

Chisholm Health Ethics Bulletin

Vol 4 No 1

SPRING

1998

Drugs and a Harm Minimisation Approach

No one could honestly deny that there is a drug problem. How to approach the problem remains a contentious issue. The zero-tolerance approach has at best limited success so perhaps the harm minimisation approach has something to offer.

Is Harm Minimisation With Drug Use the Only Way to Go?

Drug use is becoming an increasing problem within the community. Like other social ills, such as youth suicide, it does not discriminate on whom it affects. Drug use affects the user, their family and friends, and often the wider community. The community is affected in many ways such as being the victim of theft and burglary and sometimes violence. Ideally, all drug strategies should aim to eliminate drug use. However, education and prevention programs have not solved the drug problem, which is both enormous and complex. In this article I would like to consider why the harm minimisation approach was established and briefly examine some strategies aimed at drug use. For the purposes of this article the term drug use will refer to the intake of 'hard' drugs such as heroin and cocaine. The restriction of the discussion to hard drugs does not deny there are some problems associated with 'softer' drugs. I want to avoid the debate over the harm and complications caused by softer drugs such as cannabis.

"Mercy Hospice. Community based palliative care."

Social and Medical Approaches to Drug Addiction

Before examining some of the harm minimisation strategies implemented in Victoria I will consider two different perspectives on drug addiction; the social and medical perspectives and the drug policies that such perspectives generate. Drug use, at least since early this century, has been seen as a moral threat to society.¹ This idea has formed the basis of the social perspective on drug use. Drug users, traffickers and manufacturers are all seen as the enemy within the community. This outlook towards drugs, which views drug use as a social problem, has gen-

FEATURING

<i>Drugs and a Harm Minimisation Approach</i>	<i>1</i>
<i>From the Director</i>	<i>4</i>
<i>Culture and Ethics</i>	<i>4</i>
<i>Review Article. Law and Medical Practices: Rights, Duties, Claims and Defences</i>	<i>7</i>
<i>Material Cooperation in Abortion</i>	<i>10</i>

erated policies aimed at prohibition, repression and criminalization. On the other hand, the medical approach towards drug addiction focuses not on drug use as a moral vice but on drug use as a disease. Terms like 'the drug epidemic' assume that drug use is a disease which spreads throughout 'at risk' populations. Drug use viewed under this approach is not so much an action of choice, it is rather a disease state which implies the drug addict requires treatment not punishment.

Repressive Policies – Have They Been Effective?

Repressive policies aim to control the drug problem, viewed primarily as a social problem, rather than treat it, viewed as a health problem. Repressive policies often lead to attempts to limit the supply of drugs to the community. The effectiveness of these types of policies has been frequently questioned. In spite of their well intentioned efforts, police crackdowns on the availability of drugs to users have sometimes succeeded in limiting the supply of drugs, only to force an increase in the price of those drugs. This in turn can lead to increased drug related crime because drug users need extra money to feed their habit. Repressive policies have also seen drug-dependent people spend time in prison for drug related offences. This has resulted in the further marginalisation of this segment of the population. Nevertheless the social perspective on drug addiction and associated repressive policies on drugs remain an important part of controlling the drug problem but the medical approach to drug use is also essential.

Harm to the Individual

The failure of repressive policies to eliminate drugs from the community leaves only limited options open. One of those options consists of policies which attempt to limit the social and physical harm caused by drugs and drug related behaviours.

What harms are caused by illicit drug use? Firstly, I will concentrate on the harms facing the drug taking population themselves and then consider the harm that drug use can cause the community. The list of harms and their relationship with drug taking is complex. Some harms connected with drug use are controversial because it is not clear whether they are a result of drug taking or have actually led to the drug taking. For example, unemployment is frequently linked closely with the use of illicit drugs. Is this because entering the drug-taking subculture restricts an individual's ability to remain employed, or, because the depression associated with unemployment leads people to seek an escape in the form of drugs? Other social harms include decreased socialisation and involvement with crime and

an extension of harm minimisation is required

violence.

The taking of illicit drugs also involves the risk of physical harm. The risk of a drug overdose is an increasing problem especially with heroin, because often the purity is not known to the user. In Victoria, in 1997, there were 245 deaths from drug overdoses but in 1998, up to July there had already been 170 deaths.² Paul McDonald, director of the Youth Substance Abuse Service in Melbourne, claims that certain trends need to be reversed. These trends include the increased availability of heroin on the streets, its low price and consistently high grade, younger people experimenting with heroin and a six-fold increase in drug related deaths. This change, McDonald argues, cannot be achieved with the "naive" zero-tolerance approach generated by repressive policies. What is required is an extension of harm minimisation to halt the increasing death toll.³

Intravenous drug use also entails the risk of contracting blood borne viruses. These viruses include HIV and hepatitis. While HIV receives a

great deal of media attention it is important to remember that hepatitis is easier to contract than HIV and can have diabolical consequences. It is currently estimated that 50-70 per cent of injecting drug users are infected with the hepatitis C virus. Hepatitis C attacks the liver and 20 per cent of Hepatitis C carriers progress to cirrhosis within 20 years which can result in death.⁴

Drug users, but heroin users in particular, are also at risk of harm because the drugs they use are not pure. Pure heroin causes very little damage to body tissue and other organs. As I mentioned earlier, the risk of an overdose is tightly connected with the purity of a drug, that is how much actual heroin is in a purchase of street heroin. The added problem of diluting heroin with other substances is the toxic effect injecting those other substances can have. Heroin is often mixed with substances such as talcum powder, baking powder, starch or glucose. They can cause collapsed veins, tetanus and damage to the heart, lungs, liver and brain.⁵

Harms to the Community

Risks of harms to the community from drug use include: risk of needle stick injuries in places such as public toilets or the beach, increased rates of theft and burglary and increased violence. It should also be remembered that while drug taking is illegal, the more prevalent the practice becomes, the more likely vulnerable young people are to experiment with drugs, and possibly be caught up in long term drug use. The community is also affected through the many families who struggle to deal with a drug-using family member. It is not an easy issue to deal with and requires long term professional assistance. Having a child, parent or partner who is addicted to drugs impacts on how an individual can function within society, their work place and their home.

