Caroline Chisholm Centre for Health Ethics

BULLETIN

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From the Director

This issue of our **Bulletin** is the fourth and final number for 1995-96. I would like to remind subscribers that subscriptions are now due for the first number of the second volume. Please return the subscription form insert. Our first conference held on 3 May was a great success; speakers and topics are listed on p. 12. Ms Sylvia Skonietzky is taking maternity leave and we wish her every joy and happiness for the birth of her baby.

Given the beneficial community debate on drug abuse, I believe a brief comment is warranted. But it would be of little use to treat the symptoms if the underlying causes of drug abuse are not tackled.

The following causes need to be considered: the demoralising impact of unemployment and social alienation; the loss of a sense of meaning in life due, in part, to a drop in religious belief and practice; the culture of individualism, living for the moment and the expectation of an easy fix for every problem; the breakdown in family stability; the effect of poor parenting skills on some youngsters and the initial taking of drugs out of curiosity.

The harmful effects of all illegal drugs, including marijuana, on the health of mind and body need more research. It is well known that drug abuse impairs a person's capacity to drive a car safely. Existing laws in this respect must be upheld. It is pointless limiting blood alcohol levels for drivers if nothing is done to detect drivers under the influence of other drugs. Funds must be provided to speed up the development of a roadside test to detect dangerous levels of drugs in drivers' bodies.

The community should protect the young from drugs because of their liability to exploitation and the greater harm drugs cause to their developing bodies and brains. The law should ban the possession of marijuana for personal use by minors, but the sanctions should be civil rather than criminal.

Clearly the community must provide the funds needed for education about drug evils and effects, drug abuse prevention and treatment and counselling against experimentation. Relying on policing alone is insufficient. Religious faith and education can help the young find a personal meaning for their lives. A coherent and co-ordinated multi-media educational campaign for schools and the broader community is imperative. Much could be learnt from the successful campaigns of the T.A.C. and the Alcohol and Drug Foundation.

"One of more than 5,000 bonnie babies born at Mercy Hospital for Women each year"

It may be problematic in a democratic state today to justify using criminal sanctions for adults who possess small quantities of marijuana for their personal use. But it would be irresponsible to relax the present drug laws before better education, prevention and treatment programs are in place. The community needs more information and time to absorb it before making a final judgement. ✣

Norman Ford SDB

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Resourcing Health Care: Some Moral Reflections

Frequently references are made to the need for the rationing of healthcare resources. This article briefly discusses some of the relevant moral considerations.

A Biblical Perspective

The Bible portrays the gift of life in a positive light, with men and women equally sharing a sublime dignity, 'created male and female in the image of God' (Gen. 1:27). Christians believe that through his sufferings, death and resurrection Christ saved humanity, brought freedom and gave hope for an eternal life of happiness, including the resurrection of the body (see I Cor. 15: 3-24; Eph. 1:14). His triumph over death meant it should no longer be viewed as an ultimate evil, one to be overcome at all costs.

Jesus demanded the Ten Commandments be kept and showed love and compassion by curing the sick and diseased. He gave preference to the poor, the merciful and those who seek justice (see Matt. 5:3-10). He was one of our stock, in solidarity with humanity. He abolished social category distinctions and unjust discrimination: 'There is neither Jew nor Greek, there is neither slave nor free, there is neither male nor female; for you are all one in Christ' (Gal. 3:28). Christianity neither imposes nor detracts anything from humanity. The Pastoral Constitution of the Church in the Modern World says: 'Whoever follows Christ the perfect Human Being, becomes himself or herself more a human being (n.41, Vatican II). Indeed, because of the authentic humanity of Christ, the Christian, with Terence, may well say 'Homo sum: humani nil a me alienum puto - I am a human being: I reckon nothing human is foreign to me'.

Christian Values

The Christian values of respect for life and patient freedom, health promotion, non-discriminatory access to basic health care for all, justice, compassion and due acceptance of the inevitable reality of death should drive resource decision making in health care. These values should be reflected at every level of health service -- health care professionals, administrators and the government. The basic moral principle is simple to state: there is a duty to provide reasonable care and treatment for the sick but there is no duty to go to unreasonable lengths. It is a matter of interpreting this principle in the contexts of persons, time, place, culture and a country's available resources. It is unreal to expect the same health care services in a developing country as in a developed country.

Often compassion and reason in decision making for the equitable use of resources for health services will be in polar tension. This does not imply the State is to spend beyond its means nor succumb to the heartless dictates of theoretical economic calculations.
Priority in medical treatment must be

"Priority in medical treatment must be given to those whose need is greatest and who will benefit most from it"

given to those whose need is greatest and who will benefit most from it. Sound social policy requires adequate funds be diverted to educating people how to care better for their health and to prevent sickness and disease, both in schools and the community. Preventing sickness is a priority because its benefit is universal -- it saves unnecessary illness, suffering and public expense.

