# Caroline Chisholm Centre for Health Ethics

BULLETIN

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## From the Director

As this issue of our **Bulletin** goes to the press we are still celebrating the Pascal Mystery which recalls how Jesus triumphed over humanity's sufferings, sorrows and death. Among many others, believers in Jesus are called to perform works of mercy and show compassion for ill family members or relatives in their homes, the sick in hospitals, the aged in nursing homes or the dying in hospices. The quality of care shown, coupled with expressions of their faith, can strengthen the belief of the sick and the frail that God's power is at work. Their belief that they will share Jesus' resurrection in due time grounds their hope of triumphing over sickness and death and helps them endure their sufferings serenely until the Lord calls them to Himself. We may live in times of economic restraint and cuts to the health budget, but there should be no restrictions on the compassionate care of the sick, from the young to the aged.

We welcomed Tracey Scott and Anna Stokes to join the Centre's staff as research officers at the beginning and end of February 1996 respectively. Tracey has a Science degree and an Honours Arts degree, majoring in Philosophy, from Monash University. She is currently pursuing her Master's degree in Bioethics at Monash University University's Centre for Human Bioethics. Anna comes with a Law degree and an Honour's Arts degree, majoring in English, from Melbourne University and is currently continuing her studies to complete her Master's degree in English Literature. Both have their first articles appearing in this **Bulletin.** We hope they will enjoy contributing to achieving the aims and objectives of the Centre.

A workshop was recently held for, some moral theologians, experienced nurses and the Centre's staff to discuss the limits of the moral duty to provide ongoing medically assisted nutrition and hydration for patients who are **permanently unconscious.** The following invited experts in the field provided relevant medical information for the discussion of this difficult moral dilemma in clinical practice: Professor David Kissane, University of Melbourne, Director, Centre for Palliative Care, Caritas Christi Hospice; Professor Ed Byrne, University of Melbourne, Director, Clinical Neuroscience Centre, St Vincent's Hospital, Ms Chris Holland, Nurse Coordinator, Neuroscience Care Centre, St Vincent's Hospital, Dr Bernard Clarke, Senior Physician, St Vincent's Hospital, Dr Janet Gross, Lecturer in Pathology, University of Melbourne and Pathologist, Mercy Hospital for Women. We all learnt the problem is more complicated than it first appeared and that there is no simple solution for all cases. The condition of each unconscious patient is unique and requires individual diagnosis and prognosis for treatment options, before any consideration could be given to withdrawing medically assisted nutrition and hydration. Much more study, reflection and discussion is needed before resolving this problem. ✣

*Norman Ford SDB*

*"Being there for others" - Bethlehem Hospital*

## FEATURING

# Euthanasia: The Perspective of Pallative Care Nurse Practitioners

*What do experienced palliative care nurse practitioners think about euthanasia? This article outlines the perspectives and ideas about euthanasia held by experienced palliative care nurse practitioners at Caritas Christi*

Palliative care practitioners have daily experience with dying people and their families, identified in densely descriptive stories of people and their real experiences of suffering and death. Dying people are confronting death and suffering in every moment of their *"right now"* experience. Each person faces the completion of their life in this final stage of living. Nurse practitioners who care for dying people come to have an intimate knowledge of what it is to face suffering, confront death and to complete this final stage of life. The experience of these nurses encompasses: the anticipation of death by patient, family and friends; the suffering created by terminal illness which cannot be cured; the grief of family, friends and children; the reality of living with what is unendurable; and the finding of meaning in death.

## Euthanasia: Irrelevant to the Practical Experiences of Suffering

Palliative care nurses find the whole notion of euthanasia to be irrelevant to the practical experiences of suffering and death.

The definitions of euthanasia are confusing to them. Terms such as active, passive, voluntary and involuntary only serve to obscure the reality that euthanasia in its modern meaning is the killing of patients to end their suffering.

***"Euthanasia is simply killing someone regardless of the chosen rationale"***

Palliative care nurses accept this blunt reality without equivocation. They do not have the sense of social taboos about dying with which the ordinary person chooses to soften this reality. To them euthanasia is simply killing someone regardless of the chosen rationale.

## Removing the Patient: Not the Answer

Euthanasia is removing the patient instead of dealing properly with the suffering. For these nurses, caring for the dying cannot include killing their patients. The confusions created by the jargon surrounding euthanasia from their point of view, prevents the reality of deliberate killing from being clearly understood and openly discussed. The whole notion of a deliberate intentional act of death is identified by these nurses as excusing killing, just because it is motivated by compassion in the face of suffering.

## Ceasing Medical Treatment is not Euthanasia

Turning off machines which are keeping people alive when they would have died is not euthanasia. Respecting a person's wishes to refuse treatment is also not euthanasia and there is a legal and moral right to refuse treatment.

Palliative care nurses realise that poor medical decisions about treatments have often been based on the fact that there is technology available to do something. All too often such treatments have been applied: without adequate consideration of the wishes of the patient; without effective quality of life outcomes; and without adequate information or exploration of the options available.

***"Palliative care nurses feel strongly that it is time they spoke up for their patients"***

Palliative care nurses feel strongly that it is time they spoke up for their patients advocating their right to choose good medical treatment to relieve symptoms rather than impose an added burden of intolerable suffering.

