

Chisholm Health Ethics Bulletin

Vol 12 No 4

WINTER

2007

Catholic Health Care and its Ethical Challenges

Catholic healthcare facilities fulfil their mission in the world of the sick and dying of all ages. Challenges occasionally arise to remain faithful to their identity and mission in a world whose ethical standards are changing. This article discusses the nature of the challenges ahead.

Identity and mission of Catholic healthcare institutions

Jesus Christ taught that the greatest commandment is to love God with our whole heart and our neighbour as ourselves. He gave innumerable examples, especially by curing disabled and sick people. In the early Christian Church the apostles imitated Jesus by working miracles to cure the disabled and the sick. Throughout the centuries Christians, without the gift of working miracles, carried on the legacy of Jesus by caring for elderly and ill persons. Eventually religious congregations of men and women were founded to continue the healing mission of Jesus.¹ Hospitals owned and/or managed by Catholic institutions still continue this mission today in many countries. These hospitals are run in accord with the ethical principles of sound practical reason, Gospel values and traditional Catholic moral teachings.

The Second Vatican Council held that the Christian Faith complements the ethical principles of human reason by providing important insights on the significance and destiny of human persons. Christians learn much about the meaning of their lives and their destiny as persons from the Gospel accounts of Christ 'who fully reveals the human person to himself/herself' for He is the complete, the 'perfect human being'.² Christ is no outsider; He is truly a member of the human race. Being a Christian neither imposes anything on, nor detracts anything from, our humanity. Christians may well agree with the saying of Terence, 'Homo sum: humani nil a me alienum puto' (I am a human being: I think that nothing human is foreign to me.)³

The basic moral values underpinning western literature, culture and law are derived from traditional Judeo-Christian beliefs and are accepted as authentically human, regardless of whether one has a religious faith in their divine origin.⁴ Believers and secular thinkers alike share many of these values because they are good and necessary for living together in community. Respect for the dignity

and life of all human beings, justice, truth, marriage and the conception and birth of children within marriage for family formation are held in honour in the whole world.

Ethical decisions regarding what is good *for health care* are made in the light of one's concept of the human person and relevant ethical principles, be they religious or secular. Vatican II says that 'the principles of the moral order ... spring from human nature itself', thereby linking the notions of person and nature in moral reasoning.⁵ A personalised account of natural law morality shows that morality is about being true to ourselves as persons.⁶

Where a vibrant Catholic Church exists, it gives birth to its own works of healthcare which are shaped by, and draw their identifying features from Jesus Christ, His example and moral teachings based on the love of God and neighbour. Every endeavour of Catholic health care should express this love and never countenance whatever is contrary to the moral teachings of Jesus Christ taught by the Church. To do otherwise would involve a denial of its

N.B. New subscription rates...See p. 12.

IN THIS ISSUE

Catholic Health Care and its Ethical Challenges	1
A Natural Law Approach to Ethics and Morals	4
The Harm of Non Disclosure	7
Ethical Perspectives on Palliative Care	10

Catholic and Christian identity and mission and detract from the promotion of authentic humanity in their delivery of health care.

Providing health care today

When states around the world assumed their social responsibilities towards their citizens, in addition to schools, healthcare institutions were soon established and publicly funded to provide the necessary treatment and care for disabled, sick and elderly people. The ethical codes of most hospitals were similar. Before long, Australia's State hospitals became the largest provider of public health services, whilst private hospitals also flourished, including Catholic hospitals. It is to be noted that now Catholic public hospitals and other healthcare institutions for the aged etc. provide about 42% of all non-government health care.

Health, understood as the state of physical, mental and social well-being, is an important human good. Awareness of the health of body and mind is a hallmark of modern times.⁷ Health care is practised throughout the span of life from conception to death in hospital departments ranging from perinatal, obstetrics, general medicine, palliative care and aged care. Health is not merely an abstract concept: patients are persons whose health is being cared for, and they should be shown understanding, empathy and compassion.

There is a moral responsibility to take the care reasonably required in the circumstances for patients' health. This absolutely rules out the deliberate and direct taking of the life of patients, with or without their consent. No person has direct dominion over the lives of patients regardless of their condition of health or the stage of their life, before or after birth. The right to life is absolute in that nobody, the State included, may authorise the taking of the life of any innocent human being. Life and death decisions should not be made to directly interfere with the natural course of events to cause death intentionally or by refusing to respond to the call of duty to provide the reasonably required medical treatment in the circumstances to sustain life.

Healthcare professionals and the State are not bound to go to unreasonable lengths to provide all possible medical treatments, regardless of cost, in every city and town so long as basic treatment and palliative care are guaranteed and reasonably accessible to all in need.⁸ The availability of resources, personnel, hospital and state budgets must all be considered for the location of hospitals of various levels. Drawing the line between whether or not treatment should be given is one of the most perplexing ethical dilemmas that doctors and competent patients have to face. General principles need to be applied on a case by case basis. For people with faith in eternal happiness won by the risen Christ's triumph over death for the good

of humanity, disease, suffering and death, though tragic, are not absolute evils.⁹ This belief may well impact on interpreting the duty of reasonable medical treatment in end of life decisions. Pope John Paul II clearly stated:

... when death is clearly imminent and inevitable, one can in conscience 'refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.'...It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement.¹⁰

Obviously medical treatment at the end of life should be focussed on comfort care and not be used to prolong the dying process when we believe there is a risen life to enjoy after death. Professor Moloney put it well: 'the theological commitment of Christianity to a life that extends beyond the limitations of this life is seldom heard in contemporary health care discussions.'¹¹

Contemporary ethical challenges

Australian States provide public funding to hospitals owned by religious Congregations which are allowed to follow their own code of ethics in delivering health services to the community. Catholic Private hospitals continue without public funding. The situation changed when abortions under certain conditions became legally available and were performed in State hospitals as well as private clinics. By the eighties in vitro fertilisation (IVF) and other forms of assisted reproductive technology (ART) were legalised and permitted in approved hospitals. Abortifacient pills were also permitted to be prescribed and to be sold over the counter in pharmacies.

The challenge for Australia's Catholic healthcare institutions is to understand that the above changes were ushered in under the rising influence of a utilitarian ethic, devoid of the spiritual, which broadly holds that whatever promotes the greatest happiness for the greatest number is morally right. Coupled to this is the theory that the morality of actions or omissions principally depends on their consequences, effects or outcomes and not on the kind of action done or omitted. Not surprisingly this moral theory is labelled *consequentialism* and it goes hand in hand with *utilitarianism*.¹² Added to this is the contemporary importance given to personal freedom or autonomy of individuals. These are the main pillars of support for *secular ethics* that has become a driving force in the western world, including Australia.