For individuals, a high priority should be given to alleviating painful symptoms, irrespective of whether their primary disease can, or cannot, be effectively treated or whether their condition is terminal or not. Great benefit is gained by providing medical treatment to those whose illness or disease can be effectively treated to enable them to resume their normal lives. The more debilitating a curable disease or sickness and the more effective is the treatment available, the greater priority it should have. Provision for people with disabilities should not be neglected. All things considered, waiting lists for non-emergency treatment may be fair and necessary.

The common good cannot be achieved without a fair sharing of the burdens and benefits of social collaboration. Each should contribute to health costs according to one's capacity to give. Each should receive according to one's real health needs. A willingness to contribute to the community, in proportion to one's ability, is a condition for sharing in social advantages and benefits.

Efficiency is important in the delivery of health services, but justice, compassion, non-discrimination and due respect for patient autonomy also have their rightful place. Injustice for a few is not compensated for by benefits for the many. The **common good** should not be reduced to the good of the majority without due regard to the needs of minorities - invalids, the sick, the aged and the disadvantaged.

Subsidiarity

The principle of subsidiarity requires that governments, health departments and administrators positively support individuals and families to do whatever they can to contribute to

their own health needs. They should only reserve to themselves decisions and services that families and health care professionals cannot effectively provide. Healthcare professionals should not feel they are reduced to mere cogs in the health machine. Doctors should have a say in the use of resources for their patients, but not the only say. In this way a sense of personal self-reliance, autonomy and worth is respected. Responsible participation is encouraged without denying scope for the government and health administrators to intervene whenever this is required for the good of all. The unseen sick should not be disadvantaged because they have not been able to see a doctor.

Limited Resources

Shortage of funds limits the provision of medical treatment. When there was no free medicine, decisions about the use of finances for on-going medical treatment for the sick were made by the same persons who decided the alternative use of the money. In a family a painful decision would be reached to terminate costly and non-beneficial medical treatment for a sick parent in favour of using the money to pay for the university education of the children. When a family's finances were limited and university education was not free, more than a decision to cease treatment, it would be a decision to use the money for the education and career opportunities of a son or daughter. It is easy to be more demanding when costs are met from the public purse.

Scarcity of resources is linked to people's reluctance to pay higher taxes. As in families of yester year, Governments now have to make the painful budget decisions on how much to allocate to health compared to pensions, unemployment benefits, education, arts, culture, public works, public transport etc. Whatever is required for the basic health needs of all must be supplied. Granted a ceiling on public spending must exist, additional health funds should not be taken from pensions or education without justification. Decisions are to be made at the level of health departments, hospitals and the ill to prioritise the medical treatments and health services that should be 100% publicly funded.

Careful thought needs to be given to see whether all kinds of expensive treatment warrant public funding in every case, e.g. organ transplants, heart by-pass surgery or prolonged treatment in acute care where outcomes are doubtful and the likely benefits are outweighed by the costs. It is estimated that 50% of our health budget is spent on the last 12 months of peoples' lives.
Cost intensive treatment should not be routinely employed as a therapy

"Cost intensive treatment should not be routinely employed as a therapy for our cultural death angst"

for our cultural **death angst**. Believers and non-believers alike, for different motives, must accept death. While deliberately causing death is immoral it would be good to educate the community, including healthcare professionals, to accept dying as part of life. This would help cut back on unreal expectations of continuing treatment that was disproportionate to its benefits. Pastoral care for patients and families is crucial here and should be adequately funded as an integral part of health services for all.

Damaging Litigation

Vaccinations against whooping cough fell sharply following the news of court ordered compensation for a rare case of co-incidental brain damage, erroneously believed to have been caused by the vaccine. This sort of litigation increases the costs of the vaccine and medical insurance premiums which are passed on to the health budget. Failure to vaccinate children has resulted in an alarming rise in the death rate of children due to whooping cough -- this is not in the interests of public health, not to mention unnecessary costs. Governments need to mount an effective educational campaign on the safety of vaccinations, and possibly legislate to grant certain vaccine manufacturers and doctors immunity from unwarranted civil actions. Compensation for suspected damage and birth defects from vaccinations should be paid from public funds.

Responsible Decision Making

Through their elected governments, people are responsible for making decisions on how much of the budget is to be spent on health care. Governments should listen to institutional and community healthcare professionals, district nurses, general practitioners, administrators, consumer representatives, researchers, economists, ethicists and especially taxpayers. In the final analysis, having heard all the relevant views, it is up to the Commonwealth and State Governments, not pressure groups, to make health policy decisions for the good of all.

Health departments may legitimately rule that certain medical procedures do not warrant any or full public funding. They need to be wary of the prevalent culture of the immediate fix, of consumers confusing wishes for health needs and the belief that medicine can cure all ills. As in the insurance industry, the Government may well require law breakers whose negligence is responsible for their injuries to assume liability for their hospitalisation and treatment costs. Think of motor car accidents caused by reckless driving or driving above the legal blood alcohol limit. While emergency treatment should always be given, all other things being equal, repayments to public funds on a means tested basis, should be seriously considered for most of these offenders. ✣

Norman Ford SDB

Problems of Health Care Resourcing

Funding our health care 'needs' is perhaps the most difficult ethical problem facing contemporary society. This article will give a general overview of some of the questions that this quandary raises.

