

## **Abortion Law in Victoria**

*A recent move in Victoria to decriminalise abortion invites reflection on this issue. In this article, I review the history which has led to the present situation, and then offer four comments.*

### **History**

This history begins with an English law, the Offences Against the Person Act 1861. Section 58 of this Act prohibited abortion.<sup>1</sup> To be precise, it sanctioned “unlawfully” procuring an abortion, which implies that there would have been some lawful exception(s) to the law. This was not detailed at the time, but in all probability the sole exception would have been when the mother’s very life would be lost if the pregnancy continued. Note too that this law reflected the moral views of society at this time.

This English law was the basis of legislation in many jurisdictions around the world, including all the states and territories of Australia. In Victoria, a law enacted in 1964 eventually became the Crimes Act 1958. Section 65 of this law prohibits abortion in words that are basically unchanged since 1861.<sup>2</sup>

In 1969, a doctor named Charles Davidson was charged with five offences against this law. During his trial, he sought a ruling from the Victorian Supreme Court on the meaning of the word “unlawfully.” This case, *R v Davidson*, was heard by Justice Menhennitt, and its determination is commonly referred to as the Menhennitt ruling. It was the first ruling on the legality of abortion anywhere in Australia. Its principles were subsequently adopted elsewhere both in New South Wales and in Queensland.<sup>3</sup>

Justice Menhennitt drew on a legal precedent, a 1938 English case heard in the Courts of Assize, *R v Bourne*. The judge in that case determined that a pregnancy would be lawfully terminated “if the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck.”<sup>4</sup>

Menhennitt also invoked the legal concept of necessity. As he noted, there are two tests for necessity. Firstly, it must

be demonstrated that the person who acted honestly believed on reasonable grounds that their action was necessary. And secondly, it must also be demonstrated that a reasonable person in the same position would consider that what was done was not, all things considered, out of proportion to the exigencies of the situation. These two tests are sometimes referred to as necessity and proportion.

From all this, Justice Menhennitt expressed his ruling:

For the use of an instrument with intent to procure a miscarriage to be lawful the accused must have honestly believed on reasonable grounds that the act done by him (sic) was (a) necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuation of the pregnancy would entail; and (b) in the circumstances not out of proportion to the danger to be averted.<sup>5</sup>

With this ruling, Dr Davidson was found not guilty of the charges against him.<sup>6</sup>

Nowadays, of course, this Menhennitt ruling is used to justify what is effectively abortion on demand. We should

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note, however, that there are four separate steps in this trajectory. There is the original 1861 law. There is its interpretation in 1938. There is its reinterpretation in 1969. And there is its use nowadays to justify abortion on demand. Each succeeding step claims not to change but only to clarify the existing law. However, in my opinion, each of these steps actually does change the meaning of the law. For example, the Menhennitt ruling with its twin tests of necessity and proportion simply does not justify abortion on demand. Without in any way diminishing the difficulties raised by an unplanned pregnancy, such an unplanned pregnancy even with all its challenges simply does not make abortion necessary. And while an unplanned pregnancy may present grave difficulties, the death of an unborn is out of all proportion to these. It is simply disproportionate to end one life because another life faces even serious challenges. I must conclude that all this is not good legal jurisprudence.

Moving on, on 19 July 2007, Ms Candy Broad, the member for the Northern Victoria Region in the Legislative Council (Victoria's Upper House), introduced her Crimes (Decriminalisation of Abortion) Bill 2007.<sup>7</sup> This bill sought to delete the sections on abortion from the Crimes Act.<sup>8</sup> It also created a new section which made it an indictable offence for anyone other than either a medical practitioner or someone acting under a medical practitioner's direction to perform an abortion. In introducing her legislation, Ms Broad argued that it was necessary "to ensure the provision of safe and competent health services to women having an abortion," to "bring legislation regarding abortion into line with community expectations," and to remove the "risk of criminal prosecution" which she thought was faced by abortion doctors, their support staff, and women having abortions.

Victorian Premier John Brumby stated that he did not expect Ms Broad's bill to pass. He estimated that "it would probably get 11 to 12 votes" out of 40.<sup>9</sup> On 20 August, then, Premier Brumby announced that the Victorian Government would seek advice on abortion law reform from the Victorian Law Reform Commission. He stated, "It is essential that the law reflects contemporary community standards and that it is simple, clear and transparent."<sup>10</sup> Ms Broad's bill was withdrawn on 21 August 2007.

## Comments

That, then, is the history to date. I offer four comments:

Firstly, I note that the Catholic Church has voiced its opposition to the decriminalisation of abortion. The bishops of Victoria issued a joint letter on 24 July 2007; Archbishop Denis Hart of Melbourne released a separate letter on 7 August.<sup>11</sup>

In their letter, the Victorian bishops insisted that moves to decriminalise abortion "would be a backward step for

women and their families." They noted that "Victoria has one of the highest abortion rates in the world with at least 1 in 4 pregnancies ending in abortion." They therefore called on Victoria's political leaders to find new ways to help women with unplanned pregnancies, and in this way "to reduce Victoria's high abortion rate." "Women," they added, "need good counselling and support, healthcare, welfare and housing assistance. Provision also needs to be made for their educational needs so they can finish high school or university." Finally, the bishops noted that "Catholics are ready to join with others in finding new and positive solutions to the widespread problem of abortion."

In his letter, Archbishop Hart wrote, "I appeal to all that we acknowledge and protect the human dignity of each person from the very beginning of life to its natural end. This means that we not only preserve the life of the unborn child, but work tirelessly to care for and support mothers distressed by an unplanned pregnancy." The archbishop noted that "in no way do I wish to downplay or disregard the terrible anxiety that mothers and parents can sometimes experience." But even so, Archbishop Hart concluded, "I find it difficult to comprehend how we can legislate to decriminalise abortion, which will effectively deny protection to society's weakest members."

Secondly, the Church's opposition to abortion is above all because it involves the killing of the unborn. It is for this reason that the Second Vatican Council denounced abortion as an "unspeakable crime," while Pope John Paul II confirmed that direct abortion "always constitutes a grave moral disorder."<sup>12</sup> Even so, as these two statements confirm, the Church is also concerned about the women who are affected by abortion.