Harm Minimisation Strategies

Strategies of harm minimisation differ in the degree to which they attempt to control or change drug taking behaviour. Examples of harm minimisation strategies aimed not only at preventing harm to drug users, but also the general community include safe and secure syringe deposit units. These units are often found in public toilets and night clubs where addicts might inject. Another harm reduction measure is ultra-violet lighting in public and restaurant toilet facilities which aims to prevent intra-venous drug users injecting in these places because the lights make it difficult to see veins.

strategies of harm minimisation attempt to control or change drug taking behaviour

The Needle Syringe Exchange Program is a good example of a harm minimisation initiative aimed at reducing harm to users. The program commenced in Victoria in 1987 and expanded rapidly. The program involves providing drug users with free sterile equipment to inject with and education on how to further reduce the spread of blood borne viruses. The program's effectiveness is demonstrated in the decreasing rate of heterosexual intravenous drug users with HIV, from 4.3 per cent in 1993 to 2.8 percent in 1994.⁶

Methadone maintenance programs aim to reduce the harms associated with heroin dependence by prescribing and dispensing methadone, which acts by reducing the desire to use other opiates. Methadone is an addictive opiate which can be taken orally once a day. It lasts longer than other opiates, such as heroin, which addicts inject 3-4 times daily. Methadone can only be prescribed to opiate dependent patients by medical practitioners who are approved prescribers and only after a permit had been obtained for each patient from the Victorian Department of Health and Community Services. Metha-

done maintenance is a well structured program and is effective in reducing several risks associated with intravenous drug use, specifically because it eliminates the need for injecting heroin and is reasonably successful in retaining people in treatment. Risks reduced include risks to personal health, criminal activity and isolation.

Future Strategies

Current research into further harm minimisation strategies has received funding as part of the Victorian Government's *Turning the Tide* campaign. One major project being conducted by Turning Point, a centre involved with clinical drug services as well as research and training, is comparing different therapies for opiate dependency. The project is designed to compare four alternative drug therapies in order to determine which treatment is most effective, for whom it is effective and the relative cost of each treatment. The four drug therapies, to be compared with methadone maintenance are, Levo-Alpha-Acetylmethadol (LAAM), buprenorphine, Naltrexone and Slow Release Oral Morphine (SROM). The study will investigate the safety and side effects of the treatments, as well as analyse their effectiveness in breaking heroin dependence. As methadone is not a suitable treatment for all addicts the hope is that the four other treatments, once proved effective and approved by the Therapeutic Drugs Administration, would be made available through programs similar to methadone. This would allow addicts a better chance at freeing themselves of their dependence.

There are other possible harm minimisation strategies not yet in place in Victoria. One such initiative is establishing safe injecting facilities – 'shooting galleries'. Another more controversial option is the safe prescription and supply of medical grade heroin to addicts. These two options take harm minimisation one step further than programs like methadone maintenance or even needle exchange. Both safe injecting

rooms and the supply of heroin seem to suggest approval, at least acceptance, of drug use. It is this aspect of condoning drug use which has led many people to argue that such programs are not suitable. It would be worthwhile however, to at least trial these initiatives to properly analyse their effectiveness and the impact they have on the drug problem.

Conclusion

The idea of harm minimisation as an approach to illicit drug use is not a new one. In 1926 a British Parliamentary inquiry, chaired by Lord Rolleston, found that drug addiction was a medical and not a legal condition. "The inquiry found that the provision of opiates to opiate-addicted people is well within the bounds of good medical practice."⁷ Concentrating on harm minimisation may at times appear like giving in to the reality of drug taking. It is not a surrender to the harm caused by illicit drugs, rather it is the most effective weapon we as a community currently possess to limit the harm that drugs cause.

ENDNOTES

1 Henke A.M.J. Ten Have, "Drug Addiction, Society and Health Care Ethics," *Principles of Health Care Ethics*, ed. Raanan Gillon, (Chichester: John Wiley & Sons Ltd 1994), 895-902.

2 "A fatal attraction for 170 young Victorians," Kamahl Cogdon, Herald Sun, 7 July 1998.

3 "The drug war's big losers are the young," Paul McDonald, The Age, 23 June 1998.

4 Northern Division of General Practice – Melbourne, *Division News* 5/4 (1998), 4.

5 Report of the Premier's Drug Advisory Council, "Drugs and our Community," March 1996, 148.

6 *Ibid.* 53.

7 "Small dose of humanity a big part of the cure for our drug ills," Nick Crofts, The Age, 22 June 1998. ❖

Tracey Phelan

From the Director

Observant readers will have noticed this issue bears the simpler version of the title of our journal – *Chisholm Health Ethics Bulletin*. Librarians will appreciate this.

As notified with the last issue of the **Bulletin** our Centre held its third conference on "Aboriginal Health: the Ethical Challenges" at St Vincent's Hospital on 6 August 1998. It was a full house. The Centre will soon publish the Conference Proceedings for \$20.00. Here I can only mention some of the highlights of some of the papers, not to mention the seven valuable workshops.

Sir Gustav Nossal AC, Deputy Chairman, Council for Aboriginal reconciliation, spoke passionately of the need of acknowledging the historical dispossession of Aboriginal peoples of their land and of regressing the social injustice in relation to their poor health status compared to mainstream Australians. He stressed the need of training larger numbers of aboriginal doctors, nurses, health workers and auxiliary health professionals at every level. Community control is imperative if the provision of health services to Aboriginal peoples is to be sensitive to their perceived needs and cultural differences. Reconciliation is integral to the solution of the many problems in the areas of health as well as education, housing and employment opportunities.

Mr Wayne Atkinson traced the history of the treatment and experience of Aboriginal peoples in Victoria. His excellent presentation showed that when this is understood it will be realised that Koori people are only seeking a 'fair go' for health services in their own land.

