: *'Decades of work elucidating mitochondrial disease mechanisms have culminated in the commencement of several clinical trials of novel pharmaceutical agents that may herald the discovery of urgently needed disease-modifying therapies.'*[3]

But, if the Government has already decided to change the law to permit mitochondrial donation, I will do no more than register my in-principle objection to experimentation, extraction and then destruction of human embryos and concentrate my submission on a series of practical issues.

**Germ-line modification:** Mitochondrial donation risks changing the human germ-line in ways which we do not as yet understand. It therefore constitutes a technology with as yet unknown long-term results. Professor Dowling from the School of Biological Sciences at Monash University told the Senate Community Affairs References Committee in 2018: *'In the case of mitochondrial donation, the actual transferred mtDNA will be pervasive throughout every cell of the body of the child produced. So it will be expressed in thousands of copies; this is not a 'may be'; it is invariable. If daughters are produced to produce the technique, they will therefore pass it on to their children. So it is a germline modification in 100 per cent of cases.'*[4]

However, the matter is controversial amongst scientists: some say mitochondrial DNA is non-heritable, others that it is heritable. Still others think that the matter is unclear. Carry-over changes may well emerge in future generations. In addition, '… *experimental evidence collected from several model species and human cell lines indicates that disease-causing mitochondrial DNA do not remain stable and that they have a tendency to outcompete their*

[3] Pitceathly, Robert D.S. et al. Moving towards clinical trials for mitochondrial diseases. *Journal of Inherited Metabolic Disease,* 2021, 44: 22-41

[4] Senate Community Affairs References Committee in 2018: Hansard, p 54-55

*healthy counterparts and this could lead to the re-emergence of mitochondrial disease in children born to the technique, or in the children of daughters born to the technique.'*[5]

However, if the technology is limited to its use on male embryos, then according to one scientist, that would lead to a 50 per cent reduction in the efficient rates of IVF.[6] The procedure should not be permitted unless or until this matter is resolved. In addition, it should not be resolved merely by stipulation (in the modifications required to existing legislation – the *Prohibition on Human Cloning Act*, the *Research on Human Embryos Act,* etc, or in subsequent regulations). The case needs to be made by the Parliament to the community.

**Genealogical bewilderment:** Mitochondrial donation creates confusion with respect to personal identity, parentage and kinship. Both the US national academies and the English Nuffield Council have acknowledged that mitochondrial DNA might also contribute to personal characteristics in ways that are not yet well understood. In addition, there is a striking inconsistency between, on the one hand, claiming that mitochondrial DNA will be of little or no consequence in its effects on personal characteristics and traits of the to-be-born child and, on the other, claiming that mitochondrial DNA will be of great significance in such characteristics as the disease status of the child.[7] Once again, the matter is controversial amongst scientists. So, at the very least, it ought to be accepted that the procedure risks creating the phenomenon of 'genealogical bewilderment'. That is, given that the child will inherit DNA from three people, the procedure risks causing the dismay when, later in life, people find that their origins are fragmented. [8]

The government must be truthful about the technology. It should continue to point out that this is not a cure for mitochondrial disorders. It should reject the suggestion that mitochondrial donation is comparable with organ donation and transplantation (as is sometimes suggested by its proponents). In standard organ transplants, any new DNA which is introduced into the recipient's body is unlikely to persist in the long term and is unlikely to enter the germ-line and be passed on to the organ recipient's children.

**Associated Risks:** The government should clarify the risks associated with the technology, for the to-be-born child, for future generations, for egg donors and for the community at large. (1) It should clarify that it is associated with risks for the to-be-born child, both physical and psychological; for example: (a) A carry-over of the mother's damaged mitochondria into the reconstituted donor egg. [9] (b) Unless the haplotype of the donor is matched to the haplotype of the commissioning couple, there is a (theoretical) risk that the mitochondrial DNA will not

[5] Professor Dowling, Hansard, op cit p 52

[6] Professor Thorburn, Murdock Children's Research Institute, Hansard, op cit, p 15.