Do women suffer physically and psychologically after abortion? Those who support abortion claim they do not; those who oppose abortion argue that they do. An important reference here is Selena Ewing's *Women and Abortion: An Evidence Based Review*. This forty-two page paper thoroughly reviews the recently published research on this matter, so its conclusions are based not on opinion but on fact. And frankly, these conclusions are alarming. As regards physical harm, the study reports that after abortion there are "significant physical risks, including premature delivery, infection (which may lead to infertility), uterine perforation, placenta previa, and possibly miscarriage and low birth weight in future pregnancies." It notes too that "there appear to be more deaths from all causes, including suicide and homicide, after abortion, compared with childbirth." The study also reports substantial evidence of sometimes quite serious psychological harm after abortion. It is worth quoting at length:

Ten to twenty percent of women suffer from severe psychological complications after abortion.

Many more women experience emotional distress immediately after the abortion and in the months follow-

## The Centre welcomes a new Director and thanks Fr. Norman Ford

The Caroline Chisholm Centre for Health Ethics has a new Director - Fr Kevin McGovern. Ordained in 1988, Fr McGovern is a priest of the diocese of Rockhampton in central Queensland. From 1993 to 1996, he studied ethics and moral theology at Weston Jesuit School of Theology in Boston, earning a Licentiate in Sacred Theology (STL). Since then, he has lectured at the Brisbane College of Theology, where he has taught courses on fundamental moral theology, sex and sexuality, marriage and family, Catholic social teaching, and bioethics. Each year, he has also offered two six-week courses on bioethics at the Brisbane Multi-faith Academy for Chaplaincy and Community Ministries. He is currently a Director of BoysTown, a national Catholic agency that works with marginalised youth and their families. Fr McGovern has been a member of various Human Research Ethics Committees, including those at the Royal Brisbane and Women's Hospital, and The Sisters of Charity and Holy Spirit Health Service Queensland. An optometrist before he became a priest, Fr McGovern finds that his education in health science is an asset in his work at hospitals. A popular speaker, he has given talks on a wide variety of topics to parish groups, priests and parish workers, healthcare workers, and teachers. Fr McGovern is currently completing a doctorate in moral theology.

As we welcome Fr. McGovern, we thank Fr. Norman

Ford, the retiring Foundation Director, for 12 years of extraordinary service to this Centre, its member health services, and to the field of health ethics. Fr. Ford's contribution cannot be overestimated: the creation of this Bulletin with its regular series of articles on often contentious issues of current importance in healthcare, the provision of many in-service training courses for health service staff, wise counsel on various ethics committees, annual conferences which are always topical and very well attended, and a mountain of scholarly works might seem enough. However, Fr. Norman contributed much more, particularly in his area of special interest and expertise – the ethical issues involved in that vulnerable period of life from conception to birth. Fr. Norman's views were widely sought and respected, even by those who were opposed to the Catholic view, because his contribution melded a thorough grounding in Catholic moral theology with an understanding of the often complex scientific and clinical issues, together with a capacity to explain the complexities of these areas in understandable language.

That we were able to attract Fr. McGovern to the Directorship of the Centre is evidence of the high regard in which it is held and that is entirely due to the achievements of Fr. Ford in his 12 years of service. The Centre's future has been assured by its retiring Director.

Professor Anthony d'Apice

ing, including sadness, loneliness, shame, guilt, grief, doubt and regret.

Depression and anxiety are experienced by substantial numbers of women after abortion. For a small proportion of women, abortion triggers Post-Traumatic Stress Disorder.

After abortion women have an increased risk of psychiatric problems including bipolar disorder, neurotic depression, depressive psychosis and schizophrenia.

Women who have experienced abortion also have an increased risk of substance abuse and self-harm.<sup>13</sup>

In recent years, the Church has emphasised its concern for women affected by abortion. As we reflect on this quite disturbing list of possible harms, this emphasis is very understandable.

Thirdly, I note that there is considerable community disquiet about abortion. Significant research on Australians' attitude to abortion was commissioned by the South Australian Southern Cross Bioethics Institute in 2004. This survey was designed to reflect community attitudes to within 3%. While it confirmed majority support in Australia for access to abortion, it also found that "64 to 73%

of Australians think that the abortion rate is too high while 87% believe that it would be a good thing if the number were reduced."<sup>14</sup> "Only 15% believe that abortion is morally acceptable when the foetus is healthy and there is no abnormal risk to the mother."<sup>15</sup> "99% of the community believe that women contemplating an abortion should have access to counselling," and "98%... think that women should be advised of any health risks... before choosing an abortion."<sup>16</sup> However, "only 2% thought abortion clinics would be good advisers," and "only 9% disagreed with the proposition that counselling should be independent of abortion providers... This suggests a low level of confidence in abortion providers to provide objective advice and accurate information."<sup>17</sup> "94% think all the alternatives should be seriously considered" before a woman decides to have an abortion.<sup>18</sup>

The survey contains much more information, but it reaches an important conclusion:

Australians favour both genuine choice and lowering the number of abortions. Taken together this suggests that there is a very large constituency for social policy initiatives which enhance choice without restricting access... [T]he public's strong desire for a reduction

in the number of abortions is accompanied by a clear preference for this to be achieved by non-coercive means.<sup>19</sup>

Finally, then, I suggest that there are possibilities in the present situation. It seems likely that abortion will be moved from the Crimes Act to the Health Act. The Church cannot approve of such a move which treats abortion as if it were just another medical procedure. Even so, there are possibilities during this time of change to improve the status quo. I mention three, though others could be added. Firstly, there should be an independent record of the number of abortions performed in Victoria, and of complications or adverse events. The community is concerned about the number of abortions, and there cannot be sensible discussion of this without both these records. Secondly, there should be government-funded counselling independent of the abortion clinics for those who want to explore their options or are uncertain about continuing a pregnancy. These services should follow guidelines similar to those of the Federally-funded National Pregnancy Support Helpline.<sup>20</sup> Not only would this address community concerns, but it would also offer women more chance of genuine choice. Thirdly, it is an accepted medical principle that a facility should not perform an operation unless it is able to manage possible complications. Do the abortion clinics fulfil this criterion? If not, should abortion be restricted from these clinics, and available only through public hospitals? The Australian community wants abortions to be safe. Perhaps the only way truly to guarantee this is restricting this serious operation to public hospitals.

With the laws on abortion changing, this is the time for concerned Victorians to speak to their state members about their hopes and concerns on this issue.

