The duty of care is not absolute when it comes to demanding specific treatments to cure diseases or to prolong human life. The medical profession and the State are not bound to go to unreasonable lengths to provide every possible treatment regardless of cost, so long as basic comfort and care are always provided. The availability of resources, personnel and finances of the family, hospital and government budgets must be considered along with the prospects for a patient’s recovery when determining if there is a duty to provide any specific medical treatment.

The drawing of the line between where treatment should be given and where it need not be given is one of the most perplexing moral dilemmas that doctors and competent patients have to face. More than 50 years ago, Pope Pius XII taught that:

... normally one is held to use only ordinary means according to circumstances of persons, places, times and culture — that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important goods too difficult. Life, health and all temporal activities are in fact sub-ordinated to spiritual ends.

Often it is difficult to apply moral principles in individual cases. The Catholic Church’s Declaration on Euthanasia (1980) offers the following wise guidelines:

“... normally one is held to use only ordinary means according to circumstances of persons, places, times and culture — that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important goods too difficult. Life, health and all temporal activities are in fact sub-ordinated to spiritual ends.”

“It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

“When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help a person in danger.”

Consultation among colleagues may facilitate the task of assessing the balance of likely benefits for a patient resulting from surgery against the burden of deterioration.
of health or increased suffering for the rest of one’s life if no treatment is given. The probability of a successful outcome resulting in an improved condition would need to be sufficiently high to justify surgery where the risk to the life of the patient is substantial. A doctor may accept a colleague’s alternative medical opinion but not if the advice is believed to be medically unsound.

Family members may be at their wit’s end, hoping that doctors may propose a satisfactory remedy, afraid or unable to suggest much themselves. Doctors may need to reassure them that no intervention is in the best interests of the patient. It is frequently a matter of listening to the family’s unexpressed heartfelt cry rather than merely hearing the words they utter. Under no circumstances should doctors act against their conscientious professional judgement by initiating treatment that is not in the best interests of the patient. The community should allow doctors all the necessary freedom to follow their own professional judgement. Medicine is not an exact science and errors may be made in good faith without any suggestion of incompetence or the need of actions for wrongful death.

Catholic teaching morally requires people to have recourse to ordinary means to preserve life. It does recognise competent patients’ moral right to follow their conscience when deciding that continuing medical treatment, as distinct from palliative care, is unwarranted or too burdensome and may be discontinued. In other words, informed and competent patients do have a right to draw the line in a morally responsible way between warranted and unwarranted, that is, extraordinary, medical treatment. Doctors should respect this eminently human and personal decision.

"The drawing of the line between where treatment should be given and where it need not be given is one of the most perplexing moral dilemmas …"

Pope John Paul II wrote that “when death is clearly imminent and inevitable, one can in conscience refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted”2.

Pope Benedict XVI has said much the same: “To eliminate death or to postpone it more or less indefinitely would place the earth and humanity in an impossible situation, and even for the individual would bring no benefit”3.

These quotes of two popes may well have a message for us not to seek to prolong life beyond reasonable bounds for patients afflicted by a terminal illness or condition.

Footnotes
We in Australia are used to being blood donors — and indeed, in times of emergency, we are used to being blood recipients. Our blood service is a remarkable, if unremarked, expression of human solidarity. The same, too, can be said of the recent development in Australia of public umbilical cord blood banks.

Until recently, umbilical cord blood was discarded as medical waste. Now it is considered to be a valuable medical resource from which can be extracted stem cells — stem cells that may be useful in the treatment of a range of serious conditions. At the moment, these stem cells are used by haematologists as an alternative to bone marrow transplantation. In the future, they may well be used in the treatment of a wide range of conditions. These cells are classified as “adult” stem cells – so named to distinguish them from “embryonic” stem cells. They are obtained from the umbilical cord in a process which is painless for mother and child and which poses no risks to either of them.

Much is still to be discovered about the potency of various kinds of stem cells. It used to be thought that adult stem cells were limited in their ability to differentiate — that they could only differentiate into the tissue of their origin. Now there is evidence to suggest that they can differentiate to become other cell types as well. Indeed, in 2006, scientists discovered that some pluripotent stem cells could be artificially derived from non-pluripotent stem cells by “forcing” an expression of specific genes. The development of “induced pluripotent stem cells” (IPS) is welcome for both ethical and scientific reasons. It seems likely that it will provide pluripotent stem cells, the sourcing of which does not involve the destruction of an embryo.