The dilemma of resourcing health care would not be ethically contentious if the problem was only to do with technical inefficiencies rather than the underlying enigma of deciding what should comprise a ***just*** health care system.

The definition of health is indeed contentious and open to many interpretations. The World Health Organisation sees health as a "state of complete physical, mental and social wellbeing, not simply the absence of illness and disease". With such a definition the responsibilities of a ***just*** health care system would need to include a wide gamut of services to satisfy the 'needs' of the community. A ***just*** health care system would account for all inequities in health status, whether due to genetics, environment, social factors or just bad luck. It would seem though that the health care system as it exists in Australia sets its agenda to satisfy mainly the imperative, immediate physical 'needs' of its consumers, leaving other 'needs' either unmet or severely compromised.

Health Needs

Defining health 'needs' is even more difficult than describing health. Needs are obviously subjective and therefore relative to the individual's own circumstances. One way of deciding which needs should be met in a ***just*** health care system may be to respond to only those needs which are necessary to ***maintain, restore or compensate*** for losses of ***normal (species typical) functioning*** specific to one's age. Even this limitation may be too wide, as what do we define as normal species typical functioning? In Vitro Fertilisation (IVF) is an example of a technology which it could be argued fulfils a health care need because procreation is a part of normal species functioning and therefore should be resourced in a just health care system. Yet, it is an expensive technology and it is reasonably unsuccessful in terms of the percentage of babies born as a result of treatment cycles. So should the majority have to finance a treatment that aims at achieving normal species functioning for a few unlucky people? The dilemma of whether this 'need' for procreation should be satisfied by the public purse seems to be resolved by the Federal Government by funding restrictions of six stimulated treatment cycles in a lifetime and ensuring that the individuals treated satisfy certain criteria.

"We are all health consumers"

Deciding how 'needs' and the services to satisfy these 'needs' will be resourced, as well as to what extent they will be resourced, is becoming a preoccupation for many governments, health care workers, economists and community groups. We are all health consumers (whether frequently or infrequently) and it is ***our*** expectations of the health system that have increased our 'needs', and yet debate about which 'needs' should be met, especially by the taxpayer, has been relatively scant.

Rationing

The concept of rationing health care because of inadequate resources needs to be discussed. In the area of health care, rationing may be seen as the intentional withholding of effective medical therapy, operations, procedures or any other health services which ***could*** be of benefit to the consumer but are withheld because of scarce resources. Within this definition a distinction must be made between the limiting ***of*** the health care system and the limiting of care ***within*** the health care system.

"It is very difficult to ration care or treatment at the bedside."

Limiting the health care system should be the responsibility of governments and policy makers who hopefully have collaborated with the community. Limiting of health care for particular consumers is ultimately the responsibility of health care professionals. In the latter situation many people see a conflict of interests because the doctor is supposed to treat in the consumer's best interest and how can he do this when there are inadequate resources? It is very difficult therefore to ration care or treatment at the bedside because of lack of resources (it is a different quandary if the reason for rationing is an ***unlikely*** good outcome). Rationing or 'controlling' the allocation of health care resources must be done by the community not by individual doctors for individual consumers - the exceptions perhaps are such resources as organs for trans-plantation (the availability is not dependent on the amount of money spent) where the allocation decisions have to be made between individuals based on certain criteria.

Although the fundamental issue is to decide ***which*** health care services should be included in a just health care system, there are many technical inefficiencies in the contemporary Australian system which are caused by more easily resolved problems, and the following are examples of but a few.

Governments and Policy Makers

At the level of governments and policy makers there are problems with duplicative program structures where there is too much government in both the Federal and State Health Departments. By having two bureaucratic structures there is division of responsibility for providing different health care services which has caused major shortcomings in relation to the planning, funding and administration of services. In more recent times this seems to have encouraged such activities as cost shifting; eg. the privatisation of outpatient departments whereby the federally funded Medicare pays the bill rather than the state funded public hospitals. At this government level (included here are private health funds) there is an overemphasis on acute cure, rather than basic or continuing care, and on urban instead of rural services. Although in recent times there has been a resurgence of home based care, it is still under resourced when compared with acute hospital care. Medicare allows almost unlimited access or reimbursement for visits to medical practitioners, specialists and optometrists, while other programs are severely capped.

Health Service Providers

At the level of health care providers (both the managers and the workers) inefficient resource allocation can be seen in the inappropriate allocation and under utilisation of health care staff, inefficient planning that does not involve multidisciplinary co-ordinated care, inept diagnosis, and treatment and overservicing with too many diagnostic tests and pro-cedures. The fear of medical litigation and a compulsion to use every test because it is available may be partly to blame for the overuse of some services.

