

Catholic Health Australia

CODE OF

Ethical Standards

for Catholic
Health and Aged Care Services
in Australia



Catholic Health Australia



Speaking with one voice



*At its meeting of 9 May 2001,
the Australian Catholic
Bishops' Conference approved
the publication of
this Code of Ethical Standards*



*At its meeting on 18 May 2001,
the Australian Conference
of Leaders of Religious Institutes
gave official support to
the Code and encouraged its use
in all its institutions.*

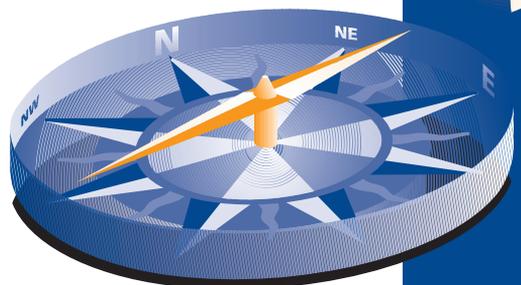


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List of Abbreviations

<i>Australian Bishops</i>	Australian Catholic Bishops' Conference.
<i>Catechism</i>	<i>Catechism of the Catholic Church</i> , 1992.
<i>Charter</i>	Pontifical Council for Pastoral Assistance to Health Care Workers, <i>Charter for Health Care Workers</i> , 1994.
<i>Christifideles Laici</i>	Pope John Paul II, <i>Christifideles Laici</i> (On the Vocation and the Mission of the Lay Faithful in the Church and in the World), 1988.
<i>Donum Vitae</i>	Sacred Congregation for the Doctrine of the Faith, <i>Donum Vitae</i> (Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation), 1987.
<i>Ethical and Religious Directives</i>	National Conference of Catholic Bishops (USA), <i>Ethical and Religious Directives for Catholic Health Care Services</i> , 1994.
<i>Evangelium Vitae</i>	Pope John Paul II, <i>Evangelium Vitae</i> (The Gospel of Life), 1995.
<i>Familiaris Consortio</i>	Pope John Paul II, <i>Familiaris Consortio</i> (On the Role of the Christian Family in the Modern World), 1981.
<i>Gaudium et Spes</i>	Vatican Council II, <i>Gaudium et Spes</i> (Pastoral Constitution on the Church in the Modern World), 1965.
<i>Humanae Vitae</i>	Pope Paul VI, <i>Humanae Vitae</i> (On the Moral Principles Governing Human Procreation), 1968.
<i>Populorum Progressio</i>	Pope Paul VI, <i>Populorum Progressio</i> (On the Development of Peoples), 1967.
<i>Salvifici Doloris</i>	Pope John Paul II, <i>Salvifici Doloris</i> (On the Christian Meaning of Human Suffering), 1984.



Preface

Life is a gift from God and health care is integral to the mission of the Church. Catholic Health Australia is committed to developing a culture which affirms life and healing, a culture which promotes the common good through just and compassionate health, aged, disability and community services. Our concern for others is motivated by the belief that proper respect for human beings entails respect for their dignity as people created and loved by God. The sanctity of their lives is an inevitable consequence of this.

A ministry to the sick, frail and dying is complex. Together with others who are engaged in health care, we offer expertise and experience and are committed to acting in the best interests of patients, residents and clients. We also acknowledge the spiritual significance of health, illness, suffering and death. This leads us to understand health care as being more than a scientific pursuit but rather an endeavour to care for the whole person, often beyond the limits of science.

This *Code* has been developed to assist those responsible for leading, managing and delivering the healing ministry to promote a culture of life. It applies across all Catholic health, aged and community care services. It sets the standards in which ethical health care practices can be pursued. Respect for the dignity of the person and the promotion of the common good are its goals.

The process for preparing the *Code* has been complex. In 1998, Catholic Health Australia commissioned the Plunkett Centre for Ethics in Health Care, under the guidance of a Steering Committee chaired by Bishop Michael Putney, to prepare the first set of ethical standards for all Catholic health and aged care services in Australia. The members of this Steering Committee,



PREFACE

together with the members of the Drafting Group, are listed on the next page. The Drafting Group prepared numerous versions of the document for consideration by the Steering Committee. Clinicians and other healthcare practitioners were consulted early in the development of the document: over twenty submissions were received from individual people working in Catholic health and aged care. Later, a draft of the document was made public at the Annual Conference of Catholic Health Australia and subsequently circulated widely for comment and suggestion: on this occasion over forty submissions were received from individuals and institutions. The Drafting Group carefully considered each submission, often seeking further advice from clinicians when an issue required more thought. At key points during the preparation process, the Steering Committee met to review the substance and the wording of the *Code*. The whole process was marked by a communal readiness to work hard and by a spirit of collegiality.

Catholic health, aged and community care services will need to ensure that their staff and those in leadership positions are aware of and understand the standards set out in this *Code*. This is important as the *Code* is a public statement of what the Catholic

ministry stands for and what the wider community can expect of Catholic health care services.

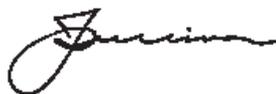
Catholic Health Australia is heartened by the approval granted to this *Code* by the Australian Catholic Bishops Conference. We are also very encouraged by the support of the Australian Conference of Leaders of Religious Institutes. We are grateful for the tremendous work undertaken by the Steering Committee chaired by Bishop Michael Putney and served so expertly by the Plunkett Centre for Ethics in Health Care.

This *Code* is not only a crucial resource for the Church's mission in health care, but can also be used by all people of good will seeking to care for the sick, the frail and the dying.



Sr. Annette Cunliffe RSC

CHAIRPERSON, CHA



Mr. Francis Sullivan

CHIEF EXECUTIVE OFFICER, CHA



Introduction

This Code of Ethical Standards for Catholic Health and Aged Care Services in Australia is addressed to all healthcare practitioners working in Catholic health and aged care organisations. We hope that it will also provide practical guidance for anyone working in health care, and for all who wish to deepen their understanding of, and reflection on, the theological and ethical context in which good health care is provided.

In preparing this *Code*, we have been mindful of two features of any Catholic approach to health care. First, we have sought to clarify the distinctive understanding of the meaning and significance of health and of health care, and of the appropriate goals of medical interventions, which is affirmed in the Catholic tradition. We realise that while this understanding has been very influential, at least in the Western tradition of health care, it is sometimes at odds with contemporary social mores. Secondly, however, we have sought to show there is no essential conflict between the best of secular medical ethics on the one hand and Catholic theological and moral teaching on the other.

We hope that this *Code* will be educational as well as action-guiding. By outlining the biblical grounds as well as the rationale in Church teaching for Catholic healthcare ethics, this *Code* seeks to be more than merely a list of directives or norms. It should be read as a whole document as well as referred to for specific guidance. We hope that the detailed index and the use of cross-referencing within the text will enable the reader to gain a comprehensive understanding of the issues relevant to any particular topic.

A word about terminology. The terms ‘healthcare service’ and ‘healthcare



INTRODUCTION

facility' are intended to refer inclusively to any Catholic hospital, aged care facility, community care facility, nursing home, hostel, hospice, palliative care service or related facility or service for people who are sick, aged or disabled.

The term 'healthcare practitioner' should be understood to refer inclusively to healthcare professionals, to doctors, nurses, allied health practitioners, community carers, administrators, etc. The words 'family' and 'relatives' should be understood to apply to all those people who are related to a sick or elderly person. We recognise that in many contexts it will also be appropriate to take into account those who have responsibility for a sick or elderly person founded on a standing relationship of care or friendship. In addition, the words 'patient' and 'resident' sometimes refer to elderly people who are frail, to people with mental illness, to people with disabilities, etc.

References have been kept to a minimum. In general they indicate the source(s), from within the Catholic tradition, of the general principles and specific provisions included in the *Code*. However, the Drafting Group and Steering Committee acknowledge with gratitude the help they have received from similar documents, in particular the *Ethical and Religious Directives for Catholic Health*

Care Services published by the US Bishops in 1994, the *Health Care Ethics Guide* published by the Catholic Health Care Association of Canada in 1991 (together with the revised 'consultation draft' of 2000), the *Charter for Health Care Workers* from the Pontifical Council for Pastoral Assistance to Health Care Workers (1995) and the various pre-existing codes of the member institutions of Catholic Health Australia.

This *Code* will be reviewed from time to time to take account of new clinical or ethical developments. In the meantime it should be read alongside any new documents or directives issued by the Church. It must also be read in conjunction not only with relevant commonwealth, state and territory legislation but also in conjunction with relevant guidelines, policies and standards promulgated by government and other statutory bodies.



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PART I

HEALTH CARE IN THE CATHOLIC TRADITION:

BASIC PRINCIPLES

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1. Respect for persons within a culture of life

Our care for people who are sick, aged or disabled is founded on love and respect for the inherent dignity of every human being.

O Lord, our God, how majestic is your name in all the earth!

What are human beings that you are mindful of them, mortals that you care for them?

Yet you have made them a little lower than God, and crowned them with glory and honour.

You have given them dominion over the works of your hands...

(PSALM 8:1,4-6)

In Jesus of Nazareth the Word of God took flesh among us (Jn 1:14). As “one like us in all things except sin” (Heb 4:15), Jesus reaffirmed the dignity and inviolability of every human being as a person created in the image of God (Gen 1:27). Through Jesus Christ, all men and women are called to a communion of life with God forever.

Life is a precious gift held in trust: we do not own our lives, nor do we have absolute dominion over life (Ps 8:6). From conception to death our lives are entrusted to our responsible stewardship as we take all reasonable measures to care for our health. Care for people who are sick, frail, aged or disabled is

fundamental to our Christian love of neighbour in imitation of Jesus, who came that we may have life to the full (Jn 10:10).

It is when a person’s life is most vulnerable — when just beginning or when about to end, and during times of illness and disability — that more vigilant and effective care is required. While never abandoning those in need, we also recognise the limits of human endeavour, and when life is ending we trust in the providence of God who counts even the hairs of our heads (Mt 10:30).

• • •

Health care is integral to the mission of the Church: Catholic Health Australia is committed to developing a culture which affirms life and healing, and which promotes the common good through just and compassionate health, aged, disability and community services and organisations.



2. Health care and the mission of the Church

Catholic health and aged care is called to respond to a person's healthcare needs with compassion and in fidelity to the healing ministry of Jesus Christ.

