

Chisholm Health Ethics Bulletin

Vol 13 No 4

WINTER

2008

FEDERAL AND VICTORIAN EUTHANASIA BILLS

This article argues against the Victorian Medical Treatment (Physician Assisted Dying) Bill and the Federal Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill. True compassion leads to sharing another's pain; it does not kill them.

Euthanasia and Assisted suicide are back on the agenda in both Victorian State and Federal Parliaments. Senator Bob Brown (Greens, TAS) and Colleen Hartland (Greens, Western Metropolitan) have introduced bills which would legalise euthanasia and assisted suicide, and are currently seeking the support of their colleagues.

Advocates of euthanasia and assisted suicide continue to campaign for a change in euthanasia laws both in Australia and overseas. Since the Northern Territory's short lived experiment with euthanasia in 1996, the Greens and the Democrats have introduced a series of bills into parliaments in SA, TAS, WA, and NSW, all of which have been unsuccessful. The NSW parliament overwhelmingly rejected Ian Cohen's *The Rights of the Terminally Ill Bill* by 28 votes to 4. The SA parliament has similarly rejected various proposals put forward by Sandra Kanck and others. Similar bills in other state parliaments have also failed; sometimes they were defeated before being put to a vote.

But perhaps with a change in the political landscape at the Federal level, euthanasia advocates see new opportunities once again to test the resolve of Australian parliaments to resist euthanasia.

Physician-assisted suicide bill introduced into Victorian Parliament

The Victorian Parliament is currently being asked to support a bill which would allow doctors to prescribe lethal pills for patients who have a terminal illness or an advanced incurable illness. *The Medical Treatment (Physician Assisted Dying) Bill 2008*¹ has been introduced by Colleen Hartland of the Greens, and has apparently been proposed and drafted by Mr Neil Francis, President of Dying with Dignity (formerly the Euthanasia Society of Victoria). It has not come at the request of those organisations or institutions that directly care for patients and their families.

Doctors would be allowed to prescribe drugs with the

direct intention of acting to end the patient's life. This is a very different step from withdrawing treatment that is no longer providing any benefit to the patient. Patients with chronic illnesses often fear being a burden to those who care for them. If euthanasia were legalised, it would put more pressure on them and make preservation of their lives dependant on the strength of their will to continue.

The Hartland Bill makes a number of claims about existential pain. Yet existential pain usually arises from loneliness and lack of a sense of self worth. Those facing serious illness need others to be close to them, to support them and empathise with them. Pain and suffering can be more than just physical pain, and can include psychological, emotional and spiritual elements. Rather than ending the life of the person who suffers, palliative care aims to see the person as a whole and cater for each dimension when and as the need arises.

Instead of increasing the options for those suffering from chronic illnesses, legalising euthanasia and assisted suicide is more likely to give an 'out' to carers, healthcare providers, institutions and governments charged with the serious responsibility of providing care for the elderly, sick and the dying. As the Australian population ages, governments will increasingly be tempted to look for new ways to save money, rather than investing in the care of the chronically sick. Such a law would further undermine

IN THIS ISSUE

Federal and Victorian Euthanasia Bills	1
Freedom in the End of Life Context	4
Male Circumcision—Facts & Fiction	7
Aboriginal and Torres Strait Islander Health Research	10

the obligation of both ordinary Australians as well as our governments to provide care for those in need.

Physician Assisted Dying would cast a shadow over the relationship between doctors and patients. Asking doctors to prescribe drugs not for the care or treatment of those with a terminal or chronic illness but to intentionally end the patient's life would undermine the relationship between doctors and their patients. Such moves continue to be opposed by the Australian Medical Association (AMA) whose policy is to "strongly oppose any bill to legalise physician assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer." In addition, the British Medical Association, the New Zealand Medical Association, the Canadian Medical Association and the World Medical Association all oppose moves to legalise euthanasia and assisted suicide.

Euthanasia Bill introduced into Federal Parliament

Bob Brown has introduced *The Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*² into Federal Parliament to allow Territory parliaments once again to legalise euthanasia and assisted suicide. Under the leadership of the then Chief Minister, Marshall Perron, the Northern Territory was the first place in the world to legalise voluntary euthanasia under the Northern Territory's *Rights of the Terminally Ill Act of 1995*, which passed by just one vote. At the time, there was very little palliative care in the Northern Territory.

Four of Dr Philip Nitschke's patients had their lives ended under the NT legislation before the Federal Parliament passed the Andrews Bill (*Federal Euthanasia Laws*) in 1997 which prevented the Australian Territories from making laws on euthanasia. It effectively ended the Northern Territory's experiment with voluntary euthanasia, and blocked similar legislation in the ACT parliament.

If Bob Brown's Bill were to be successful, it would overturn the Andrews Bill and re-instate the Northern Territory's *Rights of the Terminally Ill Act of 1995*, so that once again voluntary euthanasia would be legal in the NT. It would also give the ACT parliament the ability to pass laws on euthanasia. The Bill has been referred to the Senate Legal and Constitutional Committee, and the Committee is due to report by mid-June.

While the Northern Territory legislation is held up by many advocates of euthanasia and assisted suicide as a model, it has become increasingly clear that there were a number of significant problems with the legislation. For instance, in a report published in the *Lancet*,³ it is evident that the NT guidelines were unable to protect some of the most vulnerable patients. Despite not meeting the criteria,

one patient had his/her life ended. In addition, other patients with treatable depression were also not protected by the guidelines, despite the fact that the guidelines were specifically designed to protect such patients. Instead, they too had their lives ended under the legislation.

Do opinion polls show support for assisted suicide?

Although Bob Brown claims that "every opinion poll since the 1980's has shown that the vast majority of Australians back voluntary euthanasia legislation along the lines of that in the Netherlands and Oregon,"⁴ such claims deserve further attention.

Although some polls claim Australians support euthanasia, it is not clear what is meant by this, and depending on how the question is worded, opinion polls can easily be manipulated. Commonly, the polls ask something like "If a patient is experiencing unrelievable pain and suffering, should the doctor be able to end that pain?" Most people may want the patient's suffering to end, but it is not always clear that ending their life is the only way of ending their pain. It is also not clear that most Australians understand what is meant by euthanasia and assisted suicide, as they often confuse such terms with removing life support which is no longer benefiting the patient or the refusal of overly burdensome or futile treatment.

