
BIOETHICS OUTLOOK

Plunkett Centre for Ethics in Health Care

Volume 12 Number 2

June 2001

Sustaining Life in a World of Limits – The Role of Catholic Ethical Standards.

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In this issue

This edition of *Bioethics Outlook* is made up entirely of the text of a talk given by Dr Gerald Gleeson at the recent Mercy Health Care Conference in Auckland. The theme of the Conference was: Sustaining Life in a World of Limits.

The organizers of the Conference invited Dr Gleeson to introduce the new *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*. It seemed to us that Dr Gleeson's talk serves well as an informative introduction to the new *Code*, particularly to those who were not present at its 'launch' at the recent meeting of *Catholic Health Australia* in Brisbane.

In his talk Dr Gleeson's outlined the content of the new *Code*. He also explained the process by which it was developed and the reason why some of its key formulations were adopted. And he did all this in a manner which reflected the theme of the conference. Practical limits may well constrain what we can offer in the matter of health care. But ethical limits 'create the freedom and space for authentic human flourishing'. We are grateful to the organizers of the Mercy Health Care Conference for permission to reprint Dr Gleeson's talk.

Copies of the *Code* are available for sale at a cost of \$29.70.

Order forms are available on *Catholic Health Australia's* website; www.cha.org.au

Introduction

The provision of health care in the contemporary world is riddled with paradox. On the one hand, recent scientific advances are enabling us to combat disease and to extend life in ways unimaginable in the past. Advances in genetic manipulation, for example, are enabling scientists to alter the molecular and chemical bases of human life itself. On the other hand, millions of children each year die from minor illnesses like diarrhea, the AIDS pandemic is spiraling out of control in many countries, and there are growing fears about trans-species infection, the long term effects of intensive over-farming, and genetically modified crops.

The paradox is that at a time of increasing success in health care provision for some people in some circumstances, there are notable limitations and failures in health care provision for other people in other circumstances. The "limits" impacting on health and aged care are of several kinds: there are limitations due to human and financial resources; there are limitations due to inadequate knowledge and scientific skills. These are *practical limitations*. Because of the recent successes in medical science there is a

growing cultural expectation that before long we will be able to overcome these practical limits and thereby improve the health and life expectancy of people everywhere.

However, this cultural expectation of unlimited progress needs to be tempered by the recognition of another kind of "limit" on healthcare provision, for there are also "ethical limits" that constrain what we *can* do in virtue of our convictions about what we *should* or *should not* do.

The most obvious ethical limit on our actions is that constituted by the existence of other people, with minds, wills, desires and a personal dignity of their own. None of us is free to do whatever we can or want to do, no matter how good and noble our wishes might be — our conduct has to be tempered or limited by respect for the wishes and choices of other people. This ethical limit is most famously expressed in the Kantian rule that one should never treat others as *merely a means* to an end, but rather respect each person as an "end in himself or herself". It is this ethical limit which explains why it would be wrong to impose medical treatment on someone against that person's will, or to use people as subjects of research without informing them of the risks, or to give preference to some patients ahead of others on the basis of such non-medical factors as their ability to pay.

Moreover, individuals should not be viewed in isolation from the communities in which they live. There is a limit on what we may do for some, because of what we should do for others. As Pope John Paul II noted in his message for this year's World Day of the Sick "not everyone enjoys the same opportunities" for health care. Our challenge is "to encourage the necessary development of health services in the still numerous countries which are unable to offer their inhabitants proper living conditions and appropriate health care"... so that "the vast potential of modern medicine will be put at the effective service of human beings and applied with full respect for their dignity" (Message s.2).

This need for a *just* allocation of healthcare resources is perhaps the most obvious ethical requirement in the contemporary world, as witnessed by the recent debate over the availability of expensive drugs for HIV/AIDS in less developed countries. In addition to the requirement of just and equal regard for all, there is another key ethical requirement for health and aged care, viz. respect for the intrinsic or proper goals of healthcare and the dignity and integrity of the human person who is the subject of a healthcare intervention. Debates over cloning, reproductive technologies and euthanasia are ultimately debates about what kinds of intervention are truly in keeping with the good of the human person. In this regard, our culture is marked by a kind of "ethical schizophrenia": at one extreme, there is public outrage at the use of drugs in sport to enable someone to run faster or lift heavier weights; at the other extreme, there is public acquiescence in the use of drugs to prevent or to terminate pregnancy, or in the use of human embryos as a source of stem cells for therapies to help other people. Here is another paradox: why is it so obvious that using drugs to run faster is contrary to the proper goals of medicine, but much less obvious (at least to many people) that experimenting on human embryos is so too?