The Hon Dr Michael Wooldridge, Federal Minister for Health and Family Services, said it would take the better part of a generation to lift the life expectancy and reduce the level of illness among indigenous communities. He said "a 'fair go' means giving people what is their due and Aboriginal people are justly entitled to health care that addresses their needs." Similar sentiments were echoed by the Hon Rob Knowles, the Victorian Minister for Health and Human Services.

Dr Ian Anderson of Melbourne University's Centre for the Study of Health and Society, spoke of the need of resolving the ethical issues of: the development of models to improve resource allocation in Aboriginal health; the development of new health information systems to support such models and the reform of the system of service delivery. †

Norman Ford SDB

Culture and Ethics

This article will discuss the role of culture in ethics and moral responsibility.

Due to technological advancements and expanding communication capabilities, the world has become a smaller place. We have become more aware of other cultures and their practices. Scientific discoveries in the area of health and medicine have been so rapid (especially in this century) that there is much ongoing debate about their implications, and the challenges that they present to traditionally held cultural values and beliefs.¹ Black and white answers to ethical dilemmas are not self-evident, and there needs to be

to perpetuate other cultural practices which many outside the culture see as wrong

much reflection within an ever evolving context. More recent examples of the exponential progress

of science such as cloning, assisted reproduction, the use of animal organs for transplantation or the retrieval and use of tissue from the dead, are causing much controversy and the issues remain unresolved in the community at large. The implications of some medical and scientific practices become particularly pertinent in certain cultures when they are used to perpetuate other cultural practices which many outside the culture see as wrong. Some examples include the use of prenatal testing for sex selection so that the undesired 'wrong' sex can be aborted; the buying and selling of organs for transplantation; the use of organs from so called 'criminals' who have been executed; or the potential use of genetic information to discriminate against certain people in their employment or insurance

policies.

What is culture?

A culture may be defined as the "way of life of a given social group that is shaped by more or less intricate patterns of normative expectations about emotion, thought, and action."² These patterned expectations will typically take the form of social rules that give a characteristic shape to the practices of the group. Some kinds of social rules are more formal than others such as legal codes which typically regulate the more public life of the group.³ Culture in part arises from the fact that humans create symbols. They build and impose meaning on things around them and on the actions taken by them and they produce rituals. Culture is not static and changes

occur according to life experiences, social change and processes of acculturation. Culture can be construed to include differences in practices and behaviours by gender, race, ethnicity, religion, economic class, sexual identity, age and many other variables. Culture is also as much about what is shared as what is not. According to David Thomasma "culture provides a set of perspectives by which groups of people interpret their lives and what happens to them including sickness and death."⁴ Culture may be seen as a map for comprehending the world and it provides the unwritten rules for living. These unwritten rules include ethical guidelines and values so that culture and ethics are inextricably entwined.⁵ It has been argued that norms and principles in ethics should transcend specific cultural and ethical beliefs, but, as we become more cognisant of different cultures and the values that underpin cultural practices, we have come to realise that norms become specified within a context. Cultural beliefs are not necessarily right or wrong or

clashes within cultures just as there are clashes between cultures

good or bad; they are a fact of our multicultural world and relative to the context from which they originate.

The complex effect of overlapping cultural influences in any society, which may include such things as ethnicity, religious affiliation and education, makes it reasonable to think that ultimately each individual has their own subculture, or even their own culture or, alternatively, their own version of a given culture. You can't use a single homogenous stereotypical perspective of culture as there are clashes *within* cultures just as there are *between* cultures. There can be clashes between genders, classes, ethnic groups or religions. However, if you privilege culture as the only reason and explanation for certain practices then you are blind to the commonalities; to change; to multiple culture; to the

practical issues of everyday life; to global culture; and to the wider political and economic context. "... what is wrong with blaming culture is that such blame ignores the ways in which cultural conventions are modified, reshaped, and sometimes radically revised in individual action. No culture is perpetuated without some modification of cultural patterns in the lives of individual agents."⁶ In most societies each person occupies a variety of roles and may be a member of several different social or cultural groups. Every person therefore, is affected and shaped by a variety of cultural influences.

Health care itself (and this encompasses both biomedicine and ethnomedicine) may be seen as a culture, and those working within it have been socialised into the particular health care system's practices, customs and values. In the case of western biomedicine this means that those who work in the health care system are primarily middle class (and mainly white) and therefore the health care system and the dominant culture are interrelated and overlapping.⁷ Western biomedicine must be appreciated as much as a sociocultural enterprise, as it is a scientific one. It is a system made up of ideas, practices, roles and institutions which must be seen in its historical and cultural context. It could be argued that the practice of health care cannot be ethical unless cultural factors are taken into consideration.

Culture and Moral Responsibility

Much of our behaviour may only be understood, or made sense of, by reference to generally approved cultural practices. However, the following questions must be asked. Can culture operate as a mitigating circumstance with respect to individual responsibility? Are wrongs committed because they are socially and culturally accepted? Does this put individuals at moral risk when they had no intention of doing anything wrong? One often hears a person

trying to excuse wrongdoing – although this is often in reference to actions that are unlawful but are not generally seen as morally wrong – by referring to the normalcy and social legitimacy of their actions. This same excuse may be used for ongoing resistance to finding out whether there is anything wrong with what one is doing. According to Michele Moody-Adams "one of the most influential philosophical views about cultural impediments to responsibility involves the claim that sometimes one's upbringing in a culture simply renders one unable to know that certain actions are wrong."⁸ This then leads to a claim of diminished responsibility. But, is an agent's ignorance of what they ought to do, an excuse for wrongdoing? Do people experience a sort of 'cultural blindness' which renders them unable to question the morality of their culture's practices and therefore, they cannot be held responsible for their actions? Or, is it that they are *unwilling* to question the status quo –

simple refusal to consider whether some practice in which one participates might be wrong

that they have made a conscious decision not to? It cannot be ignored that it is *human beings* who perpetuate the culture.