Catholic healthcare professionals and administrators need to know that some actions in themselves are contrary to the *authentic human good*, regardless of motives or circumstances. Examples of such acts are genocide, direct abortion, euthanasia and torture, etc.¹³ St Paul con-

demned the proposition 'that one should do evil that good may come of it' (Rom. 3:8). Moral dilemmas arise when harm may result as an unwanted side effect of doing a morally good action. It needs to be recalled that the Christian tradition rightly distinguishes between *directly willing* an immoral action, and permitting a foreseen harm as a side effect of a morally good action. It is ethical to perform a morally good action from which a good and harmful effect may equally follow, provided the foreseen harmful effect is not chosen nor directly willed and the benefits outweigh the foreseen harmful effects. One's moral integrity is not necessarily damaged by *permitting foreseen* harm in such cases, but it is always eroded by directly choosing an action whose object is immoral or by *permitting* harm without proportionately justifying reasons.¹⁴

Drugs may be given for the relief of pain, even though it is possible life may be somewhat shortened as a side effect. This should not be confused with deliberately choosing to cause a painless death, even if death soon follows in both cases.¹⁵ It is also morally permissible to withdraw burdensome treatment from the sick and the terminally ill to lessen pain, even if it is foreseen that the lives of patients may be somewhat shortened, provided normal nursing care, including reasonable provision of nutrition and hydration, are continued and the chosen purpose is the effective relief of pain.¹⁶ Such palliative care is not to be confused with the giving of a lethal dose for the purpose of killing the terminally ill out of a sense of misguided compassion: this is euthanasia and cannot be condoned in Catholic institutions.

Since consequentialists give scant importance to the moral object or purpose of an action, they do not admit the validity of the moral distinction between treatment and its omission in cases where the outcome, death, is the same, sooner or later: they would say the doctor would be morally responsible for the death in both cases.¹⁷ But surely in a moral sense, the withdrawal of burdensome treatment does not entail a deliberate intention or will to kill even if an earlier death is foreseen as a result. Again, consider the case of a surgeon who removes a life-threatening gangrenous section of a patient's leg, with due consent and who intends and wants to save the patient's life. Both patient and surgeon regretfully tolerate the loss of a section of the leg. But it is unreasonable to hold that the doctor would be morally responsible for the loss of a section of the patient's leg. The Principle of the Double Effect objectively justifies doctors' decisions in such cases.

Provision of services in public hospitals

As mentioned already, the State cannot provide all healthcare services in every hospital: economic factors do exist and the rationalising of healthcare services is necessary. Not all public hospitals provide a full range of medical

services. For the sake of sound rationalising of healthcare services, specialised medical services such as neonatal intensive care units are not usually located in small country towns. Newborn babies in need of these services are regularly and safely transferred to these units in metropolitan cities. The same applies to other specialised medical services that are usually located in large cities. However, public health authorities, should, and do, ensure that basic, and other frequently required, medical services are made reasonably available and accessible to all in need of them.

Sometimes complaints are aired by individuals or groups, but not Government authorities, that Catholic hospitals do not perform abortions, sterilisations for men and women as well as IVF procedures. Governments in most Australian states contract the provision of many medical services to Catholic and other religious hospitals because they have a track record of providing excellent medical services and pastoral care. These public hospitals are not required to provide procedures contrary to their own ethical standards. Citizens have a right to go to a public hospital of their choice but they cannot demand that the hospital of their choice or the one nearest to them provide every healthcare service. Autonomy applies to institutions as well as to individuals. Autonomy can cut both ways. Catholic hospitals have a right to refuse to provide health services that they regard to be unethical – this is not unjust discrimination.

If a woman requires abdominal surgery and would like to have her fallopian tubes tied at the same time, it would be in her own interests to choose a hospital that provides both services. It is no secret in medical circles that Catholic hospitals morally object to providing sterilisations. The same applies to IVF procedures. Couples who wish to have a child by IVF should know that Catholic hospitals do not provide IVF services. It is pointless going to a Catholic hospital only to finish up complaining IVF is not done in the hospital of their choice: IVF is provided in many other institutions.

The law in a democratic society should respect the conscientiously held moral beliefs of all citizens, but it should not legally oblige any persons, including health professionals and administrators of Catholic hospitals, to act contrary to their sincerely held conscientious ethical convictions. The law in a democratic society should avoid this at all costs. This is so because the value central to the foundation and integrity of a democratic society is the protection of each person's conscience in a way that is compatible with the protection of everyone's conscience. This is a fundamental goal of all democratic societies.

Conclusion

Staff of Catholic healthcare institutions should be proud

of their heritage and the valuable services they are currently providing. They should not be concerned about critics who complain about some services that are not provided because these are unethical services that they should not provide.

Looking now to the future, this *Bulletin* has often dealt with embryonic stem (ES) cells and the ethics of their use. If they ever prove to be successful in clinical practice, Catholic Hospitals would not be able to take advantage of such ES cell therapies. The ethical challenge for Catholic hospitals is to support research into therapies using human non-embryonic (adult) stem cells, including pluripotent stem cells which could make the use of ES cells superfluous.

ENDNOTES

¹ Go'mez, J A. 'The Care of the Sick', *Dolentium Hominum. Church and Health in the World*, 31/9 (1996) 45-47.

² Vatican II, *The Church in the Modern World*, Nos. 12 and 22.

³ Terence, *Heauton Timorumenos*, I, 1, 25

⁴ Frye, N. *The Great Code: The Bible and Literature* (London: ARC Paperbacks) 1983.

⁵ *Declaration on Religious Freedom*, n.14.

⁶ The following article in this issue is on natural law issues.

⁷ Ford, Norman M. *The Prenatal Person. Ethics from Conception to Birth*, Blackwell Publishing, Oxford 2002, 44.

⁸ *Ibid.* 45.

⁹ *The Church in the Modern World*, N. 18.

¹⁰ John Paul II, *Evangelium Vitae*, N 65; *Declaration on Euthanasia*, 515-16.

¹¹ Moloney, Francis. 'Life, Healing and the Bible: A Christian Challenge', *Pacifica* 8 (1995) 229-30.