It is in the context of such ethical confusion in modern societies that Catholic Health Australia is about to publish a new *Code of Ethical Standards for Catholic Health Care*. In this paper I will report on the development of this *Code*, and ask what light it sheds on debates about the limits of ethically-sound health and aged care.

Before turning to this new *Code*, there is one other introductory remark I would like make. It is probably inevitable that ethical requirements (such as those in a Code of Ethics) often present themselves primarily as *limitations* on our wills, as restrictions on what we would otherwise like to do. It is worth recalling, therefore, that the right kinds of "ethical limits" have a positive effect: they create the freedom and space for authentic human flourishing. For example, the decision

to marry one person sets a limit on the kinds of relationship one may pursue with others, but more importantly the bond (or "limit") of marriage creates the space within which spouses can pursue and experience the unique depth of committed relationship in life-long marriage. The decision not to use embryos as a source of stem cells will open the way to vital research into other ways of obtaining these cells. The decision not to short circuit the care of terminally ill patients by resorting to euthanasia should be the spur to the development and provision of palliative care.

In short, ethical limits should be liberating because they provide both guidance and clarity in the midst of competing uncertainties. They should bring the right kind of simplicity to what might otherwise remain confusingly complex situations.

Why develop a code of ethics

The development of this new code was an initiative of Catholic Health Australia in response to several felt needs:

- Many small Catholic facilities have been seeking assistance in preparing clinical and ethical protocols to deal with emerging situations (e.g. the provision of CPR in nursing homes and hostels).
- Catholic facilities and organisations are increasingly entering into collaborative relationships with other providers (e.g. participation in a regional or publicly funded palliative care service; auspice of a prison health service). They needed a clear statement of the ethical principles that underpin their ministry.
- There is an increasingly vexed question about the limits of cooperation with other providers who do not share Catholic moral beliefs (e.g. a Catholic pathology service which serves a number of non-Catholic facilities).

In short, a statement of our key ethical positions was seen to be crucial to

understanding our Catholic identity as health care providers: such a statement should help us to know who we are and what we are about, and help others to do likewise.

Doubts about developing a code

Nonetheless, most people associated with Catholic health care were aware of the pitfalls in developing a code of ethics. First, there was past experience. A previous attempt in Australia saw one draft text come to nothing. Secondly, it could be argued that the US and Canadian documents, each with its own emphasis, already provide us with sufficient ethical guidance for there to be no need to go to the expense of preparing another document. Thirdly, there is the view that – given Catholic moral teachings that are in the public domain – clinical ethical decisions should simply be left at the local level, and interpreted with "prudence". In this vein one author in the US described the 1994 US Catholic Bishops *Ethical and Religious Directives* as "a memo from central office" and argued that the emphasis on central control by the bishops represented a model of Church that is no longer acceptable (Wildes, 1995).

In preparing our Australian code we took cognisance of these objections. First, our undertaking was collaborative from the outset. A comprehensive and representative group of Catholic ethicists and moral theologians worked as a "steering committee" to oversee the project. Secondly, we did not try to re-invent the wheel; we used the US and Canadian models and other Church documents where we could. We also tried to do things they did not do, and to develop a document that would be an additional resource.

The third objection – that ethical principles should be left to local interpretation – raises more complex issues about the way a code should be written and used. I will seek to respond to this objection in stages in the remainder of this paper.

The process

As noted, the development of a code was the initiative of Catholic Health Australia (CHA). They asked the Plunkett Centre in Sydney to be responsible for its drafting. With CHA we recognised, however, the need for "peer review" and for Episcopal endorsement. We helped CHA establish a "Steering Committee" of representative Catholic ethicists, and we were most fortunate to obtain as our Chairman, Bishop Michael Putney, a distinguished systematic theologian and, at that time, Chair of the Australian Catholic Bishops' Conference Committee for Doctrine and Morals (the committee that would eventually evaluate the *Code* for the Bishops' conference). (See page 12 for membership of the Steering Committee.)