Moody-Adams calls the choice *not to know* what one *can* and *should* know – 'affected ignorance' and although she sees it as a complex phenomenon, Moody-Adams also describes it as the simple refusal to consider whether some practice in which one participates might be wrong. She describes the following four types of affected ignorance. Firstly, there is the use of linguistic deceptions to mask the reality of what is really being done, whereby the connection between the wrongdoing and the suffering of the person on whom the wrongdoing is being done, can be denied. Moody-Adams uses the example of the torturers who use deceptively benign phrases to describe their horrific actions in order to deny the connection between their actions and the suffering of their victims. Secondly, there is

the situation when someone asks for something to be done but insists on knowing nothing about how it will be done, thereby not wanting to be responsible for any potential wrongdoing. Thirdly, there is the situation where no questions are asked about some state of affairs, despite the fact that some investigation is needed into the wrongdoing so that it can be stopped or prevented. An example of the second and third type of affected ignorance may be the organ transplant who performs the operation without knowing where the organs have come from when there is a possibility that they may have been bought or procured under dubious circumstances. Lastly, there is the tendency to avoid acknowledging our human fallibility; that as "finite and fallible beings, even our most deeply held convictions may be wrong."⁹

Ethnocentrism

Ethnocentrism may be described as a person's belief that their *own* cultural group's beliefs and values are the best, the most superior or even the *only* acceptable beliefs. It is an inability to understand the world view or to appreciate the beliefs of another culture.¹⁰ According to Eliason ethnocentrism may arise because of a lack of exposure or an ignorance about another culture. We are all exposed gradually over time to the beliefs, customs and values of our own culture in a process which may be known as socialisation. Socialisation may involve two components. There is the formally learned or cognitive component which is what you are told about the culture such as formal education, religious instruction or reading and then there is the experiential component which may involve being praised or rewarded for 'good' behaviour, being punished for misbehaviour or being silenced for expressing unacceptable views. The personal experience component of socialisation is much stronger, more emotionally charged and prevalent in the memory than the cognitive or theoretical compo-

nent. Eliason feels "that most people have internalised the values of their culture well, but cannot always articulate them readily, and if they examine the beliefs carefully, do not always agree with them. A first step in developing cultural sensitivity is to examine one's own culture carefully and become aware that alternative viewpoints are possible."¹¹

There are dangers inherent in being ethnocentric, in being unable to either hear or tolerate an alternative view. In caring for people in the health care system we must appreciate that biomedicine (that is based on a Western understanding of sci-

cultural meanings of illness which are imposed on the illness by the culture

ence and culture) does not have all the answers and that the ethical principles, which it gives priority to, are not necessarily the only ones worth entertaining.

There are cultural meanings of illness which are imposed on the illness by the culture and which shape the illness experience of the individual and, as such, carry significance for the sick person. The illness itself may have a cultural meaning such as heart disease, cancer or AIDS, or it may be the specific symptoms or the labels of the disease which hold the cultural meaning. The cultural meanings of certain illnesses can change over time, not least because of the ever increasing knowledge that is learned about the disease. Examples of diseases where the meanings have changed over time include AIDS and tuberculosis.

We must appreciate that cultures advance in their moral thinking when the individuals perpetuating that culture do so. Change can occur when individuals question the moral status of those practices which their culture accepts. Moral knowledge like other types of knowledge (such as scientific and medical knowledge) may only be known at certain stages in our historical development, and not

everyone becomes aware of new advances and insights at the same time. The development of moral knowl-

informed consent is not a fully recognised concept in some cultures

edge, like knowledge in other areas, is a process that builds upon and revises what is already known.

When looking at such ethical principles as beneficence and autonomy, and trying to decide which of the two should be given priority, the cultural context is crucial. In some cultures, doctors and health professionals simply do the best they can for the patient, and the patient doesn't have to make many decisions about their health care. Informed consent is not a fully recognised concept in some cultures. It is not that health care professionals are intentionally trying to limit autonomy, but that they do not think that the patient will benefit from full information and choice. At a time of great vulnerability, when patients are sick, anxious and often in pain, health professionals want most to care for their patients. In some cultures this may be by taking away the burden of decision making. In situations of terminal illness, patients in some cultures are not informed of a terminal diagnosis and prognosis (as discussed in a previous edition of this Bulletin¹²). Although non-disclosure of such information is predominantly seen as unsatisfactory within the health care systems of countries such as Australia, England and the United States, we must remember that even in these cultures the telling of the whole truth to patients has only been a supported practice in the last twenty years.¹³

Conclusion

In areas of health and ethics there needs to be a cooperative multicultural discussion so that underlying human universal experiences such as illness, incapacitation, suffering and the process of dying can be explored together to improve those experiences for all.¹⁴ To give fair hearing

to the views of those from other cultures one has to learn to temporarily suspend one's own deeply held values and listen to those of others. One has to appreciate the context from which these values and views have arisen rather than judging them on face value. "A willingness to engage in cross-cultural moral debate makes us better able to lead the examined life that makes possible a reflective and critical commitment to our own culture."¹⁵ It must also be remembered that not every aspect of human behaviour can be explained by reference to culture. There are some individuals in almost every culture or society who do not conform to normative expectations about emotion, thought and action and it may be the case that, in areas of serious aberrations of practice,

these people find themselves in breach of the law.