## Another way to Relieve Suffering

Palliative care nurses see another way to relieve suffering. Palliative care nurses are committed to respecting the patients rights to the best care possible to relieve their suffering, to prevent unnecessary prolongation of dying and to ensure real comfort and support for the persons involved physically, mentally, emotionally, spiritually and socially. This committment includes the whole family and extends through the loss and bereavement experiences of the family and friends.

Quality of life is subjectively experienced by the person concerned. In a crisis people can feel helpless and disempowered by the knowledge available to professionals. Being *fully supported* and *well informed* plus having *symptoms under control* means an informed patient is able to make effective personal decisions and choices about their care. Such people no longer feel helpless, but empowered and in control of their lives. This should be the experience of every dying person.

## Asking for Death when Distressed

Some people do ask for help to die when they are distressed. This is because they fear death and/or fear severe pain, unrelieved vomiting, diarrhoea, breathing difficulties and so on. It is the experience of palliative care nurses that once people are well supported, well informed and have relief from terrible symptoms, they rarely request to die but actually become actively involved again in living and completing their dying with dignity and courage.

## The Danger of Eroding the Nurse Patient Relationship

Any change in the current laws which already allow a patient to refuse treatment, is seen as likely to erode the nurse-patient trust relationship. Currently nurses are identified by the community as the most trustworthy and caring professional group. The integrity of nurses is accepted without question in the community. Nurses have worked hard to earn this respect and it would be disastrous to undermine this trust relationship. It is the foundation on which is built the practical support and intimate caring that nurses provide to people who are dying.

Palliative care practitioners are

***"Legalised euthanasia will destroy the trust relationship we have with patients and families"***

fearful that legalised euthanasia will destroy the trust relationship they have with patients and families. This special relationship is based on *respect* and the *journeying with* the *totality* of the experiences of suffering, dying and death. Legalised euthanasia could put palliative care practitioners into the unenviable position of being required to assist in a deliberate act of mercy killing. This would violate the values and principles underpinning the compassion, healing and caring of palliative care. This is an intolerable and impossible situation for any health professional with values respecting human life and focussed on caring for suffering people.

## Polarised Views

It is recognised that there are strongly polarised views about euthanasia in both the health professions and the community. It is natural for compassionate and caring people to feel passionately emotional about relieving the suffering and tragedy created by terminal illnesses. The sad truth is that excellent and experienced palliative care can provide relief of this suffering in all but a small minority of patients.

## Legalising Euthanasia is Neither Necessary nor Desirable

It cannot relieve the suffering of death experienced by the family and friends of the person dying. It cannot help the dying person find meaning in their life and their death, and it cannot provide humane and effective human compassion built on an unmitigated respect for what it is to be a human being. From the perspectives of palliative care nurses, euthanasia is a way of dealing with failure to heal and cure when what is really needed is comfort and care of the highest order from one human being for another.

The provison of good palliative care expresses the practical reality of what it is to truly relieve suffering. It is access to this good palliative care that we should be advocating for and providing to our community of suffering and dying people.

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*Marguerite Menon*
*RN BEd DipHEd MEd FRCNA*
*Community Education Manager*
*Pallative Care Education Centre*
*Caritias Christi Hospice - Kew*

# Youth Suicide and Suicide Prevention

*This article discusses why young people resort to suicide and how parents and others should act to dimish its incidence.*

## Introduction

One of the saddest things happening in our society is the increasing numbers of young people who are taking their own lives, with youth suicides at times outweighing road accidents as the major cause of death among youth. The figures of the World Health Organisation (WHO) for 1993 show Australia as having the fourth highest rate for suicide deaths among young males between 15 and 24.

***"Each year about 400 young Australians commit suicide, the majority of these being male"***

Each year about 400 young Australians commit suicide, the majority of these being male. In recent years the rate of male youth suicides in major Australian cities has remained more or less constant, whereas for young males living in rural areas the suicide rates have increased more than fivefold.

Females make more attempts at suicide, but as one writer has stated, it seems "boys are better at it". The means they use are likely to be more effective, i.e. firearms, whereas girls frequently resort to barbiturates. At present among indigenous Australians, male and female, youth suicides number 39 per 100,000 compared with 20 per 100,000 among the general population.

## An Intermesh of contributing Factors

The reasons why young people are take their own lives are unclear and searching for explanations can be frustrating. It perplexing that no one factor has been identified as causally related, although many factors are associated. Youth suicides occur among young people who are depressed, who are unemployed, who perform poorly at academic work, who lack friends or who come from upset family backgrounds.

Yet the majority of people in these categories do not take their own lives and youth suicides occur also among young men and women who seem to be the "life of the party", who do have jobs, who are A+ students, who have plenty of friends and who come from cohesive family backgrounds. This is not to say the factors associated with youth suicide are to be discounted. Rather these factors, being indicative of the way our communities operate, are part of our normal living patterns and pose a challenge to probe deeper into their significance.

## Constraints on Freedom of Choice

Considerable advances over the past few decades in psychology, theology and the social sciences can be of assistance in discerning the danger signs associated with youth suicide. We have now a much clearer comprehension than previously of the complex relationship between what a person actually does and his or her intentions, this brings a readiness to accept that although each of us is free, we are not completely free in what we do.

The development of the theological concept of diminished responsibility enables us to take into account that a person's behaviour is influenced by physical, biological, psychological, emotional, cultural, moral, educational, environmental and other considerations. There are different models of suicide, for example a "cry-for-help model", a "medical model", and a "sociogenic model". In any one suicide, or suicide attempt, elements of more than one of these models may be intermixed.