Over the next two years the steering committee met several times to review the drafting work and our responses to the various consultation undertaken. The atmosphere in early meetings was at times tense: each of us probably thought he or she could have written a better document on our own! By the final meeting, however, there was a remarkable spirit of mutual respect, courtesy and good will between committee members. It was a learning experience for all of us – not only on technical matters of ethical principle, but also in terms of respect for those with whom we might disagree on some points.

Readership and authorship

Before examining the content of the document, several key parameters need to be named. First, our *title*. We have chosen to speak of "standards", not "directives" or "guidelines". "Standards" is used widely in many areas of professional practice today. It sounds less authoritarian than the US Bishops' "directives", but is not as "open ended" as is the popular term "guidelines". These "standards" refer to what is expected of Catholic healthcare professionals at their best. The Standards articulate both aspirations and obligations. They are a

statement of what "should" be the case, even if we recognise that our practices may not as yet always meet these standards.

Secondly, our *readership*. This *Code* is directed to healthcare professionals – to practitioners and administrators in Catholic institutions and organisations. Of course we hope it will be useful to many other people, to individuals and to those in other institutions. Our focus, however, are the ethical responsibilities of professionals insofar as they are working in Catholic organisations.

Thirdly, our *authorship*. This *Code* is written as an ethical statement – our language is meant to have the precision of moral philosophy and moral theology, not the "scientific detachment" of the medical textbook or the "colour and movement" of journalism. One of the criticisms we received in the final stages of consultation was that our work lacked sufficient "clinical input", that there were, for example, no clinicians on the drafting group or the steering committee. I do not believe this is a fair criticism. Our task was to develop a statement of Catholic healthcare ethics, and the expertise needed was primarily ethical, not clinical. There are many excellent clinicians and practitioners whose practice is entirely in accord with Catholic moral teaching; however, these excellent clinicians are not necessarily educated or literate in the subtleties of Catholic moral theology. Moreover, even if a few clinicians had been included in the drafting group or steering committee, the question could still have been asked as to how representative they were? There is no more unanimity of view among clinicians than there is among ethicists.

The ethical and the clinical

This is not to say that clinical expertise is not relevant to the formulation of the code. Our responsibility was to test our formulations with clinicians to ensure we were not saying anything that was factually inaccurate or contrary to sound clinical practice. We were

saved from a number of errors by the advice of the many clinicians and other professionals who commented on our drafts.

Reference to clinicians does raise a different question about the content of the code. Should a code be confined to the articulation of ethical principles, or should it also reach down to comment on the specifics of clinical practice? Let me point to some examples.

- When speaking of the presumption in favour of giving nutrition and hydration to dying patients, the code includes the *ethical* principle that nutrition and hydration would not be obligatory if it imposed disproportionate burdens on others, and then adds the practical or *clinical* judgment that in a developed country like Australia providing nutrition and hydration does not normally involve significant burdens to others (5.12).
- In relation to the use of reproductive technologies, the code states the ethical principle that technology may assist marital intercourse, but not replace it. It makes the clinical judgment that IVF contravenes this principle, but leaves open to the conscientious judgment of couples and doctors whether or not GIFT (as practiced in the way specified in the *Code*) contravenes this principle (see 2.10-12).
- Finally, in relation to harm prevention strategies (e.g. in relation to misuse of drugs) the Code remains entirely at the level of ethical principle, simply stating that health professionals may intervene in morally and practically available ways (3.3).

Reviewing these examples we find that on different occasions the *Code*:

- Adds a relevant practical comment to the ethical principle in order to "send a message" to providers and to the wider community.

- Leaves some scope for prudent and conscientious judgments by patients and practitioners.
- Remains silent on the application of some issues.

Clearly there is much room here for debate about how specific a code should be, about the detail of its clinical judgments, its tone and emphasis on particular points, and about the extent to which there is room for more than one reasonable opinion within the Catholic moral tradition. (Indeed the debates we had while writing the *Code* were numerous and at times strongly contested. No one got all he or she wanted, but everyone got something, and the document is clearly superior to anything that a single author could have produced.)