Around the world, research on the therapeutic potential of stem cells is regulated by law. The key difference is between jurisdictions which prohibit research involving the destruction of the human embryo and jurisdictions which do not. Until 2002, Australian law prohibited such research; now it merely “regulates” it. As a matter of interest, a few weeks ago the European Court of Justice ruled that research involving the destruction of human embryos could not be patented.

Responses to the decision of the European Court show that the debate about what the law should say about research that destroys human embryos was and continues to be complex. One dimension of it concerned a debate about means and ends.

Proponents of legalisation emphasised the desirability of the end — that is to say, their position focussed on the development of therapies that would likely result from research which involves the destruction of human embryos. Opponents of legalisation emphasised the moral status of the means, with their position focussed on an ethical evaluation of the means used in pursuit of a therapeutic goal, in particular that the means should not include the destruction of human embryos.

Proponents generally thought that there was nothing wrong with destroying human embryos in and of itself (so they rejected the claim that they were inattentive to the ethical status of means — they said that they just had a different view of those means). Opponents often thought that the likely therapeutic benefits of research involving the destruction of human embryos were being shamelessly
hyped. Certainly in the last 10 years there have been some wonderful discoveries about the therapeutic potential of adult stem cells — indeed, it seems increasingly likely that the human body contains the ingredients of its own regeneration. We shall certainly need wisdom, as well as scientific expertise, in harnessing that potential!

One by-product of the debate is the widespread misconception that the Catholic Church opposes stem cell research. For nearly 10 years, the Catholic Archdiocese of Sydney has awarded a significant grant, on a competitive basis, to stem cell researchers from around Australia for research which meets the highest standards of scientific excellence, from which therapeutic applications are likely to arise, which is innovative in that it displays novelty in its experimental approach, which is undertaken by researchers with a track record of success in undertaking similar or related research and who have obtained matching funds from another source and for whom receipt of the grant will be significant for the undertaking of the research.

Of course, it goes without saying that the research must comply with the standards set out in the Code of Ethical Standard for Catholic Health and Aged Care Services in Australia. Over the years, the researchers who have won this grant are conducting research on stem cells found in the blood, the teeth, the skin and the “connective tissue”.

To return, then, to the topic of umbilical cord blood banking. The stem cells found in umbilical cord blood can be used in either autologous or allogeneic transplants. In an autologous transplant, the person’s own stem cells are transplanted back into his or her body. In an allogeneic transplant, stem cells are collected from a donor and transplanted into another person. Allogeneic transplants are possible only where the donor and the recipient have matching tissue types. At the moment, only about a third of patients who need an allogeneic transplant find a suitable donor within their family. Most therefore have to rely on either adult volunteer donors who are registered with a bone marrow donor registry or on umbilical cord blood that has been donated to a public bank.

Nowadays, however, parents in affluent countries like Australia are being urged to store their child’s umbilical cord blood in a private bank. These private banks are commercial concerns — not surprisingly they “talk up” the likely need the child will ever have for his or her own cord blood. And of course the more that cord blood is stored in private banks, the less it is available for people who actually need it.

Though there is nothing inherently wrong with setting up or using such banks, I think that their existence undermines the availability, for those who need it, of a resource for treating serious illness. If so, then those responsible for governing Catholic health care institutions have a reason, derived from solidarity with the sick, not to give institutional support to arrangements that undermine equity of access to needed treatment.
The following is an abridged version of a talk given to the annual Catholic and Anglican Clergy day, Brisbane, 2011.

One of the reasons I chose this topic is because it is one of the ones about which I am most frequently consulted. The second reason was because I have found that we have lost the language with which to talk about such matters. By “we” I mean Christians who think in terms of a tradition that holds that every human life is sacred. Because we have lost our language, we tend to adopt the language being forged by the secular society, and that language will often lead us to places we would rather not go.

We begin with a general ethical principle regarding respect for human life. In the context of health care, we can express that principle as follows:

“If a person is ill, he or she is obliged to seek help to maximise their chances of recovery and to minimise the effects of chronic disability or handicap. If illness is life-threatening, a person should seek to avert the threat.”