Those who work in the area of ethics need to have a better understanding of the different cultural traditions which can often structure conflicts over the morality of particular practices and policies. "They should be more attentive to differences linked to ethnicity, culture, religion, gender, and socioeconomic class, because these differences can play profound roles both within clinical settings and within public-policy making arenas."¹⁶

ENDNOTES

- 1 David Thomasma, "Bioethics and International Human Rights," *Journal of Law, Medicine & Ethics* 25 (1997), 295.
- 2 Michele M. Moody-Adams, "Culture, Responsibility, and Affected Ignorance,"

- Ethics* 104, (January 1994), 295.
- 3 Moody-Adams, "Culture" 295.
- 4 Thomasma, "Bioethics" 301.
- 5 Michele J. Eliason, "Ethics and Transcultural Nursing Care," *Nursing Outlook*, (September/October 1993), 225.
- 6 Moody-Adams, "Culture" 306.
- 7 Eliason, "Ethics" 226.
- 8 Moody-Adams, "Culture" 293.
- 9 Moody-Adams, "Culture" 301.
- 10 Eliason, "Ethics" 226.
- 11 Eliason, "Ethics" 226.
- 12 *Caroline Chisholm Centre for Health Ethics Bulletin* Summer 1997, 3/2.
- 13 Catherine Berglund, "Bioethics: A balancing of concerns in context," *Australian Health Review* 20/1 (1997), 48.
- 14 Thomasma, "Bioethics" 300.
- 15 Moody-Adams, "Culture" 309.
- 16 Leigh Turner, "An anthropological exploration of contemporary bioethics: the varieties of common sense," *Journal of Medical Ethics* 24, (1998), 128.✦

Deirdre Fetherstonhaugh

Review Article: *Law and Medical Practice: Rights, Duties, Claims and Defences* by Loane Skene.

Sydney: Butterworths, 1998. 299 pp. R.R.P. \$54.00.

The following article gives a brief review of the latest book by Loane Skene, Associate Professor in Law at the University of Melbourne. Containing an analysis of current law compared with its actual practice, the book will be a valuable resource for both medical and legal practitioners.

Introduction

Law and Medical Practice: Rights, Duties, Claims and Defences, the latest book by Loane Skene, is a welcome addition to the previously small number of text books on medical law in Australia. It is one of several books published in the last twelve months that fill a formerly noticeable gap in this area.

An Associate Professor in Law at the University of Melbourne, Skene has a long history in health law and is currently Director of Studies in Health and Medical Law. Her new book analyses the law in Australia up to February 1998.

Recognising that one text book cannot possibly cover all issues in the fields of health and medical law Skene, in her Preface, says that this book has a somewhat narrower focus. It concentrates on "the civil

and criminal law concerning doctors in their day-to-day practice" (Skene xi). In particular, as the author explains in her introduction, the book explains the "various categories of law that may be relevant to the relationship between doctor and patient and examines the circumstances in which doctors may be subjected to civil or criminal proceedings" (Skene 2).

As such, she divides her analyses of the legal issues into:

- The context: recent changes in society, medicine and law
- The legal duties of doctors
- Consent to medical procedures
- Consent to medical procedures for children
- Consent for adult patients who are not mentally competent to consent
- Doctor's duty to provide information
- Injuries caused by medical treat-

ment

- Access to medical records
- Confidentiality
- Withdrawal of treatment, and euthanasia: adult patients
- Withdrawal of treatment: infants and children
- Abortion

Black Letter Law Compared with its Operation in Practice

The author stresses that what particularly interests her in these issues is not so much the substance of the law as its operation in practice: she compares black letter law with actual scenarios. In her introduction she states that "when doctors' legal duties are analysed ... it appears that some of them are not enforceable ... or, if they are enforceable, they are unlikely to be "enforced" for practical reasons" (Skene 6). She concludes that "legal rules may seem

little more than a recommended course of conduct and breaches may, at most, be the subject only of administrative complaint procedures, disciplinary action by a registration body or adverse reports in the media” (Skene 6). She hastens to add, however, that this does not mean that doctors may ignore the law, even if for no other reason than that the outcome of legal proceedings is never certain and the fact that legal proceedings can attract adverse publicity, regardless of outcome (Skene 6).

The So-called “Medical Malpractice Explosion”

In Chapter One Skene analyses why there has been a perceived “explosion” of litigation in the area of medical practice and attributes it to the following: rapid scientific development promoting debate about medical ethics; changes in the way medicine is practised; and changes in society, “especially the greater recognition of people’s autonomy, their right to make their own decisions and their right to be given information that affects them” (Skene 11). In this I would agree. Gone are the days when people took what doctors said at face value. Society now believes that patients have a right to ask questions and to make their own informed decisions. Skene then goes on to assess the so-called “Medical Malpractice Explosion” and concludes that, particularly because of the “great difficulties plaintiffs face in proving their case to a court”, litigation is actually relatively infrequent (Skene 18).

This becomes the central premise of the book, which examines the types of legal action to which doctors may be subject and, more importantly, the likelihood of success. In particular, the relatively infrequent success “raises questions about the practical impact of all the new laws” (Skene 23).

It is this aspect of the book that makes it of specific interest to both legal practitioners working in the field of medical law, and to medical

personnel.

The Legal Duties of Doctors

Chapter Two gives a critical assessment of the legal duties of doctors, drawing a contrast between civil offences, which are committed against an individual, and criminal offences, “which are regarded as so serious that they are an offence against the whole community” (Skene 28). Interestingly, this chapter also includes an analysis of the ethical duties of doctors. Skene’s rationale for this is sound: while not strictly enforceable, she says, “ethical obligations may have legal effect, either as an indication of accepted practice within the profession ... or what is ‘unprofessional conduct’ ... ” (Skene 31).

“it is essential to distinguish ... between ‘rights’ that are assumed or claimed and those that can actually be enforced”

This chapter is extremely well set out and provides a clear exposition of the different types of laws to which doctors may be subjected. These range from civil laws, such as duty to obtain consent; provide information and take reasonable care; statutory obligations imposed by Acts of Parliament; criminal laws; disciplinary laws such as professional misconduct; and public laws such as “reportable deaths”.

The analysis of whether there are universal human rights, such as a “right” to be given treatment, which impose obligations on doctors, is especially good. This, as Skene admits, largely speculative section is particularly interesting in the light of her repeated assertion that “it is essential to distinguish ... between ‘rights’ that are assumed or claimed and those that can actually be enforced” (Skene 60). In other words, a patient may have a general “right” to treatment in our society, but imposing that general right on a specific doctor or hospital could be well nigh on impossible.