## A Cry-for-Help Model of Suicide

Research opinion is divided on whether a cry-for-help model should really be counted as a suicide, since here a person's death simply may have been a cry for help gone wrong.

This model, developed by Schneidman and Farberow in the 1950s, is seen as a "com-municative", or a "manipulative" model, in which someone's threatening to take their lives is intended to draw attention to an unacceptable environment with an unspoken plea that those witnessing the gestures will do something to change the situation. Unfortunately, in a cry-for -help model the victim at one stage, and without meaning to do so, passes the point of no return.

## A Medical Model of Suicide

The medical model of suicide, developed from the works of Freud and taken up in recent years by Schneidman, focuses on psychological and family background factors.
This model is supported by studies showing that in over 85% of suicides

***"In over 85% of suicides the victims have been depressed"***

the victims have been depressed, have made previous suicide attempts or have come from a family history of mental illness.
Psychological aspects, as developed from this model, point to a young person's acute experience of being generally upset **(per-turbation),** which in turn develops into feelings of self-hate, shame, guilt or self-blame **(inimicality).**

This leads to a tunnelling of thought processes which make it impossible for this person to see viable options **(constriction),** until finally there comes an awareness it is possible to put an end to all this suffering by stopping an "unbearable flow of consciousness" **(cessation).** Another scholar, Lipman, sees suicide not so much as a movement towards something, i.e. a final outcome, as a movement away from an unacceptable situation.
Professor Balson, for many years a renowned family educator at Monash

***"Professor Balson has associated youth suicide with parents' ineffective child rearing practices"***

University, has associated youth suicide with family living patterns, particularly with parents' ineffective child rearing practices. He gives examples:

a) of pampering parents, who are unable to say "No" to a child;

b) of coercive/controlling parents, who are habitually criticising their children; and

c) of perfectionist parents who are never satisfied.

These attitudes divert a teenager's attention from accepting responsibility for his or her decisions, incite negative reactions and may have suicide appear as a way of escape from being judged worthless.

## A Socio-Genic Model of Suicide

Family living patterns can be associated with the sociogenic model of suicide, which was pioneered by the sociologist, Emile Durkheim (1858-1917), who distinguished between "normal" and "pathological" social group functioning. In times of transition the "normal" person-to-person interactions among group members become upset and the result is a "pathological" group functioning. Members now act to destroy intra-group practices by committing acts

of suicide with the aim of destroying the life of the individual and also the life of the group. Durkheim used to term "anomie' to describe advanced pathological groups, and the process can be applied today to members of traditional groups undergoing unprecedented disruptions to their traditional living patterns.

As examples, we have in Australia those in rural areas and Aboriginal peoples and overseas the Indians of North America and the native Alaskians of Canada, each group having experienced soul-rending changes to time honoured living patterns and exhibiting exceptionally high suicide rates in comparison with other groups. Industrialised society in general (although to a less intense degree) is undergoing accelerated changes in social support systems through decreased employment opportunities, the demise of work tenure, frequent career changes, family break-ups and divorce, the stress on single parent families and youth leaving home. These changes make it difficult for youth to develop positive attitudes of belonging, of identity and self-worth.

## A Spiritual Dimension to Living

Each of the factors discussed above can be related to the spiritual. A young person's feelings of self-worth and of health in its broadest context lead to an inner peace, which underpins personal wholeness and as a spiritual dimension. Whatever its contributing factors, youth suicide is a sign that these young men and women are unable to feel wholeness within themselves and are experiencing instead an inner dis-ease (disease). The unfulfilled promises of materialism have left teenagers dejected and in tension, and often with no one to remind them of Jesus' words, "Come to me all who labour and are heavily burdened and I will give you rest" (Matt. 11: 28).

Thus, young people can face a future without promise or hope.

Youth suicide raises challenges to each of us to discern and act on ways of reversing the trend. Basically, suicide is an error in judgement and the fundamental challenge is to facilitate opportunities for young people so that they do not see suicide as a viable option.
Young people need role models who have developed positive life attitudes, who are enthusiastic, with a sense of personal autonomy and self-worth.

***"Youth suicide is a sign that young men and women are unable to feel wholeness"***

Youth are entitled to the example of a non-preaching witness of the place of the spiritual, of moral values and of religion in our lives.

## Working Towards Suicide Prevention

Suicide prevention requires more than well-wishing words and the example of adults who have their own lives nicely in order. It needs the provision of youth services such as job creation schemes, education projects with the guarantee of career entry on their completion, medical and psychological support centres, counselling opportunities in venues attractively arranged and of easy access to those living in remote rural areas, Aboriginal peoples and others who are marginalised. Community resolve in monitoring access to drugs and firearms needs strengthening. A basic strategy for the parents, friends and teachers of teenagers is to develop an awareness of the warning signs, such as sudden changes in a teen's behaviour, tidying up one's room, giving away possessions or reconciling differences. One can always ask them, "Are you thinking of suicide?" which may open up opportunities to "let it all come out." Specific ways could be by seeking a teen's advice on problems normally handled by parents, enjoying their company, affirming them, and by admitting parents and other adults make mistakes.