The Netherlands

When mercy killing and assisted suicide was semi-legalised by court order in the Netherlands in 1973, it was supposed to be only limited to a very few exceptional cases and even then meant to be only for those whose pain could not be eliminated by any other means.⁵ But experience in the Netherlands has shown that it has not remained limited to the very few, but has expanded to include many other vulnerable people. Physician-assisted suicide is granted not only to those experiencing 'unrelievable pain' who ask for it, but now also the terminally ill who ask for it, the chronically ill who ask for it, people with disabilities who ask for it, and, more recently, the depressed who ask for it.⁶ There is also evidence that doctors provide euthanasia for those who have not asked for it.⁷

A study carried out with the support of the Dutch Medical Association in 1991⁸ found that physician-induced deaths accounted for more than 9.1 per cent of annual deaths. Of those deaths:

- 2,300 were from requested euthanasia
- 400 were assisted suicide
- 1,040 were carried out without the patient's knowledge or consent
- 50% of Dutch physicians suggested euthanasia to their patients

Studies in 1991 and 1995 found that although Dutch physicians were required by law to report physician assisted deaths, the majority of deaths went unreported.⁹

The Netherlands legalised euthanasia and physician assisted suicide in 2001,¹⁰ and gave minors aged between 16 and 18 access to assisted suicide. Children aged between 12 to 16 years of age can also request euthanasia and assisted suicide with the support of their parents or guardians.

We should not be surprised to learn that the Netherlands has a high suicide rate and an 'increasing trend toward youth suicide.'¹¹ Many elderly and sick people are afraid to seek medical help, afraid that they might be euthanised without their consent.¹² A 2005 study found that as many as 50 percent of patients killed under the Dutch euthanasia programs were suffering from depression.¹³

Oregon

Physician-assisted suicide was legalised in Oregon in 1997 under the *Death with Dignity Act*. Since then, at least 341 people have had their lives terminated.

Experience in Oregon has shown that as many as 21 per cent of those seeking lethal prescriptions had symptoms of depression.¹⁴ Other studies have confirmed that depressed patients are significantly more likely to seek physician-assisted suicide. Despite this, only a small percentage of those seeking assisted suicide in Oregon, are being referred for psychiatric evaluation, even though this is required under the law. Patients cannot give genuine informed consent if they are suffering from depression or other untreated mental illness.¹⁵

Can a 'right to die' become a 'duty to die'?

We should be concerned that what may begin as 'death with dignity' or a 'right to die' can soon become a 'duty to die' as insurance companies and governments struggle to manage limited healthcare resources. Assisted suicide is without doubt cheaper than caring! US cancer patient Barbara Wagner was devastated to learn that Oregon Health Plan would cover her doctor-assisted suicide should she choose it, but not the cancer drug her oncologist had prescribed. "To say to someone, we'll pay for you to die, but not for you to live, it's cruel," Barbara said. "I get angry. Who do they think they are?"¹⁶

The Catholic response to end of life care

Death by euthanasia or assisted suicide is never 'death with dignity.' Instead, it is a tragic act of despair, a tragic rejection of the truth about human life and human dignity, and a tragic rejection of the care of other people.

We do not lose our dignity by allowing others to care for us when we are no longer able to look after ourselves. Indeed, at the very beginning of our lives, we could not survive without the care of others. There is nothing undignified in accepting acts of love and kindness from others. In spite of what we might feel or think about the 'quality' of our lives, we can never lose our dignity.

Every human life is created out of love and destined for eternity. It has great value simply because it is human. As Pope John Paul II reminded us, life is ultimately about giving and receiving love. Even if we can do little else, we can still love until the end. Once we understand this, we can see that 'dying with dignity' means living through the dying process. True 'compassion' leads to sharing another's pain. It helps people to 'die with dignity' by helping them to live intensely the final chapter of their lives. "True compassion does not kill the person whose suffering we cannot bear."¹⁷

Growing opposition to euthanasia and assisted suicide

As more people have time to reflect on the true meaning of 'dying with dignity,' increasingly they tend to reject the idea of euthanasia and assisted suicide, and resistance to the practice grows. A number of parliamentary inquiries – the New York State Taskforce on Life and the Law, the British House of Lords, the Senate of Canada, the Parliament of Tasmania, and the Parliament of South Australia¹⁸ – although tending to be pro-euthanasia, after investigating the experience in places like the Netherlands and Oregon, have come away a little shaken. They have realised that euthanasia and assisted suicide cannot be made safe in practice. It is why the House of Lords again rejected euthanasia in 2006 by a vote 148 to 100. It is without doubt the reason why 89 proposals to enact euthanasia in 22 US states in the years 1994 to 2007 failed.¹⁹

There are many good reasons why parliaments all around the world continue to reject euthanasia and assisted suicide. Indeed, the NT parliament has had a change of heart with the current Chief Minister, Paul Henderson, saying that he is not happy, and that Bob Brown should have consulted the people of the NT and the NT parliament before going ahead with his bill! Both Colleen Hartland's Bill and Bob Brown's Bill should be rejected in order to protect sick and vulnerable Australians.

ENDNOTES

¹ [http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/97A3D62C55E9C6ACCA2574560026DC28/\\$FILE/561PM12bi1.doc](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/97A3D62C55E9C6ACCA2574560026DC28/$FILE/561PM12bi1.doc)

² <http://parlinfoweb.aph.gov.au/piweb/Repository/Legis/Bills/Linked/15020801.pdf>

³ DW Kissane, A Street, and P Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," *Lancet* 352 (1998): 1097-1102.

⁴ "Euthanasia bill in Parliament" 8/2/08, Bob Brown, www.

bobbrown.org.au

⁵ "Assisted Suicide & Death with Dignity: Past, Present and Future, Part III, International Perspective," International Taskforce on Euthanasia, www.internationaltaskforce.org/rpt2005_3html

⁶ Wesley J Smith, "Increasing Reasons for Euthanasia in the Netherlands," 28/3/2008, LifeNews, www.Lifenews.com; Wesley J Smith, "Continent Death: Euthanasia in Europe" *National Review* (December 23, 2004), www.catholiceducation.org/articles/printarticle.html?page=eu0025; see also Euthanasia, www.euthansia.com

⁷ "Assisted Suicide & Death with Dignity;" see also Commissie Onderzoek Medische Praktijk inzake Euthanasie, Medische Beslissingen Rond Het Levensende, Sdu *Unitgeverij Plantijnstraat* 1 (1991):13. The study is popularly known as the "Rommelink Report."

⁸ Ibid.

⁹ Ibid; see also Paul J. van der Maas et al, "Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995," *New England Journal of Medicine*, 336, no 19 (May 8, 1997): 1385, citing van der Maas et al, "Euthanasia and other medical decisions concerning the end of life," (Elsevier, 1992) and Diane M. Gianelli, "Dutch data indicate physician-assisted death on rise," *American Medical News*, January 13, 1997, p.6.