Content

I will now summarise the content of our *Code*. We wanted a document that would be educative, not simply a list of directives. We hope our *Code* will assist the "new evangelisation" of health care by offering the wider society an understanding of our motivations, and of our approach to human life and the goals of health care. Accordingly we begin with a positive statement of the key principles underpinning Catholic health and aged care. In Part I we reflect on these principles under seven headings:

1. Respect for persons within a culture of life
2. Health care and the mission of the Church
3. The goals of health care
4. Justice in health care
5. Collaboration in health and aged care
6. Respect for personal embodiment
7. Solidarity and the mystery of suffering and death

In Part II, we discuss and provide an ethical judgment on specific issues under eight headings:

1. Decision making in health care
2. Human sexuality, procreation and the beginning of life
3. Respect for bodily integrity in health care
4. Older persons and others with special needs
5. End of life
6. Research
7. Healthcare institutions
8. Cooperation with others

With respect to detailed contents of the *Code*, I would like to discuss some of the key formulations and some of the contentious issues.

Some key formulations

The standards articulated in the *Code* are not new: they reflect long-standing Catholic moral teachings. In some instances, however, I believe we have been able to craft our formulations in ways that are especially precise and helpful.

- There was some debate about whether we should refer to "human beings" (our natural classification as members of a species) or to "human persons" (thus emphasising our value and dignity as created in the image of God). Behind this debate are proposals by some ethicists to exclude from the class of persons those who lack consciousness and rationality – the unborn, those who are intellectually handicapped, demented or senile. Our formulation in Principle 1 captures the objective

personhood of each human being: we speak of "*the dignity and inviolability of every human being as a person created in the image of God*".

- Our tradition does not require us to prolong life at any cost, but it is not easy to describe the course of action when treatment is withheld or withdrawn; talk of "allowing someone to die" or "letting nature take its course" is less than felicitous. In Principle 3 we say, "*Though we may never hasten death, there come a time when death ought to be accepted*".
- Catholic teaching excludes a number of procedures that are widely available in the community. Principle 4 reminds us that, "*those whom we are unable to assist in the way they would wish will, of course, be treated with courtesy, respect and compassion as they seek alternatives*".
- The term "cloning" has captured the popular imagination, yet covers various procedures with various purposes. In commenting on genetic research, the *Code* identifies "*the asexual creation or reproduction of human embryos*" as the key description that summarises what is wrong with many procedures – viz. creating human life independently of sexual union between husband and wife (6.18).
- Like the latest Canadian health ethics guide, our *Code* reflects on the ethical issues for Catholic healthcare institutions and organisations – that they be ethical institutions themselves. We seek to articulate the reciprocal responsibilities of owners and sponsors, on the one hand, and boards and executives, on the other hand. The "*board is to act in accordance with its mandate from the diocese or congregation*", while "*owners and sponsors should seriously consider the long-term strategies and management policies established by their boards*" (7.9).

- Few ethical issues are more complex than those about the refusal of medical treatment. Our culture tends to endorse an unfettered "patient autonomy" that is not consistent with Catholic teaching. However, paternalism is also unacceptable. Our formulation is careful and illuminating: *"Patients have the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable, and such refusals must be accepted. In addition, healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not they agree with the patient's refusal (see also 5.4). There is, however, an obligation to prevent suicide when this is possible."*

The "agent perspective"

The last two formulations highlight a central methodological feature of our Code, namely that ethical responsibilities are viewed from the first-person perspective of the agent. Ever since Pope John Paul II's encyclical *Veritatis Splendor*, the importance of understanding ethical issues from the perspective of the agent or "acting subject" has become widely accepted as a key to the Catholic moral tradition. The paradigm ethical question is *not*: "What needs to happen for the world to become a better place?" but rather "What should (or may) *I* do to make the world a better place?" Clearly "the happenings" that would make the world a better place are not always things that one is permitted to deliberately bring about (e.g. the deaths of lots of wicked people!). The paradigm ethical questions are always "first personal" or "I" questions: "What should I do?" and "What kind of person should I become?" These questions are connected because it is by my choices and actions that I shape my character as the kind of person I am.