¹² *The Prenatal Person*, 4-7;19-20.

¹³ *The Church in the Modern World*, N.27

¹⁴ For more see *The Prenatal Person*, 46-47. John Finnis, *Natural Law and Natural Rights*, Oxford; Clarendon Press, 1980 120.

¹⁵ Kluge, Eike-Henner W. 'Severely disabled newborns', in Helga Kuhse and Peter Singer eds, *A Companion to Bioethics*, Oxford: Blackwell Publishers, 1998, 246-47.

¹⁶ *Evangelium Vitae*, N. 65.

¹⁷ Khuse, Helga. 'A Modern Myth: That Letting Die is not the Intentional Causation of Death', *A Companion to Bioethics*, 255-68.

Norman M Ford SDB



A Natural Law Approach to Ethics and Morals

Global warming has made us much more aware of the need to respect the physical laws of nature and make responsible decisions. This article examines the nature and role of the concept of natural law in guiding us to choose morally and wisely in face of the responsibilities and especially the conflicting values encountered in daily living.

Life presents us almost daily with complicated situations demanding decisions for the best overall treatment of this particular person. For example: a woman in her mid 80's presents with severe gynaecological cancer, operable to a point for palliation. On what basis do we make a judgement whether to operate and/or give chemotherapy or radiation, knowing that we have the ability to her extend life, but with severe side effects? When do we offer only palliative care with reasonable health for a shorter period, or extended lower quality of life from the effects of the operation or chemo therapy over a long period? How do we come to a decision?

After World War II when the Allied nations were establishing what became known as the Nuremberg Trials in an attempt to redress the barbarity of war and bring to justice those who were considered war criminals, the question was debated: On what ethical and legal grounds could so-called 'crimes against humanity' be judged and punished? The legal basis accepted for indicting *crimes against humanity* at Nuremberg and elsewhere as the words imply is what is known as a Natural Law ethic.

Closer to our own time we can ask: What is the rationale for going to war, e.g., in Iraq, or Afghanistan? Is it to promote respect for life, or for the common good, e.g., to

bring 'democracy' to an autocratic rule? What underlying principle do we use to justify the goal?

A brief look at the origin and history of the term, natural law, will help us understand its meaning and the validity of such an approach to ethical problems. Importantly, when we use the term natural law we need to note that we are using metaphorical language, for we are not speaking strictly of either 'nature' or 'law'. We need to understand that the term natural law is an abstraction from the total reality, which is man or woman (and the physical world) as understood here and now.

Origin of the approach

Practically speaking, the theory came from the Stoics, a philosophic group around the time of Julius Caesar and into the early Christian era, though its foundations can be discovered in the writings of the ancient Greek philosophers, Aristotle and Plato. It was also utilised by the important Jewish philosopher, Philo. The famous Roman lawyer, Ulpian, applied the theory more universally to the treatment of animals as well as humans.

An over-simplified interpretation of the theory in its beginnings would say that nature is our guide and law-

giver: what is natural is good; that which deviates from the natural is bad. Confer our loose use of the term with regard to ‘natural foods, natural medicines’, meaning that what is natural is good or better for us than the artificially produced product.

In a more sophisticated sense Christian writers like St Paul held that the naturally good is known instinctively to the whole human race. The Creator made us in a certain way and we can discern the plan of creation (Rom 1:20; 2:12-15).

Development of the theory

Clearly, the first question would be: how do we know what is natural, besides what is externally evident in nature? The Roman philosopher and lawyer, Cicero, who explained the Stoic concept wrote: “there is present to everyone, the mistress and queen of all, reason, which, by improving itself and making further progress, becomes perfect virtue.”¹

The operative word is ‘reason’ by which we discern what is basic to human existence and is universally applicable. Roman citizens considered themselves fortunate to have good laws worked out in detail for them. (Cicero got into trouble for questioning this position). For non-Roman citizens the Romans spoke of a natural law applicable to all others, that is, those who did not come under Roman positive law or legal system. In other words, non-Romans must be guided and ruled by what is natural for them according to reason.

The Scholastic philosophers and theologians of the high middle ages also stressed the role of reason, thus avoiding a purely naturalistic approach to ethics or morals. Natural law was not something self-evident for them, but was the result of a reasoned approach to the nature of the human person (understood as created in God’s image and destined to become more conformable to that image). In the scholastic understanding the human being is able to discover the basic tenets of natural law because of a participation in the eternal wisdom of the Creator. They reasoned to natural law from the evidence of nature and human experience, and also the evidence of what, today, we would call the social or behavioural sciences. (‘We hold these truths as self-evident...’ says the U.S. Constitution).

Later, from the 18th Century with the development of the natural sciences in the strict sense there was a return to a greater emphasis on the physical laws of nature so that we find civil laws enacted punishing ‘unnatural sex’ and homosexuality. In this naturalistic vein, for example, a lie was defined as false speech; that is, words which contradicted the facts. Today, many moralists would define a lie not just in a physical sense as false speech, but as false speech which injures another’s right to the truth. Today there are those who promote evolutionary and genetic de-

terminism, denying the absolute or unchanging quality of natural law along with its universal application. They consider that evolution and genomics have eliminated the natural law approach. However, such arguments misunderstand the real meaning of natural law; they overemphasise the physical facet as the decisive factor.

Contemporary and Christian Perspectives²

The application of a natural law theory developed as we gradually understood the human person better, especially through the growth of the social sciences and psychology. We have now realised more clearly that some of our practices ought to change if we are to act in accord with the more comprehensive appreciation of the nature of the human person. Examples of such formerly accepted practices are: slavery, the domination of women and lack of equality, abuse of and use of children in the workforce, bastardising of police and army recruits, inadequate care for the poor and aged, forced colonization of weaker peoples, crimes against humanity. We react in face of the absolute authority that some of the powerful accrue to themselves, the paternalistic attitude of some very rich and professional people, and the upholding of class distinctions as being an affront to human dignity.

Most nations subscribe at least in theory to the United Nations *Universal Declaration of Human Rights* promulgated more than fifty years ago, whereby we acknowledge that all people are born equal with basic rights to life and freedom (Art.1), and imply that fundamental respect for the dignity of the human person is the foundation of a well-ordered society which acknowledges justice for all.