The negative norm is: You should not directly attack the good of life — there is no such thing as a life unworthy of life. The positive duty rules out one kind of bad practice, which is referred to as “under-treatment”. Under-treatment can be defined as the failure to take appropriate measures to treat symptoms or the condition itself, when those measures could bring real relief and are not considered too burdensome or intrusive.

The language that is often used here to justify lack of treatment is that of futility. Medical personnel, family or even the patients themselves might say that treatment is futile because they are going to die anyway or because they will not be restored to the level of functioning that they consider desirable. We need to be very careful of the use of the language of futility here. Often what is meant is that the person’s life is judged to be futile. It is a judgement about the meaning of someone’s existence. But we cannot judge the meaning of someone’s life. We cannot judge someone’s life to be “futile”.

However, there is a correct usage of the word “futile”, and that is when it is properly applied to the proposed treatment. A treatment is futile when the treatment does not achieve its purpose. So if the treatment is aimed at cure, when cure is no longer possible, then that is futile treatment.

I have stated our positive duty and that it rules out under-treatment. But like all positive duties it has limits. A failure to respect those limits can lead to “over-treatment”. Over-treatment can be defined as continual use or commencement of procedures aimed at cure where that is no longer possible, or use of burdensome and intrusive procedures which are of no real benefit.

So how do we walk the line between under-treatment and over-treatment? Many will talk about the quality of life of the patient, or their own quality of life, and make a judgement on what they consider an acceptable quality of
life. However, the corollary of that is that there is such a thing as a life no longer worthwhile. Others will simply talk of autonomy and say that it is up to the patient to decide, and if they are not competent, then someone who can speak for the patient might decide. However, they offer no real criteria for making these judgements.

In our tradition we used to speak of ordinary and extraordinary means. Those terms used to be fairly common currency. They appeared in medical dictionaries as well as ethical textbooks. However, today you will find that fewer and fewer people in the medical profession are familiar with those terms. Last year I did a series of seminars in various Catholic health and aged care facilities. I asked how many were familiar with those terms at every seminar. About four out of every 100 people were familiar with the terms. That came as a bit of a surprise to me. It did not worry me too much because I do not use that terminology either, but it did make me think about what was the language they were using to discuss these matters. Most of them had taken on board the language of “quality of life”. I am going to suggest an alternative.

And then there are those who cannot afford drugs that would sustain their lives.
• For oneself or others, but does not mean that “others” can relieve themselves of the burden of care.
• In light of the patient’s condition. The patient’s condition is relevant. This is not a judgement on the quality of life, but an assessment of the consequences of treatment for someone in this condition.

These are the kinds of things that need to be considered in deciding what is best for this patient. In talking with patients, families and carers, you could ask them to consider or to ask the doctors: How will the person handle the treatment? Will it cause him or her pain and discomfort? How much benefit will it give?

It has been my experience that people — relatives and patients themselves — find the language of the benefit and burden of the treatment helpful in making such decisions regarding treatment in these end-of-life circumstances. First of all, it removes them from making some kind of judgement on

“So how do we walk the line between under-treatment and over-treatment?”

I said that there are limits to our positive duty. The limits can be expressed as follows: There is no obligation to have a treatment which has little or no chance of succeeding, that is, no futile treatment; and there is no obligation, other things being equal, to undergo treatment that imposes excessive hardship or is overly burdensome. If we look back at the usage of “ordinary” and “extraordinary” we discover that ordinary meant obligatory and extraordinary meant optional. But what made something extraordinary treatment? Its burdensomeness. So today we talk about the benefit and the burden of the treatment proposed.

The burden may be:
• physical, which refers to pain and discomfort. Before anaesthesia, many treatments we consider normal today would have been considered physically too burdensome.
• Psychological, including cultural and personal sensibilities. This might refer to the stress of being away from one’s family and familiar surroundings, or it might be cultural taboo regarding a man being examined by a woman doctor.
• Moral. The classic case here is the Jehovah’s Witness refusing a blood transfusion.
• Economic. We might tend to think that this is rarely the case here in Australia, but it is very prevalent. People are dying waiting to see specialists in our public hospital system because they cannot afford to see them privately.

