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JUSTICE AND HEALTH CARE

Bernadette Tobin

The question of how resources ought to be allocated in health care is one which perplexes many people. If someone in our immediate family - a young child, for example - requires treatment in hospital, we want everything possible to be done. In those circumstances, we (understandably) do not advert to what we generally recognize: that the treatment which one person receives often has an impact on the treatment which will be available for another. We want everything possible to be done for the person we love.

Correlatively, doctors have always been encouraged: not only to be altruistic and put the interests of their patients ahead of their own interests, but also to be utterly individualistic about their responsibilities, to act (as Robert Veatch puts it) as though in all the world there were only one physician and one patient.¹

In addition, the available forms of health care are sometimes determined as much by the professional interests of practitioners as by the needs of a local community. On a recent visit to Vietnam, Terence O'Connor (an Australian colorectal surgeon) could see that the major health problems of that country related to malaria, hepatitis, malnutrition, ascariasis, and the need for immunization. But when he asked doctors there what was needed in their hospitals, their replies were: cyclosporin for renal transplantation and heart/lung machines for cardiac bypass procedures!

Other factors also influence the availability of different forms of health care. Take, for instance,

the cost of drugs used in the treatment of people with chronic myeloid leukaemia. The conventional drugs cost \$200 a year for each patient and are associated with an average survival rate of about four years. But newer, genetically-engineered drugs cost \$35,000 a year per patient and are associated with only a slightly higher survival rate (sixty per cent of patients at five years). The social implications of starting someone on the more expensive form of treatment are obvious: Who is to pay for the drugs? What other treatments - for which patients - are to be foregone?

In general it is no longer possible for us to provide all the hospital or nursing home beds, all the artificial nutrition and hydration, all the life-prolonging drugs, all the organs for transplantation, all the neo-natal intensive care, all the preventive screening and health education, etc., from which people could *benefit*, let alone that people *want*. Hard choices have to be made. It is not enough to rehearse the great social principles which have traditionally motivated our health care system. We need to develop them into a "social ethics of health care". We need to spell out *how* the principles of compassion and justice structure the moral context in which we decide which treatments and drugs are to be made available in our society and which are not.

Robert Young - in a recent seminar on resource allocation sponsored by the John Plunkett Centre - claimed that, so far at least, we recognize two levels of decision-making which affect the provision of health care: the macro level at which governments decide how much of our available wealth will go to providing health care (Dr Young pointed out that as yet there exists no *theory* of rational allocation of

the gross domestic product; allocations often reflect nothing more than the strength of particular lobby groups) and the **micro** level at which individual practitioners decide what treatment to give to each patient.² (Though Dr Young thought that decisions are generally well-made at this level, he urged that we scrutinize several factors that operate on our thinking at this level: better prognosis, social worth, "first come, first served", and the employment of market mechanism in health care are all ethically-loaded.)

However, he argued that the critical decisions are really being made at a third, **intermediate** level. Once the macro decision has been made, and we know how much of our wealth is to go to health rather than to defence, education, etc., and before the individual practitioner decides what tests and treatments to authorize for this particular patient here and now, crucial "intermediate" decisions are made about how the health care budget is to be divided up: decisions about the proportion that will go to the provision of non-medical care such as meals-on-wheels, home help, nutrition education rather than to medical services, about the proportion which will go to hospital care rather than to the provision of services by general practitioners, about the proportion which will go to the various specializations within hospitals, etc. If we want to ensure that we are just in the allocation of health care, we need (he urged) to reflect on the range of issues which arises at this "**intermediate**" level. Dr Young set out and commented on seven issues. Let me mention just three.

A Wider Conception of Health Care

First, what counts as health care? If the moral purpose of health care is in general to maintain and to restore in an individual the normal functioning specific to his or her age, then we need to think carefully about the things which have a bearing on that. Home help for the elderly, meals-on-wheels, respite care for people looking after chronically-ill relatives, may well turn out to be cost-effective means of maintaining health in many elderly people. Indeed, if we extend our notion of health care to include the provision of these services, it will be hard not also to include the provision of healthy working environments and the creation of opportunities for adequate rest and relaxation for (say) migrant women. And the more of our health care budget we spend on these services, the less will be available for more high-tech forms of medicine.

Slice of Time and Lifetime Perspectives

Secondly, there are two perspectives from which we can consider what health care is appropriate for an individual. A "slice of time" perspective

focusses on what things are like at the present moment. A "lifetime" perspective focusses on how resources are allocated over a lifetime. The first is appropriate in emergency situations: in an emergency what matters is not how much health care an accident victim has already consumed in his life but what he needs *now*. The same perspective is appropriate in situations when someone is in intense pain. However, an "over a lifetime" perspective may be more appropriate when what is being considered is life-prolonging treatment for the very elderly and for the terminally ill. (In the United States, it is now estimated that forty per cent of the health budget is spent on people in the last eighteen months of their lives.) Which perspective is appropriate differs from circumstance to circumstance, and "it would be utterly improper from an ethical point of view to get it wrong and to use the wrong approach in the wrong circumstance".