## ENDNOTES

<sup>1</sup> As well, Section 59 forbade supplying a woman with any drug or instrument which she intended to use for abortion. Similar laws were found in earlier Acts from 1837, 1828 and 1803. For the text of this Act, see <http://www.swarb.co.uk/acts/1861OffencesAgainstThePersonAct.shtml>

<sup>2</sup> Section 66 parallels Section 59 from the 1861 law.

<sup>3</sup> See the Levine ruling on *R v Wald* (a case heard in 1971 by the District Court of New South Wales), and the Maguire ruling on *R v Bayliss & Cullen* (a case heard in 1986 by the District Court of Queensland).

<sup>4</sup> [1938] 3 All ER 615 at 619.

<sup>5</sup> [1969] VR 667 at 672.

<sup>6</sup> For more on the Menhennitt ruling, see [http://en.wikipedia.org/wiki/R\\_v\\_Davidson](http://en.wikipedia.org/wiki/R_v_Davidson)

<sup>7</sup> To view this bill and related documents, see <http://www.legislation.vic.gov.au>

<sup>8</sup> As well as Sections 65 and 66, this included part of Section 10 which applied the offence of child destruction to abortion.

<sup>9</sup> Gardiner, Ashley and Borensztajn, Jordana, "Abortion Show-down," *Herald Sun* 21 August 2007, p. 7.

<sup>10</sup> Ker, Peter, "Brumby Takes Stand on Abortion," *The Age* 21 August 2007, p. 1.

<sup>11</sup> Both these letters can be accessed at <http://www.melbourne.catholic.org.au>

<sup>12</sup> Vatican II, *Pastoral Constitution on the Church in the Modern World (Gaudium et Spes)*, #51; John Paul II, *The Gospel of Life (Evangelium Vitae)*, #62.

<sup>13</sup> Ewing, Selena, *Women & Abortion: An Evidence Based Review* (Women's Forum Australia, 2005), 1-2.

<sup>14</sup> Fleming, John I. and Ewing, Selena, *Give Women Choice: Australia Speaks on Abortion* (South Australia: Southern Cross Bioethics Institute, 2005), 3, 9, 15-17.

<sup>15</sup> *Ibid*, 3, 10, 14. <sup>16</sup> *Ibid*, 4, 10, 19. <sup>17</sup> *Ibid*, 19.

<sup>18</sup> *Ibid*, 4, 10, 20. <sup>19</sup> *Ibid*, 5, 21.

<sup>20</sup> Note that these guidelines accord with the *Preliminary Advice on Pregnancy Support and Counselling Services* issued by the Australian Bishops' Commission for Doctrine and Morals. For this, see <http://www.acbc.catholic.org.au/bc/docmoral/200609101682.htm>

Kevin McGovern



## The Integrity of Neonatal Care

*This article is especially concerned with aspects of neonatal care where considerable uncertainty in prognosis preceding death creates unique ethical dilemmas. Emphasis is initially given to the dynamics of uncertainty, and the need for medical care to be administered with compassion, and follows with the idea that ethical principles can guide difficult decisions by forming a symbolic navigational compass.*

### The dilemma of uncertainty

Ethical dilemmas that encroach the treatment plans of babies in the Neonatal Intensive Care Unit (NICU) are often confronting and emotionally painful. This is especially true where an assessment of the neonate's condition is indicative that treatment will likely be futile, and the neonate's capacity for continued life seems questionable, but where this finding is not yet completely certain. Understandably, the question of uncertainty of outcome may be especially hard for parents, who in many respects are not

naturally postured to be able to decide, and then articulate, that it would be in their child's best interest to be allowed to die.

These fundamental concerns raise important questions about how to integrate the right proportion of exceptional clinical intervention with the provision of ordinary comfort care, as the neonate's condition deteriorates over time. Khushf suggests that the balance of care needed for dying patients is much broader than what can be properly administered through medicine alone.<sup>1</sup> The question of thera-

peutic proportionality in defining and reaching this balance, in its proper context, needs to be enlightened by the perspective of the whole team. Father Cormac Nagle advises that this would include the physicians who have responsibility for clinical decision making; social workers who are especially able to relate to the practical implications of critical decisions for parents; pastoral care workers who can provide a meaningful context and support for human suffering; psychiatrists who are positioned to bring expert medical guidance on the impact of certain decisions; nurses who have significant responsibilities for the monitoring of the neonate's condition and daily care; and the parents<sup>2</sup>, who, as McHaffie illuminates, bring values from familial expectation to the decisions at hand.<sup>3</sup> We are given a powerful reminder by Browning that the distinctiveness of the role of care provider comes with special responsibility for the wellbeing of the care recipients:

The work of communicating with children and families at the end of life places special demands on practitioners, not the least of which is an obligation to nurture relationships that can hold within their embrace both vulnerability and suffering: that which is experienced by our child patients and their families, and that which we experience within ourselves.<sup>4</sup>

The benefit of the delivery of neonatal care by a cohesive and well co-ordinated team lies in the collaborative benefits of having a group of professionals to actively monitor parental well being. A team carries much stronger surveillance and observational capacity than if this responsibility is singularly assigned. The integrity of the shared journey of the paediatric team and parents, in working towards the knowledge of what is in the child's best interest, must be nurtured with sensitivity and care. Even with depth of support, parents may naturally struggle to come to terms with the medical dilemmas facing them. Vigilance to this issue may assist the neonatal team to monitor the relational dynamics that have the potential to jeopardise the neonate's quality of care.

A lack of consensus between professional and parent on neonatal prognosis frequently generates *ethical confusion or uncertainty*, particularly in countries such as Australia, where parents are usually afforded the final say in the treatment decisions for their child. A lack of agreement on a way forward, often results in clinical decisions that have a weaker association with what is considered to be in the child's best interest. The physician's acquiescence to parental pressure to maintain treatment at all costs is problematic if this leads to what would otherwise be known as a poor medical decision. A case in point is made by Wilkinson who refers to the situation of Bella. 'At operation almost all of her intestine is found to be necrotic. Her parents are immediately counselled that her long term outlook is grim, but they wish everything possible to be done.'<sup>5</sup> Wilkinson notes that this case is hypothetical, but significant attention to such issues in the in-

ternational medical literature confirms that it may not be uncommon for neonatologists to be caught in tensions of this kind. Himmelstein adds further insight that it is possible for parental denial of a child's condition to give way to a lingering treatment regimen that becomes increasingly inappropriate. Himmelstein comments 'Hope for a peaceful death, comfort, lack of suffering, and escalating engagement with care providers may be lost with wishes to maintain life at any cost.'<sup>6</sup>