The value of the life of the person that they love. They are able to focus on the treatment and assess its value. It also gives them a language which they can use in talking to the medical personnel. Medical personnel are able to give a reasonably objective answer to questions such as: How will that treatment help or benefit my mother or father? What kind of burden or suffering will it inflict upon them? This kind of language is helpful for the competent patient when you are talking directly to the patient, and for the relatives who might have to make a decision for a non-competent patient.

One of the most difficult cases is that involving a young person. Parents find it very difficult to let go and say enough is enough. I was involved in a case where there was conflict in the family. One parent was ready to let their young child go; the other wanted the doctors to continue treatment. When we spoke to that parent, not simply in terms of the prognosis, but in terms of the suffering that the treatment itself was inflicting upon the child, then that parent was able to let go. The parent realised that the treatment itself was causing suffering, and not treating was not killing their baby, but allowing the child to die.

Finally, this way of thinking and talking is helpful if someone is considering completing an advance health care directive and is the language used in the documents regarding advance health care planning on the CHA website.
This is an abridged version of a talk given on September 1 at the Catholic Health Australia national conference at the National Convention Centre in Canberra.

Let me begin with a story — or, more accurately, a conversation. “I don’t understand you,” said the businessman to the nurse. The businessman was a patient in a Catholic hospital. Perhaps it was your hospital, or a hospital in your town, because this is a true story. The nurse who tells it describes herself as an ordinary nurse in an ordinary Catholic hospital.

The businessman continued: “The people I move with, we all try to make as much money as we can. Some of us sometimes cut corners, because we want as much money as possible with as little effort. Beyond that, people like me live large — we practise what is sometimes called conspicuous consumption.

“But I don’t understand you,” the businessman repeated.

“I’ve noted the hours you work, the shifts, and how hard and demanding your work can be. I’ve noticed that you try very hard to care for everyone. And I know more or less what you’d be paid, and I know that you could make much more money with much less effort doing any number of other jobs.

“I don’t understand you at all,” the businessman said yet again. Then he added as his eyes suddenly filled with tears, “But I’m very glad that there are people like you in this world.”

“As a group, we Boomers are the Enlightenment vision carried to its extreme.”

In my opinion, one of the most important clashes that is happening in today’s world is the clash between traditional morality and a “new” morality that has emerged over the last few centuries. This clash is happening all over the world, and it happened in a simple way in this conversation.

In this article, I will first describe both traditional morality and this “new” morality. As I do so, you will probably notice that the nurse in the story is an exemplar of traditional morality, while this businessman is an exemplar of the new morality. I will then explore the clash between these two worldviews. This reflection should highlight just how important it is that we “remain true” — the theme of this conference.

Indeed, the challenge for traditional morality is to hold these three concerns in the right balance and not to be so concerned about one area that it neglects the others. Within this creative tension, though, its focus above all is on the common good — the good of society, the good of all.

Note that the nurse from my story is an exemplar of this worldview. More than that, note the profound connections between traditional morality and the distinctive ethos of health care. To commit oneself to give care and to be a healer — as a nurse, as a doctor, or in any other role within health care — is to recognise that we find our own fulfilment through service. It is to commit oneself to the common good through a mission of care and healing.
It involves a profound recognition of how precarious and fragile life really is. And it is to accept some measure of self-sacrifice, in many different forms, as the price one pays for one’s commitment to healing and to the common good. There are indeed profound links between traditional morality and the distinctive ethos of health care. Over the centuries it was within the culture or worldview of traditional morality that the distinctive ethos of health care has been formed.

the “new” morality

In historical terms, the “new” morality really is new—it dates back only to the 17th or 18th century. Specifically, it dates back to the so-called Enlightenment, which saw itself as a new beginning within western civilisation. The Enlightenment assumed that we have no common understanding of right or wrong, or even of what it is to be human. There is only my view and your view and everyone else’s views, and the Enlightenment assumed that we have no way of deciding which views are more accurate or more true.2

For this reason, the only vision that the Enlightenment offered is that, as much as possible, each of us should be free to follow our own path and pursue our own goals and live our own way. Its emphasis is therefore on autonomy and free choice. Thus, the Enlightenment assumes that human beings find their fulfilment above all not through service but through freedom and through free choice. This concern for individual freedom is the most distinctive feature of the new morality.