Prevention, Cure and Rehabilitation

Third, how much should go to preventive care rather than to curative or rehabilitative care? Certainly many groups in our society - migrant women and aborigines come to mind - have suffered because of inadequate attention to preventive measures. On the other hand, it would be quite unethical now to put all our resources into the preventive. For the present generation of elderly people in Australia can legitimately point out that they were significantly disadvantaged during the earlier phases of their lives. The kinds of health care *now* available to younger people were simply unavailable to them earlier in their lives. And a similar point needs to be made about older people who suffer from "self inflicted" illnesses associated with smoking and alcohol. When they acquired these habits, they did not have access to the information now available to young people about the deleterious effects of smoking and drinking too much.

As already mentioned, Robert Young's comments came in the context of a seminar on justice in the distribution of health care. He was one of seven speakers. Anyone who would like to read the full text of Dr Young's talk, together with those of the other speakers, is invited to obtain a copy of the proceedings of the seminar. An order form is to be found on page 12 (and another is found on the back of the address sheet for *Bioethics Outlook*.)

1. Veatch, R: "Theories of Medical Ethics: The Professional Model compared with the Societal Model", *Organ Replacement Therapy, Ethics, Justice, Commerce*, edited by W. Land & J.B. Dossetor, Springer-Verlag, Berlin, 1991
2. Young, R: "Justice in the Allocation of Health Care" *Resource Allocation: The Ethical Issues*, John Plunkett Centre For Ethics, 1992

On The Difference Between Prohibitions And Obligations

Gerald Gleeson

In September this year a British rheumatologist was convicted of attempting to murder a patient who asked for her life to be ended because she found it no longer bearable. His action has aroused both support and condemnation and raises an important factual question: could it be the case that the only relief a (dying) person can be given is that of ending his or her life? Conversely: is refusing to end someone's life in these circumstances tantamount to forcing him or her to continue to live in unbearable agony?

In the case of Dr Cox's patient, Mrs Boyes, afflicted with rheumatoid arthritis, it is reported that massive doses of dia-morphine gave no relief, and that her tissue had deteriorated to the point where she could no longer bear even to be touched. She had septicaemia, burst blood vessels, ulcers on every limb, a calcified heart, malfunctioning lungs, and more.

Nonetheless, deliberately ending her life was not the only course of action available to Dr Cox. Commenting in *The Tablet* (September 26, 1992), Dame Cicely Saunders, chairman of St Christopher's hospice in London, said this was "a very unusual case". She agreed there can be pain which is morphine-resistant, but said that in those cases combinations of drugs and modes of delivery could be helpful. She said that in very rare cases it might be necessary to sedate someone before he or she would be free of pain.

Palliative care specialists also emphasise the distinction between "pain" and "suffering", between sensory and emotional distress. In almost every case today excellent methods of pain-relief are available, which not only successfully relieve pain, but which, furthermore, need not have the side-effects of depressing consciousness or shortening life (as was common in the past). Palliative care is a matter of sophisticated expertise, and it is significant that press reports suggest that

Dr Cox did not seek advice from specialists in the field.

The relief of a person's suffering is a more complex matter, for emotional suffering is linked with many different aspects of one's life, including one's history, socio-economic factors and, above all, one's relationships with others. It would seem that Mrs Boyes' life-situation was not good, and her wish to die seems primarily to reflect the dismal state her life had come to. Appropriate care of Mrs Boyes would have involved attention to both pain-relief and to improving the quality of her life-experience, especially her relationships to others.

Sympathy for Dr Cox, and support for voluntary euthanasia, derives largely from the belief that the pain and suffering of dying patients might be unrelievable, so that just maintaining their lives would amount to prolonging their dying. It is necessary to reiterate that respect for human life does not entail prolonging it unduly, or forcing patients to die in agony. We have the medical expertise to ensure that pain can be managed (if necessary, in exceptional instances, by sedation) so as to allow people to approach their death with dignity and comfort, and in particular to enable them to address the many other issues which may cause them suffering.

Turning from factual questions about our resources for palliative care today, I wish to take up the explicitly moral questions about euthanasia. How ought we care for someone whose life is drawing, perhaps painfully, to an end? Indeed, to put the issue most sharply, why should we even bother with the palliative care of those in severe pain or suffering? Would it be "kinder" all round, and less drain on human and medical resources, deliberately to end the lives of people who have come to find life unduly burdensome?

Debate about euthanasia often centres on the

validity of distinctions between "active" and "passive", between "killing" and "letting die", and so on. While these distinctions are important, I am convinced that more fundamental issues should first be addressed, concerning the way in which we understand what it is to do good and to do wrong, and concerning the difference between prohibitions and obligations. In this article I will seek to explain the understanding of what it is to act morally (or immorally) which underlies the significance of these distinctions, and so the ethical framework for determining how one ought to care for the terminally ill.