The *long term implications* of acquiescence of this kind requires further analysis, with attention to the question of whether it is a hidden dynamic of neonatal care that should be given more exposure and discussion. Wilkinson's case scenario above exemplifies an uneasy paradox, because whilst it represents a style of clinical management that may be ethically untenable, it is also understandable. Consider for example, where a parent pleads with a surgeon to try one last intervention, and buckling under the pressure of the parents' intense grief the surgeon agrees, albeit with remorse and a sense of foreboding, to go ahead, knowing full well what the outcome will be. The Royal College of Paediatrics and Child Health (United Kingdom) states: 'There is no obligation to give treatment that is futile and burdensome - indeed this could be regarded as an assault on the child.'<sup>7</sup>

## Need for compassion

Where parents are overwhelmed by feelings of shock and intense pain, a sense of detachment may make even small decisions difficult. As a neonate's treatment becomes seemingly futile, attempts by the neonatal team to discuss the ways in which the child's medical condition may impact future *quality of life*, may even seem remote and discordant. Father Cormac Nagle substantiates that it can be very difficult for paediatricians to try to explain to a parent the future implications of disability, when the effects of such can not yet be seen.<sup>8</sup> This is compounded by the aesthetics of a medical environment which can appear to make the comfortable and delicate support of even the frailest neonate seem effortless. In the field of paediatric oncology, Himmelstein analyses the problems associated with delayed acceptance of prognosis and refers to Wolfe et al's finding that 'Earlier recognition of poor prognosis by parents was associated with...a better chance that both the parent and physician would identify comfort as the primary therapeutic goal.'<sup>9</sup>

The finding that impaired parental decision making, and delayed acceptance of presenting futility, can negatively affect a child's quality of care, gives precedence to the need to vigorously prevent the occurrence of professional indifference to the suffering of parents. An awareness of this issue is especially warranted where the neonatal team's daily exposure to grief, suffering or intense hope can anaesthetise them to the effectiveness of compassion. Meyer et al note that 'Staff members' genuine expression

of emotions and concern is generally perceived positively, encouraged, and well remembered by parents.’<sup>10</sup> Kavanaugh describes how one mother took tremendous comfort after the loss of her daughters’ when the nurse attending her bedside, in silence, also cried.<sup>11</sup> The grief-stricken mother absorbed a sense of comfort from the nurse’s response to her own feelings, and reveals in her narration: ‘...But I saw tears just coming out of her eyes...I mean all the nurses were great, but this woman actually let me see how she felt...I’ll never forget that. She felt that loss with me, and it just seemed like she was the only person there.’<sup>12</sup> This is a stark contrast to the suffering of Mrs Gonzalez, as Kane recalls:

...We talked about her seizure management, developmental delay, and respiratory complications. Mrs. Gonzalez would sit by Miriam’s bedside grabbing one of her daughter’s little fingers and would stare at her vulnerable face and body now violated by endotracheal and nasogastric tubes, catheters, and dressings. Mrs. Gonzalez appeared in shock. She was motionless, had nothing to say, a hopeless expression on her face...Many times I have wondered about this anguished woman and her fragile child and the things we could have said or done to bring them comfort...<sup>13</sup>

## Professional responses to uncertainty

One of the responsibilities of participating in the delivery of health care is in being able to take a few steps back, and create some meaningful distance over which the analysis of important trends can be considered over time. For Catholic health organisations it is particularly important to examine the ways in which social consensus can shape the delivery of health care, especially where such consensus filters into the hospital organisation and creates significant departures from the teaching of Christ. Whilst Catholic health organisations do not condone the abortion of the disabled foetus they can however engage in a style of medical intervention ‘which preserves life with all means and at any cost.’<sup>14</sup> Father Kevin McGovern cautions, ‘Just as the Catholic Church challenges the existing view that it is acceptable to terminate a viable but disabled foetus, we must also be prepared to challenge the existing view that we simply must do everything possible after birth to ‘save’ a dying child.’<sup>15</sup> It is worth considering whether society’s conditioning to accept either extreme of medical practice is somehow indicative of a prevailing ethical blindness. There is a need across Australia, for organisations involved in neonatal care, to re-establish the relevance of *ethical principles to guide practice, assess whether they are applied with proper care, and whether they can in fact guide difficult decisions so that a symbolic navigational compass prevails, which arguably does not violate the dignity of the child.*

Catholic health care organisations should embrace the challenge to ensure the adoption of principles to govern clinical pathways are consistent with the Code of Ethical

Standards for Catholic health Institutions, and actually motivate an outworking of compassionate and humane care. In neonatology the principles of proportionality, the best interest principle, and the interrelationship of benefit, burden and justice for the patient warrant special attention. The clinician’s attention to guiding ‘paradigm cases,’ as described by Lantos also informs decision making.<sup>16</sup> There is not the capacity to explore each of these here, but the principle of proportionality of therapeutic intervention is central to many of the ethical dilemmas of neonatal care stemming from uncertain prognosis. Taboada offers the following official Catholic Church explanation for the utility of proportionality:

To verify and establish whether there is due proportion in a particular case, the means should be well evaluated by comparing the type of therapy, the degree of difficulty and risk involved, the necessary expenses, and the possibility of application, with the result that can be expected, taking into account the conditions of patients and their physical and moral powers.<sup>17</sup>

Whilst organisational consensus on the types of principles to guide neonatal care is needed, it is imperative that physicians use their clinical expertise and knowledge to guide their interpretation of such principles according to the specific needs of each child’s clinical demands. The application of a range of principles to govern good practice outcomes is appropriate, as the principles need not be mutually exclusive. Certainly Woods reminds us that it is important to balance purposefully selected ideological principles against each other, to enhance morally difficult decisions.<sup>18</sup> It is unlikely when making moral decisions, as opposed to absolute decisions, that any one principle will appropriately cover all the contingencies that such unique medical cases present.

Notwithstanding, the problem of conflict between professionals in their understanding of such principles, should not be used as a mitigating excuse for the under development of a principled approach to decision making. An awareness of such a framework by parents may also assist them to understand why certain recommendations are made in a particular context, and why other recommendations or strategies are considered inappropriate by the neonatal team. Increasing attention in Australia needs to be given to not only the use of such decision making tools, but in how to communicate the outcomes of decisions, according to such principles, to parents in an acceptable way.