Health Care Consumers

The third level at which there is a problem with resource allocation in health care involves everyone - the health care consumers. At this level it is both technical inefficiencies and unrealistic expectations that have created resource problems for our health system. It may be that we not only overuse services such as those supplied through Medicare but that we have an expectation of numerous diagnostic tests and have a compulsion for the quick fix rather than wait for the natural course of a minor ailment. We ought to intervene in those diseases which have an unfavourable outcome if left alone - but we cannot expect a cure or intervention for such complaints as the common cold. Under utilisation of services at the level of public health measures (such as immunisations) and preventive education may also contribute to problems of resource allocation, as prevention costs less than acute intervention.

"We need to take some responsibility for our health"

Some responsibility for one's own health is necessary if we are to use the Australian nationalised health care system in a responsible way. It must be said though that low socio economic status, poor education, ethnicity and gender can affect peoples' health and that in these areas the individual may not have control of their health status. However, there are situations (such as public education campaigns against such risk taking behaviour as cigarette smoking) where the information is available to all, regardless of circumstance. In these situations the individual must take responsibility. Compliance may also be implicated in the responsibility for efficient allocation of health care resources. If you seek help within the system currently funded by the taxpayer are you compelled to follow the treatment? While compliance to a regime deemed appropriate by health professionals is open to contention it must be acknowledged that sometimes lack of compliance can lead to the irresponsible use of resources when extra hospitalisation is required. There are many other issues implicated in the question of compliance, including patient autonomy, lack of information and informed choice but these are beyond the topic of this paper.

It is at the level of the health care consumer that part of the solution to resourcing a just health care system lies. It is our expectations of a technologically adept system fuelled by often invalid and irresponsible media exposure and fear of inevitable death that must change.

The issue of resource allocation in health care is probably one of the most difficult ethical and economic problems that faces us in the late 20th and early 21st centuries. It is not only a problem for the developed world, as Third World countries are also caught up in the 'marvels' of modern technology. In the case of the Third World it seems even more of an enigma when they are balancing such elitist treatments as transplantation against basic services such as the provision of clean, unpolluted drinking water. In the developed world our romanticism with technology has overcome our ability to pay for everything that it is possible to do and we are having to develop strategies in order to cope with these problems. The economists are adamant that technical efficiency will solve our rationing problems as they feel that it is only a matter of working out the method rather than changing the agenda. In the next issue of the Bulletin I will discuss some of the various methods for improving efficiency within the health care system that have been introduced in Victoria and other parts of Australia.

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HIV/AIDS & the Law: Sexual Transmission Offences

Victorian Law treads a careful line between protecting HIV-positive individuals and the community. In the second of two articles discussing the legal aspects of the sexual transmission of HIV/AIDS, we look at the way the criminal law has been used.

Introduction

In the last issue of the Bulletin we looked at the problems of HIV/AIDS transmission and how these are dealt with by public health legislation. As was discussed, dealing with the problem of sexual transmission of HIV/AIDS involves a careful balancing of competing legal and ethical interests. On the one hand is the right of HIV-positive individuals to live a normal life, free from stigma and the fear of isolation or detention. On the other hand is the right of the community to be protected against dangerous infectious diseases. It is the difficult task of the legal system to provide this balance.

"It has been argued that adopting criminal sanctions, to control the spread of HIV/AIDS encourages shame and secrecy"

The question of whether the use of criminal sanctions to deter the spread of HIV (and indeed other infectious diseases) is necessary or acceptable is a controversial one. It has been argued that adopting criminal sanctions, as opposed to using public health legislation, to control the spread of the disease encourages shame and secrecy, subsequently leading to increased rather than decreased incidences of transmission. However, it has also been argued that public health legislation, while adequate in the majority of situations, is not sufficient to control a tiny minority. It is that tiny minority, it is argued, that necessitates the existence of criminal sanctions.

Criminal law in Victoria is a mixture of *common law* (law which is developed over time by the court system) and *statute* (law which is created by parliament). In Victoria statutory criminal offences are created in the *Crimes Act*.

In order to sustain charges under the criminal law, proof of a "mental element" is usually required; that is, there is usually a requirement of proof of some deliberate intention or omission. A person who causes or attempts to cause another to become infected with HIV/AIDS may face charges of murder, attempted murder, manslaughter (unlawful killing which is not murder) and assault.

Murder

In Victoria murder is still a common law offence involving three elements: there must be a death, the death must have been caused by the accused, and the accused must have either intended death to occur, or have been reckless as to its occurrence. "Reckless" is interpreted as meaning that the accused must have realised that death would be *probable* or *appreciable*: the *possibility* that death may occur is not enough. (Originally a fourth element was also necessary; that death occur within a year and a day of the action. This rule was abrogated by statute in Victoria in 1991.)

"To charge someone with murder it must be proved they deliberately intended that the other party become infected with HIV and consequently die"

Although it is theoretically possible to charge someone with murder in a case of HIV/AIDS transmission, it is highly unlikely for several reasons: the victim of transmission must have already died from HIV/AIDS related causes, it must be proved that the HIV/AIDS infection was definitely due to the actions of the accused and, most difficult of all, it must be proved beyond all reasonable doubt that the accused deliberately intended that the other party both become infected with HIV and consequently die.