II: Absolute vs Presumptive Conviction

The long-standing Christian approach to death and dying is shaped by two convictions: first, that it is wrong to deliberately take one's own or another's life, and secondly, that physical life is the fundamental gift and good of human existence which always demands our care and respect. The first conviction takes the form of a **prohibition**. It is more than a recognition that killing is an evil; it is the conviction that killing oneself or another could never be a good thing to do, that it should never be considered as a means to some end, however good that end appear to be. It is an "absolute" prohibition against taking human life. The meaning of "absolute" will be qualified shortly, but we need to use words like "absolute" and "unthinkable" in order to convey the force of convictions such as this.

The second conviction takes the form of an **obligation**, a duty of care with respect to health and physical well-being, but it does not issue in an "absolute" obligation to maintain physical life. In due course one's life will draw to an end, or will become such that it is futile to prolong it, and while the obligation to care for a dying person continues, the obligation to maintain his or her (or one's own) physical life may cease.

The second conviction motivates the search for even more effective means of palliative care so that we may truly accompany a person in his or her dying. However, the first conviction rules out deliberate killing as ever an acceptable "palliative" measure. What needs to be clarified in this account is the *asymmetry* between the absolute force of a prohibition and the less absolute requirements of a positive obligation, an asymmetry which explains why when the obligation to prolong life ceases the prohibition against killing does not.

The force of the prohibition against taking life is under challenge from a number of quarters. Some claim that it should be subject to the utilitarian principle of maximising happiness: human life is

one good among many, and may at times need to be "sacrificed" in the cause of achieving greater goods. Others claim that, at least in the case of one's own life, moral autonomy entitles one to end one's life as and when one judges the circumstances and quality of one's life to be no longer worthwhile. In both cases the prohibition against taking life is no more than **presumptive** - while taking life is an evil of some kind, it is an evil that at times may well be justified.

What is crucial in debates about euthanasia is whether we bring to our reflections the "absolute" or the merely "presumptive" conviction about the evil of taking human life. Catholic Christians have traditionally rejected the claim that judgments about moral good and evil are merely presumptive. Once we understand that taking human life is doing evil we encounter a fixed point of reference for moral decision making. Yet, despite this absolute conviction, the Catholic tradition has nonetheless recognised that taking life is sometimes permissible, e.g. in self-defence, where taking the life of an assailant is encompassed within the overall purpose of defending oneself.

Similarly, in the situation where unless a fetus is removed from the body of its mother both mother and child will die, removal of the fetus (though it brings about its death) is encompassed within the overall purpose of saving life as best one can. In these tragic cases one is forced to act and, although one clearly brings about the death of another, one is not necessarily acting wrongly. In these cases it can be argued that another's death is not one's directly intended goal; the death is - from the perspective of moral responsibility - a "side-effect" of one's legitimate action.

The distinction between prohibitions and obligations can be highlighted by examining how these exceptions, and this concept of the "side-effect", can be squared with the "absoluteness" of moral prohibitions.

III: Responsibility For The "Side- Effects" Of Our Actions

Talk about the "side-effects" of one's action is meaningless for utilitarian ethical theory because it holds an agent equally responsible for *all* the consequences of his or her conduct. Having summed the positive and negative consequences of a proposed act or omission, the right course of action is that with the best overall outcome, either here and now (*act-utilitarianism*) or in general (*rule-utilitarianism*). The moral agent is thus envisaged as a "cog" or "lever" in a great mechanism whose purpose is to generate maximum happiness for the greatest number. The "impersonal" causal

imagery here is appropriate because the utilitarian outlook does not recognise any special or qualitative link between the agent and the act or omission. For purposes of moral evaluation, the agent is no more closely related to his or her conduct than are all others affected by it: All that matters is the *causal* link between conduct and its consequences.

By contrast, in a tradition that goes back to Socrates, Catholic moral theology maintains that moral agents stand in a unique and constitutive relationship to their conduct. They are qualitatively affected by what they do (or fail to do). In doing good (or evil), one becomes good (or evil). This is why Socrates argued that it is better to suffer evil than to do evil.

Accordingly sound moral assessment of human conduct requires consideration of the "intrinsic" relationship between agents and their conduct, in addition to all the various consequences. It follows that there is a crucial difference between **doing evil** and **refraining from doing some good**, between, e.g., lying to spare a friend's feelings and simply refraining from speaking a hurtful truth. The prohibition against lying only entails that one must ensure the truth is spoken if there is a particular obligation to do so (e.g. in a court room). Similarly, the prohibition against taking human life does not entail that one must positively act to prevent someone dying - again, unless there is a particular obligation to do so.

There is thus a significant difference between the way doing wrong and refraining from doing some good are related to the will of an agent. In doing wrong, one makes wrongdoing one's own, one "embraces" evil with one's heart; in refraining from doing some good, one simply refrains from embracing some good, one's heart remains untouched by either good or evil. For refraining from doing good to become wrong doing, there must be an obligation to do that good or one must be acting from blameworthy motives. In these instances, albeit in an indirect way, one's heart is affected by the evil of one's refraining conduct.