## Support for Suicide Survivors

Survivors of a suicide, parents, siblings, friends and teachers also need support services. Survivors require an outlet for their grieving, someone to sit with and listen as they voice their anguish over what should not have been, their pangs of mourning and loss, of guilt and anger. Family members need reassurance they are not to blame, that the reasons why can be just too complicated to sort out, and in many cases, without answers. It is a time to engender in those who are grieving a rebirth from brokenness and to have confidence that Christ's promise of the fullness of life is to each of us, to those who have already died and those who are left to carry on. Such attitudes hopefully may not only comfort those who have lost a loved one through suicide, but also may assist in preventing future suicides.✣

*Mary C Stainsby RSM*
*BA(Hons) BTheol*
*MEdAdmin PhD MACE*

## Proceedings of the Launch of the Centre

*20 July 1995*

The Proceedings of the Launch of the Centre, **Legalising Euthanasia? - Both Sides,** are now available in kit form.

Included are the talks given by Mr Joe Delaney on Caroline Chisholm, and the Euthanasia talks by Dr Norman Ford SDB, Dr Helga Kuhse, Dr Peter Beaumont, together with the summing up of the discussion by Professor Louis Waller AO.

For a copy please write to the Centre's secretary and enclose $5.00 to cover costs and postage.

# HIV Infection: Risky Business

*With condoms promoted as the key to safe sex it is important to look at the research and examine their effectiveness. Long term studies of heterosexual couples show that condoms do reduce the risk of sexual transmission of HIV but they do not eliminate it.*

## HIV Transmission

The spread of the HIV infection is remarkable. Each year the number of diagnosed cases around the world increases dramatically. Overall figures in Australia do not mirror this trend. In 1993-94 there were 876 new cases diagnosed but that fell to 804 in 1994-95. The heterosexual exposure category, however, showed a contrasting increase from 131 new cases to 148.

***"HIV is an infectious disease but its spread can be limited"***

It is tragic that HIV is such an infectious disease but its spread **can** be limited if precautions are taken. Unfortunately there is no cure but attempting to implement effective prevention is at least a start. In order to establish how effective prevention is, it is essential to analyse the methods available and to determine their respective impact on the rate of transmission of HIV.

The HIV virus is only 0.1 micron in size and therefore requires very little bodily fluid to be transferred from one person to another in order to transfer infection. During heterosexual contact the main source of HIV protection is by use of a condom which acts as a barrier. This method attempts to prevent the transfer of semen into the vagina, as well as vaginal secretions or menstrual blood from coming into contact with open lesions on the male's skin. When used as a form of contraception condoms have a failure rate of between 5 and 10%. Some of the failures are due to the user's technique but at least 1% are due to condom breakage. It is only possible to become pregnant during a short part of a woman's menstrual cycle but HIV is not so selective - it can be transferred at any time. It appears then that condoms would have at the very least a failure rate of 10% in preventing HIV infection but clinical research shows in fact that the actual figure may be much higher.

## Condoms: The Answer?

The campaigns that have been devised to decrease the spread of HIV once the method of transmission was established are aimed at encouraging the use of clean needles for intravenous drug users and the use of condoms for sexual practice. The advertisements appear everywhere from television to toilets at the airport.

***"The use of a clean needle will protect the user from HIV but the same does not hold true***

It is true that the use of a clean needle will protect the user from contracting HIV but the same guarantee does not hold true for the use of condoms, regardless of the proficiency of the wearer. In the optimal situation to reduce the risk of an HIV infected partner transferring the virus: the female would not have vaginal ulcerations or lesions, the couple would participate in vaginal intercourse and both partners would be highly motivated to ensure a condom was used correctly. Even then there would still remain a risk of the uninfected partner contracting HIV. Studies have determined that the true permeability of condoms to HIV lies somewhere in the range of 30-97%. The barrier principle that the condom relies on for protection is not 100% effective. Even when the greatest care is taken the transfer of HIV remains a probability.

## Risk Factors Examined

Factors that can increase the risk of HIV infection include; infectivity of the HIV positive partner, number of sexual contacts and anal intercourse. The stage of infection in the infected partner can also influence the likelihood of HIV transfer. If the infection is newly diagnosed and the infected partner is asymptomatic (displaying no symptoms) the risk of transfer is dramatically less than if the infected partner is suffering from AIDS. This means that for every 100 sexual contacts with one HIV positive partner who has a low infectivity, the risk is greatly reduced compared to 100 sexual contacts with 100 different HIV positive partners. The 100 different partners all have varying infectivities, and some out of them are likely to be highly infectious. Increasing the number of sexual contacts - vaginal, oral or anal intercourse, even with the one partner - is associated with an increased risk of infection. Put simply, the number of sexual contacts multiplied by the likelihood of becoming infected will determine the risk of infection. An increase in either value will result in an increase in the risk of infection. Anal intercourse carries up to a 40% risk increase of HIV transmission partly due to the increased likelihood of tissue damage and subsequent exchange of bodily fluids. Condom use will decrease the risk of transmission during anal intercourse as it does in vaginal but anal sex remains a far more risky practice.

## Investigation Results

To investigate the transmission of HIV through heterosexual activity it is essential to study heterosexual couples in which one partner is HIV positive and both partners are willing to continue in a sexual relationship.