The same *Universal Declaration of Human Rights* evidences common agreement on the point that human dignity is inherent in every member of the human family, and is not given to the person by society. The *Preamble* to the *Declaration* puts it clearly: “[R]ecognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.” We could say that this is a statement based on a reasoned understanding of the nature of the human person integrally considered. “A right way of acting is not ethically obligatory or legitimate simply because it is ‘natural’, in the scientific sense, as ‘evolved’ or ‘genetically based’; but it is obligatory because it accords with what is good for human beings, considered comprehensively. The obligatory character of morality – the ‘law’ - binds the person to moral standards that promote the well-being, or flourishing, of the person and his or her community.”³

It is not always easy to recognise in particular circumstances what will genuinely promote human well-being and flourishing. There will be complicated situations and

dilemmas to face. Seeking to do good and avoid evil in a particular case one needs wisdom and reflection based on experience and guided by the virtue of prudence.

Another example of the use of a contemporary natural law approach, though more directly concerned with the physically natural, yet with human wellbeing as its ultimate goal, is today's emphasis on the environment. We are becoming more aware that we must respect nature and its internal norms if we are to survive on this planet. What is nature telling us through climate change and the warming of the atmosphere, through drought, landslides from denuded forests, creeping deserts from over-irrigated land, etc? Equally, we must respect the internal laws of the body if we are to remain healthy and heal unhealthy people.

Our civil laws recognise natural rights to free assembly, to marry, to freedom of conscience. The abolition of slavery was based on the gradual recognition of the basic dignity of the human person not to be under the absolute control of another, not to be bought and sold like a chattel.

We rightly condemn crimes against humanity, which is another way of saying those acts which defile the very nature of the human person. So, too, we condemn the abuse of children as something unnatural not only by reason of the physical insult to their bodies but in particular because of the ongoing damage it causes to their human person integrally considered. We employ crisis counselling to prevent or repair damage to the whole person after physical accidents and natural disasters.

A natural law theory understood in this way offers a sound basis for judging the morality or ethics of human activity.

Does natural law so understood tend to make moral decisions more relative, principles less universal? The basic principles will always remain, such as respect for human life and human dignity. However, new information as to what being fully human implies, or what enhances human dignity, may lead us to reconsider certain accepted practices such as slavery or capital punishment or 'slave wages' as contrary to the nature of the human person.⁴

It seems to me that the natural law approach to ethics would demand *a consistent ethic of life whether person is powerful or impotent, self-sufficient or dependent*. Respect for the person, the importance of life even though diminished, should be the same for premature babies, for the sick and aged, as for other members of the human family. The effects of a more materialistic and utilitarian approach leaves the infant in the womb which can't argue for its life (infans – 'can't speak') vulnerable to the power and perhaps convenience of others. Some ideologies including terrorism, communism, ethnic cleansing wars, or

religious wars discountenance an ethic grounded on the nature of the person and logically proceed to treat persons as disposable, as means to an end.

Conclusion

It seems to me that a contemporary theory of natural law means in practical terms that we always act in such a way as to respect the human person integrally considered.⁵

ENDNOTES

¹ Tusculan disputations, II, 47 in <http://www.thelatinlibrary.com/cicero/tusc.shtml>. Confer C. D. Yonge's translation, *The Academic Questions, Treatise de Finibus and Tusculan Disputations of .T. Cicero*. London: Henry G. Bohn, 1853, at II, 21: "There is present to every man reason, which presides over and gives laws to all; which, by improving itself, and making continual advances, becomes perfect virtue."

² The Encyclical *Veritatis Splendor* of John Paul II (on the fundamental principles of moral theology) in no. 79 speaks of the content of the natural law as "that ordered complex of 'personal goods' which serve the 'good of the person': the good which is the person her/himself and her/his perfection." The Vatican Instruction, *Donum Vitae*, on respect for human life, stresses the same principle of respect for the dignity of the person and his or her integral vocation when making decisions about human life. It states: "Physical life, with which the course of human life in the world begins, certainly does not itself contain the whole of a person's value, nor does it represent the supreme good of man who is called to eternal life."

Pope John Paul II reiterated the emphasis on the person in regard to marriage and procreation when he said: "Clearly when one speaks of 'natural' regulation, respect for the biological rhythm alone is not what is meant. In a much more complete way, it entails upholding the truth of the person's profound unity of spirit, psyche and body, a unity that can never be reduced to a simple set of biological mechanisms. It is only in the context of complete and limitless reciprocal love by the married couple that the act of procreation, on which the future of humanity itself depends, can be carried out in all its dignity.

"Respecting the person and God's design for procreation," (Address to an international convention on natural birth regulation) in *L'Osservatore Romano*, Feb. 11, 2004, p 4. See also *The Constitution on the Church in the Modern World* of Vatican II, Chapters 1-3.

³ Stephen Pope, 'Reason and natural law' in *The Oxford Handbook of Theological Ethics*, ed. Gilbert Meilaender and William Werpehowski. Oxford: Oxford Uni. Press 2005, 163.

⁴ Benedict XVI, Address to the Congregation for the Doctrine of the Faith, 10 Feb. 2006: "The Church welcomes with joy the authentic breakthroughs of human knowledge and recognizes that evangelization also demands a proper grasp of the horizons and the challenges that modern knowledge is unfolding. In fact, the great progress of scientific knowledge that we saw during the last century has helped us understand the mystery of creation better and has profoundly marked the awareness of all peoples... Consequently, every study that aims to deepen the knowledge of the truths discovered by reason is vitally important, in the certainty that there is no "competition of any kind between reason and faith" (Fides et Ratio, n. 17).

⁵ Basic texts are: J. Fuchs, *Natural Law, a theological approach*. Dublin: Gill & son, 1965, John Mahoney., *The Making of Moral Theology: A Study of the Roman Catholic Tradition*. Oxford: Oxford Uni. Press, 1987, Chapter 3.

The Harm of Non Disclosure

The quality of communication and the authenticity of interaction are undoubtedly tested in the midst of difficult and challenging circumstances. When patient harm occurs, and health care outcomes fall well below governing best practice standards, the way in which this is managed has a lasting impact on patients and their families. This is true whether or not the problem was due to an error, or a failed plan of treatment, and was unintentional and unforeseen.

The Australian Council for Safety and Quality in Health Care published an open disclosure standard which defines what is expected from professionals in their communication with patients after an adverse event.¹ The former Council states that open disclosure should include ‘an expression of regret, a factual explanation of what happened, the potential consequences and the steps being taken to manage the event and prevent recurrence.’² Whilst the ethical imperative to disclose adverse events is beyond doubt, it can be assumed from a literature review that a range of disclosure practices occur in Australia in response to medical error. Ranging from defensive communicative interactions where errors are initially concealed, to the practice of partial or limited disclosure, to completely open, supportive and honest communication.