## Conclusion

A substantial tension in the NICU, shared by parents and professionals, is in knowing when to identify that a child’s treatment is futile, and that impending death is not only inevitable, but is a desirable outcome as a natural

end point of life. This question is inherently difficult for members of the NICU and parents alike. What has been proposed here is that careful attention to the support needs of parents may directly improve the quality of care received by neonatal babies who are dying. Whilst a body of principles can provide guidance on how to navigate diverse and challenging clinical presentations of critically ill neonates, their interpretation needs to accommodate the sensitivities of each unique clinical presentation. It is recommended that members of the Neonatal Intensive Care Unit also ensure that the principles adopted support the fundamental mission of the Catholic health organisation – to compassionately administer the love of Christ.

#### ENDNOTES

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- <sup>2</sup> Nagle C, OFM, Ethicist, Mercy Hospital for Women, Personal Communication, Victoria, 2007.
- <sup>3</sup> McHaffie H, 'A Scottish researchers response' Journal of Medical Ethics, 30, 2004, 406.
- <sup>4</sup> Browning D, 'To Show Our Humanness – Relational and Communicative Competence in Pediatric Palliative Care' Bioethics Forum, 18, 3/4, 2002, 24.
- <sup>5</sup> Wilkinson D, 'Is it in the best interests of an intellectually disabled infant to die?' Journal of Medical Ethics, 32, 2006, 454.
- <sup>6</sup> Himelstein B, 'Palliative Care in Paediatrics' Anesthesiology Clinics of North America, 23, 2005, 851.
- <sup>7</sup> Royal College of Paediatrics and Child Health, Withholding or Withdrawing Life Sustaining Treatment in Children, A Frame-

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- <sup>14</sup> McCormack R, 'Chapter 3 Morality' Health and Medicine in the Catholic Tradition, New York, Crossroad, 1987, 52.
- <sup>15</sup> McGovern K, Director, Caroline Chisholm Centre for Health Ethics, Personal Communication, Victoria, 2007.
- <sup>16</sup> Lantos J, 'Chapter 3 Era of Exposed Ignorance' Neonatal Bioethics The Moral Challenges of Medical Innovation, Baltimore, The John Hopkins University Press, 2006, 82.
- <sup>17</sup> Taboada P, 'What Is Appropriate Intensive Care? A Roman Catholic Perspective' reference to the: 'Pontifical Council for Pastoral Assistance to Health Care Workers. 1995'. Charter for Health Care Workers. Vatican City: Vatican Press, in Englehardt T, Cherry M, Allocating Scarce Medical Resources Roman Catholic Perspectives, Washington DC, Georgetown University Press, 2002, 56.
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Kate Jones



## Anaesthesia and Ethics

*This article discusses anaesthesia, the role of the anaesthetist and its ethical challenges. In the current political climate of task substitution and de-professionalisation, it is worth considering the role of the anaesthetist and the relevant ethical issues pertaining to this endeavour.*

### Introduction

Anaesthesia means an absence of all sensation. General anaesthesia has recently been described as "a state of drug-induced non responsiveness characterized by absence of response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes."<sup>1</sup> Anaesthesia also includes local and regional techniques where only part of the body is anaesthetized and sedation techniques where a patient maintains their own vital reflexes but experiences no pain or discomfort and is often amnesic, (no memory), of the procedure. Each year millions of anaesthetics are administered in Australia. By their very nature, these interactions are often brief, intense and anonymous.

### The role of the anaesthetist

Anaesthetists are doctors who have undergone specialized

training to provide total, holistic care of the patient to facilitate their surgery, intervention or procedure.

The role of anaesthetists has been described by Orkin and Thomas as including:

- Preoperative evaluation and preparation of patients for surgery.
- Relief and prevention of pain for patients during and following surgical, obstetric, therapeutic and diagnostic procedures.
- Monitoring and maintenance of normal physiology during the perioperative period.
- Management of critically ill patients, involvement in intensive care, evaluation and support of respiratory function.
- Involvement in teaching cardiopulmonary resuscitation.
- Involvement in acute and chronic pain.
- Participation in clinical and scientific medical re-

search.

- Supervision, teaching and evaluation of perioperative staff.
- Involvement in health administration relating to perioperative services.
- Advocacy for the maintenance of high professional standards and patient safety.<sup>2</sup>

### **Preoperative evaluation**

With increasing day surgery admissions, patients may be seeing their anaesthetist for a brief time shortly before their procedure. Despite this, the preoperative evaluation is the crucial interaction where the anaesthetist makes an assessment of the patient's clinical state and considers the optimal anaesthesia approach. Patients are encouraged to ask questions and critically discuss their concerns so an informed decision about how to proceed may be reached. Anaesthetists are also involved as perioperative physicians, directing preoperative investigations and therapy to optimize the medical condition of patients prior to surgery.

### **Intraoperative care**

The anaesthetist maintains optimal surgical conditions by considering several related objectives. Firstly, rendering the patient unconscious and amnesic so they have no perception or recollection of the procedure. Secondly, providing good analgesia so that patients are pain free during and after surgery. Thirdly, providing good conditions for the surgeon to perform the operation such as keeping the patient still. Finally, supporting and maintaining the patient's normal physiology. This often involves some form of support for the patient's airway and assisted ventilation, support for their blood pressure and cardiovascular system using drugs and intravenous fluids, as well as maintaining normal thermoregulation, renal and neurological function.

### **Monitoring**

Anaesthesia has undergone rapid changes in recent years in the development of monitoring equipment. This includes electroencephalographic (EEG) monitoring of the patient's brain waves to help determine if patient is asleep, specialized ultrasound probes to look at heart function and the circulation, special drips that give beat to beat information on blood pressure, heart function and pressures around the heart, as well as respiratory monitors which give information about breathing and oxygen levels. New anaesthesia machines provide more sophisticated ventilators and safer delivery of anaesthetic gases and more detailed monitoring. The anaesthetist adopts this new technology to increase patient safety.

### **Anaesthesia outside the operating room**

Increasingly anaesthesia services are required for patients undergoing procedures or investigations in remote locations such as radiology department, cardiac catheterization laboratory, endoscopy suite, and free standing day

surgery centres. The anaesthetist ensures that the appropriate equipment and drugs are available to safely deliver the anaesthesia or sedation.