This understanding of moral agency grounds the significance of the distinction between "directly" and "indirectly" doing evil, and the significance of the category of a moral "side-effect" of one's conduct, a significance which utilitarian theory cannot acknowledge. In allowing someone's terminal condition to run its course, it may be the case that she dies sooner than she would have done had I taken steps to postpone death. While there can thus be a *causal* link between my refraining and her death, moral evaluation does not turn on this causal link alone. One is always

under a prohibition against deliberately killing another, but one is not necessarily under an obligation to prolong his or her life. And if one is not so obliged, then the death which may well ensue more quickly because one refrains from life-prolonging procedures is only "indirectly" related to one's moral agency.

Of course, one can wrong another by omission as much as by commission. Allowing someone to die might indeed be morally reprehensible. Nevertheless, the moral evaluation of omissions crucially depends on their context of obligation in a way the evaluation of commissions does not. With the aid of the distinctions between prohibitions and obligations, and between direct and indirect actions, the subtleties of moral description and evaluation are more readily discerned. The following three cases should be distinguished.

Thus, (1) in lying to my friend I do wrong, I am dishonest; (2) in refraining from uttering some truth, when there is no obligation to do, I do no wrong. But (3) when there is an obligation of friendship to speak the truth and my friend is hurt because I refrain from doing so, then I am responsible for his hurt. Both lying in case (1) and refraining from speaking when I ought in case (3) are "wrong", but wrong in different ways. In lying I offend against honesty; in refraining from speaking, I offend against friendship.

Admittedly, in case (2) where I have no obligation to speak the truth, in not speaking I may be merely postponing hurt that will be felt later when the truth will out. Causally, that later hurt is a result of my conduct; morally, it is the "indirect" side-effect of my refusal to do evil. My friend may suffer hurt, but he and our relationship will not have been hurt by the distinctively *moral* evil of my having embraced a lie. In Socrates' words, it is better to suffer evil than to do evil.

Needless to say, the "indirectness" of an outcome does not of itself justify its being brought about. Justification in any particular case turns rather on the nature and extent of one's obligations to prevent precisely that outcome, and on whether the evil outcome is proportionately outweighed by the good one's conduct also realises. Unlike utilitarianism which simply justifies an evil means by a good end, this account restricts the justification of evil to those cases in which the evil is "indirect". The rationale for this restriction derives from an appreciation of the different ways in which an agent's heart may be set upon the goods and evils his or her conduct involves, and so on the different ways in which one may do wrong. An understanding of moral agency and responsibility

which recognises these differences is superior to one, like that presupposed by utilitarianism, which does not.

In short, to act well, an agent must primarily embrace the good (or refuse to embrace the evil) which is the direct object of moral choice, while simply tolerating (if proportionate) those evil consequences which are not direct means to the good sought (or evil refused), but are side-effects occasioned in its pursuit. For example, in refraining from resuscitating a patient when it is no longer appropriate to do so, his ensuing death will be accepted as the side-effect of the good course of action I have embraced, to comfort and accompany him, but without prolonging his dying.

It is thus clear how differently the same outcome, a patient's death, stands in relation to my will depending on whether I bring about his death directly by administering a lethal dose or indirectly by refraining from resuscitation. *That it is no longer appropriate to prolong someone's life does not entail that it is appropriate to kill him.*

It is also clear that the fundamental moral question in the treatment of the terminally ill is not the superficial question whether I actively do something or passively refrain from doing something. *The fundamental moral question is whether what I choose to do (or not to do) directly conflicts with either the prohibition against killing or the obligation to preserve life.* Both a lethal injection ("active") and a failure to resuscitate when one ought to do so ("passive") may offend against the prohibition on killing, and make me a murderer. Both provision of pain relief ("active") and non-provision of antibiotics ("passive") may hasten death, but not offend against the obligation to preserve life. The fundamental question is: "Given that the obligation to preserve life ceases once it becomes futile to do so, and that direct killing is never permissible, what treatment is in the best interests of this patient?"

IV

Questions about what is "beneficial" and what is "futile" are complex and would require separate discussion. Clearly they will involve issues of what is subjectively burdensome to individual patients, and so the possibility that what is futile for one is not for another. Ethically sound care of the terminally ill will acknowledge that what for one patient would be unduly prolonging life, would for another be sustaining life that remains meaningful and fruitful. The space for the making of such judgments are provided, in part, by the

recognition of the difference in the way prohibitions and obligations enter into moral reasoning, along with the distinction between "direct" and "indirect" moral responsibility.

By acknowledging that evil side-effects of human conduct are sometimes both unavoidable and morally permissible, the Catholic Christian tradition tempers the practical force of its absolute moral convictions in situations of conflict. Thus, in the treatment of pain, it has long been held that even though the unavoidable side-effects of medication may be depressed consciousness and shortening of life, it is not wrong to use such medication if it is the only way of relieving someone's pain. As noted earlier, specialists in palliative today are agreed that normally these side-effects need not occur. In the context of current medical practice, sound palliative care means pain relief which does not occasion such side-effects.