Their use or non-use of condoms and the frequency and type of sexual encounters are all essential data. Numerous studies have monitored couples over extended periods (some over 4 years) to establish how easily HIV is transmitted. After following a group of 343 subjects (HIV negative women) in monogamous relationships with HIV infected partners one team discovered that in the group not always, or never, using condoms, the rate of transmission was 7.2 per 100 person years, that is a transmission rate of 7.2% per year. This was dramatically decreased in the group that always used a condom (regardless of whether it was vaginal or anal sex) where the rate of transmission was 1.1 per 100 person years.

Attempts have been made to estimate the risk of transmission per episode of vaginal intercourse. The risk is not constant from one sexual contact to the next but it can be estimated with the help of studies that involve monitoring partners who continue to have intercourse when one is HIV positive and recording the rate of transmission. The rate of **transmission per contact has been estimated at 1 per 1000**, including all stages of HIV infection in partners (values range from 5 per 1000 when the infection is in the advanced stages to 0.7 per 1000 if the infected partner is symptom free). It is important to note that although these studies involved infected partners who were both male and female the risk of transmission is not the same in both directions. Research suggests that male-to-female transmission is twice as likely as female-to-male transmission.

## Reducing the Risks

One study monitored 124 couples who consistently used condoms for both vaginal and anal sex. After approximately 15,000 sexual contacts the study found that no HIV transmission had occurred. This exceptional result can probably be attributed to several factors. Firstly, one third of the 124 couples had a female HIV infected partner and this is believed to have a lower risk than male-to-female transmission. All the couples followed were in long term, monogamous relationships and were probably very motivated in their condom use, which would help decrease the risk of infection. Finally the team of researchers retested the couples every six months for HIV transmission and at the same time counselled them about safe sexual practices. Ongoing counselling provides timely reminders for couples that they cannot lapse in their careful practices. The fact that no transmission occurred appears to be explained by the motivated and consistent use of condoms. It is important then in promoting condoms as a method of reducing the risk of transmission not only to focus on the use of condoms but on the **careful and consistent use of condoms.**

Although in the above investigation condoms prevented any infection other studies suggest that a risk remains. One study which analysed many investigations of HIV transmission suggests that the aggregated estimate of condom effectiveness is only a 69% reduction in risk.
True effectiveness however may be as low as 46% or as high as 82%.

***"Condom effectiveness is only a 69% reduction in risk"***

The risk reduction that condoms provide in HIV transmission is dramatically less than the risk reduction observed with pregnancy (69% as opposed to 90-95%). Possible reasons for the difference include the fact that HIV can be transmitted at any time during a woman's cycle, HIV can permeate the condom itself and HIV transmission not being isolated to vaginal intercourse.

Until more is known about condom effectiveness the promotion of condom use should be carefully reviewed. It is irresponsible to promote condoms as the solution to the spread of HIV, with the guarantee of 'safe sex'. There is an important difference between 'condoms reduce the risk of' and 'condoms prevent' HIV infection.
To decrease the spread of HIV it is essential to educate people on all the

***"There is an important difference between 'condoms reduce the risk of' and 'condoms prevent' HIV infection"***

risk factors related with transmission and, if possible, how to eliminate or, at least, reduce them. If sexual contact is to occur the greatest risk reduction can be achieved by selecting a 'low risk' partner. If this is not an alternative it would certainly be prudent to use condoms in all sexual encounters. Although there remains a risk of HIV transmission, a reduction of 69% is definitely better than none.

## Sources

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*Tracey Scott*

# Morality, Use of Condoms and HIV Prevention

*Following recent media reports this article discusses the moral aspects of the use of condoms in HIV prevention.*

## Facts on the Gravity of the AIDS Disaster

AIDS is a lethal disease of worldwide proportions. As of 15 December 1995 1,291,810 cases of AIDS have been reported to the World Health Organisation (WHO). At the end of 1994 WHO estimated 16,899,950 people were living with HIV infection (see *Communicable Diseases Intelligence* February 1996). Statistics to 30 September 1995 show cumulative diagnoses of HIV infection in Australia were 19,292 (16,243 males, 935 females), AIDS diagnoses 6,292 (6,032 males, 237 females) and death following AIDS 4537 (4358 males and 164 females). In spite of public HIV prevention campaigns, in the year to 30 September 1995 there were 885 new diagnoses of HIV infection, of whom 799 were male and 86 were female. There were only 21 aged 13-19 years, of whom 10 were male and 11 female (See *Australian HIV Surveillance Report* Jan. 1996)

## Duty of Care

There is a moral duty to take all reasonable care of life and health. This includes taking reasonable precautions against risks of serious bodily harm for oneself and others. One should not drive a car dangerously or consume contaminated food. It is well known that HIV infection is transmitted by contact of bodily fluids from an infected person to those of an uninfected person.

HIV may be transmitted by the use

***"There is a duty to take reasonable precautions against***

of an infected syringe, by a HIV infected mother to her child during pregnancy or while breastfeeding a baby or by one's bodily fluids having contact with another's HIV infected fluids. It does not matter whether the contact occurs during vaginal, oral or anal sex. One has a moral duty to avoid activities that expose oneself or another to a significant risk of HIV infection, including activities that would otherwise be good, e.g. breastfeeding. The duty of care remains even if the risk to health or life occurs during the performance of an immoral act. A thief carrying loot down a ladder should still descend carefully. Hence one who engages in immoral sexual activities is still bound by health care duties.