Consent

Chapters Three to Five look at the concept of consent for medical procedures with regard to competent adults, children and incompetent adults. The need for appropriate consent is considered one of the most important areas in health law today and Skene outlines clear ethical reasons why consent is required from a patient, namely, autonomy, the “right to control and determine one’s life for oneself” (Skene 75). In chapter three, as in the two following, what most interests Skene, and one that unfortunately will not help medical practitioners, is the *lack* of clarity in the law. Her analysis of the right to refuse medical treatment, for example, demonstrates that it was the confusion created by conflicts in the common law that led to the enactment of the Victorian *Medical Treatment Act 1988*. In analysing the common law, she states that “although a doctor who administered treatment a competent patient had refused could be liable in trespass, the patient’s refusal would not necessarily provide a defence if the doctor were sued in negligence for not providing treatment” (Skene 93). This situation is best summed up in her rueful comment at the conclusion of chapter three that “it seems that there is a tension between the right of competent adult patients to make their own decisions about treatment and the duty of doctors to act in the patient’s best interests” (Skene 103).

Information Giving

Chapter Six looks at the type of information doctors are required to give patients, particularly those who are about to undergo medical procedures. Significantly, Skene suggests that despite the apparently stringent nature of the law in this area, doctors who do *not* provide adequate information are still unlikely to be sued. “However little a patient was told about a proposed procedure, the patient will have no cause of action in the absence of injury or loss” (Skene 165). In other words, it is only if something goes wrong that a patient

would have any redress in the event that he or she was not provided with adequate information. Skene reaches a similar conclusion in the next, relatively short, chapter on negligence. Her analysis here leads her to suggest that, despite a number of high profile cases, "however careless or culpable a doctor has been, the patient will have no action on that account alone. If the patient has not suffered an injury or loss which can be proved in court, the patient will fail" (Skene 180). However, as a society we endorse the concept of autonomy. It does not reflect well on doctors to only be concerned with probable legal outcomes. Ethically, doctors should give patients all relevant information in order to enable them to make a proper informed decisions.

A short but informative chapter examining the circumstances in which patients have a right to access their medical records ensues, followed by a chapter on confidentiality. This chapter draws a distinction between the situations in which a medical practitioner may *ethically* breach confidentiality, and those when he or she may *legally* breach it. There are times when, to protect third parties, a doctor should ethically breach confidentiality, but legally the risk to the third party must be serious and imminent before the law will protect the doctor for this breach (Skene 215).

Withdrawal of Treatment

It is the two chapters on withdrawal of treatment that expose the shortcomings of the law most clearly. If a doctor withdraws or withholds lifesaving treatment where there is a clear duty to treat, then a criminal offence has been committed. If, however, the treatment is withdrawn at the patient's request, if the treatment is medically futile, or if it imposes an unjustifiable burden on the patient, then no offence is committed. Part of the problem lies with the definitions of futile and burdensome. Courts tend to interpret this based on the facts before them

(Skene 226).

In practice, of course, as Skene points out, decisions on the withdrawal of treatment rarely reach the courts: "the practice has been for decisions about the withdrawal of treatment to be made relatively informally in hospitals and not reviewed by courts" (Skene 230). It is in this area that the "clear gap between the law in theory and the law in practice" is most obvious (Skene 242). Unfortunately, it is not an area

part of the problem lies with the definitions of futile and burdensome

that can be easily solved. I cannot agree with Skene's assertion that the distinction between an act, such as giving a patient a lethal dose, and an omission, such as withdrawing futile or burdensome treatment, is purely pedantic and that the law should reflect this. Treatment is not withdrawn so that death will occur. It is withdrawn because it is futile or burdensome to the patient. The patient may then die of their condition. A lethal injection, however, is given in order to cause the patient to die. The patient dies as a result of the lethal injection. I cannot agree with Skene's argument that the lethal injection is only given because of the patient's incurable condition and that therefore the condition is still the real cause of the patient's death.

Abortion

One of the problems with publishing books, particularly books about current practice, is that things can change so quickly. The final chapter on abortion law throughout Australia while thorough and well-researched does not, of course, include the recent changes to the law in Western Australia. This is by no means a fault of the author but it does illustrate that no one text book can be up to date on all issues.

Conclusion

One of the few issues I would take with this thorough and well-argued book is that, while it concentrates on

the law concerning doctors in their day-to-day practice, its style is very legalistic. For someone with no legal training it may be difficult to follow without careful reading. The author herself acknowledges this.

In particular, Skene acknowledges that much of the problem with medical law is its uncertainty. This uncertainty, combined with her own intellectual curiosity, has led her "to speculate about arguments that may be advanced in future cases, but which are not yet established principles" (Skene xi-xii). It is sometimes a source of frustration, both for legal practitioners, and for those who rely on their advice, that definitive answers cannot be given to legal problems. Essentially this is because the outcome of particular situations cannot be determined in advance by the law. Often a test case is needed in order to establish the legal principles. Even when the law is established, however, each individual situation must turn on the doctor's exercise of the duty of reasonable care in the circumstances. Consequently, I applaud Skene for being prepared to indulge in this important speculation in the course of this book. It may perhaps be frustrating to those who like their answers to be black and white, but it is an extremely welcome addition.

I thoroughly recommend this book to medical practitioners, students, and those who are engaged in the practice of medical law.

✦

Anna Stokes

Interface: a Forum for Theology in the World

Volume 1 Number 2 1998

"*The Implications for Christians of Recent Developments in Human Genetics*" (\$21.50)

and

Beyond Mere Health: Theology & Health Care in a Secular Society. (\$19.50)

are available from
Australian Theological Forum
PO Box 504

Hindmarsh SA 5007
08 8340 3060

email: hdtregan@camtech.net.au

Material Cooperation and Abortion

It frequently happens that a good or indifferent action of one person provides material assistance to another person to perform an immoral action. It is hard to avoid this sort of cooperation in our pluralistic society. This raises moral dilemmas for individuals and institutions. This article discusses the moral principles that provide guidance in decision making in relation to some ethical challenges in contemporary prenatal health care.