After this the Lord appointed seventy others and sent them on ahead of him...

“Whenever you enter a town and its people welcome you, eat what is set before you; cure the sick who are there, and say to them, ‘The Kingdom of God has come near to you.’”

(LUKE 10:1,8-9)

The healing of the sick was one of the major signs to accompany Jesus' proclamation of the reign of God. Jesus' example has inspired countless men and women to reach out to people who are sick or disabled, to those who mourn the death of loved ones, and to all who are forced to the margins of society. In caring for those in need, in fidelity to the teachings of Jesus, we meet Christ himself (Mt 25:31-46) and participate more deeply in the mystery of his death and resurrection, the mystery of grace that transforms human life and death.

Until recently the Church's institutional healing ministry was led chiefly by religious congregations of women and men. Their ministry is now being continued by, and under the leadership

of, lay men and women in collaboration with congregational sponsors and local churches. Catholic health care is also enriched by the contributions of those many staff whose religious, spiritual and other fundamental beliefs may differ from our own, but who share the convictions which motivate the Church's commitment to health care.

Catholic health and aged care is not confined to the treatment of disease or bodily ailment, and resists a mechanistic approach to dealing with illness. It, therefore, embraces all dimensions of the human person: physical, psychological, social, emotional and spiritual. Illness often provides people with an opportunity to renew or deepen their religious faith, and to appreciate their spiritual needs more keenly. The celebration of the sacraments and the pastoral care of patients, residents and their families are integral to, and distinctive of, Catholic healthcare services.



3. The goals of health care

The goals of health and aged care are

- *to promote health and prevent disease;*
- *to deepen our understanding of the causes of disease and to develop new forms of treatment;*
- *to save life, cure illness or slow the progress of disease;*
- *to relieve suffering and disability;*
- *to care for people when they are sick, disabled, frail or elderly; and finally*
- *to assist a person in his or her transition from this life in hope of the resurrection, while also caring for those who grieve that person's passing.*

“Lord, when was it that we saw you hungry and gave you food, or thirsty and gave you something to drink? And when was it that we saw you a stranger and welcomed you, or naked and gave you clothing? And when was it that we saw you sick or in prison and visited you?”
And the Son of Man will answer them, “Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me.”

(MATTHEW 25:35-40)

Advances in health care are improving the lot of human beings in ways unimaginable in the past. These advances are underpinned by research which is valuable in itself for the knowledge it yields and in its potential to further the authentic goals of health

care. This research often depends on the generous involvement of human subjects whose participation affirms their solidarity with others.

It is widely recognised that medical advances bring with them new ethical challenges. Good medicine and sound ethics go hand in hand: ethical judgments concern right and wrong ways to promote the good of the human person, and to promote the various particular goods, including life and health, which constitute human fulfilment. Clarity about what makes for health in the context of the overall good of the person, about the proper goals of medicine and research, and about the responsibilities of patients and health-care practitioners is crucial to ethically sound health and aged care. Research activities must respect the dignity of all involved.



3. THE GOALS OF HEALTHCARE

The overriding goal of health, aged and community care is to assist people to sustain the life and health which are fundamental to their total well-being. This means helping them maintain good health, endeavouring to save life when it is at risk, curing illness if that is possible or at least slowing the progress of disease, relieving distressing symptoms and otherwise caring for people.

Though we may never hasten death, there comes a time when death ought to be accepted: the goal then is to keep patients as free of pain and other suffering as is possible so that they may die comfortably, with dignity, and at peace with God, themselves and others.



4. Justice in health care

Everyone has the right to receive essential health and aged care services. These services should be allocated justly across a society, with special provision for the most disadvantaged or most vulnerable to neglect.

*He unrolled the scroll and found the place where it was written:
“The spirit of the Lord is upon me, because he has anointed me to bring good news to the poor.
He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord’s favour.”*

(LUKE 4:17-18; cf. ISAIAH 61:1-2)

Health is fundamental to a person’s total well-being. The just allocation of health and aged care resources across society is required to enable people to meet their basic health and aged care needs.

Modern medicine can be very expensive. The just use of society’s resources for the common good depends upon wise allocation decisions between health and other public goods, and within health and aged care itself. The Church’s teaching on the principle of subsidiarity requires us to recognise where responsibilities for decision making properly lie, so that decisions are made either by, or at least in consultation with, those who will be most affected by them.

Catholic health care should be distinguished by its willingness to work for justice in health care. We seek to serve and be advocates for those at the margins of society who are especially vulnerable to discrimination, for example, indigenous Australians, people with chronic diseases and chemical dependencies, and people with mental or physical disabilities.

Collaboration with other providers and integration of health care delivery can be effective ways of ensuring the just stewardship of limited resources. In these arrangements, it is essential that Catholic institutions and services be faithful to their Catholic identity, mission and ethical standards.

Australia is a pluralist society, and Catholic health care organisations may at times be asked to provide services not in keeping with the Church’s moral teachings. Although we cannot provide these services, those whom we are unable to assist in the way they would wish will, of course, be treated with courtesy, respect and compassion as they seek alternatives.



5. Collaboration in health and aged care

In the provision of health and aged care, patients, residents, practitioners, family and carers become a small community united in working for a person's good. The relationship which unites them is best understood as one of trusting collaboration in a common purpose.

For just as the body is one and has many members, and all the members of the body, though many, are one body, so it is with Christ.

God has so arranged the body that... the members may have the same care for one another.

If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it.

Now you are the body of Christ and individually members of it.

(1 CORINTHIANS 12:12,24,26-7)

Health and aged care depends upon trusting collaboration between patients, residents, practitioners and carers. These relationships should never be reduced to contractual or commercial arrangements; on the contrary, they should reflect the “covenant” relationship of faithful love between God and his people (e.g. Gen 15:18). They thus require mutual respect, trust, honest communication and appropriate confidentiality.

Patients and residents have the primary responsibility for judging which treatment and care options serve their authentic good in the totality of their circumstances. The healthcare practitioner, often working as a member of a

team, has a duty to provide people with all the information they need to make wise judgments about their treatment and care options. Healthcare practitioners must respect a person's convictions and spiritual needs, and the moral responsibilities of all concerned. They should be sensitive to individual and cultural differences which are relevant to health and aged care. Patients and residents in turn have a responsibility to use the physical and spiritual resources available to the best of their ability.

When people are incapable of making their own decisions, their family, guardian or other legal representative and the senior doctor (or other relevant professional) have the responsibility of discerning what is in the patient's or resident's best interest, in the light of what is known of the patient's wishes.

The Church recognises that it does not have a ready answer to every question that may arise, and it respects the competence and experienced judgment of professionals in their fields of expertise. In their turn, staff at all levels in Catholic health and aged care organisations should exhibit the professionalism expected of them, and should abide by this *Code*.



6. Respect for personal embodiment

Because the human person is a unity of body and spirit, a person's body is not simply an instrument to be manipulated in isolation from the authentic good of the person. Human sexuality and procreation in particular are personal, not just biological, realities.

Then the Lord God said, 'It is not good that the man should be alone; I will make him a helper as his partner...'

Then the man said, 'This at last is bone of my bone and flesh of my flesh...'

Therefore a man leaves his father and his mother and clings to his wife, and they become one flesh.

(GENESIS 2:18,23-24; cf. MATTHEW 19:4-6)

In Catholic teaching the human person is a unity of body and spirit, in which the body is not just a complex of organs, functions and energies but is the embodiment of a human person, by which he or she relates to others, God and the world. Respect for the human person thus includes respect for his or her physical life and well-being, and for the integrity of the body.

Respect for one's body means taking reasonable care of one's health with appropriate rest and relaxation and moderation in food and drink. The misuse of drugs and other substances undermines a person's freedom and capacity for relationships with others. Respect for the integrity of the body requires that organ and tissue donation never destroy a person's functional integrity.

Sexuality pervades all aspects of the human person as a unity of body and spirit, and is intended as a special expression of love, that is, of the gift of self and the acceptance of another. Sexuality embraces a person's affectivity, capacity to love and to procreate and, more generally, to form bonds of communion with others. Genital sexuality, in particular, finds its proper place in the commitment and joy of marriage, in which physical intimacy is a sign and pledge of delight in one's spouse, openness to new life and spiritual communion.

We welcome those advances of science which help couples to identify times of fertility, or which assist the natural life-giving potential of sexual intercourse while protecting every embryo so conceived. However, our understanding of the human body as a personal reality, and of the marital and procreative significance of human sexuality, leads us to reject treatments and procedures which compromise a person's bodily integrity, or which separate the various dimensions of human sexuality.



7. Solidarity and the mystery of suffering and death

Illness, disability and suffering are never good in themselves: health care properly seeks to relieve them. There are, however, limits to what health care can achieve. Even when suffering and death cannot be eliminated, they can nonetheless acquire a positive, life-giving and redemptive value, especially from the perspective of religious faith.

Then he said to them, “I am deeply grieved, even to death; remain here, and stay awake with me.”

And going a little further, he threw himself on the ground and prayed, “My Father, if it is possible let this cup pass from me; yet not what I want but what you want.”

(MATTHEW 26:38-39)

Sufferings of various kinds are unavoidable and, although death completes the natural cycle of life, it is also “the last enemy” (1 Cor 15:26), and in that sense an evil because it puts an end to this life in all its goodness. Christians, along with their fellow human beings, should work to overcome suffering and all that opposes true human fulfilment.

Suffering and death can, however, acquire a positive value in a person’s life. For Christians in particular, the encounter with suffering and death, when endured with courage and patience, and supported by others, can take on a life-giving meaning in the light of Jesus’ suffering. The Christian hope of resurrection transforms the mystery of death, and the dying person is encouraged to place his or her trust in

Christ whose life, death and resurrection have given new meaning to all of human existence (1 Cor 15).

Chaplains and pastoral care workers in Catholic healthcare services should be attentive to the opportunity that illness or imminent death may provide for a person to reaffirm or to discover his or her religious beliefs.

Catholic health and aged care services should be marked by a material and spiritual solidarity with people who are sick, disabled, frail, elderly or dying which is not governed primarily by economic considerations. We should never harm or abandon a fellow human being, but like the women who waited by the cross of Jesus (Mt 27:55) strive to accompany those in need, no matter how distressing or disadvantaged their circumstances may be.