Thus, while the moral principle of justified side-effects remains as valid as ever, in fact, the current practice of palliative care is such that normally pain-killers should be able to be administered without having the effect of shortening life. Rarely today could a medical professional claim with justification that shortening a patient's life was an unavoidable side-effect of his or her palliative care for a patient.

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Mainstreaming HIV Positive Patients

Part I: Do Health Care Workers Face Unreasonable Risks?

John Quilter

In June this year, the NSW Health Department released its policy for infection control for HIV, AIDS and associated conditions in NSW health care facilities.¹ It is based on a "mainstreaming" policy for the management of HIV positive (HIV+) patients.

"Mainstreaming" refers to the policy of treating HIV+ people as ordinary patients except where secondary infectious disease or advanced AIDS indicates treatment in a specialised unit or in isolation from general wards or the like. This policy contrasts to one of using HIV+ status alone as an indication of the need to isolate a patient or confine them to special HIV+ only wards or the like. It is therefore a central tenet of mainstreaming that, given the mechanisms of HIV transmission, exclusion of HIV+ patients from the mainstream of health care delivery especially in hospitals is unnecessary for infection control and (other things being equal) a discriminatory practice. Many health care facilities already conduct their activities on a mainstreaming basis though perhaps less as a formally adopted policy than as a practical expedient.

Two lines of thought oppose mainstreaming. The first is the claim that by mainstreaming HIV+ patients, health care workers, particularly ward nurses and certain surgeons, will be compelled to face risks of contracting the virus. The second is the thought that the practices known as "universal body substance precaution" - necessary if HIV+ patients are to be mainstreamed - are impractical even in ordinarily busy hospitals. Thus, some people conclude that the policy of mainstreaming HIV+ patients is so deeply problematic that it is therefore better not to adopt it.

I shall argue against both of these objections to

mainstreaming. As a part of my argument, I shall first outline some moral considerations preliminary to the question of mainstreaming such patients. In the rest of this discussion, I will confine myself to a consideration of the first objection to mainstreaming. I will attend to the second objection at a future date.²

Access to Health Care

In order properly to understand the morally important considerations bearing on some behaviour or policies, we need to find the right starting point. In the matter of health care delivery, the right starting point is often to work out what justice requires of us in making health care available within our community. Considerations of justice ought to condition the way we think about the delivery of health care to the HIV+ patient.

Issues of just health care resource allocation are notoriously difficult. However, some things are clear. Health care itself is a social good. The knowledge which supports it has been discovered, continues to grow and is transmitted with the support of the wider society (it is *our* knowledge cultivated by a sub-community of experts); health care delivery is made possible by the systems of social, legal and policy infrastructure and institutions. And the provision of health care for all its members is a necessary condition of the achievement of the ends of political society: the common good. Since basic human needs must be provided for and health is among these, access to health care for all is a central social value. We can say that individuals have a *right* to access to necessary health care. This applies to HIV+ patients no less than to anyone.

There have to be limitations upon the actual

treatment of the sick because of the finitude of health care resources. Such considerations as a patient's prognosis may be relevant to such limitations. In this regard, HIV+ patients are on the same footing as other categories of patient. HIV+ status in itself is no reason to deny access to needed health care.

Further, alongside their expert knowledge and the social prerogatives of their professional status, health care professionals have an obligation to treat to the best of their ability those who need care even in the face of nosocomial risks³. This generally requires a "professional courage" not required of people who are not possessed of the necessary expertise.

Constraints on the Mode of Health Care Delivery

Given that we can develop an argument in favour of ensuring access to health care to HIV+ patients, we need next to determine the proper mode of providing such health care.

There are constraints on the way a patient may be treated arising from the competent patient's right to respect for his autonomy. The right to autonomy is the right to be self-determining with respect to decisions pertaining to one's health care within the scope of respect for other moral values that may be at stake in the case. This important right extends (in general) to information about the patient: it is in general the right of the *patient* to make decisions concerning the dissemination of information concerning himself

This right is not absolute. However, it is all too easy *not* to take with proper seriousness the privacy or confidentiality due to members of groups which are not generally esteemed in society. In particular, this puts homosexuals at risk of relatively light-minded breaches of confidentiality. Such breaches need to be guarded against. In addition, the relationship between the professional and the patient is a fiduciary one whose integrity needs to be protected. Hence, it is arguable that mandatory testing policies or the like are unacceptable. Such policies are likely to erode the trust necessary in this relationship, and have the bad consequences of forcing sectors of the HIV population out of the health care system. Thus, great care is needed in order to implement a "needs to know" policy of informing health care workers of a patient's HIV status. In particular, the professional's knowledge of a patient's condition is for the sake of better caring for the patient rather than to give the professional the

chance to refuse to treat the patient.