¹⁰ Ibid.

¹¹ Smith, op cit.

¹² Personal contact with the Zwann family, Holland and Australia.

¹³ Hilary White, "Dutch Study show patients requesting euthanasia likely depressed," 16/1/2006, LifeNews, www.LifeNews.com

com; also see *Journal of Clinical Oncology* 20/9/2005.

¹⁴ Kevin O'Reilly, "Oregon still stands alone: Ten years of physician-assisted suicide," 12 May 2008, American Medical Association, www.ama-assn.org/amednews/2008/05/12/prsa0512.html, *New England Journal of Medicine*, 24/2/2008; Jerome R Wernow, "A Grand Illusion: Oregon's Attempt to control death through Physician-assisted suicide," July 26.2002, The Centre for Bioethics and Human Dignity, www.cbhd.org/resources/endoflife/wernow_2002-07-26_print.html

¹⁵ Ibid.

¹⁶ Tim Christie, "Oregon Health Plan's cancer coverage scrutinized," 3/6/2008, *The Register-Guard*, Eugene, OR www.registerguard.com/csp/cms/sites/dt.cms.support.viewStory.cls?cid=106873&sid=1&fid=1

¹⁷ John Paul II, *The Gospel of Life (Evangelium Vitae)*, #66.

¹⁸ *Where Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, May 1994; Select Committee on Medical Ethics, House of Lords, Jan 1994; Of Life and Death, Senate of Canada, June 1995; Community Development Committee, Parliament of Tasmania, *The Need for Legislation of Voluntary Euthanasia*, 1998; Social Development Committee, Parliament of South Australia, *Report of the Inquiry into the Voluntary Euthanasia Bill* 1996, October 1999.

¹⁹ Kathi Hamlon, "Failed Attempts to legalised Euthanasia / Assisted-Suicide in the United States," International Task Force on Euthanasia, www.internationaltaskforce.org/usa.html

Marcia Riordan

Respect Life Office, Melbourne



FREEDOM IN THE END OF LIFE CONTEXT

A Reflection

The supporters of euthanasia regularly air through the media their arguments for the right to have the freedom to take one's life. The emphasis on personal freedom despite present laws struck me as I read Phillip Nitschke's description of his homemade suicide pill and self-injecting apparatus. The goal, in this situation, is to give people the freedom to end their own life with the assistance of others. I want to look at the end of life period from the other quite factual perspective, namely, that since we are not free not to die, what freedoms do we retain in these circumstances?

It is normal for people to go into shock when they realise that death, either for themselves or for a loved one, is sure within a limited period of time, as happens so often, for example, with ovarian cancer. Which freedoms remain, and how can we see and make these freedoms into a positive development of our life and character?

Freedom to give up

To those who have not suffered chronic, severe physical pain or the anguish of deep depression, it may seem strange that a person just wants to give up living. Our concern with health and longevity, witnessed not only by the ordinary means we take through visiting doctors and

hospitals, but also by the increasing number of alternative medicines, vitamins, health foods, ways of maintaining physical stamina, and other approaches to better health, demonstrates our attachment to life. Yet, there are situations, beyond active suicide, when people believe they should be free to give up the positive pursuit of living.

One case was that of a woman who was approaching one hundred years of age. The lady refused to eat. This situation forced members of the family to discuss the basic question of their mother's freedom at this stage of her life since in other ways she was a religious and positive person. What was going on? Was life just too burdensome? Was her mind functioning properly? Was life just shutting down for her? The family's dilemma was either to allow their mother the freedom to refuse to eat and eventually die, or to have her institutionalised and forced fed. They were given conflicting opinions from those they consulted.

Another case was closer to home. My brother-in-law had been diagnosed with prostate cancer some years ago and had undergone a number of burdensome treatments. He reached his mid-seventies, but was gradually suffering more. Then, his wife died suddenly of a heart attack. It was clear to anyone who knew them that they remained

very much in love and inseparable. As he put it to me several times after his wife died: "I really have no reason to live now except that I need to keep going for my children's sake." And for their sake and that of the grandchildren, he did struggle on for a few years until he had to be hospitalised for treatment. One of his sons found courage enough to say, "Dad, it is all right for you to leave us. We will be ok and look after one another." Given that freedom, he died shortly afterwards.

Reflecting on the freedom to give up in certain circumstances brings to mind the wise directives of the Church's *Declaration on Euthanasia*.¹ Speaking of the right to die peacefully with human and Christian dignity, and due proportion in the use of remedies the *Declaration* says:

In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors to decide in the light of moral obligations and of the various aspects of the case.

...However, is it necessary in all circumstances to have recourse to all possible remedies?

In the past moralists replied that one is never obliged to use 'extraordinary' means. This reply, which still holds good, is perhaps less clear today by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of 'proportionate' and 'disproportionate' means.

In any case, it will be possible to make a correct judgement as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

The *Declaration* goes on to explain some of these conditions in more detail. However, the above citation gives us some useful and practical principles on which to make a judgment about the freedom of the person faced with the question of whether or not to give up the struggle in the face of what this person considers to be disproportionate means to keep alive.

Freedom to take a creative and positive approach to this period

It is wonderfully encouraging to encounter people who retain a zest for life and the freedom to take a creative and positive approach in the face of the certainty that they

will not live too much longer. In my experience there are, for example, people who accept enough chemotherapy just to take and enjoy a trip overseas, or prepare for a family event such as a wedding, the birth of child or grandchild.

There are others who value time, short as it may be, as a precious gift to become more mature, less selfish, even to begin a new hobby or language. It is important for those close to the sick person not to give a negative impression in face of what might seem to be a 'waste of time' when it is so short. Freedom is so personal in such situations that it must be respected.

When the future is unknown, that is, the other side of death, people need to be free to talk about this, even creatively, whether it be about their religious faith or their philosophy, even home-spun, without fear that our minds may be so closed one way or the other that they may be not listened to, or worse, badgered or quietly ridiculed.

For those with faith in God it is important that they be free to express openly their belief in God, and especially in Jesus Christ and his resurrection, whether their family or friends share their faith or not. None of us have a clear vision of life after death. We should have the freedom to express our doubts of faith, freedom, also, to deny the judgement of a cold scientific approach to life and death.²

Freedom to forgive

We all make enemies during life; some people hurt us deeply for reasons we sometimes cannot fathom, or for revenge, or because they are envious of us: they have to bring us down. It could be most difficult to forgive someone who has made life hell for us over many years. Realising that whatever the injury was the hurt is going to finish before too long can offer us the chance to be free from a weight, even a bitterness that has shackled or enervated our free spirit from being more creative and joyful.