Attempted murder is also a common law offence. Unlike murder the attempt does not result in death but otherwise the elements of causation and intention are the same: an intent to kill is an essential component. Although charges of attempted murder have been laid in Australia in cases of HIV transmission, no case has been followed through: charges have been dropped either for lack of evidence or because they have been replaced by charges of lesser gravity.

Manslaughter

Manslaughter, divided into the categories of voluntary and involuntary, is any unlawful killing which is not murder. Voluntary manslaughter, which is the use of excessive force in self defence or prevention of a crime, is not relevant to HIV transmission. However, there are categories of involuntary manslaughter which may apply to a person who kills by transmitting HIV to another: manslaughter by a negligent act and manslaughter by omission. Transmitting HIV in the course of sexual assault, or failing to take necessary measures to *prevent* transmission in the course of sexual contact, could both come under the category of involuntary manslaughter. It is important to remember though, that the victim must have *died* from HIV-related causes before any charges can be laid.

Statutory Offences

In 1992 the Intergovernmental Committee on AIDS suggested that it would be unwise to create *specific*

criminal offences for situations of transmission, maintaining that existing criminal penalties and public health legislation are sufficient to deal with the most recalcitrant behaviour and that specific legislation would fuel hysteria. However, in 1993 the Victorian Government amended the *Crimes Act* to create S.19A, a specific offence of "intentionally causing another person to be infected with a very serious disease". "Very serious disease" is defined as HIV. The offence carries a maximum penalty of 25 years imprisonment. This section was enacted to cover "Needle Bandit" cases where assaults are committed with blood-filled syringes. Although S.19A could theoretically be used in cases of sexual transmission, it should be noted that two factors reduce this likelihood; the difficulty of *proving* an *intention* to infect another person and the fact that the other person must have actually *contracted* HIV, not just have been at a risk of catching it. This is contrasted with the NSW legislation which stipulates "...maliciously causing or *attempting to cause* another to contract a grievous bodily disease." To date there have been no situations where S.19A has been used.

While S.19A is the only section in the *Crimes Act* that is specifically aimed at HIV transmission, there are other statutory offences that could theoretically be used in HIV situations. Most of these are based on the old common law offences of assault and in the *Crimes Act* are grouped under the heading "Offences Against the Person" The offences are "injury" and "serious injury". "Injury" is defined to include unconsciousness, hysteria, pain and any substantial impairment of bodily function, while "serious injury" includes a combination of injuries. An offence is committed if someone intentionally, recklessly or negligently causes either injury or serious injury to another. (Sections 16-18 and section 24 of the *Crimes Act*). It could be argued that HIV-infection is an "injury", or even a "serious injury", as full-blown AIDS can eventually lead to substantial impairment of bodily function, pain and unconsciousness. But could it be argued that an otherwise perfectly healthy HIV-positive person is "injured"? And if it could be successfully argued, how could it be proved that the transmission of the virus was intentional, or even reckless, given the virus' low infectivity rate? (For details of the infectivity rates of HIV see the article *HIV Infection: Risky Business* in the Autumn edition of the *Bulletin*)

Similarly, section 31 of the Crimes Act creates an offence of assaulting or threatening to assault someone "with intent to commit an indictable offence". As discussed above, intentionally infecting someone with HIV is an indictable offence, so it would also be an offence to assault someone with the intention of infecting them. However, it is unlikely that this offence could be used in the situation of sexual transmission of HIV, except perhaps in the case of sexual assault.

Reckless Conduct

The problem of charging someone with an offence, given the relatively low infectivity rate of HIV, has been discussed recently in two HIV-transmission cases in the Victorian Supreme Court. In these two cases, the facts of which are discussed below, charges were laid under sections 22 and 23 of the *Crimes Act*. Unlike the other "Offences Against the Person" in which injury must be shown in order to sustain a charge, sections 22 and 23 makes it an offence to "recklessly engage in conduct" that "may place another in danger of death or serious injury". In other words the offence is the *risk*

"Under Sections 22 and 23 the offence is the risk of injury, not the injury itself"

of injury, not the injury itself.
In the first case a prisoner, A, told a fellow prisoner, B, that he was not HIV positive. B consequently agreed to having unprotected anal sex with A. It was later revealed to B that A *was* in fact HIV positive. Although B later tested negative for the disease, A was charged. In the second case an HIV-positive man, A, had consensual sex with two women (B and C) on four separate occasions. B and C alleged that on previous occasions A had used condoms but that on these four occasions he did not. Nor did A tell them that he had recently tested positive for HIV.

In both these cases the charges were dismissed on the grounds of medical evidence showing that HIV is not a highly infectious disease. In the first case it was held that because medical evidence showed that there was only a 1 in 200 chance of B contracting HIV from A, the risk was not great enough to sustain a charge. As the presiding judge said:

....what is required is that there was an appreciable danger of death...it seems to me that it cannot cover the situation where there is only a remote possibility...