## HIV Transmission

While conception can only occur during a woman's fertile period, HIV infection may occur at any time during the menstrual cycle. The risk of infection increases during anal and in vaginal intercourse when there are sores or lesions in the genital area. This explains the high rate of HIV infected African women with untreated sexually transmitted diseases. Having sex with a high risk partner is more dangerous for health than with a low risk partner.

It is **not 100% safe** to rely on the use of a condoms for protection against HIV infection. Their proper

***"Safe sex campaigns may easily create a false sense of security against***

use substantially reduces the risk of infection where one partner is HIV infected, but it does not eliminate **all** risks. Safe sex campaigns based on the use of condoms may easily create a false sense of security against HIV infection.

## Sex Restricted to Marriage

Human sexuality is a precious natural endowment which shares in the dignity and value of the human person. Genital sex should be an expression of conjugal love. It is no mere bodily phenomenon and ought not be trivialised. It should freely and truly express the couple's faithful and exclusive marital relationship and bond their ongoing commitment to loving personal intimacy, affection and emotional openness, with mutual acceptance of its inherent procreative destiny. Hence the Catholic Christian tradition holds that it is always immoral to engage in genital sexual activities outside of marriage, regardless of whether a condom is used to reduce the risk of HIV infection.

## Case of HIV-Infected Spouse

A HIV infected husband or wife may choose to abstain permanently from sexual intercourse to avoid infecting one's partner. But it would be unreal to expect all couples with a HIV infected spouse to do so. In view of their need to express their love for each other some such couples may be justified if they were to deem the risks of HIV infection from sexual intercourse to be morally insignificant if extreme care were to be taken in the proper use and selection of quality condoms. [See the previous article by *Tracey Scott* on the incidence of HIV infection risk reduction by couples using condoms in heterosexual intercourse.]

Though the unitive meaning of the conjugal act is lessened by the use of a condom, it would not totally eliminate its mutual intimacy. From the moral perspective it would still be a conjugal act. Some theologians believe the use of the condom in this case would still be immoral, claiming it would be a contraceptive act and so contrary to the Church's teaching in **Humanae Vitae**. They agree,

however, spouses would still be free to follow their conscience in this regard.

Others reply that the use of a condom would only be immoral if the purpose of its use was to prevent conception. If it were used in a conjugal act solely to substantially lessen the risk of HIV infection it would not seem to be immoral. Such a conjugal act would seem to retain sufficient mutuality for the spouses to become one flesh with an unintended incidental contraceptive side-effect. It seems there could be no contraception in the moral sense unless the intent is contraceptive. Paul VI stressed the need of a contraceptive **intention** by saying: "Similarly excluded is every action which, either in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes whether as an end or as a means, to render procreation impossible (H.V.n.14)."

This contraceptive side-effect would be justified by the Principle of Double Effect in the same way that the Church permits indirect sterilisation for a therapeutic purpose, e.g. removal of cancerous ovaries or testes. There would certainly be proportionate reasons for permitting the act in view of the legitimate desire of

***"Avoid the impression the Church condones the use of condoms within marriage for***

spouses to express their mutual love. Such conjugal acts would be neither directly contraceptive nor inherently immoral since the lessening of mutuality in the conjugal act would be an indirect side-effect of an act, the sole purpose of which was to prevent HIV infection.

It is imperative to avoid the impression that the Church condones promiscuity or the use of condoms within marriage for contraceptive purposes. Fear of misunderstandings or abuse of the truth on the part of some, however, should not prevent its prudent communication and right use.

## Protection from HIV Infection & Sex Outside Marriage

Family, school, pastoral and medical experience shows that a significant proportion of senior secondary school boys and girls have had sex. This is a reality of our culture that responsible parents and educators cannot ignore. It reflects an aspect of the ambiguity of human maturation, the frailty of human nature and the mystery of free will.

The most effective way to prevent HIV infection by sexual transmission outside marriage is to abstain from sexual activities by practising the virtue of chastity. Non-infected sexual partners do not pose a risk to each other provided they keep clear of all possible causes of HIV infection, e. g. use of infected syringes or promiscuous sex.

## Role of Catholic Parents and Educators

Catholic parents and educators have a responsibility to prevent the spread of HIV infection by collaborating to promote a sound philosophy of the human person, enlightened by the Christian faith and Gospel values. This should be the basis for an understanding of true love, mutual respect, the meaning of human sexuality and its moral principles. They should see to it that prudent and experienced persons draw up suitable AIDS prevention programs in harmony with Catholic moral teaching. Fear tactics alone are not likely to deter young people from practices that may cause HIV infection. They should be convincingly taught that the practice of chastity before marriage and fidelity within marriage are the most effective ways to prevent HIV infection from sexual activities.

Virtue is to be recommended for its own sake and not simply as a means of avoiding disease.
Educators should consult with some parents to draw up suitably graded HIV preventive educational programs to suit the various stages of development of the young, bearing in mind the different cultural back-

***"The practice of chastity before marriage and fidelity within marriage are the most effective ways to prevent HIV infection"***

grounds of their students. Care needs to be taken to present the relevant factual information and strategies in a way that suits each age group of students to minimise the risk of misunderstanding or harm to the immature. Even for teenagers care should be taken to avoid harming their personal growth and emotional development.