Freedom to rejoice over life lived

When the future is closed off from us, the temptation is to dwell regretfully on what might have been. Yet the freedom remains to celebrate life lived, on being alive here and now, on the many reasons we have had to rejoice, small matters on the global scale, perhaps, but important to us and to others close to us.

Freedom to mourn over life ending

Perhaps this is a freedom that we do not often enough grant others. While some may be pleased to leave a life unloved or heavily burdened with suffering, there will be many who really want to experience the freedom to mourn saying goodbye to so many good things of life: their loved ones, so much shared with others, projects

into which they have put much energy and love, but not yet completed, the mixture of faith and fear of the end or what may follow. These people should not have to forgo this freedom because they sense that we cannot cope with their period of mourning. It is an important freedom we could be gracious enough to offer.

Freedom to ask that others be with you while you rejoice or mourn

We glibly repeat the saying, “A friend in need is a friend indeed.” At this most significant point of a person’s life, it is a wonderful freedom to feel secure enough to ask another to be with you to the end without the fear that this will be an imposition and only granted grudgingly because of the anxieties that impede our own freedom to give. It is a great gift to be offered.

Do we feel able to accept some of these freedoms for ourselves, and grant them to others, to help people positively to be free in face of the end of life where none of us free to choose a different outcome?

The great psychiatrist/logotherapist, Viktor Frankl, who suffered through Nazi concentration camp life and came through it to become a famous therapist, based his survival on his realisation and positive acceptance of the most fundamental freedom, to be. “We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken away from a man but one thing: the last of human

freedoms -- to choose one’s attitude in any given set of circumstances, to choose one’s own way. And there are always choices to make.”³

ENDNOTES

¹ Congregation for the Doctrine of the Faith, May 5, 1980: “Declaration on Euthanasia,” Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html, [accessed 8 June 2008].

² We might apply to those who face dying the words of Pope John Paul II on disabled persons: “Disabled people are living icons of the crucified Christ. They reveal the mysterious beauty of the one who emptied himself for our sake and made himself obedient unto death. They show us, over and over and above all appearances, that the ultimate foundation of human existence is Jesus Christ. It is said, justifiably so, that disabled people are humanity’s privileged witnesses. They can teach everyone about the love that saves us; they can become heralds of a new world, no longer dominated by force, violence and aggression, but by love, solidarity and acceptance, a new world transfigured by the light of Christ, the Son of God who became incarnate, who was crucified and died for us.” See John Paul II, “Message on the Occasion of the International Symposium on the Dignity and Rights of the Mentally Disabled Person.” Holy See, http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/january/documents/hf_jp-ii_spe_20040108_handicap-mentale_en.html, [accessed 8 June 2008].

³ Viktor E. Frankl, *Man’s Search for Meaning*, Revised Ed. (New York: Pocket Books, 1985), 86. In another book, *The Will to Meaning* (New York: A Plume Book, 1970), he says on page ix, “I hope that I shall be successful in conveying the conviction to the reader that, despite the crumbling of traditions, life holds a meaning for each and every individual, and even more, it retains this meaning literally to his last breath.”

Cormac Nagle OFM



Male Circumcision – Facts and Fiction

There is currently much debate about the medical and ethical issues related to male circumcision. This article explores this controversial subject in the light of current research.

Male circumcision has been practiced since time immemorial, and is defined by medical dictionaries as the operation to remove part of, or the entire prepuce - the free fold of skin that covers more or less completely the glans or head of the penis.

Circumcision and Religion

The origins of the custom, though not clear, have their foundation in religious and cultural customs. It is most ardently associated with Judaism and Islam, with the incidence being very close to 95% in both religious groups. The most prevalent form is infantile circumcision, usually performed on the 7th to 10th day following birth. The prescription of circumcision appears in the book of Genesis, as a sign of the covenant between God and Abraham:

[God said to Abraham,] “Every male among you shall be circumcised. You shall circumcise the flesh of your

foreskins, and it shall be a sign of the covenant between me and you.... Any uncircumcised male who is not circumcised in the flesh of his foreskin shall be cut off from his people; he has broken my covenant.” (17:10-11, 14)

Based upon these holy decrees, the prevalence of this practice among Jews seems intuitive. However, despite an equivalent pervasiveness of male circumcision among Muslims, a corresponding prescription cannot be found in the Holy Quran, though references have been found in the Ahadith (teachings of the Prophet Mohammed) - the two main sources of religious ruling in Islam.

In Ahadith from the collection Sahih Bokhari, male circumcision is mentioned as one of the five practices related to fitrah which implies cleanliness and purity. This ruling is also attributable to the high reverence for the Prophet Abraham in Islamic teachings, and is considered a continuation of his legacy. Judging from

history, the practice was prevalent among pre-Islam Arabs, and acceptance of this custom was not problematic for those who embraced Islam.

In Christianity, male circumcision quickly lost any religious connotation. The only reference in the New Testament is in the Acts of the Apostles, chapter 15, where on the issue of asking converts to submit to circumcision, it was ruled that it was not mandatory.

Medicine and Circumcision

In recent times there has been much debate about the ethical and medical issues related to male infantile circumcision, and questions have been raised about the justification for this ‘unnecessary’ surgical procedure in an apparently healthy minor individual incapable of providing consent. There is a plethora of anecdotal accounts highlighting the perceived cruelty embodied in this practice and the lack of evidence regarding its benefits. However, current medical research has identified some potential advantages of the procedure, such as the reduction in risk of genital ulcerative disease (GUD) in circumcised men compared to uncircumcised or intact men,¹ and the finding that circumcision is associated with a reduced risk of penile human papilloma virus (HPV) infection in men, which consequently reduces the risk of HPV-related cervical cancer in their female partners.² Some health professions, however, object that the evidence for any demonstrable benefit of this procedure is circumstantial and not statistically significant.