The Enlightenment vision has also continued to develop through history. Enter the Baby Boomers: those of us born between 1946 and 1964.2 Yes, we’re “talkin’ bout my generation.”4 As a group, we Boomers are the Enlightenment vision carried to its extreme. We are the “me” generation. We Boomers place an extreme emphasis on individualism and on personal autonomy. Our twin cries are “I gotta be me!” and “I gotta get my way!” We Boomers therefore rail and fight against anything that would restrict our free choice. We are the generation which effectively decriminalised abortion in many jurisdictions around the world. We are the generation which is currently most passionately involved in the battle to legalise euthanasia.

A third factor in the development of the new morality is secularisation or, to give it another name, the eclipse of the sense of God. In its Pastoral Constitution on the Church in the Modern World, the Second Vatican Council warned of the significance of this. “Once God is forgotten,” the council wrote, “the human person becomes unintelligible.”5 Once we lose sight of the Creator, we no longer see ourselves as the Creator’s creation, and we gradually lose sight of who we truly are. Further, as we lose sight of the spiritual side of life, we focus only on the material side. We become materialistic, and we start to think that the purpose of life is nothing more than consumption. Finally, note that the businessman from my story is an exemplar of the new morality. I should stress that I am referring only to this particular businessman. Obviously, not every businessman is like this.

Thus, we can summarise themes of the new morality. It is focussed only on the individual and on personal autonomy. It believes that human beings find their greatest fulfilment through consumption and through getting what we want. It is therefore materialistic and consumerist.
the clash of worldviews

To consider the clash between these worldviews, we turn to John Paul II’s encyclical *Evangelium Vitae*. The late pope said that at this time “we are facing an enormous and dramatic clash between good and evil, between death and life, the ‘culture of death’ and the ‘culture of life’.” Thus, John Paul alerts us that the “new” morality is also the culture of death. He notes that it arises from a notion of freedom which “exalts the isolated individual in an absolute way, and gives no place to solidarity, to openness to others and service to them.”

This helps us to understand the significance of what is happening. “Remaining true” is not just a nice idea or a clever catchphrase. Instead, it is remaining true to traditional morality, which fosters and protects civilisation itself. It is also remaining true to the traditional morality that underpins the distinctive ethos of health care as a healing profession.

In this clash of worldviews, then, both the distinctive ethos of health care as a healing profession and even civilisation itself are at stake. In our institutions and throughout society,

“... one of the most important clashes that is happening in today’s world is the clash between traditional morality and a ‘new’ morality ...”

This intense individualism, this extreme autonomy and this excessive freedom ultimately undermine the common good. Indeed, John Paul also calls it a “war of the powerful against the weak,” for this new morality turns those who are powerful away from the weak, and the weak, who need help, are abandoned and harmed. All things considered, then, the new morality is really an anti-civilisation — a worldview that actually undermines civilisation and the common good. It is a pseudo-morality or even an anti-morality.

We fight to preserve the essence of civilisation. It is hard to conceive of anything more important. If we lose sight of traditional morality and the common good, do we stand at the beginning of a new Dark Ages?

So there is a clash going on. It is the clash between traditional morality and a new morality. It is the clash between religious faith and secularisation, between concern for the common good and a selfish individualism. It is the clash between civilisation and an anti-civilisation, between the culture of life and a culture of death. Please remain true and stand with us on the side of the culture of life.

Footnotes:
1. The Compendium of the Social Doctrine of the Church defines the common good as “the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily.” (#164) More simply, it also describes it as “the good of all people and of the whole person.” (#165) In traditional morality and also in the Catholic vision of life, “all members of society” (#167) and in particular the government (#168) must contribute to building up the common good.
2. This exclusive focus on subjective standards and the attendant refusal to recognise objective standards of right and wrong is called moral relativism. It is a deep-seated feature of contemporary culture which threatens the capacity of many individuals to truly tell right from wrong, and also endangers the authentic progress of society.
3. The different cohorts or generations are the Silent Generation (1925-1945), the Baby Boomers (1946-1964), Generation X (1965-1982), Generation Y (1983-2001), and Generation Z (2002+). My friends who belong to Gen X or Gen Y sometimes protest to me that their generations can be just as self-centred as my own. While this may well be true, I remind them that my generation thought of it first.
5. Vatican Council II, Gaudium et Spes (Pastoral Constitution on the Church in the Modern World), #36. In #22, the Council also notes that “Christ fully reveals humanity to itself.”
8. Ibid, #12.
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Earlier this year, a former student emailed me about an ethical dilemma that was occurring in her workplace. She was employed in ICU at a well known international tertiary hospital. The case involved a 35-week pregnant woman involved in a high-speed motor vehicle accident. The woman was diagnosed as brain dead. Her unborn child had also suffered severe hypoxia so it was determined that even though technically alive, it was a non-viable foetus.