While educational programs for the prevention of HIV should be encouraged, Catholic parents and educators should not support preventive measures that conflict with the principles of traditional Christian morality. Experienced Christian educators are able to communicate accurate factual information on HIV transmission, infection and prevention to students without compromising Catholic teaching on moral principles.
Even though only a low percentage of teenagers are HIV infected, they should all be told that in spite of the substantial HIV infection risk reduction when condoms are used properly with HIV infected partners, a real

***"Condom vending machines should not be installed in schools"***

risk of infection still remains.
Condom vending machines should not be installed in schools because this would implicitly endorse the immoral acts associated with their use and give a false impression their use is completely safe. Before launching an AIDS prevention program in a school, it would be wise to invite parents to a meeting so that they may learn in advance of the program's contents and strategies. In case any students bring home false impressions of what was taught at school, informed parents would be able to

correct them.

Students should be informed of the implications and likely consequences of their behaviour in a way that does not condone, nor is perceived by the young people themselves to condone, immoral acts. It should be made clear to them that one who is involved in risky sexual practices outside marriage should not be so ethically and socially irresponsible as to fail to use a precaution to reduce substantially the risk of HIV infection. From the moral perspective one evil is better than two. HIV prevention programs, however, should not undermine Catholic morality by tacitly accepting the **condom way of life**.

Students should not be given the impression it is morally good or neutral to engage in premarital sex provided a condom is used.

Young children ought not be presented with explicit examples of deviant sexual immorality before they understand the Christian meaning of sexuality and its virtuous expression.

***"Students should not be given the impression it is morally good or neutral to engage in premarital sex provided a condom is used"***

Young children who are not likely to be exposed to HIV infection through risky sexual behaviour ought not be inundated with graphic details of sexual activities. It is pointless risking psychological harm to young children generally by such exposure when they are not in any real danger of being involved sexually with another HIV infected person. Who can gauge the harm caused by the trauma of young children being taught how dangerous their human sexuality really is? Instead of human sexuality being presented as a precious endowment of nature for the joyful expression of love and fidelity at the service of life, it risks leaving an indelible image on impressionable minds of fear, mistrust and death. Where there are grounds to believe there are some young children who may be at risk, in or out of the home, their special needs must be adequately met to avoid both spiritual and bodily harm.

For preventing AIDS, chastity and fidelity in marriage together with the avoidance of drug abuse are the winners! ✣

*Norman Ford SDB*

# HIV/AIDS and the Law: Transmission Offences

*Victorian Law treads a careful line between protecting HIV-positive individuals and the community. In the first of two articles discussing the Legal aspects of HIV transmission, we look at the preventative nature of the* Health Act.

## Introduction

Dealing with the problem of the sexual transmission of HIV/AIDS involves a careful balancing of competing legal and ethical interests. On the one hand is the right of HIV-infected individuals to live a normal life, free from stigma and the fear of isolation or detention.

***"The difficult task of reconciling public health needs against the rights of individuals results in the use of controversial powers"***

On the other hand is the right of the community to be protected against dangerous infectious diseases. The difficult task of reconciling public health needs against the rights of individuals results in the use of controversial powers under public health legislation.

Victoria has some of the most comprehensive legislation in Australia relating to HIV/AIDS and Victorian legislators have used several approaches that try to achieve this balance. All attempt is made to protect the rights of HIV/AIDS infected people, and public education is seen as the most important step. However, in an effort to control the spread of the virus restrictions may, by law, be placed on the lives and activities of those who are HIV-positive. In extreme circumstances isolation, detention or criminal sanctions may be invoked.

In Victoria a person who deliberately or recklessly transmits HIV / AIDS, or exposes another person to the risk of infection, may be guilty of offences under either public health law or the criminal law. (In some circumstances they may also be personally sued, but that is beyond the scope of this paper.) Public health law is covered by the *Health Act* and its various regulations. Penalties for breaking these laws carry fines rather than jail terms. Unlike public health offences which are created by parliament (*statute*), criminal HIV/AIDS transmission offences are developed by the courts (*common law*). In Victoria the criminal law is a mixture of *common law* and *statute*, the statute in this case being the *Crimes Act.*

In this paper discussion will be concentrated on monitoring HIV/AIDS transmission by the *Health Act.* A concluding paper in the next issue will discuss criminal sanctions.

## Testing

The *Health Act* allows that testing for HIV and AIDS be entirely anonymous: it is performed on a voluntary basis only, and the patient's

initials rather than full name are used throughout the process. The Act also stipulates that if the results of the test are positive the person must be given information about the medical and social consequences of the disease, and guidelines on ways to prevent the transmission to others. Although not stipulated in the Act, the use of condoms is normally regarded as a preventive measure.

## Behaviour Restrictions and Detention

Due to the comparatively low infectivity rate of HIV/AIDS (see other articles in this Bulletin) the provisions of the *Health Act* are generally only applied as discussed above. In some cases however, counselling of an infected person may be ordered.

***"In exceptional cases, if it is believed that a person is 'likely to transmit that disease', an order may be made to restrict that person's***

In exceptional cases, if it is believed that a person is "likely to transmit that disease" and that counselling has not achieved "appropriate and responsible behaviour change", an order may be made to restrict that person's behaviour and movement. In 1993, for example, an HIV-positive transsexual prostitute was forbidden under the *Health Act* to enter St Kilda, engage in unsafe sex practices, and use intravenous drugs.

If an order restricting a person's behaviour and movement is not complied with there are powers in the *Health Act* that allow for detention and isolation. Detention and isolation orders must be renewed every 28 days and may be appealed against in the Victorian Supreme Court.