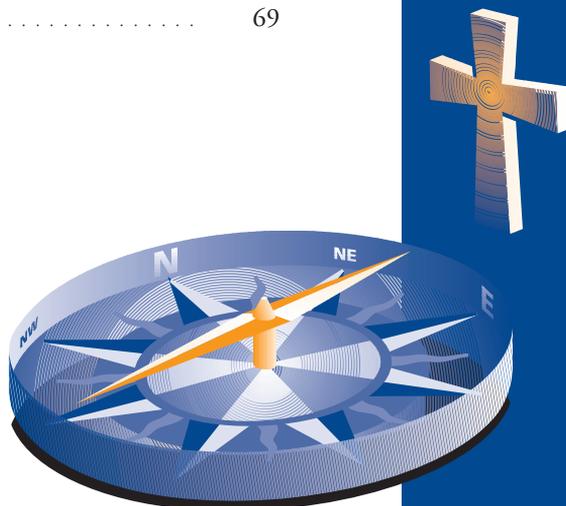




PART II

SPECIFIC ISSUES

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1. Decision making in health care

Introduction

- 1.1 Life and health, along with many other good things such as knowledge, friendship, and a sense of one's vocation, are among the goods involved in human happiness and well-being. Since each of these goods has value in a person's life, decisions about one's health care are sometimes difficult: health has to be sought in the context of a life in which things other than one's health also matter. In addition, decisions sometimes have to be taken in healthcare institutions away from the support which is often to be found in one's personal household. Accordingly, Catholic health care should seek to support and collaborate with people as they face important healthcare decisions in their lives.

Responsibility for health care

- 1.2 The primary responsibility for safeguarding and maintaining one's health so far as that is reasonable belongs to each person in his or her own right. It follows that each person is primarily responsible for making decisions concerning his or her own health (and that of any incompetent person for whom he or she is also responsible). Since people sometimes need to seek help and advice in order to make

reasonable healthcare decisions, this responsibility may at times be best exercised in consultation with others.

Information giving

- 1.3 To enable patients or their representatives to make healthcare decisions responsibly, healthcare practitioners should take care to explain clearly and accurately the patient's condition, the nature of the treatment options, the patient's prognosis with and without treatment, and the risks and harms inherent in any proposed treatment which the patient would be likely to think significant in making a decision. Where the decision to be made is a serious one, patients may be encouraged to have the assistance of a relative or friend and, if they desire, to seek a second opinion.

Decision making capacity

- 1.4 In the context of health care a competent person is someone who is able to understand the diagnosis and what is proposed and to evaluate healthcare options. Sometimes a patient's capacity to make his or her own healthcare decisions is reduced, either partially or entirely, temporarily or permanently (e.g., by immaturity, mental illness, feelings of fear and



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vulnerability, sickness, pain, ignorance or confusion). For this reason, healthcare practitioners may need to assist patients to make their own decisions, and in some cases may need to assess the patient's competence to make decisions. A clinical diagnosis of a mental health disorder (such as depression) relevant to a patient's decision making capacity should be made by a healthcare professional with appropriate expertise. If the patient is either temporarily or permanently incompetent, or reduced in his or her ability to understand or make decisions, the patient's family, primary care givers or those legally appointed (either by public authorities or by the patient's own prior decision) to represent the patient should be consulted (see also 1.6).

Consent

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1.5 Except in the case of an emergency, physical and/or psychological tests or treatment should not be administered to any *competent* patient until all relevant information has been disclosed and considered, and the patient's free and adequately informed consent has been given. Care must be taken to ensure that the patient is competent to consent, and is not being coerced or intimidated.

1.6 Except in the case of emergency, physical and/or psychological tests or treatment should not be administered to an *incompetent* patient until all relevant information has been disclosed and considered by the patient's legitimate guardian or representative, and the consent of that representative has been given. The decision of the patient's representative(s) or guardian(s) should be based on a judgement about what is in the patient's best interests. In making these judgements, those concerned should take into account not only the patient's medical condition and prognosis but also, in the first instance, the patient's previously expressed and reasonable wishes, and then the views of the patient's family and relevant others.

1.7 In the case of emergency, if consent cannot be obtained, healthcare practitioners should act in the patient's best interests, following the patient's previously expressed and reasonable wishes and taking into account the views of the patient's family and relevant others (see also 1.16-1.19).

Truth-telling

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1.8 Patients need to be able to rely on their practitioners to communicate truthfully and sensitively with, and



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to be accessible to, them. They need this for many reasons, for example, in order to fit their health care into the rest of their lives, in order to be able to consent in a free and adequately informed way, in order to be able to prepare for death. Although it is wrong to lie to patients, the information-giving process may need to take place over a period of time rather than all at once. On this matter, as on others, practitioners should be sensitive to individual and cultural differences.

Privacy and confidentiality

1.9 The privacy and the confidentiality of the patient's relationship with a healthcare professional are integral to any healthcare relationship. Information gained in the course of a healthcare relationship should be shared only with those in a therapeutic relationship with the patient on a 'need to know' basis. Respect for confidentiality will not normally inhibit/exclude the patient's family and/or friends from participating in the care of the patient. While healthcare practitioners should support the patient's family and friends in their efforts to care for the person who is ill, they should not fail to respect the patient's right to decide who shall be privy to

healthcare and other personal information. Conversations with family and others should give priority to the patient's wishes and must not exclude the patient from discussions or decisions about his or her own health care.

- 1.10 Much healthcare information is stored in medical files, electronic records, healthcare databases and genetic registers. To the extent that records identify a patient they should be treated as confidential and should only be accessible to those in a therapeutic relationship with the patient, unless he or she has consented to further access. In some situations it may be appropriate for healthcare professionals to encourage patients to share information for the sake of the health of others. In rare cases it may be morally or legally necessary for healthcare professionals to divulge confidential information in order to prevent serious harm to the patient or to others. Appropriate forms of protection of healthcare information should be implemented to ensure patients have confidence in the system of recording and maintaining information.
- 1.11 Though clinical education depends in part on the generosity of



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patients who are willing to be seen by students, the patient’s wishes should always be sought and respected.

Legitimate healthcare interventions

1.12 Medical interventions will normally be therapeutic, that is to say, they will be oriented to the health of the patient. Healthcare professionals should have a clear understanding of the purpose for which an intervention is proposed: for instance, to provide diagnostic or prognostic information, to save a life, to improve or to maintain the patient’s health by curing an illness or slowing the course of an illness or stabilising the patient in a reasonably satisfactory condition, to relieve pain or other symptoms of illness, to nourish and sustain the patient. Healthcare professionals should try to ensure that patients clearly understand the purpose of a proposed intervention.

Futile and overly-burdensome treatment

1.13 Treatment may legitimately be forgone if it is either therapeutically futile (i.e., makes no significant contribution to cure or improvement) or overly-burdensome (i.e., the benefits hoped for do not justify the foreseeable burdens of treatment). This is the same as

saying that treatment may legitimately be forgone when it is judged to be “extraordinary” or “disproportionate” rather than “ordinary” or “proportionate”. (See also 5.9-5.12)

1.14 The benefits of treatment include preservation of life, maintenance or improvement of health, and relief of discomfort. They do not include deliberately shortening the life of a person who is sometimes wrongly described as “better off dead” nor exploiting a person’s body for the benefit of others. The burdens of treatment to be properly taken into account may include pain, discomfort, loss of lucidity, breathlessness, extreme agitation, alienation, repugnance and cost to the patient. In some cases, the burdens of treatment may also include excessive demands on family, carers or healthcare resources. Judgments about the futility of a treatment outcome must be distinguished from judgments about the “futility of a person’s life”: the former are legitimate, the latter are not.

Quality of Life

1.15 Good health presupposes the sanctity of human life, that is, the truth that every human being is of unconditional worth. Care



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should be taken with the use of the concept or term ‘quality of life’. This concept is used in two quite different ways, one which is consistent with a recognition of the unconditional worth of every human being, the other which denies this truth. It is consistent with the principle of the sanctity of human life to recognise that the burdens a life-sustaining treatment may impose on a patient may be such as to make it permissible to omit that treatment. It is not consistent with the principle of the sanctity of human life to claim that the value or worth of the life of one human being can be measured, or compared with that of another, or to claim that the value or worth of a human life can be in any way reduced by illness or disability.

Refusal of treatment

1.16 Patients have the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable, and such refusals must be respected. In addition, healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not they agree with the patient’s refusal (see also 5.4). There is, however, an

obligation to prevent suicide when this is possible.

Unreasonable requests

1.17 Sometimes patients may request a test or treatment or place conditions on their treatment which a healthcare professional or facility judges to be unreasonable. Healthcare practitioners should endeavour to explain to the patient why they think the desired test, treatment or conditions are unreasonable, and thus why they are not obliged to comply with the patient’s request or, in some cases, undertake further care of the patient. However, if there are medically and ethically sound alternatives, they should offer the patient the opportunity of a second opinion and arrange for the patient to be cared for by another suitable practitioner.

Medical power of attorney

1.18 Patients should be encouraged to talk with their family, doctors and other relevant people about their hopes for, and fears of, treatment, and to communicate to them their wishes about treatment should a situation arise in which they are unable to make their wishes known. Patients and residents in care should be informed of their right to appoint someone to make decisions on their behalf should a



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situation arise in which they were unable to do so themselves (see also 1.6 and 1.7).

The role of the family and others

- 1.19 The patient's family and emotional ties should be respected and supported. When a patient is unable to participate in treatment decision making the views of family members and relevant others should be taken into consideration when health care is recommended and administered. In the case of conflicting judgments people should be helped to reach an understanding of the decisions which have been taken. (See also 1.4-1.7 and 1.9)

Minors and decision making

- 1.20 Parents have the primary responsibility for the health and well-being of their infants, young children and adolescents. Until a child is able to take legal and moral responsibility for his or her own healthcare decisions, treatment should not be administered (except in the case of emergency) without consultation with, and the consent of, the child's parent(s) or other duly-appointed guardian(s). A child's ability to understand healthcare decisions, and thus to agree to treatment, depends on his or her level of understanding and

maturity. This competence normally develops over time and thus must be (re)assessed in relation to each proposed medical intervention. Whenever possible both parents and child should be assisted to understand proposed treatment options and their consequences and implications. Where appropriate, the agreement of a child to treatment should be sought. If parents refuse life-saving treatment for a child, emergency treatment should be given and a court order or the appointment of a guardian may be appropriate.