Non disclosure – effect on physicians

Non-disclosure and partial disclosure introduce a variety of difficulties for physicians, but three in particular will be mentioned here. The practice of non disclosure against an ethical imperative to do so invokes a burden for the physician through problems of secrecy. Salib suggests that secrecy can build ‘psychologically isolated environments.’ He clarifies this self imposed position is antithetical to the known psychological benefits to be gained from the support of peers and access to wider organisational resources.³ The integrity of *due process* following medical error depends on the openness of the practitioner, a strong sense of accountability and a commitment to act in the best interest of the patient, and future patients. When consultants and the hospital entity *willingly* enter a partnership approach to accept responsibility for adverse events, the goodwill and quality of their combined relationship will be a dynamic that will enhance, rather than jeopardise the integrity of the disclosure process.⁴

Another significant burden for the physician is coping with the deceit in failing to honestly inform a patient of their condition, particularly where it is known this information would be sought. Manser and Staender refer to a survey that shows ‘non-disclosure was associated with lower patient satisfaction, less trust in the physician, and a stronger negative emotional response.’⁵ The decision not to disclose an error also contradicts the ethical beliefs held by the community that the physician’s intention is to actively facilitate the well being of patients. It is also contrary to the generalised community expectation to be well informed, where information is accessible and available.

A failure to disclose medical error where it is due also affects the integrity of the health care industry as a whole. In Australia where the effects of iatrogenic injury are substantial, a failure to openly discuss incidents of patient harm arising from medical error compromises any strategy to support a culture of patient safety. This is equally applicable for both seemingly small and serious errors. Penson et al suggest that ‘Apparently random “human” errors may represent a systematic problem that could be prevented in the future if disclosed.’⁶

There is widespread consensus that the physician’s direct involvement in medical error and adverse patient events is distressing.⁷ An excerpt from *Looking Back* reveals how involvement in a medical error leading to a fatal outcome affected one physician. The dialogue gives insight into the depth of the impact:

...and it got worse, and after half an hour my patient was dead. At my hands...Immediately after the event I was a wreck...That night I got drunk. It was the only way I could sleep...The necropsy did not absolve me from blame...It was two months before the dreams stopped. It was three months before I spent a day and did not think about the events...“getting over it” was not the issue – living with it was.⁸

Systems approach to error

The evidence from multiple perspectives highlights that the adoption of a systems approach to error, as well as enhancing patient safety, is also more likely to offer practitioners the support they need to accept responsibility for their involvement in the adverse event.⁹ Ibrahim advises that significant medical failures are often due to *a sequence of failures* that become increasingly problematic throughout a continuum of care.¹⁰ Such failures may involve substandard clinical decisions due to poor communication, will usually involve the input of more than one person, or team of people, and multiple clinical processes.

A systems approach to understanding error is responsive to the interdependent nature of accountability in complex medical environments. It does not however, dismiss the need for individual professional accountability. Braithwaite et al comment:

Moving beyond a culture of blame, however, does not mean an escape from accountability. Accountability entails, among other things, a commitment to

investigating and understanding underlying systemic factors that contribute to adverse events, and a commitment to providing personal and professional support to staff and patients (Wellington 2004b:np)... Active responsibility means voluntarily taking responsibility for putting things right in the future. Active responsibility is a virtue nurtured in a culture that values learning.¹¹

In contrast, a fractious and punitive culture of blame fosters an environment where stronger feelings of fear make the professional(s) deference to patterns of closed communication more likely. Sadly, these dynamics inhibit the policy and procedural review that are instrumental in improving patient safety. Kaldjian et al conducted a review of 316 full text Medline articles and found an 'absence of a supportive forum for disclosure' was one of the top ten most frequently given reasons to increase the likelihood of non-disclosure.¹²

Case example

A junior resident in a frantically busy tertiary teaching hospital acknowledged the deterioration of the 45 year old patient, and made a note of this. Whilst concerned for the patient's condition, and attending to multiple other patients', the resident consulted his peers. They incorrectly believed the consultant physician was aware of the patient's deterioration. In addition to this misconception they also err towards an extreme reluctance to interrupt the consultant to discuss a situation they believe is undoubtedly serious but in hand. No further attempt is therefore made to intervene at a crucial moment in the patient's deterioration. The junior resident also had a dulled sense of imminent accountability because the deterioration was noticed towards the end of a shift, and it is believed that the next shift would intervene. It was also noted that the last shift must also have been aware of the problem. The patient died 6 hours later.¹³

It is not helpful to isolate the resident with *disproportionate blame* for the patient's death, independently of consideration of the role of other participants and factors. Importantly, the professional participants in the case not only have a responsibility to the patient, but also to each other.

Non disclosure - effect on patients

The problem of incomplete and non-disclosure on families and patients are felt acutely, and often add to the anxiety they experience. Imagine the problem of knowing that something has gone catastrophically wrong, but an absence of information to be able to synthesise the issue and bring it to resolution. Lamb found that in response to medical error, among other reasons, patients' responses escalated to litigation because they were not given answers, they did not like 'the way they were

treated' after the error, or because of a lack of openness.¹⁴

Similar responses were yielded in a study conducted by Vincent et al who analysed the questionnaire responses of 227 medical negligence claimants. The questionnaire was designed to provide insight into why legal action was taken.¹⁵ Two particular sets of results are pertinent to this article: explanations given after the incident, and what would have prevented legal action.¹⁶ Regarding explanations that were offered to respondents 'In 48 cases, an explanation was given within a few days of the incident, in 28 within a few weeks, 37 said within a year, and in 15 over a year later (14 did not specify a time); 85 people said that they never received any explanation.'¹⁷ On the issue of litigation preventability, the answers are documented here with the associated number of cases who made the point: 'explanation and apology (37), correction of the mistake (25), pay compensation (17), correct treatment at the time (15), admission of negligence (14), investigation... (3), disciplinary action (4), if listened to and not treated as neurotic (5) honesty (4).'¹⁸

It is tempting to hope that if such a study were conducted in Australia today, 13 years later, the result would be different. However a perusal of reports such as Not for Service, by the Mental Health Council of Australia, and other research findings reinforce the current relevance of the study. In Australia primary carers of people with mental illness often experience unsatisfactory disclosure processes in response to error or treatment failures. There is reason to believe such occurrences are not isolated, and are possibly part of a more wide spread problem.