Our *Code of Ethical Standards* is not a list of right and wrong kinds of actions, though we often try to spell out just why Catholic

teaching holds a course of action to be right or wrong. Our *Code* is directed rather at helping healthcare professionals reflect on how they should respond in various commonly occurring situations in order to be acting rightly and in keeping with Catholic moral teaching. For instance: How should one respond to a patient whose request for (or refusal of) a treatment option one believes to be unreasonable? How should we conduct research in order to ensure that a patient's treatment is not compromised? How should we respond to requests by family members for confidential information about a patient? How should we respond to a couple's request for assistance with their infertility? To what extent may one cooperate with a healthcare provider who is acting in ways that are contrary to Catholic teaching? What are our responsibilities as Catholic healthcare providers to victims of sexual assault?

These are all "first person" questions - they alert us to the centrality of the agent's perspective and to the choices of action that present themselves for one's moral reasoning and intentional response. This is why, in the case of a patient's refusal of treatment, our *Code* highlights the crucial difference between the choices open to a patient and the choices open to his or her healthcare provider. From the patient's perspective, the judgment to be made concerns the expected benefits and burdens of various treatment options. Patients have "the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable" (1.16). Clearly, there can be a range of such reasonable judgments - what is unduly burdensome for one patient may be quite acceptable to another.

As a healthcare practitioner, by contrast, it is not normally my responsibility to judge what is burdensome for another. My main ethical responsibilities are to provide appropriate information, advice and encouragement, and to respect the conscientious judgments of the patient. If a patient is requesting a treatment I believe to be inappropriate or unreasonable, I might arrange for a second opinion about medically

and ethically sound alternatives. (1.16-1.17). However, while it is never right not to respect a patient, it does not follow that as a practitioner I am an unthinking "ethically neutral" agent who simply does whatever a patient says. If I reasonably believe a patient is suicidal, I have a responsibility prevent him taking his own life. On the other hand, I do not have the right to override a competent patient's decision and impose treatment on him, even if I think that refusal of treatment is most unreasonable.

In short, sound ethical reasoning depends on identifying the proper responsibilities that fall upon the various "agents" involved in a situation. It is by viewing issues *from the perspective of the acting subject* that it becomes clear why, although I have the right to judge another's conduct to be wrong, I do not necessarily have the right to interfere with, or prevent, that conduct by another.

Some contentious issues

This discussion is relevant to the first of the contentious issues I wish to mention, namely that about "patient autonomy". In considering some of these contentious issues, I will group them in terms of the kind of contention they involve.

(a) There are firstly points of contention between Catholic moral teaching and "popular bioethics"

Patient Autonomy

Patient autonomy has become the centrepiece of contemporary bioethics, as an often justified reaction to the medical paternalism of the past. However, unfettered patient autonomy leads to the trivialisation of personal freedom. Autonomy is unfettered when it is supposed that whatever an informed patient requests, refuses, or agrees to, is thereby morally acceptable - be it euthanasia, inappropriate cosmetic surgery or participation in dangerous experiments. The

Catholic moral tradition emphasises that personal freedom should be exercised in the pursuit of what is truly good and worthy of human persons, and in keeping with proper goals of health care.

These moral constraints on the exercise of "autonomy" do not justify paternalism. They simply locate personal decision making within its true context - namely, in relation to one's own physical and moral integrity, to other human beings, with their own proper responsibilities, to the goods that constitute human fulfilment, and to moral principles that guide our pursuit of those goods. It is for this reason that our *Code* details in the proper goals of health and aged care in its statement of Basic Principles (n. 3).

"Brain death"

There is much debate in the popular media and in professional journals about the definition of death in relation to organ procurement for transplantation. In the minds of many, death is regarded as a biological process with several stages, and "brain death" is just a certain stage of death, different from and less than "real death". This kind of thinking is often allied with proposals to make more organs available sooner by re-defining death in terms of the partial loss of brain function. The *Code* summarises the contribution of Catholic teaching to this debate in two points:

First, we distinguish between what death is and how it can be known to have occurred. Death is the disintegration of the personal self as a unified organic being. Total and irreversible loss of all brain function is a valid marker of death - it shows that death *has occurred* since in the absence of all brain function it is impossible for a person to be alive.

Secondly, Catholic teaching resists any move to make the loss of *some* brain function a sufficient marker of death: while ever there

is some true brain function occurring it is not the case that a person has died (however debilitated he or she may be). (See II. 5.22-3).