Non-therapeutic interventions

- 1.21 Persons with the maturity to make decisions freely and with understanding may allow themselves to be subjected to procedures which are not therapeutic for them and which involve some risk to their own life and health, for example, in tissue donation (see also 3.14 and 3.18-3.20) and research (see also 6.4 and 6.5). Because such decisions should be motivated by generosity, they may not be imposed on a person, nor made on behalf of those unable to give consent. In some cases the question arises whether a young child who is unable to give consent may be subject to a minor, non-therapeutic intervention conducted



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with a view to a critical intervention that is expected to be therapeutic for another family member (e.g. obtaining bone marrow to treat a sibling with a terminal illness such as acute leukemia). Out of respect for a child's personal bodily integrity great caution should be exercised in this matter. Parents or guardians, taking into account a child's fears and lack of understanding, should never expose their child to a non-therapeutic intervention which carries a significant risk or which the child, if he or she were competent, might refuse on reasonable grounds. Similar restrictions apply to non-therapeutic interventions on other people who are not competent.

Self-medication

1.22 At times, patients admitted to healthcare institutions or residents in aged care facilities may already be using alternative treatments or prescribed treatments and medications unrelated to the condition for which they were admitted to the facility. While staff should not become involved in such "self-medication", neither should they interfere with a patient's use of these medications unless their use is illegal or undermines the patient's health care. Patients should be asked if they are taking

any medications or alternative treatments, and informed that it is in their interests to make this known to healthcare practitioners.

Undergoing tests

1.23 Since decisions about whether to undergo certain tests may have significant consequences not only for the person being tested but also for his or her relatives and others, healthcare practitioners should provide advice and assistance to help individuals to make these decisions. Tests should only be undertaken when the results will be of use in the health care of the person being tested (or relevant others), or when they are required by law for public health reasons.

1.24 Because of the seriousness of the information which may be obtained through some testing (e.g. testing for HIV, Hepatitis C, genetic status), counselling should be offered about the implications of the possible results before such tests are undertaken. The results of such tests should not be divulged to others for purposes that are not of a therapeutic benefit for the person tested, unless both concerned have consented to this use, or others are endangered, or there is a public health requirement.



Bedside allocation issues
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1.25 In providing care for an individual patient, healthcare practitioners should be aware of the need to be just in the way they allocate health-care resources at the bedside (such as allocating time and attention and in the use of expensive therapies). However, no one should be denied basic or ordinary care.

References
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General: Pope Pius XII, *The Intangibility of the Human Person* (1952); *Evangelium Vitae* 19-20, 24-25, 65; Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980); *Charter* 72-74

Confidentiality: *Catechism* 2489, 2491-92, 2510-11

Information-giving, truth-telling and consent: *Catechism* 2468, 2483-86; *Charter* 72-74, 125-127

Involvement of relatives in decision making: *Charter* 74



2. Human sexuality, procreation, and the beginning of life

- 2.1 In Catholic teaching, the human body as male or female has a “nuptial significance”: marital love is sacred and purposeful, a gift from God which is intended to be a fully human, reciprocal and total gift of self, faithful, exclusive, complementary and open to new life. Catholic teaching affirms only those sexual acts which are an expression of that kind of love, and not extra-marital sexual acts be they heterosexual, homosexual or auto-sexual. Catholic facilities show no disrespect for persons when they only offer those services which are in keeping with Catholic teaching.
- 2.2 In sexual and reproductive health matters the responsibility of Catholic health care is to give counsel which is both medically accurate and a witness to the teachings of Christ and his Church. Catholic health care should treat all persons with respect, compassion and sensitivity whatever their sexual or marital status, orientation or lifestyle (see also 4.12 and 4.13).

Fertility and infertility awareness and responsible parenthood

- 2.3 Catholic health care recognises that couples should use their procreative capacity responsibly. In circumstances such as those in which adequate care for another

child seems impossible or those in which there is a high risk of a very serious genetic disorder, couples may reasonably decide to avoid pregnancy. They should be provided with appropriate knowledge and skills to enable them to determine times of fertility and infertility so that they themselves can decide when to engage in sexual intercourse.

- 2.4 An understanding of modern methods of natural family planning increases a couple’s knowledge of the reproductive cycle and thus enables them more easily to take responsibility for their marital life, reproductive health and procreation. In addition, that knowledge can also enhance their self-confidence with respect to their sexuality and fertility. Catholic healthcare professionals and healthcare facilities have a special responsibility to support scientific and professional natural family planning services, and to ensure that advice offered in this area respects the integrity of marriage and sexual and procreative dignity.

Sterilisation and contraception

- 2.5 In Catholic teaching the marital act has both a unitive and a procreative significance as an act of love making that is ordered to life



making. If either significance is deliberately excluded from the marital act, the other is also diminished. The use of procedures or drugs deliberately to deprive the marital act of its procreative potential, whether temporarily or permanently, is not permissible. Also unacceptable are birth control methods that involve a significant risk of preventing an embryo from implanting or induce the shedding of the lining of the womb together with any already implanted embryos: such procedures are in fact abortifacient not contraceptive.

- 2.6 Treatments intended to cure or alleviate a present serious physical pathology (e.g. irradiation of the ovaries in the treatment of cancer) which as an undesired side-effect cause sterility, whether temporarily or permanently, are permitted if a simpler treatment is not available and provided they do not pose an undue risk to new human life. (See also 2.5 and 4.13)

Infertility counselling

- 2.7 Infertility can be a cause of great suffering. It is seldom merely a straightforward medical problem able to be resolved by simple therapeutic intervention. Infertility counselling is thus of considerable pastoral significance and the prac-

itioner who engages in it is immediately involved in the emotional and spiritual development of the couple. Such care properly involves pastoral and other care professionals.

- 2.8 Infertile couples now have various options for overcoming their infertility by technological interventions. Some of these possibilities greatly increase the chances of conception and at the same time can be undertaken in a way which is respectful both of human life and of the dignity of all the participants. The children thus conceived have their origin in an act of marital intercourse by their parents.
- 2.9 Other forms of intervention may increase the chances of conception but only at the expense of respect for human life and dignity. For example, many embryos produced in vitro are discarded and even those who survive risk being treated as the objects of technology. Clear and compassionate counselling should advise couples on these matters.

Assisting procreation

- 2.10 Investigations and remedies for infertility must respect the integrity of marriage and the sacredness of sexual expression in



marriage. Semen should only be collected in ways respectful of human dignity and marriage (i.e. surgically or in the context of the marital act).

- 2.11 Procedures which assist the marital act to achieve its purpose are morally permissible, but those which substitute for it are not. For this reason Catholic healthcare facilities should not provide or refer for technological interventions such as in vitro fertilisation (IVF), intra-cytoplasmic sperm injection (ICSI) or artificial insemination by donor (AID).
- 2.12 Theological discussion continues on the question of the permissibility of the procedure in which the husband's sperm is obtained as a result of a marital act of love, perhaps prepared in various ways, and then reintroduced to the wife's reproductive tract with a view to fertilisation. In addition, opinion is divided on the permissibility of some methods of gamete intra fallopian-tube transfer (GIFT) in which sperm is obtained as a result of a marital act and eggs and sperm are introduced into the woman's reproductive tract, and every effort is made to maximise the chances of the embryo surviving after fertilisation in the fallopian tube. With

respect to both these procedures the question to be answered conscientiously, both by couples considering them and by Catholic facilities providing them, is whether a procedure assists the marital act or alternatively replaces it in the origin of the child.

- 2.13 Procedures designed to assist procreation should only be made available to couples who are able to give a child the security of a marital relationship.
- 2.14 Catholic healthcare facilities should not use sperm, ova or embryos derived from third parties, nor assist in conception with a view to a surrogacy arrangement.

Respect for human embryos

- 2.15 The human being from the moment of formation of the first cell is to be respected and treated as a person with an inviolable right to life. Catholic healthcare facilities should not engage in procedures which intentionally and in themselves damage or destroy an embryo.
- 2.16 Procedures carried out on an embryo *in vivo* (e.g. in the womb) are permissible where they do not involve undue risks to the embryo but are directed toward the



improvement of the embryo's health or prospects of survival.

- 2.17 Catholic healthcare facilities should not take part in procedures which lead to the asexual production of human embryos or beings like human embryos, or which are otherwise contrary to respect for human life in its origins or to respect for human dignity. Examples of such procedures include attempting to form a human embryo other than by the fertilisation of a human ovum by a human sperm, deliberately causing twinning by fission of an embryo, or attempting to gestate a human embryo outside the womb.

Pregnancy

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- 2.18 The Catholic tradition affirms the special dignity of every woman carrying a child in her womb. In pregnancy a mother becomes bound to her unborn child physically, emotionally and spiritually, and so fulfils a unique role in God's plan for the creation of new life. Catholic healthcare services should support parents and their unborn children throughout pregnancy and childbirth as an expression of respect for the inherent dignity of every human being.

Prenatal diagnosis

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- 2.19 Once pregnancy is confirmed, parents have access to a wide range of diagnostic procedures to gain information about the health and progress of the embryo or foetus and the health of the mother. Before a diagnostic procedure is undertaken, the significance of the procedure, its risks for the foetus, and the reliability of its possible results, should be explained to the parents to enable them to make an informed decision about whether to go ahead with the procedure.
- 2.20 The proper purposes of prenatal diagnosis are to monitor the health of the child, to enable earlier and more effective therapy, and/or to inform and assist parents as they prepare to welcome their new child. The consent of the parents, or at least of the mother, is required and the methods used must safeguard the life and health of the embryo or foetus and the mother. Prenatal diagnosis in Catholic facilities should not be undertaken with a view to aborting an unborn child deemed to be unacceptable for any reason. Prenatal diagnosis must not involve any disproportionate risks for the unborn child or the mother. As a matter of respect for women and children, and to ensure



the just allocation of resources, facilities should resist pressures to provide unnecessary and/or medically futile prenatal tests.