### **Post anaesthesia care unit (PACU)**

Patients have specific needs as they emerge from anaesthesia and consequently, there are specific requirements for the staffing, design and conduct of clinical care in PACU. Anaesthetists are responsible for the ongoing care of their patients in PACU and the immediate postoperative period.

### **Acute pain service**

As the scope of perioperative medicine broadens, anaesthetists are increasingly involved in the ongoing care of patients particularly relating to acute pain management and intravenous therapy. This includes performing and reviewing epidurals which are requested frequently in obstetric delivery suites.

### **Chronic pain service**

Some anaesthetists have undergone specialized training in chronic pain medicine and provide support, clinics and interventions to relieve chronic and cancer pain.

### **Intensive care**

Some anaesthetists have undergone further training to provide services to the intensive care unit. Anaesthetists are often caring for the critically ill and work closely with other specialists to provide specific therapies.

### **Research and training**

Some anaesthetists are actively involved in clinical and scientific research to better understand and develop the drugs, techniques and equipment used in anaesthesia. All anaesthetists are encouraged to think critically about the scientific literature and audit their own practice. Anaesthetists often spend time teaching trainees, other medical and paramedical staff about cardiopulmonary resuscitation, perioperative medicine and anaesthesia.

### **Safety**

Professor Michael J. Cousins, AM reports that "anaesthesia mortality rates (approximately one in 56,000 anaesthetics), have been amongst the lowest in the world."<sup>3</sup>

The drugs and techniques used to provide anaesthesia are complex and have the potential to cause harm if not administered properly. Australia is one of the safest countries in the world to receive anaesthesia because of the careful training that our anaesthetists receive and dedication to maintaining safety by the profession. This includes auditing and reporting of morbidity and mortality, promotion of professional standards by the Australian and New Zealand College of Anaesthetists, ongoing education and training through the College, Australian Society of Anaesthetists and University Hospital Department research and training activities. In Australia the anaes-

thetist is a medical doctor who has had postgraduate experience including at least a five year training programme in anaesthesia. This involves a number of written and oral examinations to determine that a high standard of competence has been achieved. General Practitioner anaesthetists have also completed further training in anaesthesia to satisfy the Joint Consultative Committee on Anaesthesia or the Australian College of Rural and Remote Medicine.

### **Holistic care.**

Sometimes there may be conflicts of interest between the different stakeholders in the perioperative setting. The surgeon may be focussed on achieving the best possible surgical result, the relatives and family may insist on maximum intervention at any cost and the hospital may have limited resources to offer the patient. When the patient is under the care of the anaesthetist, it is often this person that assumes the role of advocate for the patient and their wishes as expressed at the preoperative consultation. Sometimes difficult decisions need to be made in consultation with others but ultimately the anaesthetist reflects the views that the patient cannot express because of their clinical condition.

### **Brief, intense and often anonymous**

The interaction, that one recalls, with the anaesthetist may be brief. The patient may be unaware for most of the clinical contact time. This period is often intense in terms of disruptions to normal physiological function and the consequent clinical support and monitoring required. Often patients leave not really remembering who the anaesthetist was. The role of the anaesthetist is to "take care of the patient's life while the patient cannot."<sup>4</sup>

## **Ethical aspects in the practice of anaesthesia**

### **Duties to patients**

Patients undergoing major surgery are unable to participate with any awareness in the operations that are being performed on them. In this situation, patients are totally dependent on, and have a right to expect from, anaesthetists and surgeons that all due care will be taken of their safety, health and wellbeing. Anaesthetists owe it to their patients to keep themselves up to date professionally to ensure their patients benefit from the best anaesthetic practice available, especially if they are not involved in research themselves.

The anaesthetist, as a specialist medical practitioner, is subject to the same ethical principles and norms as any other medical practitioner for their patients. This involves the duty to become acquainted with the necessary medical information about the patient requiring surgery in good time as well as the nature and purpose of the surgery to be performed. The anaesthetist should have access to the patient's medical history. This is necessary to ver-

ify there are no contra-indications for the use of certain anaesthetics due to the age, medical condition or allergies of the patients or of a specific organ that that may have an infection or disease.

Usually the anaesthetist agrees with the medical assessment of the surgeon that the surgery is warranted and ethically acceptable. However, differences of opinion can arise and a personal decision still has to be made whether, from an ethically responsible anaesthetist's perspective, surgery requiring general anaesthesia is warranted on each occasion.

Understandably, some anaesthetists may refuse to be involved in surgical abortions on moral grounds. In practice, surgeons should team up with anaesthetists with whom they have a trusting working relationship and who share a common understanding on the relevant medical considerations along with the required ethical criteria for different kinds of surgical procedures. It is possible, but rare, for an anaesthetist to refuse involvement, on professional ethical grounds in view of the risks involved for their patient, e.g., in using anaesthesia in a case of minor surgery or cosmetic surgery.

### **Informed consent**

Competent patients need to be informed of all the relevant information, including risks and side-effects, in order to make their own morally responsible decisions to undergo medical procedures that require anaesthesia. Each competent patient's situation is personal and requires an individual decision. In the case of incompetent patients, consent should be obtained from the patient's representative with legal power of attorney (medical) or at least one parent of an incompetent child.

Patients should be informed in advance if any research procedure or an experimental anaesthetic is planned to be employed for their operation. Their consent should be obtained, and if required, also that of the hospital's human research ethics committee.

### **Responsibilities of Anaesthetists and Surgeons**

The anaesthetist is responsible for keeping the patient alive. The surgeon is directly responsible for, and is in charge of, the surgical aspects of the operation. The anaesthetist's stand should be that the operation should not proceed if it is most likely to unduly endanger the life or health of the patient. Anaesthetists should be truthful and report mortality and morbidity issues to appropriate authorities or peers without exaggeration or bias. Naturally the surgeon shares all these concerns and responsibilities as well.

Surgeons and anaesthetists must be able to work together as a team and with all the operating theatre staff, as well as with others involved in post operative care.

Anaesthetists and anaesthetic nurses are in a very privi-

leged position with access to powerful and often highly addictive drugs. They have a responsibility to ensure the safe keeping, administration and documentation of these drugs to ensure they are not misplaced or misused. Furthermore, anaesthetists have an ethical and legal responsibility not to self-administer these medications and to care for colleagues who may have become addicted. This involves immediate reporting, cessation of practice of the impaired physician and referral for rehabilitation.