Finally, any policy concerning infectious disease must be competent to manage risk appropriately. Given the mechanisms of HIV transmission, we need to distinguish between different groups of persons working and otherwise involved in the health care system whose risk exposure should be managed properly: (i) other patients; (ii) health care professionals especially special groups such as orthopaedic surgeons, theatre nurses or those who handle body substances which may carry the virus - such persons will have maximal opportunity to pick up the virus; (iii) other workers at health care facilities such as orderlies and cleaners whose work may expose them to some risk; (iv) workers who have little if anything to do directly with HIV infected or potentially infected body substances, such as kitchen staff and ground staff; (v) the general public, and (vi) the HIV+ patient himself.

Not all these groups are exposed to risk to the same degree, barring freaky states of affairs. In general, given the mechanisms of transmission of the virus, mainstreaming cannot be any worse than isolation for the people in groups (iii)-(vi). The defensibility of mainstreaming in terms of risk management turns on the risks for those in groups (i) and (ii).

Limitations on the Obligation to Tolerate Risk of Nosocomial Infection

I have accepted the idea that health care professionals are under an obligation to tolerate risks to their own welfare beyond the level of risk-taking required by ordinary courage in order to treat the sick. This obligation is not, however, unlimited.

There is a distinction between the risk which the professional is duty bound to run and the risk she runs in which she exhibits a level of moral excellence *beyond* the call of duty. While the professional is obliged to tolerate exposure to some risk in order to care for the sick, she is not thereby *obliged* to tolerate exposure to every risk. Perhaps she ought to help those suffering with cholera; but arguably the risk she runs by caring long-term for sufferers of an unknown air-borne and tactually transmitted fatal infectious disease is supererogatory. And again, we allow that the professional has an obligation to treat the sick but not if the required intervention is contrary to her conscience (within reason). And, finally, we often in practice permit the health care

professional exemption from the obligation to treat for much less weighty reasons, for instance, the professional's convenience. Some would defend financial considerations as morally legitimate reasons which may be brought to bear in weighing whether to treat this patient or that. Others would argue that a lack of liking for company of HIV+ patients is another such consideration. (However, one will suspect here a morally disreputable prejudice.)

Our question is whether the risk to which care of HIV+ patients exposes one is a risk that is beyond the level of risk exposure which one is obliged as a professional health care giver to tolerate.

The Nature of Risk

Most who have had anything to say about the occupational safety issues related to the care of HIV+ patients and AIDS sufferers have sought to alleviate the anxiety concerning nosocomial infection by pointing out how difficult it actually is to become infected and how low the probability of infection actually is. The mechanisms of the virus' transmission are well known and I will not rehearse them here. But it is well to recall that there is a number of "steps", as it were, involved in risking acquiring any infectious disease.

Firstly, it matters what proportion of one's patients are HIV+. Clearly, in a population with low percentages of HIV+ people or low percentages in risk factor groups, the probability of infection from ordinary health care operations is correspondingly low. Secondly, one should consider the probability of an exposing event such as contamination of one's open skin by infected blood or a needle-stick injury with infected needles. Thirdly, one must consider the probability of sero-conversion once an exposing event has occurred. Fourthly there is the question of the probability of a bad outcome. Finally, there is the question of the probability of transmission to others.

Not all infectious diseases are alike in all these dimensions of the probability of infection with bad outcomes. Because it is airborne for instance, infection by the Tuberculosis virus (TB) is somewhat likely among those who are caring for sufferers from the virus because the probability of an exposing event is significant. Again, Hepatitis B virus (HBV), a blood borne pathogen, is easily transmissible but also is more common among patients than TB. In contrast to both these, the figures for HIV are significantly lower. While

the likelihood of an exposing event is probably comparable to that of HBV, since the proportion of the patient population in some risk group is in general significantly lower, the probability of infection by the virus is correspondingly lower. Thus many argue that mainstreaming HIV+ patients represents no more and even less a risk than does mainstreaming for other infectious diseases. Even though the rate of HIV infection is higher among health care workers and patients in hospitals than in the general population, rates of nosocomial infection with HIV are low.

This argument is an important one in understanding the moral questions at stake in the occupational safety issues surrounding the mainstreaming of HIV+ patients. It is not conclusive, however. The weakness of the foregoing argument is that probability is only one factor in risk. The other, perhaps more important consideration, is the seriousness of the outcome. For instance, there may well be a higher probability of contracting HBV than of contracting HIV. But of course, there exists a cure for HBV and for many other infectious diseases. Neither does HBV invariably lead to death as does HIV. The same sort of point is true for Tuberculosis and many other infectious diseases. Citing the relative improbability of HIV infection will not remove the point that the seriousness of infection is unqualified. One's life hangs on it, and it will do so while we do not have a vaccine for HIV or a cure for AIDS.

The Basic Issue

Drawing these lines of thought together, I would urge that the main source of concern about mainstreaming is that it may force professionals into a situation which exposes them to a level of risk which is in excess of the level of risk they have the obligation to tolerate to care for the sick as a part of their professional commitment. The logical product of the low probability of infection and its seriously bad consequences may imply that toleration of the risk of contracting HIV is not an obligation the professional has. If it does, then if she decides to take such risks, she would be acting above and beyond the duty of displaying the professional courage required of her.