Circumcision and risk of HIV

Recently the debate around the issue of male circumcision has been rekindled, mainly in relation to the HIV/AIDS epidemic. Three major randomised control trials undertaken in Africa have shown that male circumcision provides 60% protection against HIV infection.^{3,4,5} All three trials were aborted mid way on ethical grounds due to the irrefutable evidence of significantly lower incidence of HIV among circumcised men compared to uncircumcised men. The relative risk of HIV infection in uncircumcised males is 40 times that among circumcised males, making this an important and cost-effective intervention for the reduction of HIV transmission in high prevalence regions such as sub-Saharan Africa. Thus in light of current evidence circumcising males seems highly desirable in countries with a high HIV prevalence.⁶

There are biologically plausible explanations for the advantages of circumcision in reduction of HIV transmission. For example, one study in the UK found that lack of circumcision is a risk factor for HIV acquisition among heterosexual men due to the greater number of HIV receptors (Langerhans cells) in the foreskin, and increased susceptibility to minor trauma during

intercourse due to inadequate keratinisation of the foreskin.⁷

One of the criticisms of research on male circumcision for HIV prevention has been that most studies and trials have been conducted among high-risk populations where HIV/AIDS is endemic. The argument presented is that disease behaviour is highly varied depending on population characteristics, and the prevalence of the disease and the findings of these studies may not be generalisable, and thus cannot be extrapolated to populations with low HIV prevalence. Despite this, the results of studies that show protective effect of circumcision cannot be completely ignored, as the benefit they show may have far-reaching consequences if applied to the population that was used to generate the evidence.

Recently, a paper by Halperin and colleagues has raised an interesting question: whether male circumcision can be considered a ‘vaccine’ against HIV?⁸ In late 2006, the U.S. National Institute of Health announced the discovery of an intervention to reduce heterosexual HIV transmission, which they considered to be at least as effective as an AIDS vaccine might be. That intervention was: male circumcision. Every day over 2000 men in sub-Saharan Africa become infected with HIV, and this exponentially increases the risk for their partners and children.⁹ A 60% reduction in heterosexual transmission of HIV as seen in the three major African trials brings a small ray of hope to these impoverished people devastated by AIDS.

Despite overwhelming evidence for the benefits of this procedure, the medical and pharmaceutical fraternity has been reluctant to accept the results and to add this procedure to the armament in the fight against AIDS. Halperin et al. assert that the main reason for this is that this procedure is not patented or trademarked and thus no entity stands to gain from the widespread use of this intervention. As they state, “if this were an actual vaccine, packaged with a pharmaceutical company logo and shiny labelling, few people would be deliberating, constantly emphasizing a multitude of caveats... there would instead be massive mobilization, press releases...”⁸ At a time like this, we need to ask if financial gain should be such a major driver in public health interventions. Should an opportunity to save humanity from a deadly disease be abandoned largely because it cannot be made profitable?

A recent study published by researchers at the University of Melbourne has shown that oestrogen cream applied to foreskin can increase keratinisation of the Langerhans cells, thereby reducing the ability of HIV virus to enter the body through these cells.¹⁰ They have suggested applicability and benefit of this cream in populations where male circumcision is taboo, and also in circumcising populations as an adjunct to improve healing post-circumcision and preventing HIV infection

through any residual foreskin thereby complementing the overall protection conferred by circumcision. Their suggestion for using the cream in conjunction with circumcision highlights the changing attitude of health researchers with more now favouring circumcision in the light of current evidence. It would be interesting to follow the progress of this intervention to see if it makes it into the AIDS preventative armoury, since it can be packaged in a shiny box with a pharmaceutical logo and may lead to financial gain.

This evidence clearly emphasizes the significance of male circumcision as a preventative strategy against HIV/AIDS. However it is pertinent to mention that the greatest benefit of adopting this practice will be observed for populations where HIV/AIDS is endemic. Such a policy may not be as relevant to low prevalence countries such as Australia, where the prevalence was estimated to be 0.1% in 2006.¹¹ On the other hand, it is a cost-effective and long-term solution for the suffering millions in countries struggling with the HIV/AIDS epidemic.

Victorian ban on public hospital male circumcision

Up until the 1970s, male circumcision was common in Australia, and the majority of the male population was circumcised. This changed in the next decade and the prevalence fell to 50% by the 1980s. Since then, the procedure has become even less common.¹² It is estimated that currently only 10 to 20% of Australian males are circumcised. This downward trend has been encouraged by health service providers, under the influence of economic, human rights and health service considerations.

In July 2007, the Department of Human Services under the Victorian State Government issued a statement on the provision of male circumcision services in Victoria adjudicating that: 'from September 1 2007 non-medical circumcision will not be routinely available in a public hospital'.¹³ This ruling was made on the advice of the Paediatrics and Child Health Division of the Royal Australasian College of Physicians based on a review and policy statement that concludes that 'there is no medical indication for routine male circumcision'.¹³ An information sheet was also put together for parents considering circumcision for their son for religious or cultural reasons, which explains the rationale behind the policy and provides alternative options. The 'alternatives' provided by this statement are private health insurance or the possibility of incurring an out-of-pocket cost in the range of \$500 to \$1,200 in the absence of private insurance.

This ruling prohibiting public hospital male circumcision is likely to predominantly affect the Muslim population. Despite the religious significance of male circumcision in

Judaism, the Jewish population may not be as affected by this ban. They do not rely on the state health system for the circumcision of their boys as the Jewish community includes *mohelim*, men who are specially trained to perform circumcisions and who usually offer the service without any charge. On the other hand, there are no such provisions for the Muslim community who have the procedure done in hospitals.

All Australian states except Queensland have enforced this policy on male circumcision.¹⁴ Interestingly Queensland has a very small Muslim population, while states such as New South Wales and Victoria which have imposed this ban are home to the majority of Australian Muslims. Victoria has the second largest Muslim population in Australia¹⁵ who will bear the brunt of this ban due to the prohibitive cost of circumcision in the private sector. This may force financially disadvantaged parents to resort to cheaper alternatives such as clinics which may pose greater risk if not fully equipped and with inadequately trained personnel. This will in turn increase the risk of complications and subsequent morbidity for the infants.

In a democratic society, can we justify legislation that will adversely affect a minority group? From a secular point of view, the lack of convincing scientific evidence for the benefits of circumcision may be enough to dictate legislation, but often the obligations of faith go beyond scientific evidence and popular societal norms. At the same time, the latest research is identifying significant benefits of this procedure. This may have led to the current revision of the Royal Australasian College of Physicians' statement on male circumcision.¹⁶ However, until this revision is undertaken, the present ban will remain and may cause significant damage.

Conclusion

Male circumcision has been practiced for centuries and was the rule rather than the exception in most societies. This has begun to change due to anti-circumcision lobbies. However, recent research has provided evidence for its benefits. The debate is ongoing, and a conclusion seems unlikely, thus parents would be well-advised to make informed decisions about the future of their sons in light of expert opinion and current research.

ENDNOTES

¹ Robert S. Van Howe, "Genital ulcerative disease and sexually transmitted urethritis and circumcision: a meta-analysis," *International Journal of Sexually Transmitted Diseases and AIDS* 18, no. 12 (2008): 799-809.