Prenatal and genetic counselling

- 2.21 The results of prenatal testing and diagnosis should be presented to the parents fully and objectively, and in a manner which respects human life. Responsible counselling and pastoral support are to be made available to parents and family, especially when foetal abnormalities are diagnosed. Counselling must not create a link to abortion. If appropriate, parents should be helped to consider the alternatives to abortion and offered support during pregnancy and following the birth of their child.
- 2.22 Because of a family history or for other reasons, genetic counselling may be appropriate to inform couples of the likelihood of their children having a genetic abnormality, of the difficulties this would involve, and of the assistance available should that occur. Genetic counselling may also include advice about fertility and infertility in accordance with Catholic teaching on sexuality and marriage so that couples may make responsible decisions about forming a family and about the timing and spacing of

children (see also 2.3).

Abortion

- 2.23 Catholic facilities should not provide, or refer for, abortions, that is, procedures, treatments or medications whose primary purpose or sole immediate effect is to terminate the life of a foetus or of an embryo before or after implantation. Such procedures, treatments and medications are morally wrong because they involve the direct and deliberate killing of an innocent human life in the earliest stages of development.
- 2.24 Women (and men) are often hurt by abortion. While not condoning the decision to abort an unborn child, Catholic healthcare services should treat with courtesy and respect all who seek assistance, and should be ready to offer compassionate physical, psychological, moral and spiritual care to all who have suffered from the trauma of abortion.

Miscarriage

- 2.25 Pastoral care that is sensitive to the emotional and spiritual needs of the parents is to be provided to parents who lose a child through miscarriage or stillbirth. A child who is miscarried but who may be still alive should be baptised if



this is possible and is desired. Procedures should be in place to assist with the proper disposal of the body or remains in ways respectful of the dignity of human life and in keeping with the parents' wishes.

Difficulties during pregnancy

- 2.26 Catholic health care has a special commitment to providing material and emotional support to parents for whom pregnancy is not a welcome event, or for whom, though welcome, pregnancy brings with it significant burdens. Women should be assisted to continue with their pregnancy and should also be directed to agencies which may be able to provide additional help with the many matters that arise during pregnancy.
- 2.27 Should situations arise during pregnancy in which the health of either the mother or her unborn child is at risk, the goal of Catholic healthcare facilities is to provide the best possible care for both mother and child, and to help parents make prudent judgments about treatment options which may affect the health of mother or child.

Threats to health and life

- 2.28 In some cases a woman may develop a life- or health-threatening condition for which the only effective and available treatment is one that would endanger the life or health of her unborn child. Such treatment is permissible provided the risks to the woman's life or health posed by her condition are at least comparable to the risks the treatment would pose for the life or health of her child, and provided any harm to the unborn child is neither the intended goal nor a means to the treatment goal. Every effort must be taken to minimise the adverse effects of the mother's treatment on her child, both before and following birth.
- 2.29 An ectopic pregnancy can pose a grave threat to the lives of both a pregnant woman and the embryonic child she carries. Careful monitoring is required and ectopic pregnancies may safely resolve themselves in time. However, a woman's life should never be endangered by an inappropriate delay in treatment. When treatment is required, the pathological situation should be resolved quickly, though not by resort to any procedure or treatment that is abortifacient (in that the death of



the embryo is being intended as an end or as a means to the treatment goal), nor by any treatment that involves a surgical or chemical assault on the developing embryo (see also 2.23).

Interventions prior to birth

2.30 Unless there is a serious risk to the mother's life, she should be encouraged to carry her child until approximately full term. However, when the continuation of pregnancy poses a serious threat to the health of the mother or child, therapeutic interventions (e.g. induction of labour) are permitted provided they do not involve a direct assault on the unborn child, nor involve an unwarranted risk to the child's life or health, given the medical resources available and the child's prognosis if the intervention is delayed.

2.31 Parents awaiting the birth of their child face special difficulties when an abnormality is so severe that their child, even if born alive, will not be able with ordinary assistance to maintain life outside the womb for long, if at all. In managing such pregnancies, the unborn child with a severe disability (e.g. anencephaly) must be treated with the same unconditional respect that is due to a healthy child. In some of

these cases, a serious threat to the health of the mother or the deteriorating condition of the child may make it appropriate to induce delivery before full term. The timing and method of induction should not unduly risk causing the child's death.

Neonatal care

2.32 The care of new born children with severe abnormalities, or with extremely low birth weights or other serious health needs, can involve difficult ethical decisions both about the just allocation of resources and about the benefits and burdens of treatment. Ordinary care and comfort is to be given to all newborn children, regardless of their life expectancy (see also 5.10-5.12). The appropriateness of more extensive measures, for example, surgery and specialised neonatal intensive care, is to be determined in the light of the child's condition and of the foreseeable benefits and burdens of the treatment options for the total good of the child.

Foetal surgery and experimentation during pregnancy

2.33 Surgery may in some circumstances permit earlier and more effective treatment of foetal disorders, or may be necessary to ensure



the safe delivery of a child. The mother is also the subject of the surgical intervention, and it is her responsibility, both prudently and conscientiously, to determine the appropriateness of surgery, given the benefits, burdens and risks it would pose for both herself and her unborn child.

- 2.34 In some cases where surgery is indicated, a woman may be unable to make her own decision and may

be in need of representation. In other cases a mother and/or father's own decision may unjustifiably risk the child's life, or risk causing permanent damage to the health and well-being of the child. In these circumstances, Catholic healthcare practitioners may need to provide expert counselling for the parents and/or take other ethical and lawful measures to enable the unborn child to receive appropriate treatment.

References

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3. Respect for bodily integrity in health care

Introduction

3.1 The human person is a unity of body and soul, and our living bodies are intrinsic to our personhood. While injury, disease or congenital malformation may reduce a person's ability to participate fully in the goods of this life, he or she always remains a member of the human family. Every sick or disabled person is to be respected and protected at every phase of development, from conception until death. Catholic health care has a particular mission to continue to care for a person even though disease or disability has severely diminished his or her capacity to participate in social, economic and even spiritual life.

Health promotion

3.2 Research and education to promote healthy living, to maintain health and to prevent illness and disability are significant parts of Catholic health and aged care, which has a particular vocation to assist those who are impoverished or lacking educational or employment opportunities and whose health and well-being are therefore at greater risk.

Harm prevention

3.3 While Catholic healthcare institutions must always give positive witness to respect for life and health, they should always seek to be a place of welcome and safety even for those who endanger themselves by attempting suicide, misusing substances, engaging in high-risk sexual activity, or undertaking other activities which endanger health and life. They will assist those in danger of self-harm to believe in their own worth, to recover and maintain good health, and to be rehabilitated. If patients are determined to act in dangerous or self-destructive ways, health professionals may intervene with morally and practically available means to help avoid that harm.

Drug rehabilitation

3.4 Misuse of substances such as alcohol and drugs jeopardises the ability of the human person to think and act responsibly and has the potential gravely to damage the person and others. The care of those who misuse substances should always be directed to the good of the person with an addiction rather than to mere containment of drug problems. Accordingly, in their care for such



3. RESPECT FOR BODILY INTEGRITY IN HEALTH CARE

people and their families, Catholic healthcare facilities should be places of welcome, providing outreach and support with the immediate goals of detoxification, rehabilitation, sustaining the person in abstinence and responsible behaviour thereafter and throughout caring for the family.

- 3.5 Catholic programmes aimed at dealing with the harms associated with the misuse of substances must have rehabilitation as the primary goal and must give clear witness both to the evil of the misuse of substances and to the goal of overcoming addiction (see also 8.10-8.13 and 8.16).

*Care of persons who
have been sexually assaulted*

- 3.6 Rape and other sexual assaults are terrible acts of violence and violations causing great personal suffering. By what they say and do healthcare professionals in Catholic facilities hope to be agents for restoring the person's trust and confidence in others, her or his self-esteem and sense of security. When caring for victims of sexual assault, Catholic healthcare facilities should seek primarily to be a source of support and reassurance to those who have been brutally abused. Catholic health

services should, wherever possible, have trained staff to care for those who have been sexually assaulted.

- 3.7 The privacy of those who have been sexually assaulted is a major concern. Catholic healthcare facilities should endeavour to shelter them from further hurt while at the same time respecting legal requirements and the need to bring perpetrators to justice.
- 3.8 A woman who has been sexually assaulted may be particularly traumatised by the prospect of pregnancy. Catholic facilities can assist her in identifying periods of fertility and infertility, ovulation and menstruation, and by providing her with the best scientific information available, as well as morally permissible treatment options, reassurance, counselling and support based on that information.
- 3.9 A woman who has been the victim of rape is entitled, as a matter of justice, to defend herself against its continuing effects. Interventions following an assault which are aimed at preventing the union of sperm and ovum through, for instance, suppressing ovulation are therefore permissible. Interventions aimed at causing abortion after rape, however, are not



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permissible. Measures designed to prevent ovulation or fertilisation may only be used when they involve no significant risk to the life of a developing embryo. Direct referral to those rape crisis centres which routinely administer abortifacients should only occur if reasonable steps have been taken to exclude the likelihood of pregnancy.

*Body image, gender
reassignment and mutilation*

- 3.10 Catholic healthcare facilities should resist cooperation in the excessive cultural emphasis on physical appearance. Those suffering from various psychological and spiritual disorders associated with poor body image should be assisted to resist the misuse of drugs, surgical and genetic procedures in pursuit of some idealised ‘perfect body’.
- 3.11 The first priority in dealing with adults who experience conflict in relation to their gender identity is sensitive psychological and/or psychiatric management. Positive means should be found to assist the person to come to terms with his or her bodily nature. Interventions should be limited to authentic therapies for pathological conditions. Procedures or interventions that deliberately render a healthy sex organ dysfunctional,

mutilate it or remove it, as a treatment for a psychological or psychiatric problem, are not permissible.

- 3.12 The care of children born with ambiguous sexual physiology should allow for and/or assist a developmental resolution. Parents should be advised to consider surgery only as a last resort. (See also 1.20)
- 3.13 Respect for the human body excludes those procedures which unnecessarily damage or destroy any part or function of the body, for example, direct sterilisation, female genital mutilation, and some kinds of cosmetic surgery. For the sake of a person’s bodily health as a whole, it may be advisable to repair, modify or even remove a part of the body.