Case example

The problems for the family have been numerous. Although the service provider expressed condolence, this was not made to the deceased woman's parents, who were actively engaged in her care, and was complemented by a lack of sensitivity and a wall of silence. The family's strong desire for open and honest dialogue about what was inevitably an unsuccessful treatment decision, and communication problems did not occur. Time has not removed this need.

The Coronial inquest lasted five and a half days and was initiated by the parents of the deceased. The Coronial inquest was pursued to seek expert opinion regarding the contributing factors to their daughter's violent suicide, less than 30 hours into her leave from a service provider as an involuntary patient. It was hoped this would inform the necessary changes to the hospital's processes, where needed, to both improve the experience of other patients, and prevent the inclusion of yet more families, in such an agonising situation. The reality for the mother of the deceased woman is that the absence of genuine and heartfelt compassion by the

service provider with a deprivation of opportunity to work through issues of extreme importance is like a wound that won't heal. The finding of the Coronial Investigation was that the service provider was not at fault. The way in which traumatic adverse events are managed by hospital staff can have a lasting impact on families for all the wrong reasons. All this family ever asked for was honesty, transparency, accountability and reconciliation.¹⁹

Addressing preventability

The care to explain how the situation is being managed to prevent recurrence is a significant part of the disclosure standard in Australia. Vincent et al illuminate that in response to medical error patients often have a need to know what is being done to prevent such problems occurring to other patients.²⁰ In Victoria, 1995, an audit was undertaken to assess whether any of the 629 suicide deaths by people who had 'contact with Victorian public psychiatric services', between 1989 and 1994 could have been prevented.²¹ Burgess et al determined that in 20% of cases the Victorian public psychiatric service system could have altered the outcome with a different response, and these deaths were therefore preventable. They especially note that in 311 cases, the deceased had been recipients of Victorian public psychiatric care 'within 4 weeks of death.'²² Issues of preventability regarding *Inpatient Treatment* included reference to difficulties in the areas of staff-patient relationships, staff communication, leave and discharge planning.²³

Closing thoughts

In a complex service system, such as characterises acute inpatient health care in Australia, many dynamics must shape the ways in which physicians come to regard the needs of their patients. It is possible that local pattern's of thought towards individualisation, autonomy and privacy and the legislation which protects such 'rights' influences the practice of disclosure to a third party, such as a carer, when a medical error involves an adult patient. But for adult patients whose personal autonomy fluctuates with cycles of illness and wellness, it is evident that more attention needs to be given to the needs of family members, who in the community, in every respect fulfil the role, if not intermittently, of primary carer.²⁴ Bowden proposes:

Reflection on the ethical dynamics of mothering relations highlights, specifically, the developmental aspects of moral autonomy. What enables autonomy is the support and guidance of emotionally engaged others...Such an insight into the necessary developmental and relational achievement of autonomy contrasts starkly with conceptions in which autonomy is seen to be a matter of erecting a protective

wall of rights between an individual and those around her or him.²⁵

ENDNOTES

¹ Australian Council for Safety and Quality in Health Care, 'Open Disclosure Standard: A National Standard For Open Communication In Public and Private Hospitals, Following An Adverse Even In Health Care,' *Commonwealth of Australia*, 2003, 5.

² *Ibid*, 1.

³ Salib M, 'Secrecy as a Means of Control: Coersion versus Groupthink,' 2002, 1, accessed at [http://www.web.mit.edu.msalib/www/writings/classes/STS.011.pdf](http://www.web.mit.edu/msalib/www/writings/classes/STS.011.pdf) on 30/5/07.

⁴ Lumley C, *Personal Communication*, St Vincents and Mercy Private Hospital, Melbourne, 2007.

⁵ Manser T, Staender S, 'Aftermath of an adverse event: supporting health care professionals to meet patient expectations through open disclosure' *Acta Anaesthesiologica Scandinavica*, 49, 2005, 729.

⁶ Penson RT, et al 'Medical Mistakes: A Workshop on Personal Perspectives' *The Oncologist*, 6, 2001, 94.

⁷ Manser T, Staender S, "Aftermath of an adverse event" 49, 2005, 728.

⁸ Reviews – Personal views, 'Looking Back' *British Medical Journal*, 320, 2000, 812.

⁹ Braithwaite J, Healy J, Dwan K, 'The Governance of Health Safety and Quality' 2005, 18.

¹⁰ Ibrahim JE, Conference Keynote Presentation, Clinical Liaison Service, Specialist Investigations Service, Victorian Institute Forensic Medicine, Department of Forensic Medicine, *Monash University*, 2007.

¹¹ Braithwaite J, Healy J, Dwan K, 'The Governance of Health Safety and Quality,' 2005, 18.

¹² Kaldjian LC, et al 'An Empirically Derived Taxonomy of Factors Affecting Physicians' Willingness to Disclose Medical Errors' *Journal General Internal Medicine*, 21, 2006, 944.

¹³ Ibrahim JE, Conference Keynote Presentation, 2007.

¹⁴ Lamb R, 'Open disclosure: the only approach to medical error' *Quality Safety Health Care*, 13, 2004, 4.

¹⁵ Vincent C, Young M, Phillips A, 'Why do people sue doctors? A study of patients and relatives taking legal action.' *The Lancet*, 343/8913, 1994, 1609-1610.

¹⁶ *Ibid*, 1612, 1613.

¹⁷ *Ibid*, 1612.

¹⁸ *Ibid*, 1613.

¹⁹ Case Example, *Personal Communication*, 2007, Australia.

²⁰ Vincent C, Young M, Phillips A, 'Why do people sue doctors?' 1994, 1609.

²¹ Burgess P, et al 'Lessons From a Comprehensive Clinical Audit of Users of Psychiatric Services Who Committed Suicide' *Psychiatric Services*, 51/12, 2000, 1555-1560.

²² *Ibid*, 1556.

²³ *Ibid*, 1557.

²⁴ Submission #178 in Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia, *Mental Health Council of Australia*, Canberra, 2005, 161.

²⁵ Bowden P, 'Nursing ethics and the 'ethic of care' in institutional settings' in *Expanding the Horizons of Bioethics*, Proceedings of the Fifth National Conference of the Australian Bioethics Association Melbourne, April 2007, 76.