² Xavier Castellsagué et al., "Male Circumcision, Penile Human Papillomavirus Infection, and Cervical Cancer in Female Partners," *New England Journal of Medicine* 346 (2002): 1105-12.

³ Bertran Auvert et al., "Randomised, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: the ANRS 1265 Trial," *PLoS Med* 2, no. 11(2005): e298.

⁴ Robert C. Bailey et al., "Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled

trial," *Lancet* 369, no. 9562 (2007): 643-56.

⁵ Ronald H. Gray et al., "Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised controlled trial," *Lancet* 369, no. 9562 (2007): 657-66.

⁶ Roger Szabo and Roger V. Short, "How does male circumcision protect against HIV infection?," *British Medical Journal* 320 (2000):1592-94.

⁷ Abigail Macdonald, Harold W. Jaffe and Joanna Humphreys, "Prevention of HIV Transmission in the United Kingdom: What is the Role of Male Circumcision?," *Sexually Transmitted Infections* 2008 (forthcoming).

⁸ Jeffery Klausner et al., "Is male circumcision as good as the HIV vaccine we've waiting for?," *Future HIV Therapy* 2, no. 1 (2008): 1-7.

⁹ UNAIDS, "AIDS Epidemic Update 2007", http://www.unaids.org/en/HIV_data/2007EpiUpdate/default.asp (accessed May 20 2008)

¹⁰ Andrew J. Pask et al., "Topical Oestrogen Keratinises the Human Foreskin and May Help Prevent HIV Infection," *PLoS one* 3, no. 6 (June 2008).

<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=2396280&blobtype=pdf> (accessed June 5 2008).

¹¹ UNAIDS, "2006 Report on the global AIDS epidemic",

http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN1A-B_en.pdf (accessed

June 12 2008).

¹² Juliet Richters et al., "Circumcision in Australia: prevalence and effects on sexual health," *International Journal of Sexually Transmitted Diseases and AIDS* 17, (2006): 547-554. <http://www.cirp.org/library/general/richters1/> (accessed June 10 2008).

¹³ State Government of Victoria, Department of Human Services, "*Guidelines for male circumcision in the Victorian public hospital system – Information for health care professional from the Department of Human Services*," (Melbourne 2007).

¹⁴ Peter Lavelle, "Circumcision: back on the table," *The Pulse, ABC*, January 31, 2008. <http://www.abc.net.au/health/thepulse/stories/2008/01/31/2150927.htm> (accessed June 12 2008).

¹⁵ Australian Government, Department of Immigration and Citizenship, "Muslims in Australia – a snapshot," www.immi.gov.au/media/publications/multicultural/pdf_doc/Muslims_in_Australia_snapshot.pdf (accessed June 12 2008).

¹⁶ Royal Australasian College of Physicians, Paediatrics and Child Health Division, "Policy Statement on Circumcision, 2004." <http://www.racp.edu.au/index.cfm?objectid=A4268489-2A57-5487-DEF14F15791C4F22> (accessed June 12 2008).

Rida Usman Khalafzai



Aboriginal And Torres Strait Islander Health Research

This article explores statements from the National Health and Medical Research Council (NHMRC) about health research involving Aboriginal and Torres Strait Islander peoples.

On 13 February 2008, both Prime Minister Kevin Rudd and Opposition Leader Brendan Nelson offered an apology to Australia's Indigenous peoples for the harm done to them since white settlement, especially through the removal of children from their families in the Stolen Generations.¹ The President of the Australian Catholic Bishops Conference, Archbishop Philip Wilson, noted that "the Catholic Church in Australia welcomes and affirms the apology." He continued:

But it must not end there.... Rather, we must take the hope that this Apology represents and move forward, determined to increase our efforts to improve the particular circumstances of our Indigenous brothers and sisters. This must be done by addressing the fundamental causes of entrenched disadvantage, in full consultation and collaboration with Indigenous communities.²

This is a mammoth task. On average, Indigenous Australians die 17 years earlier than non-Indigenous Australians. Further, there are many causes of this disadvantage. These particularly include the social determinants of health, such as housing, early childhood care, family and community dysfunction, violence and substance abuse, education, employment, and ready access to health care.

Health research has a role in overcoming Indigenous disadvantage, for problems which are better understood can be more effectively remedied. One of the functions of the National Health and Medical Research Council

(NHMRC) is to allocate Federal government funds to health research. It is committed to spending at least 5% of these funds on Aboriginal and Torres Strait Islander research. Indeed, between 2000 and 2007, the NHMRC directed over \$98 million to such research through 735 grants and awards. This article, then, examines the documents which the NHMRC has produced to guide this research. Five documents are paramount. Three relate to research conduct; another two are related to research priorities. We will look at each in turn:

Research Conduct

*The National Statement on Ethical Conduct in Human Research*³ has a chapter on research involving Aboriginal and Torres Strait Islander peoples. The *National Statement* is based on the values of research merit and integrity, justice, beneficence, and respect. This chapter details guidelines for Indigenous research which are based on these values.

This brief treatment is amplified in *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*.⁴ *Values and Ethics* begins by warning about the dangers of "difference blindness." Aboriginal and Torres Strait Islander peoples are truly different from other peoples. They have their own distinctive cultures, customs, values, norms, and aspirations. Difference blindness is the failure to recognise this. It is also the failure to recognise real cultural diversity among Aboriginal and Torres Strait Islander peoples.

Difference blindness “jeopardises both the ethics and quality of research.”⁵ It can lead to research which is not valued by Indigenous peoples, or which is actually harmful to them (for example, by stereotyping or stigmatising them, or by revealing cultural information which should be kept secret). It causes poor communication and inadequate community consultation. It can cause offence through inadvertent cultural insensitivity. It is a major reason why much research has led to so little real benefit for Indigenous communities. Indeed, because of difference blindness, there is a lasting legacy of suspicion and mistrust of research among many Indigenous communities world-wide, including many Aboriginal and Torres Strait Islander peoples.⁶ For example, there is a Native Alaskan saying that “Researchers are like mosquitoes: they suck your blood and leave.”⁷

Values and Ethics seeks to limit difference blindness and to promote high quality, ethical research in two ways. Firstly, while the *National Statement* requires Indigenous research to conform to mainstream research values, *Values and Ethics* (which has the same authority as the *National Statement*) also requires this research to conform to Aboriginal and Torres Strait Islander values. This is rightly recognised as “one step closer to the ideal” in Indigenous research.⁸ These values were articulated at a two-day workshop at Ballarat, Victoria in June 2002, which involved representatives of Indigenous organisations, government, researchers, and other Aboriginal participants. A draft statement prepared after this gathering was subsequently revised in the light of 56 submissions received through public consultation. This transparent process implies widespread endorsement that the values articulated are indeed core values for most if not all Aboriginal and Torres Strait Islander peoples.⁹ At the same time, individual peoples, communities or organisations can understand and apply these values in their own distinctive way.¹⁰