Organ and tissue replacement

- 3.14 Today many people owe their lives to organ and tissue transplants. Such new technologies are hailed by the Church as a great service to life. One way of nurturing a culture of life is through a willingness to donate organs and tissues with a view to offering a chance of health and even of life itself to people who are sick.



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- 3.15 Patients who need these interventions often have few options if they are to survive, may be especially dependent, and may be offered interventions which are experimental and/or very expensive. Care must therefore be taken to ensure that their participation is fully voluntary and that information about the burdens and risks associated with the transplant procedure is presented realistically. Other treatments should be made available whether or not the patient opts to take part in organ or tissue replacement.
- 3.16 Parts of the human body are not to be treated as commodities. Trade in human body parts is unacceptable, as is any other disrespectful use of the organs or tissues of a living or deceased person.
- 3.17 Organ and tissue replacement technology involves significant costs and burdens and can present especially acute dilemmas for the just allocation of resources. Patients should be treated equally when being admitted to transplant programmes. There should be no unjust discrimination on the basis of social factors such as inability to pay, mental illness, past misuse of substances, lack of family support, lack of education or English language

skills, advanced age, remoteness or ethnicity. Only clinical factors such as urgency, need and ability to benefit should be taken into account.

Tissue procurement from living donors for research or transplantation
.....

- 3.18 The giving of excess or regenerative tissue, for the purposes of testing, research or donation to others, is to be encouraged provided there is appropriate consent and there are no significant risks to the patient.
- 3.19 Donation of non-regenerative tissue is only permissible where this will not seriously impair function, be detrimental to the discharge of the donor's responsibilities, or involve serious danger to the donor's life, future health or identity. Given the risks, such an intervention would only be warranted if the needs of the recipient were very great and could not reasonably be met by other means and the prospective benefits were very considerable.
- 3.20 Respect for the inherent dignity and inviolability of the human person demands that removal of tissues from living donors is done in response to an informed decision to donate the tissue as an



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act of genuine charity. (In the case of children and others unable to comprehend the intervention see also 1.20 and 1.21)

- 3.21 Special care must be taken to ensure that members of families or small communities are not unduly pressured to consent to tissue removal or reception for the sake of other members. Healthcare personnel must ensure that confidentiality is maintained and that potential donors and recipients have a real opportunity to refuse.

Tissue procurement from the deceased ('cadaveric organ donation')

- 3.22 The donation of organs and tissues after death is a generous act of charity which can give life to someone else. Respect for the inviolability of every member of the human family, however incapacitated or disabled, requires that death be established with moral certainty before vital organs are removed for transplant (see also 5.21-5.23).
- 3.23 Respect for the body as the principal relic of a deceased person and as a focus of grieving requires that the body never be treated merely as a field for 'harvesting'. Organs and tissues may only be removed from

a deceased person who has bequeathed them verbally or in writing or, in the absence of such clear expression of the deceased person's 'will', with the permission of the family. Even in the face of a clear expression by the deceased of intent to donate organs at death, Catholic facilities should always take into account the wishes of those grieving the person's death and seek to ensure that sufficient time and information have been given for them to comprehend the situation before proceeding.

- 3.24 The families of potential donors, together with relevant others, must be treated with sensitivity to their grief and to their religious and cultural background, and be given counselling and accessible information about issues such as the determination of death by the brain function criterion, organ and tissue procurement and transplantation. They should be offered adequate evidence that provides them with appropriate assurance that death has occurred (see also 5.22, 5.23 and 5.25). Appropriate signs of reverence for the deceased and pastoral care for those grieving are especially important at this time.



***Determination of death
with a view to cadaveric
organ procurement***
.....

- 3.25 To avoid any conflict of interest, a determination of death should be made by appropriate healthcare practitioners committed to the care of the deceased person, rather than by those associated with the organ procurement or transplantation process. However, because successful transplantation is dependent upon the organs being as viable as possible, it is legitimate to keep a body on artificial life-support after the person has been declared dead.
- 3.26 Infants born with anencephaly or who have prolonged loss of consciousness must not be treated as dead for the purposes of organ procurement.

***Foetal tissue procurement
for transplant***
.....

- 3.27 Though embryonic and foetal tissues may have various advantages in transplantation over tissue taken from maturer human beings, great care must be taken with respect to the sources of such materials. To take tissue from a live foetus for transplantation is unethical. Great care must be taken to ensure that all cadaveric

foetal tissue to be used for transplantation is derived from natural miscarriages or from ethically obtained cell lines.

Xenotransplantation
.....

- 3.28 For the transplantation of animal organs or tissues to human beings to be permissible, it is necessary that the procedure will not impair the integrity of the recipient nor impose inordinate risks on the recipient or others. (See also 6.4-6.11)
- 3.29 The introduction of parts of the human genome into animal tissue or vice versa must not involve extensive animal-human hybridisation, inheritable changes to a human being, or the formation of an organism possessing some human and some animal material which may be capable of further development as an embryo.

***Brain and reproductive
organ transplants***
.....

- 3.30 The brain is significantly determinative of personal identity. The reproductive organs are associated with reproductive identity. Neither the brain nor the gonads may be procured from human beings or animals for transplant to a human person.



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4. Older persons and others with special needs

Introduction

4.1 Catholic healthcare services should be distinguished by their care for people with special health care needs, in particular older people, people with chronic illness, physical or intellectual disability, HIV/AIDS, mental illness or dementia, and children and adults who have been abused. The care of people with special needs involves some distinctive ethical standards, in addition to those standards of care generally applicable.

Care of older persons

4.2 As people age they may become frail, some of their capacities may be reduced, they may suffer various health problems, and they may become less self-sufficient. The community has a responsibility to ensure that they receive appropriate assistance in these circumstances. Catholic health and aged care services should provide such help at every stage of the ageing process.

4.3 Respect for the dignity of older persons and solidarity with them requires care which fosters their opportunities to participate in family, church and community life and, if possible, to live in their home environment. Catholic health and aged care should seek to

provide a continuum of care from high quality home- and community-based programmes to independent, semi-independent, dependent and acute residential care, as required.

4.4 Every effort should be made to ensure that institutional environments for older persons respect their individuality and are as homelike as possible. In addition to high quality nursing care and social services as required, special provision should be made for the spiritual needs of older persons.

Care of people with chronic illness and/or physical disabilities

4.5 Persons with chronic illnesses and/or disabilities have the same basic needs and desires as other human beings, and enjoy the same rights and responsibilities. The community has a responsibility to ensure that people who are chronically ill and/or disabled are provided with appropriate assistance. Catholic health, aged and disability services should promote the dignity of persons with chronic illnesses and/or disabilities by ensuring that they enjoy a positive environment and access to appropriate services which enable their own personal development and their participation in family, Church and society.



4. OLDER PERSONS AND OTHERS WITH SPECIAL NEEDS

4.6 Respect for the dignity of persons with chronic illnesses and/or disabilities and solidarity with them requires the provision of high quality home- and community-based programmes and institutional care where appropriate. While assisting those with a chronic illness or disability may sometimes make significant demands on others, such dependency in no way alters the fundamental equality between persons nor lessens the need to provide appropriate assistance to the carers as well. In addition to high quality health, aged or disability services as required, special provision should be made for the spiritual needs of persons with disabilities.

Care of people with HIV/AIDS

4.7 HIV raises many of the same issues as does any infectious disease and AIDS raises many of the same problems as do other life-threatening illnesses such as cancer and chronic heart disease. In addition, HIV/AIDS currently raises other complex issues both in the Australian context and in the global context in which it is a pandemic. People affected by HIV have the same rights and responsibilities as every other member of the community.

Catholic healthcare services should seek to promote the dignity of people living with HIV/AIDS by ensuring that they have access to appropriate medical, nursing and pastoral care, regardless of how they contracted the infection, and by ensuring that they enjoy the same opportunities as people afflicted with any other serious disease.

4.8 The complexity of the experience of HIV and the social stigma attaching to it at the present time highlights the fact that health has not only physical but also psychological and spiritual dimensions. For most people the information that they have HIV is devastating news. They may have grave fears about the likely course of the disease, about the implications of any minor infection, and about rejection and alienation. They may find telling family and friends both about the condition, and perhaps about homosexuality or intravenous drug use, very difficult. They may have to contend with anger and grief, with anxiety about infecting or having already infected others, and with limitations on their future opportunities and relationships. In addition to high quality medical and nursing care as required, special provision



4. OLDER PERSONS AND OTHERS WITH SPECIAL NEEDS

should therefore be made for the emotional and spiritual needs of people with HIV/AIDS. They may also need advice about not putting other people at risk of infection.

- 4.9 Care of the individual as a whole, including counselling prior to and after HIV testing, should continue throughout the course of the disease. Great care must be taken to ensure that the social and personal complications of the disease do not jeopardise the provision of supportive, compassionate care.

Care of people with intellectual disability
.....

- 4.10 Intellectual disabilities vary in extent and kind. Attention should be given to both the biological and the psychological causes and treatments for intellectual disability. People with intellectual disability have the same rights as everyone else. The community has a responsibility to ensure that they are provided with appropriate assistance. Because this tends to be an under-resourced area of care, Catholic organisations should seek to ensure that such people have access to appropriate services which enable them to achieve as high a degree of functionality as possible, and to participate in the life of family, church and wider society. In addition to high quality health, educational and social services as required, special provision should be made for the spiritual and sacramental needs of people with intellectual disability.
- 4.11 The general principle that responsibility for healthcare decision making rests in the first place with the individual also applies to people with intellectual disability. As far as possible such people should be enabled and encouraged to take an appropriate part in decision making regarding their care. Such decision making power should only be overridden in the case of diagnosed incompetence to make rational decisions. Even where a person is incapacitated to consent and the consent of the legitimate guardian is required, as far as possible the agreement of the person should also be sought.
- 4.12 Because sexuality and fertility are God's gifts and parts of our common human nature, interventions upon the intellectually disabled, such as sterilisation and hysterectomy which are not therapeutic but which are simply aimed at resolving social problems, are unacceptable. Catholic disability services should seek to assist people



with disabilities in their vocations as single people, spouses or parents.