[7] Dr Newson, University of Sydney. Hansard, op cit, p 52

[8] Nicholas Tonti-Filippini. Submission No 2 to NSW Parliamentary Inquiry into Inclusion of Donor Details on the Register of Births, 18 November 2011

[9] 'Even with efficient techniques, invariably mutant mitochondria will be transferred to the donor oocyte.' Prof Dowling, Hansard, op cit. p 52

be compatible with the nuclear DNA, and that incompatibility itself may cause disorders.[10] (c) Given that the child will inherit DNA from three people, the technology risks causing 'genealogical bewilderment' explained above. There are unresolved questions of kinship and parentage associated with mitochondrial donation.[11] (2) It should clarify that it is associated with risks for future generations (through possible germ-line modification). (3) It should clarify that it is associated with risks for egg donors. The procedures used to obtain the eggs are invasive and associated with risks.[12] (4) It should clarify that it is associated with risks for the community, for example, the prospect of further commercializing assisted reproductive technologies and of adding to existing inequities in the healthcare system. [13], [14]

**Continue to prohibit anonymous donation:** The government ought to maintain the legal prohibition on anonymous donation of eggs. People want to know 'where they came from'.[15] In addition, whether they want that information or not, the history of adoptions and of anonymous donation of sperm underscores the community's obligation to ensure that identifying information is available.

**Prohibit use of technology for other purposes:** The government should outlaw the use of the technology for any purpose other than circumventing severe mitochondrial disorders (eg to circumvent age-related infertility).

**Require anticipatory consent:** The standard of anticipatory consent should be required. Anticipatory consent is the principle according to which, if we cannot reasonably assume that someone - for example, the 'to be born child' - affected by our decision, who is not present, would consent if present to what is proposed, it is not ethical to proceed.[16] (This ethical principle is thus more demanding than the well-known principle of informed consent, according to which (except in cases of emergency treatment) physical treatments should not be administered to any competent person until all relevant information has been discussed and considered and the person's free and adequately informed consent has been given.

**Facilitate follow up studies** The government will need to devise a way of balancing respect for the privacy of couples who make use of the technology with the community's entitlement to the knowledge to be gained by follow up studies which evaluate the uses of the technology.

[10] Professor Thorburn, Hansard, op cit. p 15; An analysis across studies conducted in animals suggests that the effects of creating new mitochondrial-nuclear interactions are more often negative than positive.' Prof Dowling, Hansard, op cit. p 53

[11] This was acknowledged by a biologist, who points out that in debates about the technology, the part that mitochondrial DNA plays in human characteristics is sometimes 'underplayed'. Hansard, op cit. p 50

[12] The scientists say that fresh eggs will be needed. So, the introduction of this technology will in no way reduce the thousands of stored and frozen human embryos.

[13] So clinics should be prohibited from charging for the procedure on any basis other than cost recovery.

[14] One report contrasts *mitochondrial replacement* which could ultimately 'benefit "a slice of a slice of the affected communities", namely women with mutated mitochondrial DNA who want to have genetically related children', with *gene therapies* which offer hope to everyone with mitochondrial disease. Dolgin, Elie. Beyond three-parent babies: new drugs offer hope for mitochondrial disease, https://www.statnews.com/2016/02/11/mitochondrial-disease-therapies/ accessed 23 Feb 2021

[15] Ironically, the arguments for anonymity inadvertently reveal (contrary to what is sometimes claimed) just how significant is the donor's mitochondrial DNA.

[16] Somerville, M. op cit.

# COVID vaccine consent for aged-care residents:

# It's ethically tricky, but there are ways to get it right

**Xavier Symons**

The much anticipated rollout of the Pfizer-BioNTech COVID-19 vaccine will begin in Australia on Monday 19th . The first groups to receive the jab will be quarantine and border workers, frontline health-care workers, aged-care and disability-care workers, and aged-care and disability-care residents. For aged-care residents, their age, health and living situation makes them especially susceptible to becoming very sick or dying from COVID-19. So it's right they are receiving priority access to a vaccine. But there are also ethical issues that arise when administering vaccines to aged-care residents, who often have diminished capacity to provide consent. Health authorities now face a significant challenge to ensure older members of the community feel safe, comfortable and respected during the vaccination process.