The question of organ donation was presented to the woman’s husband — but also for that of the unborn child for foetal tissue sampling. It was with regards to this latter scenario that my past student contacted me for some ethical guidance. Throughout our correspondence she constantly stated: “I’m so glad we studied ethics Jo — I reckon I would have walked away from nursing by now because of issues like this one!” Another time she also indicated that even though she still did not know the “answers”, at least she could understand all sides of the ethical debate, know the processes for the deliberation at an institutional, legal and social level, but more importantly be in a position to be the best possible patient advocate given the complexity of the clinical scenario.

The Australian Catholic University has a long tradition in the education of health care professionals in the area of ethics. The university’s mission statement provides reasoning for the inclusion of such education in these courses. This statement presents the commitment that the “University explicitly engages the social, ethical and religious dimensions of the questions it faces in teaching and research, and service”. This mission statement has its foundations in the Catholic Church’s intellectual tradition, social justice teachings and respect and defence of the inherent and inviolable dignity of every human person.

It is important that through their own intellectual engagement with the course content, students will come to a further understanding of ethical reasoning beyond the strongly relativist views presented at clinical and academic level and in contemporary Australian health care ethical discourse. These students will then become effective patient advocates in situations of moral uncertainty, to protect vulnerable members in society and advance the professionalism of their study specialisation.

Despite the International Council of Nurses’ development and adoption of a professional code of ethics for nurses in 1953, health care ethics has traditionally been the domain of the medical profession. It is of interest to note that when there are calls for social, media or professional commentary on an ethical dilemma in the provision of health care, such as abortion or euthanasia, nurses are rarely asked to voice their reasoned argument despite being the largest health care profession in Australia.

Traditionally there has been a dismissive approach to the role of nurses in health care ethical deliberation, in that “others” – such as doctors, philosophers and theologians – know best and for nurses just to continue care, not contribute to these discussions. This paternalistic attitude towards nurses has been challenged in recent decades through the increasing number of nurse ethicists employed in academia and health care settings at a national and international level. Nursing is a moral undertaking. As prominent Australian nurse ethicist Megan-Jane Johnstone states: “It is because of the potential to cause morally significant harm to others — not to mention the breach of trust that could occur as a consequence of such harm being caused — that nurse practice warrants attention from an ethical view.”
Despite this need for registered nurses to be engaged in policy and clinical decision-making regarding health care ethics, it is often our own profession that does not provide effective leadership in these areas. One example is the Victorian Abortion Law Reform Act (2008) and the stated provisions that have negatively impacted Victorian registered nurses. During the Victorian Law Reform Commission’s 2008 public consultation into the potential social, legal and ethical impact of decriminalisation of abortion in this state, over 500 submissions were received from various Victorian and national representative groups.

From these submissions, the Victorian Abortion Law Reform Bill was drafted and then subsequently adopted in parliament. Out of these 500 or so submissions, not one was from a professional nursing or midwifery body to present a reasoned position on the impact of such law changes to Victorian registered nurses. This lack of representation of nurses to the VLRC allowed the complete negation of Victorian registered nurses’ right to full conscientious objection to their direct participation in any treatment or procedure that procures an abortion.

Another area where the nursing profession has not had adequate and balanced representation is in the current debate about the adoption of a “studied neutrality” position in end-of-life care, in particular with regards to an action of assisted suicide or euthanasia.

What these issues present is that there needs to be more health care ethics education at an undergraduate and postgraduate level for all professional groups involved in the day-to-day clinical management of vulnerable patients in our health care system. Without such engagement, the resulting outcome may be the negation of the notion of registered nurses as moral agents in the provision of care, essentially risking the professional status of nursing in the health care team.

It is hoped that several past, current and future students will become the future leaders in this complex area of health care. In this sense, ACU is contributing to the development of the professional standing of many health care disciplines through ethics education.