#### ENDNOTES

<sup>1</sup> Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Australian and New Zealand College of Anaesthetists, Royal Australian College of General Practitioners Australian College of Rural and Remote Medicine, "Position Statement on the Provision of Obstetric Anaesthesia

and Analgesia Services" March 2007, 8.

<sup>2</sup> Orkin, Frederick K and Thomas, Stephen J, "Scope of Modern Anaesthetic Practice" Miller's Anaesthesia, Elsevier Churchill Livingstone, 2005, 55-65

<sup>3</sup> Cousins AM, Michael J, "Safety of Anaesthesia in Australia"; Dr Neville Gibbs, Australian and New Zealand College of Anaesthetists, 2006, 5.

<sup>4</sup> Australian Society of Anaesthetists, "Anaesthesia and You" 8, ASA website <http://www.asa.org.au>; for further information and slide shows see the following useful web sites:

<http://www.asahq.org/index.htm>

<http://www.asa.org.au/>

<http://www.anzca.edu.au/about/index.htm>

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## The Problem of Childhood Abuse

*The family unit is entrusted with the responsibility to nurture life. It is intended by our Creator to be a nurturing, loving place where the family members, through mutual respect, learn the significance of relationship. The ethical problems for nurses in responding to concerns of child abuse are discussed here, with a call to the whole community to invest in creating a safer place for children.*

To witness the vibrancy of a young child at play can be most intriguing and revealing. As the child's communicative ability expands, their earliest development is a creative mixture of shifting dynamics: imitating and copying, asserting their own unique personality and own ways of doing things, and considering situations with innocence. However we consider childhood development and the passing of key milestones, scientific and sociological evidence firmly illuminates that the quality and range of early childhood experiences in the midst of the familial home significantly affects a child's development.

In any context, child abuse by a trusted parent, carer or guardian is shocking, and the implications for the child are disturbing and perhaps difficult to consider. How does a child reconcile that the person who tucks him/her into bed at night is also the one who inflicts lasting pain and serious injury?<sup>1</sup> Equally shocking is the insight that unremitting abuse, trauma and neglect may jeopardise the child's progress through their own personal development. Child abuse may negatively affect speech development, interpersonal skills, and difficulty in trusting and relating to other people.<sup>2,3</sup> Most sadly, it may retard personal potential through fear, and a broken spirit, accompanied by a loss of confidence, and a world of personal confusion and conflicting dilemmas. Not every abused child will suffer these problems. But the very possibility should be a serious cause for alarm.

### Defining Childhood Abuse

The abuse of a child is considered here to be a problem caused by an adult whose natural position power is used to purposefully violate the child in their care. Within the

family unit, the abuse of children can take on many different characteristics with significant variation in motivation, but there is general agreement that it may occur in the form of emotional, physical, sexual abuse and neglect.<sup>4</sup> More than one type of abuse may occur concurrently. It is also assumed here that a child who is abused in any way over a period of time must also be suffering emotionally. The World Health Organisation in 1999 presented the following definition of child abuse:

Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.<sup>5</sup>

The abuse of a child by adult carers, guardians or parents is potentially devastating to the child regardless of the degree of harm, injury or trauma experienced. The problems experienced by the child may be further compounded where the child does not have access to the protective or nurturing influence of another adult in the home. This might be where the protective influence of the other parent is minimised through fear or control, such as is often found to be the case in domestic violence or intimate partner violence.

### Ethical Issues

**When abuse is overlooked, the community fails:** Community reticence to acknowledge child abuse increases the likelihood that the community, such as is made up by neighbours, friends and family, will have a diminished

role in improving the plight of children who silently suffer the effects of abusive relationships. By refusing to acknowledge the problem exists, the community demonstrates that it is uncomfortable in responding to the issue in the first instance, and then proceeds to reinforce this belief by pushing the issue to the periphery by choosing to believe it happens *elsewhere*.<sup>6</sup> A significant challenge hampering the safety of Australian children is the disinclination of adults to accept that the prevention of child abuse is a whole of community responsibility. Research commissioned by the Australian Childhood Foundation and the National Research Centre for the Prevention of Child Abuse sought the 'attitudes' of 720 adults in Australia regarding child abuse.<sup>7</sup> Tucci et al advise 'the problem of child abuse continues to fail to register as a major community issue. At a spontaneous level, child abuse rated as less of an issue than the increasing cost of petrol or problems with roads and public transport.'<sup>8</sup> The authors reveal 'after prompting, child abuse moved from fourteenth to the number one issue of concern for respondents.'<sup>9</sup> The wider community needs greater exposure to educational and social strategies to alert responsible adults to their role in the prevention of child abuse.

#### **Positioning of Nurses to respond to childhood abuse:**

An ethical challenge exists for nurses, as a body of professionals, to explore their potential leadership role in assisting the wider community to become increasingly responsive to the seriousness of child abuse. The Department of Human Services reveals that compared to '*all sources*' who made a notification of child abuse in 2000/01, nurses had a higher rate of substantiation.<sup>10</sup> They advise 'approximately 33 per cent of the notifications made by nurses were substantiated' in contrast to under 20% from '*all sources*.'<sup>11</sup> That nurses historically hold a higher rate of abuse substantiation potentially affirms their suitability to assist other sectors of the community with abuse-awareness issues. Arguably, the involvement of health care professionals in a community advocacy role could make significant inroads to strengthen collaborative social and educational strategies to heighten the community's awareness of child abuse.

**Stress and high levels of emotion:** It is often highly stressful for nurses to care for seriously ill children who are dying. A flow of highly difficult decisions along a continuum of care, made with and in the midst of devastated and grief-stricken parents is not easy. The stress in working through this complicated care scenario may become even more intense when the parents by the gravely ill child's side are also directly responsible for the infliction of serious or terminal injury to the child. It introduces the ethical challenge to accept that the dynamics of parental grief are no less real here, and the nurses' responsibilities of professionalism to the child's family not at all diminished. Situations of this nature normally present a very challenging occasion for anyone. The Department of Human Services suggests that a real stressor for

nurses who care for abused children is that 'You are frequently faced with your own values plus those of your clients and possibly other staff.'<sup>12</sup> Such situations make it necessary to consider a range of strategies to manage conflict, suspend judgement, and remain impartial from biases that may not be factual.