Kate Jones



Subscriptions for Volume 13 are due now.
Invoice enclosed.
N.B. New subscription rates...See p. 12.

Ethical Perspectives on Palliative Care

An underlying tenet guiding this article is that every person is unique. Whilst a philosophical uncertainty exists in knowing how to discuss important issues for people facing death, we can be guided by our faith, ethical reflection, and the published and public material of dying people, and their carers.

The definition of palliative care endorsed by the World Health Organisation (WHO) identifies the types of underlying values which are helpful in guiding the delivery of specialised care for people in the terminal stage of their illness.¹ Quality of life, support to face the problems of life threatening illness, treatment for pain, an awareness of the physical, psychosocial and spiritual needs of the person, and attention to the needs of families are all highlighted in the definition.²

It is not wise to stereotype how people cope with the process of dying; how could we ever assume consensus? But we do know that the suffering to accompany the premature loss of close family relationships presents one of the most stressful life events to be experienced. Schofield et al confirm: 'Hearing the news of incurable disease is understandably devastating for most people.'³ Regardless of how calmly or expertly people cope with the death of a close family member, it is not uncommon for carers to recall it as a *most challenging* time.⁴ Many personal accounts recorded by terminally ill people also testify to the enormity of the challenges they have had to overcome in the course of their dying.

There is also a challenge for the aloof spectator, positioned arbitrarily on a scale of relative good health, when invited to stop and imagine how a dying person feels about approaching death. When confronted with such a question, we may hesitate to wonder whether the *unknown* person is comfortable with the plans they have made, have they said goodbye, has this been very hard...? Our answers, coloured by the limitations of our own understanding are easily shaped by our feelings, and further filtered by a greater number of other influences. But when we do stop and consider how a dying person might feel about their approaching death, more often than not, we are actually asking it of ourselves. We ask, how would we feel and what would define our sense of loss?

Autonomy in illness

It has been a humbling experience to conduct an informed search on the effects of illness on autonomy, and to learn what's of importance to people who are dying. Beauchamp and Childress suggest that to exercise autonomy, people should act with intention, understanding, and freedom from controlling influences.⁵ But they clarify that this is not a static formulation and argue that autonomous status should be extended to patients' with clear intentions, even if they have a substantial, but not a full

'degree of understanding and freedom from constraint.'⁶ Consideration of autonomy is especially complex in relation to the dying person. Autonomy does gradually slip away where the person's consciousness diminishes. This may be due to requested sedation to cope with pain and trauma, or as a natural aspect of the disease trajectory leading to death. But until this occurs, it is thought provoking to ponder that autonomy is not necessarily totally relinquished even in the presence of significant frailty.

Kellehear and Ritchie, editors of *Seven Dying Australians*, capture Iain Ross Gardner's statement:

Facing death hasn't been scary for me. It's been a shock. I think my view, based not only on my own experience but having spent time with other people who have died, is that for most of us our bodies and our minds and our – I don't know what you call it – our spirit, are actually quite resilient, and look after us. And I think you've just got to trust yourself. And be true to yourself.⁷

With honesty another participant, Marion Miller shares that 'my world closed in gradually'⁸ and in response to one loss after another she says 'You just shed life, you do.'⁹ Ritchie says of the interviewee's of the *Seven Dying Australians* 'Contrary to my initial fear, these people are not fragile but strong enough to put their feelings into perspective, to think through and to anticipate their eventual deaths, and to attempt to provide a sense of meaning for others.'¹⁰ Whilst this seems contrary to the predominant image of the palliative care patient we are conditioned to accept, a wider examination of the writings of palliative care patients and carers reveals that inner strength and courage are frequently a very real highlight of their own narratives. Such dialogue reveals that in spite of the physical and mental impact from an exhausting disease process, the imminence of death does not necessarily strip away a sense of resilience and a belief in oneself. Surely the capacity to exert this is rightly an expression of autonomy.

With approaching death, autonomy may preside through the outworking of the care-giving-receiving relationship, through shared understanding and equal respect for the dignity of the patient, family and caregiver. Bowden reflexively proposes that 'Ethically successful relationships, relationships maintained in ethical care, are mutually empowering... As a result individual moral autonomy is dependent on appropriately nurturant relational

ties.’¹¹ Bowden’s attention to the importance of relational ties is essentially also an affirmation that the value of autonomy is enhanced when it works towards the mutual good of those in the care giving relationship. The care-giving-receiving relationship is strengthened when the participants choose to freely work for the good of each other, even when they have different needs and capacities.

Reciprocally, there is a personal ethical challenge to choose to operate with a certain generosity of spirit which beckons our consideration of the needs of the palliative care patient, from their own point of view. This does not diminish the other truth: a focus on the integrity of the care giving relationship also necessitates that ‘The principle of respect for autonomy should be viewed as establishing a stalwart right of authority to control one’s personal destiny, but not as the only source of moral obligations and rights.’¹² Consider the situation where a palliative patient would like to die at home, but the carer can not physically or emotionally cope with the extent of the care needs of the dying patient. The focal issue broadens to become a mixture of concern for the potential harm to the carer and for the potential psychological discomfort of the patient.

Ethical challenges

The period accompanying the transition from acute to palliative care for patients is predisposed to be one where the potential for ethical challenges proliferate.¹³ These are shared, albeit sometimes unequally, by the patient, their family, and service providers. Ethical challenges materialise when the capacity to make the right decision is hindered either because the best choice is not easily apparent, or because the process involved is difficult because anticipated outcomes are obscure, uncertain, or unwanted. It could be that a sense of pressure obscures decision making capacity because there has simply not been enough time to adjust to rapid health deterioration.

In relation to proxy decision making, there is a moral obligation to carefully consider the implications of pursuing a style of medical intervention that will have the effect of reducing the patients’ consciousness and autonomy, especially where this is against the established facts of an advanced care directive or known patient preference. For example, it is highly feasible that a patient might prefer death, rather than an alternate existence on life support where their life is coupled with absolutely no autonomy. There is an even stronger case for this when it is extremely unlikely that a functioning level of autonomy will be restored. The following narration by Nelson and Nelson on dialogue regarding medical proxy decision making, appropriately captures the power of the ethical impact of our choices:

...the choices made...in a very important way deter-

mine who we are, who we have been, and who we will be as moral people; this gives the choices their proper weight, and defends us from the kind of self-deception that is sometimes a part of having to decide in morally difficult circumstances.¹⁴

The suffering of loss experienced by patients and their family is also predisposed to an ethical challenge of another nature. It is where the pathway required of us will not be in any doubt, but depends upon the investment of personal effort beyond what we feel we are able to give; a situation where it would be easier to take another path, but we labour and press ahead regardless. Yancey tells of the enormity of such a challenge in a man’s anguish for his 10 year old daughter.