I do not know how to settle this question conclusively. While I am inclined to believe that the level of risk is *within* what professional obligation implies, I can understand the nurse or doctor who is not prepared to accept such risks in the conviction that she has no obligation to and has other legitimate moral interests which make

it pressing that she not expose herself to undue risk.

Some Suggestions

First, it is better to give professionals the chance to own the decisions to run the risks in question than to impose those risks on them. This is so even for those risks that their professional commitment requires.

This point could be taken to support the idea that contracts of employment of nursing staff and doctors could explicitly include the opportunity to accept or negotiate terms concerning care of HIV+ patients. Such provisions should not violate the privacy and confidentiality rights of HIV+ patients.

Secondly, there are some groups of health care professionals who have more occasion to run these risks than others and bear a degree of the burden of these risks beyond that borne by others. This should be acknowledged and honoured in the wider community. Furthermore, it may be feasible (where the good will exists) to explore the possibility of sharing the burden around. This may imply, for instance, that Area Health Regions look into cooperatively making it available that the professionals at a hospital with a relatively higher incidence of HIV+ patients have the opportunity to share the burden of their mainstreamed HIV-related work with professionals whose main work does not involve many cases of HIV+ patients. I will not pretend to have practical suggestions as to how such sharing of responsibilities may be implemented. The main idea I wish to urge is that we owe professionals in these areas some fair sharing of the burden they have.

I have argued that mainstreaming does not clearly impose undue risks upon health care workers. I have also argued, however, that the standard explanation of this in terms of the probability of infection overlooks the relevance of the *seriousness* of the bad outcome of infection. That mainstreaming exposes the professional to risk of possibly fatal infection does not imply that the professional has no obligation to tolerate that risk in order to care for the sick. On the other hand, it does not follow that she is so obliged. Clarity about the limits of the professional's obligatory risks will be assisted if we recognize that we should do everything we can to help professionals voluntarily to consent to accept these risks while there is no cure for HIV/AIDS. It is essential that support be shown for the work of

those who run the greatest risks in performing their health care work with HIV+ patients and that the exposure to these risks be as fairly shared as possible.

- 1 NSW Health Department, *NSW Infection Control Policy for HIV, AIDS and Associated Conditions* (Prepared by the AIDS Bureau), June 1992.
- 2 *Bioethics Outlook*, forthcoming
- 3 Rival explanations of this obligation need not detain us. See, for example, Norman Daniels, "Duty to Treat or Right to Refuse?", *Hastings Center Report*, Vol. 21 (1991), no. 2, pp. 40ff. A different explanation is given by A. Zuger and S. Miles, "Physicians, AIDS and Occupational Risk: *JAMA*, vol 288, no. 14, 1987.

ETHICS IN NURSING PRACTICE - SEMINAR PAPERS

The papers presented at the Ethics In Nursing seminar held at St Vincent's Hospital in September 1992 will be published and available early in 1993. All full fee-paying participants will be forwarded a free copy of these papers.

Others may purchase a copy of the Proceedings by completing the following order form and sending it with cheque or money order (made payable to St Vincent's Hospital Nurse Education Fund) to:

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BIOETHICS OUTLOOK

Editor: Bernadette Tobin
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CONFLICT ISSUES OF THE 90s: TECHNOLOGY, RESOURCES, CARE.

In her keynote address at the National Conference of the Catholic Nurses' Guild of Australia which was held in Melbourne on 14th and 15th November, Dr Liz Hepburn argued that three falsehoods distort the public discussion of health care issues in Australia.¹

Utilitarian Thinking

In the first place, it is often assumed that decisions about the allocation of resources should be determined by the principle that one ought always do whatever will bring about the greatest good for the greatest number. Dr Hepburn argued that this utilitarian principle cannot capture much that is ethically significant: for instance, the irreplaceability of an individual human being. She also argued that, in some health care settings at least, it can lead people to make decisions on morally-irrelevant grounds (for instance, disabled newborn infants being allowed to die in the interests of those who do not wish to care for them).

Language of Rights

A second mistake is the idea that, in matters of conflict, individual rights may be discussed independently of a consideration of social justice in a particular community. Too great an emphasis on rights can blind us to the essentially social nature of human life. It can lead us to ignore our social obligations and the fact that there are limits to individual liberty. As Simone Weil said: "To place the notion of rights at the centre of social conflict is to inhibit any possible impulse of charity..."²

Rational Calculation

Finally, Dr Hepburn argued that it is a mistake to think of ethical understanding as the product of mere rational calculation, and specifically a calculation of the outcomes of actions. For this omits the affective aspects of sound ethical understanding and deliberation. The Good Samaritan did not make a rational calculation of the consequences of stopping to help: rather, he was moved to pity!

¹ Dr Liz Hepburn, I.B.V.M., a Research Pharmacologist, is the Co-Ordinator of the Centre for Research in Ethics and Health Issues, Mercy Campus, Australian Catholic University, Victoria.