In Australia, society seems to foster quite strong thought categorisations that a person is either 'good' or 'bad'. Categorising someone as 'bad' may weaken both our empathy for them, and our understanding of people who do intentionally and seriously injure their own children. This acknowledgement does not condone abusive behaviour in any context, but we need to be aware that it is a dynamic that may challenge or shape our conduct even subconsciously, affecting our professional interaction with others. It is important that health care professionals acknowledge these attitudinal dynamics of our community, and remain vigilant to the need to frequently evaluate whether patients, and their carers, are treated with the respect that is grounded from professional impartiality.

**Mandatory Requirements:** Nurses have a dual responsibility to not only be informed of the signs of suspected intentional injury to children, but to also ensure there are strong referral relationships between the hospital and family support agencies in the community. This supports the spirit of the legislation underpinning mandatory notification. Where it's identified that parents are struggling in their parental role and negative consequences are anticipated for the child, non-judgmental communication could be a salient factor in parental acceptance of a referral for support. A responsive attitude to signs of severe parental stress should be supported by the hospital's policy infrastructure, so the hospital also participates in a preventative approach to child abuse.

There is a mandatory requirement for nurses to notify the statutory body of suspected physical and sexual abuse.<sup>13</sup> This places nurses in a difficult position if they perceive they're required to make a notification where other colleagues or team members disagree with their decision. The implementation of organisational policy to guide nurses through the process of statutory notification of child abuse needs to be respected by all staff equally, regardless of their position in the organisational hierarchy. Blaskett and Taylor found that from a base of 392 cases of child abuse in Victoria, in 8.7% of cases, professionals 'feared' the responses of other staff when making the abuse notification.<sup>14</sup> Whilst nurses may benefit from peer consultation if they experience uncertainty due to a lack of training or expertise in the field of childhood development or abuse, the process of the consultation must not ameliorate the responsibility to notify once reasonable grounds for abuse have been determined. The importance of training and education on the topic of childhood abuse needs emphasis, to afford all staff an equal opportunity to professionally navigate the notification process required

of them with commensurate assurance.

Across Australia there is evidence that increasing attention needs to be given to the commitment to create a workplace culture that empowers staff to act on a suspicion of, or direct evidence, of child abuse.<sup>15</sup> Blaskett and Taylor undertook a research study in Victoria on 'health and welfare professionals employed in seven different occupations about their knowledge of, training in, attitudes towards and compliance with child protection legislation.'<sup>16</sup> The study is significant in Victoria because the survey sample represented Melbourne, regional cities and other Victorian rural locations.<sup>17</sup> The report cites that in 392 cases of child abuse, only 2.3% of cases were associated with concern that the wrong decision had been made by the notifier.<sup>18</sup> Predominantly, the responses indicate professionals worry about the consequences of making a notification that they can't control, such as the response of the offender (68.1%), the response of the child protection agency (73.5%), and possible loss of anonymity after disclosure (48%).<sup>19</sup> Blaskett and Taylor state:

Responses to this question revealed that many respondents were concerned about the response of Child Protection Services in the event of making a notification, in relation to the adequacy of the Services' response, the possibility of revealing the notifiers identity, applying pressure to the notifier or doing more harm to the child.<sup>20</sup>

Clearly there are ethical implications in withholding an abuse notification when there is substantial evidence of the abuse. In spite of this, Blaskett and Taylor found that 78% of nurses surveyed *were not sure* if it was ethically permissible to withhold notification.<sup>21</sup> A synthesis of the research findings reveals a highly complicated network of issues that impact the *potential* for lack of compliance with the mandatory reporting requirement.<sup>22</sup>

## ENDNOTES

<sup>1</sup> Tucci J, Chief Executive Officer, Australian Childhood Association, *Personal Communication*, Victoria.

<sup>2</sup> Butchart A, et al 'Chapter 1 The nature and consequences of child maltreatment' *Preventing child maltreatment: a guide to*

*taking action and generating evidence*, Geneva, World Health Organisation and International Society for Prevention of Child Abuse and Neglect, 2006, 8.

<sup>3</sup> Culp R, et al, 'Maltreated children's language and speech development: abused, neglected, and abused and neglected' *First Language*, 11/33, 1991, 377 – 389.

<sup>4</sup> State Government of Victoria, Australia, Department of Human Services, Children, Youth and Families, 'What is Child Abuse' accessed at: [http://www.office-for-children.vic.gov.au/child\\_protection/library/publications/protection/what](http://www.office-for-children.vic.gov.au/child_protection/library/publications/protection/what).

<sup>5</sup> Krug E et al, 'Chapter 3. Child Abuse and Neglect By Parents and Other Caregivers' *World report on violence and health*, Geneva, World Health Organisation, 2002, 59.

<sup>6</sup> Tucci J, Chief Executive Officer, Australian Childhood Association, *Personal Communication*, Victoria.

<sup>7</sup> Tucci J, Mitchell J, Goddard C, *Out of sight Out of mind, Community attitudes about child abuse and protection in Australia*, Victoria, Australian Childhood Foundation, National Research Centre for the Prevention of Child Abuse, Monash University, 2006, 1. <sup>8</sup> Ibid, 11. <sup>9</sup> Ibid, 13.

<sup>10</sup> State of Victoria Department of Human Services, Child Protection and Family Services, formerly known as Child Protection and Care 'Module 4 – The Educational Context, from the Safe from Harm publication' *Professional Development and Education Resource for Nurses*, Victorian Department of Human Services, 2001, 76.

<sup>11</sup> Ibid. <sup>12</sup> Ibid, 92. <sup>13</sup> Ibid, 79.

<sup>14</sup> Blaskett B, Taylor S, *Facilitators and Inhibitors of Mandatory Reporting of Suspected Child Abuse*, Victoria, The Criminology Research Council, 2003, 51.

<sup>15</sup> For information from another Australian Research study on nurses' experience of making abuse notifications see: Nayda R, 'Registered Nurses' Communication about Abused Children: Rules, Responsibilities and Resistance' *Child Abuse Review*, 13, 2004, 189, 188 -199.

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<sup>17</sup> Ibid, 15. <sup>18</sup> Ibid, 51. <sup>19</sup> Ibid. <sup>20</sup> Ibid. <sup>21</sup> Ibid, 55.

<sup>22</sup> The Caroline Chisholm Centre for Health Ethics would like to especially acknowledge their appreciation of the Australian Childhood Foundation and the Gatehouse Centre for the Assessment and Treatment of Child Abuse, Royal Children's Hospital, for their generous assistance with information and access to resources for this article: Australian Childhood Foundation, PO Box 525, Ringwood, Victoria, 3134.

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