Reference:
Imagine this. You are a doctor, and you admit an elderly lady, Betty, to hospital. Betty requires treatment for her diabetes — a serious and ongoing health problem and one that she has suffered from for some time. She needs to spend several weeks in hospital.

Because she lives alone, Betty arranges for her daughter, Karen, who has been caring for her for some time, to have access to her bank accounts so that bills and other household expenses can be dealt with while she’s in hospital. Under your care, the treatment goes well and Betty is able to return home. But just before she is discharged, it becomes clear that Karen has drained her mother’s savings in going on a ‘well-earned’ holiday, rather than spending the money on maintaining the house. Distraught, Betty asks you, “Doctor, what should I do? Can you help me?”

Should you call the police or social services? Advise Betty that the most important thing is to rebuild her relationship with her child? Contact Karen?

Here at the University of Notre Dame School of Medicine in Sydney, we know that – most of the time – there are no simple answers to ethical problems. And doctors are presented with ethical dilemmas every day of their professional lives. Just as we train our medical students in the knowledge and technical skills they need to be safe and competent doctors, we must also equip them with a capacity for ethical reasoning that is invaluable to a strong foundation of effective medicine and compassionate care. They must also recognise that their patients are people whose well-being is impacted by their physical, mental, social and spiritual needs.

The first step in ensuring that our graduates are both excellent and ethical doctors is to select students who understand that a career in medicine means that they will constantly engage with ethical questions. Additionally, we hope our students will show capacity for empathy and compassion, and will particularly value Notre Dame’s knowledge and teaching in ethics in addition to what they will learn through an excellent medical curriculum. Notre Dame delivers our medical training in the context of Catholic faith and values. While we welcome students and teachers of all faiths, the mission of our organisation is distinctively Catholic with the utmost respect for life from conception, a deep concern for the physical, emotional and spiritual needs of the individual and a passion for social justice and global health. This is apparent to students from their first days at the university.

One of the practical ways in which our mission is expressed is through the “core curriculum” that all students at the university are required to complete as part of their degree...
course. Entitled the LOGOS program, the core curriculum has been recently updated to offer more choice and relevance to the needs and preferences of students.

There are four compulsory modules in the program:

- **Think** — an introduction to the foundations of philosophy and, in particular, the skills of critical thinking and informal logic.
- **Choose** — an introduction to the key concepts and theories in western moral philosophy as well as skills in practical reasoning and decision-making.
- **Live** — an introduction to some key concepts in theology.
- **Learn** — a final module that provides students with an opportunity to learn about what the Catholic Church believes about some key issues, including a number of controversial topics.

The LOGOS program is not about teaching students the “right answers” to the challenges they will encounter, but rather it equips them with the tools to think and act ethically. This is not always easy. Learning to be a doctor is enormously challenging — intellectually, emotionally and through the heavy study load. Students respond to these challenges in different ways. As part of their course, students compile a portfolio of reflections and insights they have gained from encounters with patients and the lessons they learn.

We also ask students to keep a journal of their thoughts and feelings as they progress through the course. These private reflections are a useful way of working through the emotional and sometimes spiritual challenges that are an essential part of learning to be a humane and compassionate doctor. Why is all this important? Isn’t it enough that we aim to educate our students toward high ethical standards and then trust them to do the right thing? The answer to this challenge is found in medicine itself. Our medical students are at the start of their careers. Some will be practising medicine for the next 40 or even 50 years. Students graduating now will be treating patients in 2050. And just at the medical practice of 1971 was transformed by 2011, so too will things be different by 2051.

Advances in medical knowledge throw up new ethical challenges that require a response from individuals and the profession. Stem-cell research is one such example. This simply was not something that a doctor trained 40 years ago would have needed to think about. Now it is but one topic at the forefront of debates in medical ethics. Medicine is a career that challenges us to be lifelong learners.

As our graduates move through their careers, they will face dilemmas that we have not even thought of yet. That is why as Dean of Medicine I see it as our job to help them “learn how to learn” across their lifetimes. We believe our school’s mission, underpinned by the core curriculum, will contribute to the excellence of care and the high standard of ethical behaviour that we want from the next generation of Australian doctors.

Christine Bennett with students on “Birthing Kit Assembly Day”, a social justice initiative to provide sterile birthing kits to women in the developing world. (Photo by Gerard Williams, The University of Notre Dame Australia)