- 4.13 Every effort should be made to ensure sufficient understanding and consent to any marriage, sexual intercourse and responsible parenthood by persons with an intellectual disability. If a person is intellectually impaired to the point that he or she does not understand the consequences of sexual intercourse or is easily manipulated to give supposed consent, then sexual intercourse with that person may constitute an assault. Caregivers have an obligation to take all reasonable care to protect people with intellectual disability from sexual assault. Only where this is genuinely impracticable may temporary measures to prevent conception be used as a last resort. (See also 2.6, 3.6-3.9)
- 4.14 One goal of the care of those with intellectual disabilities is to assist their integration with family and community. ‘Mainstreaming’ the care of such people and assisting their living within the community are in principle to be applauded as long as this serves the best interests of the person concerned rather than economic or social goals, and as long as such care is appropriately supported by human and financial resources.

*Care of people with
mental illness or dementia*
.....

- 4.15 Mental illnesses and dementia vary in extent and kind. However people with mental illnesses or dementia have the same rights as everyone else. The community has a responsibility to ensure that such people are provided with appropriate assistance. Because mental health services unjustly tend to be an under-resourced area of health care, Catholic organisations should seek to ensure that such people have access to appropriate services which enable them as far as possible to recover health and to participate in the life of family, church and wider society. In addition to high quality mental health and social services as required, special provision should be made for the spiritual and sacramental needs of people with mental illness.
- 4.16 Psychiatry and counselling have as their goal not social control but care and support of the individual. They should always be conducted in ways which respect the dignity and privacy of patients. Physical and chemical restraints should only be used as a last resort to protect the patient or others from harm.



4. OLDER PERSONS AND OTHERS WITH SPECIAL NEEDS

- 4.17 Every effort should be made to ensure that institutional environments for people with dementia or mental illness respect their individuality and are as familiar and supportive as possible.
- 4.18 Suitably adapted principles applicable to those with intellectual disabilities apply also to those with mental illness or dementia, in areas such as responsibility for decision making, sexuality, and integration with family, church and community.

Care of sick children and babies

- 4.19 Children and babies have special needs when they are sick. Pain and other symptoms of illness can be overwhelming for young children who are unable fully to understand the causes of their distress, nor able to find meaning in their experience. A child naturally looks to his or her parents and family for support. As far as is practicable, Catholic healthcare services should provide facilities to enable the family to remain with a sick child. Whenever this is not possible or appropriate, it should be discussed with the family and the patient if possible. Every effort should be made to respect the individuality of each child and to enable the child's participation in his or her care at the level to which that child

is capable. (See also 1.20, 1.21, 3.20 and 6.8)

- 4.20 Where possible children should be cared for in facilities specifically designed for them. If it is necessary to accommodate a child in an adult ward, every effort should be made to ensure the child has private space and is screened and sheltered from the other activities of the ward. The care of children should normally be supervised by clinical staff experienced in their care and supported by the appropriate equipment and staff.
- 4.21 The holistic care of children requires an acknowledgment of their spiritual and emotional needs and recognition of the significance of their family. When children are ill, spiritual and pastoral care will often need to be extended to close family members and should, where possible, be provided by people experienced in such care.

Care of children who have been abused

- 4.22 Child abuse fragments and distorts a child's confidence in self, parents, family, friends and the whole community of adults. Catholic healthcare facilities and welfare services should aim to prevent any further harm to children who have



suffered physical, psychological or sexual abuse, and to re-build the child's trust and confidence and sense of security. (See also 3.6-3.9)

- 4.23 Suspected child abuse requires immediate investigation and intervention. Any decision to override parental wishes is, however, a grave matter and one which should be subject to due legal process. Services provided must always comply with Catholic Church protocols and state or territory laws.

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Care of the carers

- 4.24 In addition to caring for those with special needs, Catholic health, aged and community care facilities should also seek to assist those who care for them. Through education, support services, opportunities for respite and pastoral care, these facilities should seek to help family, friends, volunteers and practitioners who care for dependent persons.

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5. End of life

Introduction

.....

- 5.1 Healthcare practitioners are called upon to respect, love and care for patients and residents in care (and their families). They seek to give hope at a time when many people find it very hard to face the dependency, helplessness and discomfort which may accompany the process of dying. Catholic health care witnesses to the belief that God created each person for eternal life. Christians affirm that death is the end of life on earth and the beginning of an eternity of fuller personal life with God. Death is thus regarded with awe, profound respect, faith and hope.
- 5.2 A patient who knows that his or her life is nearing its end, and in particular that an illness is likely to end in death, may need an increased level of support both from family, carers and healthcare practitioners. Those caring for the person should therefore seek to establish a relationship of trust, compassion and confidence with all those in their care, and, should thereby place their humanity, knowledge, experience and skill at the service of the dying person.

- 5.3 The use of life-sustaining technologies needs to be evaluated in the light of Christian beliefs about life, suffering, death and resurrection. In so doing two extremes should be avoided: on the one hand, an insistence on futile and overly-burdensome treatments which merely obstruct death, on the other hand, the deliberate withdrawal of treatment in order to bring about death. Since good medicine treats a person rather than a condition, respect for persons requires that they neither be under-treated nor over-treated; rather, when people are dying they should have access to the care that is appropriate to their condition.
- 5.4 Patients' religious and other beliefs, especially those concerning suffering, treatment, dying and death, should be respected. When their patients' beliefs differ from their own, those caring for the patient should, in ways consistent with their own conscientious beliefs, endeavour to help their patients to find meaning in their dying. (See also 1.16 and 1.17)

Care for the whole person

.....

- 5.5 In receiving physical, psychological, social and spiritual support, patients may need help to make the most of what remains of their lives,



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not only by the alleviation of their suffering but also by the respect accorded their personal dignity and the quality of their living. Vulnerable patients may need to be protected from pressures which lower their self-esteem or encourage self-abandonment. They may need help not only with the many symptoms of illness such as pain and discomfort and its psychological sequelae such as anxiety, fear and distress, but also with its spiritual effects such as crises of faith, hope and love. Depression, for example, is often an unrecognised and untreated symptom of illness and practitioners should strive to relieve it by clinical and other means (see also 1.4).

Palliative care

5.6 Specialist palliative care is oriented to caring for, and accompanying, a dying person and his or her carers in the final phase of life, upholding that person's dignity and respecting his or her spiritual, physical, emotional and social needs. It also encompasses care for bereaved family and others. Though it is integral to all health care, the relief of symptoms has a special place in the care and support offered to people with advanced and inevitably progressive disease.

5.7 Catholic hospitals should develop this area of health care, by advancing knowledge of palliative medicine, by perfecting the skills involved in the provision of good palliative care, by educating health-care practitioners, and by organising their resources to ensure that all patients have access to first-class palliative care.

Pastoral care

5.8 The work of Catholic health and aged care facilities is illuminated by hope in the Resurrection. It should, therefore, be distinguished by the quality and accessibility of the pastoral care offered to the dying person and to his or her close family and friends. A supportive context in which the dying person has the opportunity to find meaning in death should be provided. Healthcare practitioners should be alert to the particular religious and sacramental needs of the dying person and be ready to link the person with his or her clergy and community.

Withdrawal or withholding of treatment: grounds for the decision

5.9 Decisions about life-sustaining treatments for patients who are terminally ill raise two sorts of challenge: which treatments should be



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- recommended and who should be involved in the decision making process. The fundamental ethical principle in this regard is that treatments may legitimately be forgone (withheld or withdrawn) if they are therapeutically futile, overly-burdensome to the patient or not reasonably available without disproportionate hardship to the patient, carers or others. (See also 1.12-1.14)
- 5.10 Artificial means of life support (including dialysis and ventilation) are often appropriate. Cases do arise, however, in which patients judge that the burdens of using a life support to themselves and/or to others are very grave. If so, a decision to withdraw a complex means of life support may be justified.
- 5.11 Likewise, the decision not to instigate a form of treatment (e.g. some forms of resuscitation) would be justified if the burden of treatment would be disproportionate to its expected therapeutic benefits or if it would involve an unreasonable burden on the patient (in particular on a frail, elderly or dying patient). Hospitals and aged care facilities should draw up protocols for the use of resuscitation and ensure that these protocols are well known by their staff and patients.
- 5.12 Continuing to care for a patient is a fundamental way of respecting and remaining in solidarity with that person. When treatments are withheld or withdrawn because they are therapeutically futile or overly-burdensome, other forms of care such as appropriate feeding, hydration and treatment of infection, comfort care and hygiene should be continued. Nutrition and hydration should always be provided to patients unless they cannot be assimilated by a person's body, they do not sustain life, or their only mode of delivery imposes grave burdens on the patient or others. Such burdens to others do not normally arise in developed countries such as Australia. (See also 1.12-1.14)
- Withholding or withdrawing of treatment: the decision making process*
.....
- 5.13 Patients and residents in care should be encouraged while they are still competent to discuss their hopes for, and fears of, treatment options with their families, their doctors and other relevant people. They should be informed of their moral right to appoint someone to make decisions about their health care should they become unable to make their own decisions.



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- 5.14 Because physical or mental illness may impair a person’s decision making capacity, it will sometimes be necessary to assess whether a patient or resident is competent to make decisions about life-prolonging treatment (see also 1.4).
- 5.15 In the case of a *competent* patient or resident, a decision to withhold or withdraw a treatment normally requires that the responsible doctor discusses the matter with the patient and establishes that he or she judges on reasonable grounds that the proposed treatment would be therapeutically futile or overly-burdensome.
- 5.16 In the case of an *incompetent* patient, a decision to withhold or withdraw a treatment should only be made after the responsible doctor has judged that the treatment would be therapeutically futile or overly-burdensome. There should be discussion between the responsible doctor, the family, any legal guardian or representative and others relevant to the care of the patient. In particular, proper account should be taken of
- (a) any information about what the patient would have wanted (if anything is genuinely known about that),
 - (b) any signs as to what the patient in fact wants now,
 - (c) the capacity of the family or others to look after the patient,
 - (d) the views of the family and relevant others regarding the appropriateness of the proposed care, and
 - (e) any relevant authority required by law.
- 5.17 Treatment decisions should be communicated and explained to nursing and allied staff. The family and relevant others should be given opportunities for discussion and pastoral care. Sensitivity should always be shown towards the religious and cultural background of patients and residents, especially when it is proposed that a treatment be withdrawn or withheld.
- 5.18 Treatment decisions (including decisions to limit, withdraw or withhold a treatment) should be documented in the patient’s record. Documentation should include a brief statement of reasons for the decision, together with a note on the consultation process. These decisions should be reviewed regularly and in response to any significant change in the patient’s condition or at the request of the patient, family or relevant others.