In the second case medical evidence was again used to show that on each separate occasion of intercourse the risk of HIV-transmission was not high enough: the risk of infection had to be "appreciable" rather than merely "possible". In this case the presiding judge criticised it as being "a difficult if not an impossible con-

"There is no offence committed when someone is merely placed at risk of contracting HIV"

cept to apply".
The problem that these two situations reveals is that there is no law against deliberately placing someone at risk of infection. As discussed in the previous issue of the *Bulletin*, the *Health Act* makes it an offence to 'knowingly infect" someone. Similarly, the *Crimes Act* creates an offence of "intentionally causing" infection.

Consequently, there is no offence committed when someone is merely

placed at *risk* of contracting HIV. While it would be unfair (and unrealistic) to enact legislation proscribing any sexual activity by HIV-positive individuals, there does appear to be a gap in the law. As the presiding judge in the 1995 case said:

> I would nonetheless want to record that I am troubled having to make the ruling that I have made...There are issues apart from that as to the level of danger of death...This appears to be a special problem which might call for a special solution...This ruling may warrant consideration being given to enacting a provision whereby certain conduct is proscribed even though the possibility of death resulting from the conduct is relatively low.

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Anna Stokes

BOOK REVIEW

ELIZABETH HEPBURN,
Of Life and Death. An Australian guide to Catholic bioethics.
(North Blackburn: Harper Collins Publishers, 1996) ISBN 1 86371 602 5. Pp. 234. Rrp. $22.95

Dr Elizabeth Hepburn is the Director of the Provincial Bioethics Centre, Brisbane. In the preface she makes it clear the book's readers need no special theological or philosophical background because it is not meant to be a comprehensive or scholarly work. All the same it is a book of substance and a valuable manual and resource book for teachers and nurse educators who would like to know the basic teaching of the Catholic Church in a reader friendly form on controversial topics related to life and death issues. The bulk of the book represents a development from lecture notes on ten biomedical topics given to student nurses.

Part One of the book begins with a brief and clear account of the main moral principles used for decision making in biomedical ethics -- justice, autonomy, beneficence and non-maleficence. She gives a balanced critique of ethical theories that rely too heavily on the proportion of benefits over harm or on inflexible moral rules. She accepts the valid contributions of feminist philosophers but the framework of her own moral thinking is provided by the principles of Catholic moral theology. These give importance to divinely established ends or purposes established in human nature which can be discovered by reason and be found in the scriptures or in Catholic tradition and/or teaching. The main concepts and principles from the tradition are explained -- the divine gift of life, the importance of the human body in relation to the dignity of the human person, personal autonomy. She also discusses the meaning and application of the distinction between proportionate and disproportionate means of treatment in biomedical ethical decision making. The meaning of human sexuality in the Christian tradition is well explained before discussing human infertility and its causes. She points out how the principles of social ethics and solidarity need to be employed in medical ethics to counter our cultural bias in favour of individualism.

Part Two of the book covers the ten topics -- euthanasia, organ transplantation, human experimentation and research, the manipulation of genes, assisted reproductive technologies, surrogacy, contraception, abortion, HIV/AIDS and resource allocation. For each of these chapters the relevant scientific, medical and historical information are given from Australian and overseas perspectives before a clear moral evaluation is made in the light of Church teaching. Important features of the book are a glossary of scientific and technical terms and interesting timelines for just about all the topics discussed in Part Two.

I am pleased to be able to heartily recommend this book not only to the author's intended readership -- teachers and nurse educators -- but also for interested lay readers. Lest there be any misunderstanding, I would like to say this reviewer **does** believe human life should be respected from conception. ✣

Medical Abortion: In Search of the Easy Way

Abortion is immoral but this article does not attempt to discuss its morality. It investigates the search for new methods of procuring an abortion and raises questions concerning what can be done.

In May of this year, the Federal Government passed an amendment to the Therapeutic Goods Act to restrict the importation and use of the controversial group of drugs known as *"abortifacients"*. The Amendment lists among its restricted goods, all abortion drugs, with exceptions to the restrictions being granted solely by the Federal Health Minister. The ban includes restricted access to Mifepristone, better known as RU486. The taking of RU486 and abortifacients in general, including Methotrexate, which will be discussed later, can cause what is known as "medical abortion". This differs from the current practice of "surgical abortion" which involves either suction curettage or vacuum aspiration.

RU486 is used extensively in Europe and China for pregnancy termination, but so far has been restricted for use within the United States and now Australia. In an attempt to find a way of procuring medical abortion, United States researchers have turned to already available drugs such as Methotrexate. Methotrexate was originally developed for use in chemotherapy and has subsequently been used in ectopic pregnancies. Ectopic pregnancies occur when the embryo implants in one of the fallopian tubes rather than in the uterus. These pregnancies cannot continue normally and pose grave risks to the woman's health. Now investigation of Methotrexate's potential as an abortifacient has begun.