² Simone Weil: "Human Personality" in *The Simone Weil Reader*, edited by G.A. Panchias, New York, David McKay & Co, 1977, p. 325

MELBOURNE BIOETHICS SEMINAR PROGRAMME 1993

Mondays: 4.30 - 6.00 p.m.
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Sr Regis Mary Dunne RSM,
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Reflections on the issues surrounding the formulation of policy in a democratic, pluralistic society.

1st March.

Fr. William Daniel SJ,
Moral Theology, United Faculty of Theology,
Parkville

'Euthanasia: Can we be Passive about it?'

An exploration of the meaning of life contrasting Catholic traditions and the Utilitarian approach.

15th March.

Mr Chris Mulherin,
Royal Melbourne Institute of Technology
'Teaching Facts and Teaching Values'

An examination of the process of thinking and a suggestion that the philosophy of science offers a way of integrating objective and subject beliefs.

22nd March.

Dr Bernadette Tobin,
John Plunkett Centre for Ethics in Health Care,
Australian Catholic University

'Resource Allocation: Ethical Issues'

How and where do we begin thinking about justice in the allocation of resources?

29th March.

Prof. Tony Coady,
Philosophy, University of Melbourne

'Ethics in the Public Forum: Whither Catholic Ethics?'

A discussion of the role of the philosophy in public policy.

5th April.

Dr Paul Komesaroff,
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'Ethical Issues associated with the Menopause'

For further information, please contact
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Fees are \$10 per day
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NOTEBOOK

KENNEDY INSTITUTE BIOETHICS COURSES, WASHINGTON D.C. 1993

The Kennedy Institute, located at Georgetown University, Washington DC, will hold its **19th annual Intensive Bioethics course** on June 16-23 1993. The course, open to physicians, nurses, chaplains, lawyers, policymakers, and other healthcare practitioners, will address four principles of biomedical ethics and their application to current problems in health care and research through lecture and small group discussion format. Proposed topics include informed consent, health care allocation, death and dying, and human gene therapy. Approximated course cost is US\$1400 including all materials and most meals. Invited faculty include Tom Beauchamp, James Childress, Ruth Faden, Edmund Pellegrino, Robert Veatch, and LeRoy Walters.

Advanced Bioethics Course IV is to be held March 6-10 1993. The course, which builds on the intensive course and has a similar format, will focus on the specific problems in health care micro and macro allocation. Cost will be US\$950, including all materials and most meals. Invited faculty include Dan Brock, James Childress, Norman Daniels, Ruth Macklin, Robert Veatch, and other Kennedy Institute scholars.

The Kennedy Institute of Ethics is located at Georgetown University. Further information about courses, membership and the University's graduate program in applied ethics is available from: Diane Michutka, Kennedy Institute of Ethics, Georgetown University, Washington DC 20057.

ETHICS IN NURSING PRACTICE St Vincent's - September 9th and 10th 1993

The first *Ethics in Nursing Practice* seminar, held at St Vincent's Hospital in September this year, was an outstanding success. The participants themselves were keen that another seminar should be planned for next year. And a significant number of nurses and other health care professionals have let us know they would like advance notice of the dates of any future seminar.

We are pleased therefore to announce that the next *Ethics in Nursing Practice* seminar will be held at St Vincent's Hospital, Darlinghurst, NSW, on September 9th and 10th, 1993. Please make a note of these dates. Details of the issues to be discussed, speakers, etc., will be provided in future issues of *Bioethics Outlook*.

CONFERENCE OF INTERNATIONAL BIOETHICS INSTITUTE.

The Third Annual Congress of Healthcare Ethics and Ethics Committees is presenting "**Beyond Autonomy: New International Perspectives for Bioethics**" in San Francisco, on April 16-18, 1993.

The Congress will explore current critiques of autonomy-based ethics from an international perspective, notions of personhood from embryos to the demented elderly, the place of persons in the community of values, and how far the envelope of concern should be extended.

The keynote speaker will be Edmund Pellegrino, M.D., Director of the Georgetown Centre for Advanced Study of Bioethics. Further information is available from: William Atchley, M.D., International Bioethics Institute, 1721 Mar West, Tiburon, CA 94920. Ph 415-435-4900. Fax 415-435-2635

SEMINAR PROCEEDINGS: ORDER FORM

The John Plunkett Centre for Ethics in Health Care held a seminar at St Vincent's Hospital on 27th October 1992 entitled **Resource Allocation: The Ethical Issues**. The papers for this are now available.

The Seminar was broken into two sessions. In the first session, a panel, including Associate Professor James Biggs, Dr Terence O'Connor, Professor Don Chisholm, Mr George Jepson and Mr Richard Gilbert, presented short reports about the hard choices facing them in their work. In the second session, Mr Robert Young, Reader in Philosophy at La Trobe University, showed how recent developments in ethical and social philosophy can help clarify and resolve some of these problems.

For a copy of the Seminar's proceedings, please complete the form below and forward it with a cheque for \$15 (Associates of the Centre \$10) to the John Plunkett Centre for Ethics in Health Care, St Vincent's Hospital, Victoria St, Darlinghurst 2010.

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Seminar Proceedings

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