## Offence of Infecting Other Persons

The major transmission offence in the *Health Act* stipulates that: "A person must not knowingly or recklessly infect another person with an infectious disease. (HIV and AIDS are both defined as infectious diseases). The key words in this section are "infect" and "knowingly or recklessly". The HIV-positive person *must* have *transmitted* the virus in order to be prosecuted under this section. It is not enough that there was a *risk* that the other person may have become infected. In addition, the HIV-positive person must have known that the virus would be transmitted, or that there was a probability that transmission would occur. (The definition of "reckless" is "probable" rather than "possible") The section allows for a penalty of up to $20,000.

It is a consequence of this section that an HIV-positive person cannot be charged with practising "unsafe sex". If they persistently continue in unsafe sex practices they may be detained or isolated, but unless someone has actually contracted the disease from them, they cannot be charged. This was illustrated in the Supreme Court last year when an HIV-positive man was charged under the Crimes Act (offences under the Crimes Act will be discussed in the next issue) after lying about his HIV-status and having unprotected sex with another man. In that case the judge agreed that because the risk in a one-off situation was relatively low, the man had committed no offence. However, the judge was prompted to add: "This ruling may warrant consideration being given to enacting a provision whereby certain conduct is prescribed even though the possibility of death resulting from the conduct is relatively low."

## Defence of Consent

There is a defence to the charge of "knowingly or recklessly infecting" someone with HIV/AIDS if it is proved that "the person infected with the infectious disease knew of and voluntarily accepted the risk of being infected with that infectious disease." In other words, if an HIV-positive person tells his or her sexual partner that they are infected, then the sexual partner voluntarily accepts the risk that they too may become infected.

Standing on its own, this section could be interpreted quite narrowly. It could be argued that anyone who

***"If an HIV-positive person tells his or her sexual partner that they are infected, then the sexual partner voluntarily***

agrees to have "unsafe" sex with someone (i.e.: agrees to have sex without a condom) is voluntarily accepting a risk of contracting HIV/AIDS. And given some of the statistics as to condom effectiveness (in some statistics only 69% effective), a person using a condom could still be said to be voluntarily accepting a risk. If "voluntary acceptance of risk" is interpreted in this way it would render the offence meaningless.

## Interpretation

In practice the preventive nature of the *Health Act* in comparison to an Act involving criminal sanctions means that this defence may not be widely interpreted. One of the factors that must be taken into account is the interpretation section in the *Health Act* that stipulates that "a person with an infectious disease must take necessary measures to ensure that others are not unknowingly placed at risk of becoming infected." This section, which is also used to interpret whether a person's behaviour is such as to warrant isolation or detention, appears to stipulate that an HIV-positive person should always reveal their HIV status in situations where another person may be placed at risk. By revealing that they are HIV-positive they place the onus of responsibility on the other party.

But it must be stressed that it is *not* an offence to fail to comply with this section. Compliance with this section is simply a factor to be taken into account when interpreting the other "infectious diseases" sections. For example, imagine a situation where an HIV-positive person consistently uses condoms but refuses to inform their partner or partners as to their HIV status. The law is unclear in

this situation. It does not appear to be an offence for that person to fail to tell others of their HIV status. It only becomes an offence if someone *contracts* HIV. This was demonstrated in 1991 when charges against two prostitutes were dropped because there was no proof that they were practising unsafe sex.

What about a situation where an HIV infected person refuses to tell their long-term partner about their infection? Does their partner have a *right* to know? The law cannot coerce the infected person to tell them, and placing the infected person in isolation or detention would seem to be extreme under the circumstances. Does the law allow for the *doctor* who performed the test to tell the partner? Under normal circumstances this would be a breach of the doctor/patient relationship. The Intergovernmental Committee on AIDS recommended that in these sort of circumstances there should be a discretion on the part of the doctor to tell the patient's partner but the law is currently unclear on this issue.

That the provisions of the Health Act dealing with HIV/AIDS do seem to have loopholes and contradictions reflects the problem of balancing the competing interests of the public and the individual HIV/AIDS sufferer. This is starkly reflected in the 1993 case of the transsexual prostitute. An effort was made to keep his name out of the media but, on appeal to the Supreme Court, it was held that:

***"A person with an infectious disease has a right to privacy so long as those rights do not infringe on the***

[The section of the *Health Act*] provides that "a person with an infectious disease has a right to have his or her privacy respected *so long as those rights do not infringe on the well-being of others.*"
(Emphasis added).

There could be no clearer expression of Parliament's intention to strip a person suffering from HIV or AIDS of his or her right to privacy if that person fails to behave responsibly and that failure infringes on the well-being of others.

*(This discussion will be concluded with a look at criminal sanctions in the next issue of the Bulletin.)*

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*Anna Stokes*


# *Caroline Chisholm Centre for Health Ethics*

7th Floor, 166 Gipps Street EAST MELBOURNE VIC 3002
Tel (03) 9270 2681 Fax (03) 9270 2682

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**Director / Editor:**
*Rev. Norman Ford SDB STL PhD*

**Research Officers:**
*Deirdre Fetherstonhaugh* DipAppSc PGCert(Renal)BA(SocSc) MA(Health Studies)
*Tracey Scott* BSc BA(Hons) (Phil)
*Anna Stokes* BA (Hons)(Eng.) LLB.

**Layout:**
*Ms Sylvie Skonietzky*