Often when we do good, there is an *unwanted, but foreseen*, side-effect of helping another to do something immoral or unethical. It is difficult to go through life performing good, or at least morally indifferent, actions which others take advantage of to perform something wrong. This does not mean that these good actions should not be done even if performing them may raise moral dilemmas. We know that we should not only refrain from doing moral evil, but that we should avoid helping others do harm or moral evil. At times, we may even have a duty to take reasonable steps to prevent others doing harmful or unethical actions.

Principle of Double Effect and Material Cooperation

Over the years Catholic moralists have developed the so-called *Principle of Double Effect* which may be employed to help solve some of the moral dilemmas that arise when it is known that some evil or harm may result from good acts. According to this principle our acts will be good or morally indifferent if, when acting, we comply with the following four conditions:

- 1 The act itself must be good or at least indifferent, and certainly not unjust towards any third party (ies).
- 2 The good sought must not be obtained through the evil or harmful effect.
- 3 The evil effect is not intended, but only tolerated.
- 4 There must be a justifiable proportion of benefit to the harm caused by the action.

This principle rules out as morally

impermissible *formal cooperation* where a person shares in the intended immoral purpose of a principal agent. Depending on the circumstances of each case, *material cooperation* may be morally permissible if one's morally good or indifferent action gives material assistance to another's immoral action, provided that this does not involve sharing in the immoral purpose or intention of the principal agent.

Proximate Material Cooperation

Material cooperation is said to be *proximate*, when it is close to the harmful action of the principal agent in a morally relevant sense. It is said to be *remote* when it is distant in a morally relevant sense from the harmful action of the principal agent. It is important to note that in the context of material cooperation we are dealing with moral, not geographical, proximity of the action of the coop-

proximate material cooperation is not generally morally permissible

erator.

Proximate material cooperation is not generally morally permissible. If one's material cooperation is practically indistinguishable from the purpose of the immoral action of the principal agent, proximate material cooperation would be immoral. It would be proximate material cooperation for a passer-by to volunteer to comply with a request from a thief to load stolen goods into a getaway vehicle. Even under a threat to life or limb, proximate material cooperation in direct abortion, or the carrying out of orders to execute a hostage would be immoral. However, proximate material cooperation which causes damage to property may be morally

justified if the cooperator is forced to do so under a threat of death or serious injury. A case in point would be a bank teller handing over money during an armed robbery.

Remote Cooperation

Remote material cooperation is frequently justified for good reasons in many situations. The chief issue to consider case by case is the *proportion of benefit to harm* resulting from one's material cooperation, including the harm that failure to cooperate may cause the cooperator. Necessity may be a relevant factor to be considered for material cooperation to be morally justified. An instance in point would be the need for someone to keep their job or to perform duties which are part of their job. Greater reasons for material cooperation are required where the evil concerned is serious. The risk of risk of death for an innocent person is a greater evil than the

the closer one's cooperation is the more serious one's reasons must be to justify cooperation

risk of financial loss.

The closer one's cooperation is to the action, the more serious one's reasons must be to justify material cooperation. In the case of a printing firm which prints some hard core pornographic literature, the material cooperation of the firm's driver by delivering, among other publications, pornographic books and magazines to retail outlets, would be ethically permissible. It may be morally permissible for the typesetter to cooperate, but it would be morally unacceptable for the firm's director. Again, a hospital employee whose duties include cleaning an operating theatre where abortions are often performed would be justified to do the cleaning as this would be only remote material coop-

eration in abortion. One would not be justified in refusing to pay taxes on the grounds that some of this public revenue is used to fund abortions. In this case the relationship is too remote to have any significant moral relevance.

If the principal agent of the intended immoral action cannot act without the assistance of a qualified person, then greater reasons for cooperation would be needed on account of their *indispensability* for the action to occur. A sole motor mechanic in a small town would need greater reasons to materially assist suspected robbers to escape by repairing their broken down car. Likewise persons who have a professional responsibility to prevent specific harms or evils need greater reasons to cooperate, even if the cooperation consists in their failure to take preventive action, e.g. police, security officers and people responsible for children.

Material Cooperation and Abortion

The principles for the moral permissibility of material cooperation in immoral actions done to others have significant applications in the area of health care. Abortion comes to mind immediately. In the case of a doctor performing a direct surgical abortion, the material assistance provided by the anaesthetist and the theatre nurse would, in a moral sense, be practically indistinguishable from the abortion itself. Proximate material coop-

it would be unethical to oblige health professionals to participate in abortion procedures

eration of this sort would be immoral. It would be unethical to oblige health professionals to participate in abortion procedures. Provision should be made for medical and nursing staff who work in hospitals where abortions may be performed to conscientiously object to participating in abortion procedures.

The question arises whether tissue taken from aborted fetuses and used

a policy of collaboration between the abortion provider and the transplantation team would inevitably involve collusion with direct abortion

for transplantation involves unethical cooperation with the abortion provider. Even if no payments were to be made, the adoption of a policy of collaboration between the abortion provider, the transplantation team and/or the organ provider would inevitably involve implicit prior collusion with direct abortion. The same would apply to pathology tests which check the suitability of these tissues for transplantation. But the use of suitable tissue taken from a spontaneous abortion would pose no moral problems.

The use of a cell culture derived from an aborted fetus many years earlier to produce vaccines for immunisations would only involve remote material cooperation with the original abortion. The use of these vaccines today does not objectively imply approval of the original abortion and is morally permissible. There would be no moral problems if use was made of culture tissue, obtained from fetal tissues without any collusion with abortion, e.g. a miscarriage.¹

A serious ethical problem is whether prenatal testing amounts to material cooperation with the subsequent abortion of abnormal fetuses. For more information on these tests I refer readers to my article on prenatal diagnosis.² It is to be noted that in Victoria in 1996, of the 5048 women whose fetuses were tested, 94.2% of chorionic villus sampling and amniocentesis tests gave normal results.³ These results were reassuring for the vast majority of the women concerned. Major chromosome abnormalities occurred in 3.4% of cases. These test results change parents' anxiety of incertitude to the trauma of knowing that their unborn children are affected with serious genetic defects.⁴ A survey at a Melbourne hospital over a 5 year period found that only 3 of 179 women decided to continue the pregnancy after a diagnosis

of Down syndrome – equivalent to an abortion rate of 98.3%.⁵

Pathology tests are sometimes performed on aborted fetal tissues to investigate the cause of congenital abnormalities detected by ultrasound and on account of which the abortions were done. These tests may increase scientific knowledge but they do not involve material cooperation with, nor approval of, the abortion of the fetuses from which the tissue samples are derived.