Let us examine the six Indigenous values identified by *Values and Ethics*, and in each case also note at least one way in which researchers might conform with that value:

- **Reciprocity** is the mutual obligation in Indigenous communities to distribute equitably such things as resources, responsibilities, capacities, and benefits. Researchers might conform to this value by undertaking research designed to build capacity within an Indigenous community.
- **Respect** is demonstrated through relationships which acknowledge and affirm each person and community, their dignity and worth, and their values, norms and aspirations. Researchers might conform to this value by consulting and involving an Indigenous community in every step of the research process.
- **Equality** recognises the equal value of all people. It also affirms the right of Aboriginal and Torres Strait Islander people to be different. Researchers conform to this value by modifying their research until an Indige-

nous community is satisfied with every aspect of it.

- Indigenous communities have **responsibility** for such things as country, kinship bonds, caring for others, and cultural and spiritual realities. Above all, in all these areas they must not do harm. Researchers conform to this value by negotiating with an Indigenous community processes to prevent the inadvertent publication of cultural information which should be kept secret.
- **Survival and Protection** indicate that Aboriginal and Torres Strait Islander peoples seek to preserve their cultures, languages and identity. Researchers might conform to this by ways of reporting to the wider community which enable an Indigenous community to speak to the value of their distinctive culture.
- **Spirit and Integrity** is the overarching value which binds together all the others. It affirms the essential continuity between past, present and future, and directs behaviours which will preserve and not damage this continuity. Researchers might conform to this value by research which builds the capacity of an Indigenous community to preserve its culture.¹¹

There is a second thing which *Values and Ethics* calls for. Aboriginal and Torres Strait Islander peoples complain that researchers can fulfil all the requirements of a written code, and yet still communicate and consult poorly and still cause offence and harm through cultural insensitivity. *Values and Ethics* therefore moves away from “sole reliance on the quasi-legal consideration of compliance with rules,” and calls instead for “the development of ethical relationships.” This requires “engagement between people,” and a sustained effort to develop and maintain trust. It involves “consultation and other strategies that facilitate Aboriginal participation... in all phases of [the] research process.” And it demands both ongoing effort to eliminate difference blindness, and “a subtlety of judgement required to eliminate prejudice and maintain respect and human dignity.” It rightly notes that as this approach moves from compliance to trust, it is more rather than less demanding of researchers.¹²

Finally, there is a third document related to research conduct. It is titled *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander Peoples about Health Research Ethics*. As its title suggests, it offers Indigenous communities a detailed explanation of “how you can make research work for your community or organisation by becoming involved in every step of the research journey.”¹³

Research Priorities

Within the (Commonwealth) Department of Health and Ageing, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) has responsibilities to improve health outcomes for Australia’s Indigenous peoples. In 1997, the NHMRC and OATSIH jointly established the

Aboriginal and Torres Strait Islander Research Agenda Working Group (RAWG) to develop a comprehensive strategy for Indigenous health research. Early in 2001, RAWG began working on a 'Road Map' of research priorities. This involved an extensive consultation process. In 2002, this included four workshops in Perth, Darwin, Brisbane and Melbourne, attended by a total of 211 representatives and individuals from Aboriginal and Torres Strait Islander communities and organisations, research and academic institutions, research funding agencies and governments.¹⁴ It also included a written submission process which yielded 24 submissions from 19 organisations. The Road Map was endorsed by the NHMRC Council in October 2002. It is discussed in two documents, *The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research*, and the *Final Report of Community Consultations on the NHMRC Road Map*. These two documents "complement each other."¹⁵ Six priorities are identified:

- (i) **Descriptive research** is needed where there are gaps in our understanding of the patterns of health risk, disease and death. This should "inform the development of sound preventative, early diagnosis and treatment based interventions." In general, however, this sort of research, is "less important than intervention-based research." An important focus is "to fully harness what is already known."
- (ii) There should be a research focus on **factors and processes that promote resilience and wellness**. This should consider "the key transition points in peoples' lives, whether these be age, life or community events." Above all, the focus should be on "the periods of pregnancy, infancy, childhood and adolescence." Findings from this research should "form the basis of good health throughout the lifespan."
- (iii) Another priority is **health services research** "which describes the optimum means of delivering preventative, diagnostic and treatment based health services and interventions to Aboriginal and Torres Strait Islander peoples."
- (iv) Many **factors outside the health sector** profoundly influence health (eg housing, poverty, education, employment, racism). Explicating the links between these factors and either current health status or possible future health gain is another priority for research.
- (v) Yet another priority is **under-researched Aboriginal and Torres Strait Islander populations and communities**. As well as populations in some geographical areas, these include Torres Strait Islander communities, and Indigenous people living in major cities and urban settings. Among many research questions, one is "the changing place of men and masculinity" in Indigenous cultures,

especially as many communities have "lost their positive male role models due to imprisonment and premature death." The "incidence of injury, violence, sexual assault and child abuse" is another concern.

- (vi) A final important focus is **developing the nation's Aboriginal and Torres Strait Islander health research capacity**. This includes building the capacity and infrastructure of Indigenous communities. It also includes building an Aboriginal and Torres Strait Islander research workforce, and the training of Aboriginal and Torres Strait Islander researchers.¹⁶

Since the implementation of the Road Map, the NHMRC has continued to develop the effectiveness of its response to Indigenous health issues. It has established an Aboriginal and Torres Strait Islander Health and Research Advisory Committee. It has sought to develop Indigenous research capacity through programs such as the Indigenous Short-Term Exchange/Study Scheme, Training Scholarships for Indigenous Health Research, and the Aboriginal and Torres Strait Islander Health Research Fellowship. Its focus on Indigenous research has also continued and strengthened. For example, when \$4.3 million of research funding was announced on 31 March 2008, three of the nine projects, totalling almost \$1.2 million, addressed Indigenous health issues.¹⁷ It is currently undertaking a review of the Road Map.¹⁸ And at the 170th Session of the NHMRC Council on 24 April 2008, there was extensive discussion of Indigenous health with resolve expressed for further development of Indigenous health research.¹⁹

I conclude with a personal comment. It is difficult not to be impressed and inspired by the commitment of the National Health and Medical Research Council to Aboriginal and Torres Strait Islander health research. I believe this offers an important challenge to the Catholic Church and its various institutions. When Pope John Paul II visited Australia in 1986, he told Aboriginal and Torres Strait Islanders people gathered at Alice Springs:

You are part of Australia and Australia is part of you. And the Church herself in Australia will not be fully the Church that Jesus Christ wants her to be until you have made your contribution to her life and until that contribution has been joyfully received by others.²⁰

If we as Church and as Church institutions are truly to respond to the Pope's prophetic challenge, we must continue to pursue the same sort of engagement and relationship with Aboriginal and Torres Strait Islander people that the NHMRC strives to exemplify.