The Abortifacient RU486

RU486 in scientific literature is often referred to as a "contragestive" rather than as an abortifacient. The term contragestive is an attempt to suggest that the action of RU486 is contrary to the gestation of the foetus, rather than what it is, an abortion inducing drug. RU486 operates as a "progesterone antagonist". That is, it prevents reception by the uterus of the hormone progesterone which is essential to pregnancy because it sustains implantation of the embryo by maintaining the lining of the uterus. After administration of RU486, progesterone reception is blocked and the lining of the uterus is shed, taking with it the embryo or foetus if pregnancy has occurred. RU486 alone induces abortion of early pregnancies (first trimester) in up to 85% of cases, and when used in conjunction with Misoprostol, a synthetic prostaglandin (prostaglandins stimulate contractions of the uterine muscles), procures abortion in 97-100% of cases, without resort to surgical intervention. The same success rate can be achieved **up to the second trimester and perhaps beyond** following the same procedure.

RU486 induces abortion by initiating a process similar to a natural miscarriage, but it can also interfere with placental hormone secretion without inducing an abortion. This indicates that **damage to the foetus can occur**.

The side effects of RU486 when used in terminating early pregnancies include heavy bleeding (the abortion itself), vomiting, nausea and abdominal cramps. Second trimester abortions using RU486 generate similar, but more severe, side effects as well as introducing life threatening complications, including uterine rupture, myocardial infarction (heart attack) and cardiac arrest. The long term effects of RU486 are only just coming to light. There may be lasting effects on the tissue of the uterus and the effects of multiple doses at the level necessary to initiate abortion are as yet unknown. RU486 remains a relatively new drug and its real effects are still being uncovered.

"RU486's real effects are still being uncovered"

The action of RU486, in shedding the lining of the uterus, means that it can also be used as an extremely early abortifacient. When administered alone, within 72 hours of unprotected sex, RU486 is more effective than two alternative methods of preventing embryo implantation, either the Yuzpe regimen or Danazol. RU486 is used in this instance before pregnancy has been determined, so its effectiveness is judged according to how many pregnancies continue after its administration. If a pregnancy were to continue after the administration of RU486 in those first few days following conception, and if the woman were to decide that she did not want an abortion once the pregnancy had been established, there is no knowing what damage may be done to the foetus. If RU486 fails to prevent the pregnancy from continuing, the potential harm it causes remains undetermined.

Methotrexate as an abortifacient

Methotrexate is being hailed as the "new abortion pill". Research on its possible impact on terminating pregnancies began in the United States when the introduction of RU486 was stalled. Methotrexate destroys trophoblastic tissue. Trophoblastic tissue attaches the embryo to the uterine wall and supplies it with nutrients. It is this tissue which Methotrexate attacks. The obvious consequence of this is damage, destruc-

tion or death of the embryo or foetus. Recent studies show that when used early in pregnancy (up to 63 days gestation) Methotrexate injected intramuscularly in conjunction with subsequent administration of Misoprostol (or other synthetic prostaglandins) procures abortion in 96% of cases.

"Risk to the foetus is completely unknown"

Examination of the aborted foetuses has shown **degeneration and destruction of the foetus** as a result of Methotrexate. These pregnancies may have terminated spontaneously without the need for Misoprostol but it does raise serious concerns. In cases where after administration of Methotrexate a person fails to continue or complete the abortion process, and the pregnancy continues the risk to the foetus of potential damage or malformation is completely unknown. Side effects associated with the use of Methotrexate include nausea, cramps and diarrhoea. The same dose of Methotrexate used to initiate abortions is used in ectopic pregnancies and so far there appears to be no long term side effects to fertility.

Other uses of RU486 and Methotrexate

Recently it has been suggested that RU486 has been active against conditions as diverse as breast cancer, meningioma (a tumour of the membranes surrounding the brain), endometriosis (tissue resembling uterine tissue located throughout the pelvic cavity rather than just within the uterus) and others. Endometriosis affects as many as 1 in 15 women and its symptoms include severe pelvic pain and uterine cramping. RU486 not only diminishes these symptoms but also results in a regression of the disease itself. The benefits of RU486 to endometriosis sufferers are achieved in the absence of any significant side effects.

Not designed specifically as an abortifacient Methotrexate has long been considered a very safe and useful drug. It is one of the oldest chemotherapy drugs useful in treating cancerous tumours of the breast, head and neck as well as oestrogenic sarcomas (malignant bone tumour). Methotrexate in lower doses is active against nonmalignant conditions including psoriasis (skin disorder) and rheumatoid arthritis. It has been used successfully and is widely accepted as a treatment for unruptured ectopic pregnancies. It is these positive effects of Methotrexate which have resulted in it becoming a readily available drug both here and in the United States.