A survey was conducted of 1000 participants aged 16-44 in a cystic fibrosis screening program in which they were asked what they would do if their future pregnancy carried a one in four risk of being affected by CF. Their replies to the question whether they would consider terminating an affected pregnancy were: 26% yes, 17% no but 57% replied they did not know what they would do.⁶ This showed that only a minority of participants would consider terminating a future, or wanted pregnancy if the fetus was found to be affected by CF. Few would form an actual intention

it is ethical to perform prenatal tests to provide women with information on the condition of their unborn children

to terminate a wanted pregnancy until it was *certain* the fetus was abnormal. Prenatal diagnosis, then, is not always, nor necessarily, linked to abortion and should not be deemed *per se* unethical. It simply provides information to women which they have a moral right to seek to receive, even if this does not imply a strict right for public funding for all tests. Unless one has a prenatal test with the *firm* intention of aborting a fetus with a major abnormality, prenatal diagnosis is ethically distinct from a subsequent decision to have an abortion.

There is, however, a remote material link to a subsequent abortion in the approximately 3% of cases of prenatal diagnosis when the results indicate that the fetus is abnormal. Can

this remote material cooperation of prenatal diagnosis in general with abortion be justified? In view of the fact that up to 98% of women have an abortion once it is confirmed that their fetuses are affected by Down syndrome, one view argues that prenatal diagnosis involves sufficient material cooperation with abortion to constitute collusion with it.

On the other hand it is necessary to give more weight to the fact that in about 97% of cases, the results of prenatal tests indicate that fetuses are not affected by the major abnormalities for which they are tested. This shows that in most cases prenatal diagnosis is not materially linked to abortion. It is ethical to perform prenatal diagnostic tests to provide women who request it with accurate information on the condition of their unborn children with respect to specified anomalies, e.g. Down syndrome. This is not substantially changed by the fact that most of the 3% of prenatal tests that detect major abnormalities do have a

material link to subsequent abortion.

Institutions and Material Cooperation

The above principles for cooperation apply to institutions as well as to individuals, e.g. government, schools, the Catholic Church and its hospitals, etc. Clearly these institutions should not *adopt a policy* that *formally* permits, regulates, or cooperates in, abortion. Hospitals which support the *sanctity of life principle*, together with their staff, should adopt an ongoing prophetic pro-life stand from the very start of prenatal care. This means they should take the necessary steps to guarantee that all prenatal practices are guided by ethical principles and do not in practice become search and destroy missions.

It should not be forgotten that prenatal diagnosis may enable early therapy for some fetuses.

Where remote material cooperation

with moral evil done by other persons and institutions is morally permissible, the risk of *scandal* or harm caused through misunderstandings is to be minimised as far as possible.

ENDNOTES

- 1 Benedict M. Ashley & Kevin D. O'Rourke, *Health Care Ethics: A Theological Analysis* (Washington, D.C.: Georgetown University Press), 338-39.
- 2 *Caroline Chisholm Centre for Health Ethics Bulletin* 3 (1997), 10-11.
- 3 Carole Webley and Jane Halliday, *Report on Prenatal Diagnostic Testing in Victoria*, (Melbourne: The Murdoch Institute), 1997, 14.
- 4 *Ibid.* 14.
- 5 Lachlan De Crespigny, Meg Espie and Sophia Holmes, *Prenatal Testing: Making Decisions in Pregnancy*, (Ringwood, Victoria: Penguin, 1998), 130.
- 6 E Watson *et al* "Screening for genetic carriers of cystic fibrosis through primary health care services," *British Medical Journal* 303 (1993), 504-507. ✚

Norman Ford SDB

Now available: *New thoroughly researched*
RESOURCE KITS

\$20.00 each [including postage and handling]

Euthanasia

- Euthanasia: Background
- Law in Australia: Treatment Decisions at the End of Life
- Euthanasia: The Dutch Experience
- Legislating Death: The Northern Territory Rights of the Terminally Ill Act 1995
- Review of End of Life Decisions in Australia
- Review of Rejection of Euthanasia by the Select Committee on Medical Ethics
- Euthanasia: Practical Issues for Nurses and Palliative Care Nurse Practitioners

Surrogacy

- Surrogacy: An Introduction
- Why Surrogacy? The Experience of Infertility
- The Issue of Autonomous Decision Making
- The Legal Situation of Surrogacy in Australia: A State by State Analysis
- Case Studies: The Issues that Arise in Surrogacy Arrangements

Health Care Resources

- Rationing
- Mechanisms of Rationing
- The Australian Health Care System
- Casemix
- Private Health
- A Christian Moral Perspective

Caroline Chisholm Centre for Health Ethics

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

Tel (03) 9270 2681

Fax (03) 9270 2682

email: ccche@mercy.com.au

Copyright © 1998 Caroline Chisholm Centre for Health Ethics Inc.

Subscription fees: Single - \$25.00; 5 subscriptions - \$80.00; 10 subscriptions - \$120.00; Overseas [single] - AUD\$35.00

Director/Editor:

Rev. Norman Ford SDB STL PhD,
Adjunct Professor, Australian Catholic University

Research Officers:

Deirdre Fetherstonbaugh DipAppSc PGCert BA MA
Tracey Phelan BSc BA(Hons)
Anna Stokes BA(Hons) LLB MA

Administrative Assistant/Layout/Sub-editor: Margaret Casey BTheol