ENDNOTES

¹For these speeches, see *The Australian*, 14 February 2008, 2, 13.

²Archbishop Philip Wilson, "National Apology to the Stolen

Generations an historic and hope-filled moment for Australia," Australian Catholic Bishops Conference, <http://www.acbc.catholic.org.au/bishops/confpres/200802131369.htm> [accessed 3 June 2008].

³ NHMRC, *National Statement on Ethical Conduct in Human Research*, NHMRC, http://www.nhmrc.gov.au/publications/synopses/_files/e72.pdf [accessed 4 June 2008].

⁴ NHMRC, *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, NHMRC, http://www.nhmrc.gov.au/ethics/human/conduct/guidelines/_files/e52.pdf [accessed 4 June 2008].

⁵ *Ibid.*, 3.

⁶ C Whitbeck, "Truth and Trustworthiness in Research," *Science and Engineering Ethics* 1, no 4 (October 1995): 403-416; LT Smith, *Decolonizing Methodologies: Research and Indigenous Peoples* (Dunedin, NZ: University of Otago Press, 1999); SJ Eades, AW Read, and Bibbulung Gnarnep Team, "The Bibbulung Gnarnep Project: Practical Implementation of Guidelines on Ethics in Indigenous Health Research," *Medical Journal of Australia* 170 (1999): 433-436; K Humphery, "Dirty Questions: Indigenous Health and 'Western' Research," *Australian and New Zealand Journal of Public Health* 25, no. 3 (2001): 197-202; D McAullay, R Griew, I Anderson, *Ethics of Aboriginal Health Research: An Annotated Bibliography* (Melbourne: Koori Health Research and Community Development Unit, University of Melbourne, 2002); *Values and Ethics*, 4, 5, 18; Paul Stewart, Sanchia Shibusaki, Ian Anderson, Priscilla Pyett, Terry Dunbar, and Jeannie Devitt, "Aboriginal and Torres Strait Islander Participation in the Ethical Review of Health Research," *Aboriginal and Islander Health Worker Journal* 30, no. 6 (Nov/Dec 2006): 22-25 at 22; Patricia AL Cochran, Catherine A Marshall, Carmen Garcia-Downing, Elizabeth Kendall, Doris Cook, Laurie McCubbin and Reva Mariah S Gover, "Indigenous Ways of Knowing: Implications for Participatory Research and Community," *American Journal of Public Health* 98, no. 1 (January 2008): 22-27 at 22; Anne P F Wand and Sandra J Eades, "Navigating the Process of Developing a Research Project in Aboriginal Health," *Medical Journal of Australia* 188, no. 10 (19 May 2008): 584-587 at 584.

⁷ Cochran, Marshall, Garcia-Downing et al, 22.

⁸ *Ibid.*, 25.

⁹ This endorsement is not universal. The National Aboriginal Community Controlled Health Organisation (NACCHO), the national peak Aboriginal health body, does not endorse *Values and Ethics*, but instead recommends the 1991 *Interim Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research* and the guidelines of the Aboriginal

Health and Medical Research Council of New South Wales. For more on this, see Wand and Eades, 585-586, NACCHO Annual Report 2002-2003, NACCHO, http://www.naccho.org.au/Files/Documents/NACCHO_AR03.pdf, 26, and NACCHO Annual Report 2003-04, NACCHO, http://www.naccho.org.au/Files/Documents/NACCHO_AR04.pdf, 30-31 [accessed 6 June 2008].

¹⁰ NHMRC, *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander Peoples about Health Research Ethics*, NHMRC, http://www.nhmrc.gov.au/publications/synopses/_files/e65.pdf, 8 [accessed 6 June 2008].

¹¹ For fuller accounts of these values, see *Values and Ethics* 8-20, and *Keeping Research on Track*, 8-9.

¹² *Values and Ethics*, 4, 23.

¹³ *Keeping Research on Track*, 2.

¹⁴ The Aboriginal and Torres Strait Islander Research Agenda Working Group (RAWG) of the NHMRC, *Final Report of Community Consultations on the NHMRC Road Map*, NHMRC, http://www.nhmrc.gov.au/publications/synopses/_files/r27.pdf, 6 [accessed 12 June 2008]. Elsewhere, this figure is stated as "about 250." For this, see The Aboriginal and Torres Strait Islander Research Agenda Working Group (RAWG) of the NHMRC, *The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research*, NHMRC, http://www.nhmrc.gov.au/publications/synopses/_files/r28.pdf, 1, 5 [accessed 12 June 2008].

¹⁵ *NHMRC Road Map*, v; *Final Report*, v.

¹⁶ For fuller accounts of these priorities, see *NHMRC Road Map*, 6-15, *Final Report*, 18-26.

¹⁷ <http://www.nhmrc.gov.au/news/media/rel08/0803311.htm>, [accessed 12 June 2008].

¹⁸ Felicia R Fletcher, Cindy Shannon, Terry E Dunbar, for the Aboriginal and Torres Strait Islander Research Advisory Committee, "The National Health and Medical Research Council Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research," *Medical Journal of Australia* 188, no. 9 (5 May 2008): 525-526.

¹⁹ <http://www.nhmrc.gov.au/news/communique/2008/080508.htm>, [accessed 12 June 2008].

²⁰ John Paul II, "Address to Aborigines and Torres Strait Islanders," in *The Pope in Australia Collected Homilies and Talks* (Homebush, NSW: St Paul Publications, 1986), 166-172 at 171-172.

Kevin McGovern



Caroline Chisholm Centre for Health Ethics

Suite 47, 141 Grey Street, East Melbourne Vic 3002

Tel (03) 9928 6681 Fax (03) 9928 6682 Email: ccche@stvmph.org.au
www.chisholm.healthethics.com.au

Copyright © 2008 Caroline Chisholm Centre for Health Ethics Inc.

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

Director/Editor: Rev. Kevin McGovern, Dip Ap Sc (Optom) (QIT), STL (Weston Jesuit School of Theology).

Research Officers: Kate Jones BN, MBA
 Dr. Rida Usman Khalafzai, MBBS

Administrative Assistant/Layout/Sub-editor: Josette Varga