## A vulnerable group

One challenge of vaccination in aged care is the fact many older people have dementia, or other conditions that affect their ability to communicate and process information. Around one in 15 Australians over the age of 65 have dementia, and the risk of developing some form of dementia increases significantly once people enter their 70s and 80s. Among a host of challenges, dementia makes it more difficult for people to consent to medical treatment. Older people with dementia may also become upset and agitated when things change in their routine or living environment. This means they can easily become distressed during medical procedures. Evidence supporting the safety of COVID-19 vaccines is growing every day. We do know, however, that mild side-effects like headache, fever and chills are more common in COVID mRNA vaccines than standard flu vaccines (the Pfizer vaccine is based on mRNA technology). These mild side-effects may be exacerbated when someone is already frail and suffering from several pre-existing illnesses. That said, trial data suggests people over the age of 55 are less likely to experience side-effects from the Pfizer vaccine than younger people.

## Informed consent

A special team of health-care workers assembled by the federal government will administer COVID vaccines in aged care. These health-care workers must obtain consent from residents receiving the vaccine.

One challenge here is determining whether aged-care residents have capacity to consent. Capacity refers to a person's ability to make their own decisions.

Generally, a person is said to have capacity if they understand the information relevant to the decision, and the effect of the decision. In the case of vaccination for COVID-19, people must understand they are receiving a vaccine for coronavirus. They must also be made aware of relevant risks and benefits of the vaccine.

The concept becomes more complicated when a patient has a condition like dementia, as their decision-making capacity can ebb and flow depending on the time of day, their location, and the support they have when receiving information.

Unfortunately, the stigma surrounding ageing and physical and cognitive decline means older patients are sometimes subject to prejudice and inappropriate treatment.

It's important clinicians avoid making assumptions about older patients' decision-making capacity before speaking to them, and then provide information in a manner the person can understand.

When health-care workers determine a person doesn't have capacity to consent, they will require what's called a substitute decision-maker. This is usually someone who has a close and continuing relationship with the person (such as a partner or other family member).

Many people, particularly in aged-care settings, would have completed the relevant legal documentation to appoint a substitute decision-maker (sometimes known as medical power of attorney). Where a substitute decision-maker has not been appointed, aged-care staff must determine who is legally allowed to make decisions on behalf of the patient.

## What can we learn from other countries?

Many countries are already weeks or months into their vaccine rollout, so we can take their experiences into account.

One challenge that's arisen overseas has been tracking down substitute decision-makers when they're needed. This process can sometimes take days or weeks.

We should also be prepared for complex situations where substitute decision-makers refuse vaccination for those in their care. In a recent case in the United Kingdom, the British Court

of Protection ruled it was in the best interests of an 80-year-old woman with dementia and diabetes living in a care home to have the COVID vaccine, despite her son's objections.

Similar situations will likely come up in Australia. Aged-care staff should contact substitute decision-makers as soon as possible to avoid unnecessary conflicts.

Some aged-care providers have already released messages to residents and their families addressing common concerns about vaccination in general, and COVID-19 vaccines in particular.

## Looking ahead

There will be immense pressure on medical practitioners to deliver COVID-19 vaccines quickly to those who are most vulnerable to infection and illness. It already takes significant time and resources to deliver vaccines in aged-care homes, and there may be a temptation to give less importance to consent procedures.

But it's vital COVID-19 vaccines are given in a manner that respects the autonomy and dignity of older members of the community.

This is particularly important in light of the disastrous response to COVID-19 outbreaks in aged-care facilities during the height of the pandemic in Australia and around the world. Residents' dignity and autonomy has already been violated once, and we can and should avoid a repeat.

**Xavier Symons is a Post Doctoral Research Fellow at the Plunkett Centre. This article was originally published in The Conversation:**

*https://theconversation.com/covid-vaccine-consent-for-aged-care-residents-its-ethically-tricky-but-there-are-ways-to-get-it-right-155380: 19th February 2021*


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