Non-therapeutic interventions on children

One of the most difficult points of contention in the drafting process concerned non-therapeutic interventions on young children (e.g. removing bone marrow for transplantation to an older sibling suffering from leukaemia). Within the Catholic tradition there are different opinions on this matter. Between the Catholic tradition in general and the wider culture, however, there is a more fundamental difference in that Catholic moral teaching resists the reduction of morality to "utilitarian" calculation. For many people considering cases like these, the answer is obvious: a certain amount of pain and distress, along with the very small risks of mortality, for the "donor" child is justified by the hoped-for good outcome of saving the life of a sibling.

In Catholic teaching, however, this "utilitarian" or "consequentialist" analysis is insufficient. We must first address the primary moral issue of doing something that hurts and/or harms a child with no therapeutic benefit to the child. We may not wrong one child even to do good for another child. This is not to say that non-therapeutic interventions on a child are never permissible. Steering committee members, despite their different views on the kind of non-therapeutic interventions they judged acceptable, settled on the following wording: "Parents or guardians, taking into account a child's fears and lack of understanding, should never expose their child to a non-therapeutic intervention which carries a significant risk or which the child, if he or she were competent, might refuse on reasonable grounds." (1.21) I take it this formulation, at the very least, rules out anything that would amount to an "heroic" sacrifice on the part of a child subject to a non-therapeutic intervention.

(b) The last example shows there are also legitimate points of contention within Catholic bioethics about the *meaning* of key moral principles. Another example concerns nutrition and hydration.

Nutrition and Hydration

What are our duties towards terminally ill patients, especially those who are persistently unconscious or who are suffering from advanced dementia? Some members of the steering committee wished simply to use Pope John Paul II's recent statement that nutrition and hydration should be given "to those patients who need them", leaving the judgment about who "needs" nutrition and hydration to clinicians and family. In the context of current debates and the pressures not to give terminally ill patients all the care they need, a majority of the committee, however, wanted to spell out this principle in terms of the presumption that nutrition and hydration be provided *unless* they were contra-indicated because futile or overly burdensome (to the patient or others) (II.5.12).

(c) Finally, there are the points of contention between Catholic bioethicists themselves over the *application* of agreed moral principles.

Cooperation with others

The Catholic moral tradition is notable for its insistence that there are some things one should never do, such as lie to one's patients, experiment on human embryos, or deliberately take innocent human life. The Catholic tradition also tempers these absolute teaching with a recognition that we live in a morally flawed world and that our actions are often interconnected with actions by others that we hold to be wrong. Catholic moralists are often asked for guidance about the extent to which one may cooperate with those one believes to be acting wrongly. Their guidance takes the form of principles governing cooperation with others, and these principles

are especially relevant to Catholic health and aged care services today.

Contemporary health care providers, both public and private, endorse a number of activities that are excluded in Catholic teaching: abortion, obviously, but also most forms of reproductive technology and birth regulation, and many approaches to minimising the harmful effects of disordered behaviour. The complex connections between different healthcare entities, along with the pressures on the identity of Catholic healthcare institutions in a modern, post-Christian society have led some Catholic theologians to wonder if "Catholic healthcare on the scale to which those in some countries have become accustomed and which those in other countries would like to become accustomed, is no longer possible" (Fisher, 1997, p. 229).

It may be tempting for Catholic providers to focus on a narrow range of services that can be provided "safely", without raising ethical difficulties (e.g. provide hospices for the dying). It is increasingly difficult, however, for any one area of health care to be quarantined from other areas. Complex questions of cooperation arise in the course of what are otherwise exemplary healthcare services, for example: the integration of a publicly funded Catholic palliative care service within the government's regional palliative care service; the auspice by a Catholic facility of a Community Health team whose work involves harm prevention strategies among persons with HIV/AIDS.

The principles for legitimate cooperation have a long and honoured place in the Church's moral teaching, and were recently invoked by Pope John Paul II in relation to the case of a member of parliament voting for laws to limit abortion, when such laws are clearly preferable to the only available alternatives (EV 78). Yet both the formulation and the application of these principles are widely disputed. All Catholic moralists agree that cooperation and collaboration with others is permissible under certain conditions. But as

the US Catholic Bishops found when preparing their *Directives*, and as we found when drafting our *Code*, it is difficult to get Catholic moralists or bishops to state publicly which particular cases they believe meet those conditions. This disagreement about the application of principles has now spilled over into disagreement about the articulation of the principles. In the latest draft revision of their *Ethical and Religious Directives* the US Bishops are proposing to omit any statement of these principles – on the grounds that this could lead to misunderstanding and abuse.