...for eighteen months he had run, frenetically seeking every prayer or healing technique that might bring his daughter relief from Leukaemia. Now, though, as her life slipped away, he could do nothing but sit by her side, hold her hand, soothe her lips with moisture, and weep. It took every ounce of spiritual energy to keep from fainting.¹⁵

Our close personal relationships play an important role in shaping how we travel through difficult life experiences. The willingness to build a partnership approach to care can be an opportunity that can have life long significance for the family. It can become a point from which the family can let go and move forward, and work towards building a shared history of value. This can pose all sorts of tensions for families who engage in the palliative care of a close family member. It is not uncommon for different members of a family unit to consider a situation or challenge from diverging perspectives or values. Particularly in countries of a western culture, each member of the family may be afforded personal biases of individualised choice regarding what is important.

Compassionate care

The availability of a team of people to assist the family through the palliative process can be especially important to help them through their ordeal. It might be that close friends, family, clergy and pastoral carers have a special role in giving comfort to lighten burdens wrought through difficult relationships, conflicting perspectives and hard decisions. Especially where the patient and carer have not had a close or amicable relationship, such support may strengthen those at the centre of the care-giving relationship. It may help carers to cope with the dynamics that flow from the outworking of the dying person’s concerns about essential issues surrounding death, their thoughts on life after death, or other spiritual beliefs.

Special attention is needed to enable dying people to work through deeply personal issues of importance. As death approaches, life experiences may rise to the surface

and bring an inner awareness of issues that are unresolved. Forgiveness may need to be given and/or received. To avoid personal discomfort or confrontation, our natural response to this might be to gloss over problems, and provide a false assurance that everything is fine. But usually such a response will only serve to increase the anxiety, suffering and pain for the dying person who seeks relief from the bonds of grief, guilt or remorse. It might also ultimately deprive a dying person from a further attempt to partake in a spiritual act of cleansing where this is needed to bring relief, such as the sacrament of reconciliation and absolution for Catholics. It is very important that in such intimate relational interactions that the moral values that guide our responses, are not merely self serving. Care needs to be taken to ensure that acceptance and support of religious faith and deep spiritual convictions of the dying person are treated with the dignity and respect they deserve.

Conclusion

From the Christian/Catholic perspective death is an essential part of the journey of life. But the issue of palliative care can be a difficult and deeply painful topic, because we all inherently expect to live with a sense of wellness, and premature death goes against the grain of this hope. It is not plausible to generalise how people cope with the challenge that comes when the fundamental aspects of personhood are sorely tested. We also run into real difficulties when required to stipulate on behalf of another person what contributes to a good death. Even for people to whom we are close, unless we have appropriately engaged in such a discussion, we may not be sure of all the preferences that would bring good closure to unattended choices. Quite legitimately, the answer to this most sensitive question may be a little different for each of us. Webb shares that 'Relatives and friends may assume that they know, but what may be a reasonable assumption in health may not be so in ill health.'¹⁶

ENDNOTES

¹World Health Organisation, definition found at <http://www.who.int/cancer/palliative/definition/en/>

² Ibid.

³ Schofield P et al, 'Would you like to talk about your future treatment options?' discussing the transition from curative cancer treatment to palliative care, *Palliative Medicine*, 20, 2006, 402.

⁴ Palliative Care Australia, 'Alex's story' *a journey lived: a collection of personal stories from carers*, Australia, 2005, 20.

⁵ Beauchamp TL, Childress JF, 'Chapter 3, Respect for Autonomy' *Principles of Biomedical Ethics, Fourth Edition*, New York, Oxford University Press, 1994, 123.

⁶ Ibid.

⁷ Iain Ross Gardner 'Not dying a victim' in Kellehear A, Ritchie D, *Seven Dying Australians*, Bendigo, Innovative Resources, 2003, 55.

⁸ Marian Miller 'You just shed life' in Kellehear A, Ritchie D, *Seven Dying Australians*, 27.

⁹ Marian Miller 'You just shed life' in Kellehear A, Ritchie D, *Seven Dying Australians*, 36.

¹⁰ Ritchie D, 'Listening and Understanding' in Kellehear A, Ritchie D, *Seven Dying Australians*, 124.

¹¹ Bowden P, 'Nursing ethics and the 'ethic of care' in institutional settings' *Expanding the Horizons of Bioethics, Proceedings of the Fifth National Conference of the Australian Bioethics Association Melbourne, April 1997*, Australian Bioethic Association, 76.

¹² Beauchamp TL, Childress JF, *Principles of Biomedical Ethics*, 126.

¹³ Schofield P, et al 'Would you like to talk about your future treatment options', 397.

¹⁴ Nelson HL, Nelson JL, 'Chapter Five, When I'm Sixty Four' *The Patient In the Family, An Ethics of Medicine and Families*, New York, Routledge, 1995, 136.

¹⁵ Yancey P, 'Chapter Sixteen, Spiritual Amnesia' *Reaching for the Invisible God*, Michigan, Zondervan, 2000, 200.

¹⁶ Webb P, 'Chapter Four Advocacy' *Ethical Issues in Palliative Care, Reflections and Considerations*, Manchester, Hochland and Hochland Ltd, 2000, 74.

Kate Jones



Caroline Chisholm Centre for Health Ethics

7th Fl., 166 Gipps Street East Melbourne Vic 3002

Tel (03) 9928 6681 Fax (03) 9928 6682 email: ccche@mercy.com.au

www.chisholm.healthethics.com.au

Copyright © 2007 Caroline Chisholm Centre for Health Ethics Inc.

Subscription fees: Single \$30.00 + GST; Overseas [single] AUD\$40.00

Director/Editor: Rev. Norman Ford SDB STL PhD, Adjunct Professor, Australian Catholic University; Lecturer, Catholic Theological College / Melbourne College of Divinity; Senior Honorary Research Fellow, Monash University.

Research Officers: Kate Jones BN, MBA

Administrative Assistant/Layout/Sub-editor: Alice Stinear BEcon