Medical Abortion

In France, where RU486 was developed, about half of women seeking abortions prefer medical abortions. Medical abortions can be performed sooner than surgical abortions, therefore preventing the wait. It means that women can make rash decisions, decisions that if forced to wait and contemplate they may not have made. In the case of RU486 it is not even necessary to determine whether or not the pregnancy exists, if used within 72 hours of unprotected sex. This could prevent or diminish feelings of guilt in the woman over the death of her foetus. Unsure of whether or not the pregnancy ever existed she cannot experience the same emotions or guilt as one who definitely knows they have taken the life of the foetus.

These abortifacients mentioned do have side effects, but in practice women are sent home once treatment has been administered to deal with the abortion at home and alone. Complications can develop and may go unchecked. The process itself is drawn out, in the case of Methotrexate there is 5 to 7 days between administration of the Methotrexate and subsequent treatment with Misoprostol. This increases the chance of someone failing to attend the second treatment, after perhaps rethinking their decision, and continuing the pregnancy, perhaps delivering children with malformations.

Considerations

Drugs that can act as abortifacients can also be effective in treating a multiplicity of medical disorders. It is then difficult to say a total ban of such drugs for all cases would be beneficial. The current restrictions placed on abortion drugs do leave open their possible therapeutic use. Exceptions to the restrictions can be made by the Federal Health Minister. If it could be demonstrated that someone's use of RU486 would treat their endometriosis, then an exception could be authorised. These are certainly tight regulations, but when a drug is capable of inducing abortions and its long term effects are unknown such a policy is necessary. Methotrexate, which is already available, will need to be considered soon in a similar light as research continues. Is it possible to monitor the use and misuse of drugs? It would be difficult to restrict Methotrexate to the extent that other abortifacients have been restricted but the matter certainly demands attention.

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Moral Reflections on Abortion

Media reports have raised the possibility of using pills to prevent human embryos implanting in the womb. This article discuss the morality of medical abortion at this early stage.

Absolute Respect Due to Human Life

God's creative act, together with the co-operation of parents, is a unique gift that constitutes every human being in existence. We are morally bound to respond to this truth by promoting the well-being of our youngest neighbours in their mothers' wombs in a morally responsible way. They are innocent and completely defenceless, but their right to life remains inviolable. They have their own inherent personal worth and dignity, irrespective of the choice of their parents to accept them. The inviolability of the lives of the unborn and newly born are morally the same: they may not be used as mere means for the benefit or convenience of others. The Second Vatican Council was quite forthright in upholding the Christian tradition on this inviolable principle: '**Life must be safeguarded with extreme care from conception; abortion and infanticide are abominable crimes**.' (*Church in the Modern World*, n.51).

For most women the prospect of giving birth to a baby is a joyous occasion. It is regrettable that some women, at times due to tragic circumstances, find themselves in the sad and harrowing situation of unwanted pregnancies. Every effort should be made to help them through the difficult months of their pregnancies so that they may give birth to babies who will be loved and cared for by their own or adoptive parents.

Direct Intentional Abortion

People who respect the truth and beauty of the Creator's gift of the life of a human being should not formally approve or closely cooperate in direct abortion. One may always alleviate suffering, but not by **direct intentional** abortion i. e. an action which of itself and by intention terminates the life of the unborn child by surgical or pharmacological assault or by removal of a non-viable fetus from the womb.

It would be misguided compassion to suggest abortion to such women as a way out of their predicament. One's right over one's body does not justify the deliberate termination of the life of another innocent human being, namely that of the unborn child.

Pro-abortion attitudes tends to undermine the right to life of all beginning from defective infants to the chronically sick and aged. Humanity risks losing its moorings altogether if a pregnancy is able to be deemed a simple mistake to be erased at will.

Indirect Therapeutic Abortion

What I have said so far does not conflict with the proper application of the principle of double effect to allow for what is technically called the **indirect** or **unintentional willing of the cause of** the death of the fetus. For really proportionate reasons a person may posit a morally good or even indifferent action in order to bring about a good effect even though one foresees that as an incidental, but nevertheless unintended con-sequence, an innocent human life may be lost. This could occur in the case of **indirect therapeutic abortion** where the life of the mother was at risk.

On account of the proper use of the principle of double effect, the moral law does not forbid the performing of those medically indicated procedures that are judged necessary to save the life of the mother or safeguard her health from a serious pathological condition, provided there is no direct or intentional assault on the life of the fetus. The death of the fetus may be foreseen as a consequence of the intervention, but it should not be intended. This is often referred to as an indirect therapeutic abortion.

There is an enormous moral difference between **direct**, **intentional** and **unintentional or indirect** causing of death. This difference allows the action in the one case but not in the other. Thanks to medical advances, the life of the mother can be saved without any need of recourse to intentional termination of the life of the fetus.

Chemical or Medical Abortion

There are some pills which can prevent pregnancy by inhibiting the implantation of the early human embryo in the womb. The taking of these pills for this purpose is morally equivalent to direct abortion in the sense they abort human life at its outset by preventing the implantation of the embryo. These pills are said to be abortifacient. Examples of early abortifacient pills are the so called 'morning after pill' and the French pill RU486. ✣

Norman Ford SDB

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