I am happy to report that in Australia, the steering committee for our *Code* agreed on a consensus statement of the principles of cooperation, a different kind of statement from that which has generated such debate in the US. Our formulation includes a case study example – concerning collaboration by a pathology service – on the grounds that a statement of principles that cannot be applied to actual cases is worse than useless. Time will tell whether those who use our *Code* find its statement of these principles helpful.

Harm minimisation

In the case of collaboration with others whom we believe to be acting wrongly, we should ensure that our cooperation neither explicitly or implicitly endorses their wrongdoing nor encourages others also to act wrongly. This same concern underlies the debate over harm minimisation strategies which start from the premise that, whether we like it or not, some people are resolved to act wrongly thereby harming themselves and others.

The Vatican's intervention over the proposal by the Sisters of Charity Health Service (SCHS) to conduct a medically supervised injecting room at Kings Cross in Sydney is one of the most publicised bioethical issues of the past few years. While the SCHS was obviously not intending to support or encourage the misuse of drugs, there has been fierce debate about whether providing a "safe" environment

would increase drug use or would only minimise its harmful consequences.

A more fundamental issue here concerns whether harm minimisation strategies are to be encouraged or merely tolerated. Should we accept that many people are determined to act wrongly and set out to lessen the harms associated with their conduct or should our primary efforts be directed to getting people not to act wrongly in the first place? Where should a Catholic healthcare service put its emphasis? Once again, no Catholic moralist or bishop will deny that "harm minimisation" strategies are required in some situations. In practice, however, there is always debate about whether a particular strategy is appropriate in a particular case. In the light of the Vatican's clear preference in these matters, the final version adopts a studied generality: "If patients are determined to act in dangerous or self-destructive ways, health professionals may intervene with morally and practically available means to help avoid that harm" (II.3.3).

Conclusion

I have noted some of the key formulations in the *Code*, and some of ways in which we have dealt with contentious issues. In doing this I have sought to highlight some of the guiding principles for a Catholic approach to healthcare ethics, in particular the importance of the agent's perspective, that is, the importance of understanding what are properly one's own responsibilities and what are one's available courses of action. This perspective constitutes one crucial "limit" on the way we should conduct our healthcare ministry in order to maintain our integrity and Catholic identity.

In addition to respecting these ethical limits, limits which create the space for the Catholic healthcare apostolate, we should also recognise that the Catholic moral tradition at its best has been marked by flexibility and a respect for the uniqueness of particular cases. "Casuistry" is the art of applying moral

principles to particular cases, and of identifying the rationale for moral judgments on types of cases in order to clarify the scope for identifying new kinds of cases. [One such development in this century concerns live organ donation (e.g. a kidney), in which what at first seemed to be a case of "mutilation" was later recognised as a case of "generosity".] At its worst, of course, casuistry became a matter of bending rules and finding loop holes, and was associated with the idea of moral experts (theologians or committees) who would give rulings on particular cases, telling people whether they could or could not undertake a certain procedure. At its best, however, casuistry is a matter of identifying the rationale for making sound moral judgments in ways that can illuminate a range of like cases. This is why, for the most part, therefore, our code of ethics articulates the principles underpinning sound clinical practice, while leaving the application of these principles to clinicians.

It has been a privilege to be so closely involved in the preparation of this *Code*.

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Bioethics Outlook is a quarterly publication of the Plunkett Centre for Ethics in Health Care,
a university centre of Australian Catholic University and St Vincent's & Mater Health Sydney.

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Editor: Bernadette Tobin

Layout: Linda Purves

Subscription is \$71.50 (institutions), \$44.00 (individuals), \$22.00 (Students & Pensioners)
\$15.00 (airmail postage - overseas subscribers)

Plunkett Centre for Ethics in Health Care, St Vincent's Hospital, Darlinghurst, NSW 2010

ISSN 1037-6410