Professional accountability

- 5.19 While the ultimate responsibility for decisions about a patient's treatment usually lies with the patient and his or her medical practitioner, all those involved in the care of the patient should be given the opportunity to make their own professional contribution to these decisions and should be held accountable for their own practice. With due regard for the privacy of the patient, they have a right to appropriate information about the rationale for a particular intervention they are asked to perform, or for the withholding or withdrawing of a particular form of care they are asked to undertake, and they in turn have an obligation to provide the medical practitioner and others involved in the care of the patient with relevant information.

Euthanasia

- 5.20 It is never permissible to end a person's life (whether that decision is made to relieve a patient's suffering by euthanasia, to comply with the wishes of the family, to assist suicide, or to vacate a bed). By *euthanasia* is meant any action or omission which of itself and by intention causes death with the purpose of eliminating all suffering. Examples of euthanasia

include administering deliberate overdoses of otherwise appropriate medications, and the unjustified withholding or withdrawing life-sustaining forms of care. Euthanasia must be distinguished from other care decisions which sometimes risk or have the effect of shortening life but which are not intended to hasten death (e.g. the giving of appropriate pain relief, the withdrawal of burdensome treatments). Advances in palliative care are now such that the control of pain should not normally lead to side effects such as loss of lucidity or consciousness or to the shortening of life.

Death

- 5.21 Since death is of significant spiritual and legal importance (for instance, prayers for the dying are replaced with prayers for the dead, and organs may be made available for donation to others), it is crucial that judgments about the determination of death can be made with confidence and accuracy. The death of a human being consists in the total disintegration of that unitary and integrated whole that is the personal self. Although death is an event which cannot be directly identified, biological signs or 'clinical markers' that inevitably follow can be recognised with



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increasing precision. These clinical markers indicate the irreversible loss of the integrated and coordinated life of the person as a single living organism.

Clinical markers of death

- 5.22 In current Australian medical practice and legislation, a person is said to be dead when there is either irreversible cessation of the circulation of the blood or irreversible cessation of all function of the brain (so called ‘brain death’). Generally death is determined by the irreversible loss of cardio-respiratory function. However, modern medical technology often severs the links between death and the cessation of cardio-respiratory function. It has thus become necessary to recognise that in the absence of all brain function it is impossible for a person to live as an integrated and coordinated organism. Total and irreversible loss of all brain function, accompanied by an evident cause, is thus a valid medical criterion of death.
- 5.23 Pressures to change the way death is determined from the loss of *all* brain function to the loss of *some* brain function should be resisted. Rather, Catholic hospitals should lead the way in trying to perfect the diagnostic criteria for death.

Respect for the deceased, for families and for relevant others

- 5.24 Appropriate professional services and support should be provided not only to patients, but also to their families, care givers and others. This includes support through the period of dying, grief and bereavement. After death has occurred, the body of the deceased should be tended with care, reverence and in accordance with the religious beliefs and expressed desires of the deceased.

Post-mortem examination

- 5.25 Information gained from even a limited post-mortem examination may be valuable for both the family and friends of the deceased person and the wider society. Benefits may include accurate analysis of a pathology, identification of the medical cause of death, knowledge of a poorly understood disease, the evaluation of new medical therapies and techniques, as well as provision of a factual basis for counselling those concerned about any anxieties they may have about the death. Where a post-mortem is required by law, information about the reasons for the post-mortem, the procedures involved and any tissue to be retained for coronial



purposes should be made available to the next-of-kin and relevant others. If the post-mortem is not legally required and has not been authorised by the deceased, the consent of the next-of-kin must

be sought if they are available before even a limited post-mortem is conducted or any tissue is retained for medical and scientific research and educational purposes (see also 3.23).

References

General: *Evangelium Vitae* 64-67; Pope Pius XII, “The Prolongation of Life”, (1957), *The Pope Speaks* 4/4 (1958), pp. 395-398; Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (1980); *Charter* 114-135, 147-150

Care of the dying, withdrawal of inappropriate treatments, ongoing care and euthanasia: *Evangelium Vitae* 64-67; *Catechism* 2276-79, 2324; *Charter* 114-138, 147-150; Pontifical Council Cor Unum, *Questions of Ethics regarding the Terminally Ill and the Dying*, (1981); Australian Bishops, *Euthanasia* (1995); Pro-Life Committee of the Bishops of the United States, “Nutrition and hydration: moral and pastoral reflections,” *Origins* 21(44) (1992)

Death: *Catechism* 1006-16, 1020, 1681-83; *Charter* 128-135; Pope John Paul II, *Address to the 18th International Congress of the Transplantation Society* (2000); Pope John Paul II, “Address to U.S. Bishops on Ad Limina visit” *L’Osservatore Romano* (October 7, 1998)

Palliative care: *Catechism* 2279

Pastoral care of the sick and dying: *Catechism* 886, 896, 1014, 1284, 1307, 1520-23, 1526, 1681-83, 2299; *Charter* 108-113, 133-134; *Introduction to the Rites of Pastoral Care of the Sick and Dying*

Respect for corpses and autopsy: *Catechism* 2300-01

Sickness and suffering: *Evangelium Vitae* 46-51, 97; *Catechism* 164, 1508, 1521; *Charter* 3, 53-55, 68-71



6. Research

Introduction

- 6.1 Research may be defined as any systematic activity undertaken for the purpose of gaining new knowledge, understanding or insight or confirming current knowledge. Catholic health care affirms and promotes the value of research, recognising that new knowledge is good in itself and has the potential for application in new therapeutic options. Research into healthcare policy and bioethics, underpinned by the mission and values of Catholic health care, has the potential to contribute to the development of a compassionate and equitable healthcare system (see also 6.19). Those Catholic services in a position to do so should give special attention to research of particular relevance to Catholic teachings, for example, in relation to palliative care, fertility and infertility, and genetic interventions which respect the marital context of human conception (see also 2.1).
- 6.2 Research differs from *clinical practice* in that the primary purpose of research is to gain knowledge, whereas the primary purpose of clinical practice is to benefit the patient, whether by diagnosis, cure, stabilisation or

palliation, etc. It is also important to distinguish between research which is *therapeutic*, that is, conducted with the intention of providing a direct clinical benefit to the participant along with the gaining of knowledge, and research which is *non-therapeutic*, that is, conducted not with the intention of providing a direct benefit to the participant but rather with the intention of gaining information that may in time benefit others.

- 6.3 Research in Catholic facilities should meet all professional, scientific and legal requirements as determined by appropriate bodies. Relevant guidelines, for example those derived from privacy legislation and those of the National Health and Medical Research Council, should be taken into account.

Research involving humans

- 6.4 Research involving human beings must always both respect the personal dignity of the research participant and serve the common good. Research must never pose an unreasonable danger to a person's life, sanity or health. However, a person who understands the extent of the risks involved may choose to accept some risk, discomfort



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or inconvenience in order to contribute to developments in medicine and thereby contribute to the common good.

Consent

6.5 Research depends upon a partnership between participants and researchers with a view to meeting the needs of future beneficiaries. Researchers must, therefore, seek the adequately informed and freely given consent of potential research subjects. Each person must be informed of the risks and benefits involved in participating in the research. Participants must be free to withdraw at any time. Researchers, in particular those conducting clinical trials, have a responsibility to ensure that participants understand they are enrolled in a research project. Reimbursements should not be so large as to become unwarranted inducements. Where it is proposed that epidemiological or retrospective studies will use identifying data, as far as practicable consent should be obtained.

Vulnerable participants

6.6 In the case of any person, or group of people who may be particularly vulnerable (such as incompetent participants, older children, people with mild intellectual impairment, those highly dependent on medical

care, the poor and people who are institutionalised), there is a more stringent requirement to ensure that benefits justify risks. Research involving vulnerable people must only be undertaken when the knowledge to be obtained is sufficiently important to warrant involving such vulnerable people and this knowledge cannot be obtained by other means. The research method should be designed to meet the specific needs of the particular participants with their best interests being paramount. Non-therapeutic experimentation must involve no significant risk at all.

6.7 When a potential research participant is in a dependent position in relation to the researcher, for example, as the patient of a doctor-researcher, there is need for extra diligence in the obtaining of consent to ensure that the patient can distinguish between the procedures of the research trial and those needed for his or her care. Patients should be assured that their health care needs will be met, without discrimination, even if they choose not to participate in, or to withdraw from, a research project. Likewise subordinate staff, prisoners, students and others must be assured that they will not lose any



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entitlements if they choose not to participate in, or to withdraw from, a research project.

Incompetent participants

6.8 Consent for participation in a research project by an incompetent person is to be sought from the person who has legal responsibility for his or her medical treatment decisions. In these matters the person responsible and the researcher are to be guided by what is judged to be in the participant's best interests and by what is known of his or her wishes. Where possible the agreement of the participant should also be obtained and any refusals should be respected.

Research design and methodology

6.9 All reasonable precautions must be undertaken to minimise the potential harm to participants. Where appropriate, prior experimentation with non-living models and animals should be undertaken to determine possible harmful effects of the intervention.

6.10 To be ethically acceptable research must also be scientifically sound. When the research project fails to provide its expected benefits, or unexpectedly harms participants, either a new consent should be sought from the participants or the

research discontinued. Researchers should provide participants with any new information about the risks of participation.

6.11 Patients may choose to forgo standard treatments which offer little or no benefit in order to receive experimental treatments. However, patients should never be denied access to standard or accepted forms of treatment. The use of placebos, or non-treatment control groups, is acceptable only if they are necessary for the purposes of the research, do not deprive the patient of available, beneficial and needed standard treatment, and do not place the patient at risk of harm. Participants should be informed in advance of, and give their consent to, the possibility of receiving a placebo.

Donation of body for research and teaching

6.12 Some research and some teaching of healthcare practitioners requires the use of cadaveric tissue. The use of such tissue, where necessary and other than when required by law for autopsy, is permissible if the use is in accordance with the prior expressed wishes of the deceased person or the consent of the family or other relevant person has been obtained.



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*Research involving
human embryos and fetuses*

- 6.13 Medical research involving live embryos or fetuses may only be undertaken *in vivo* (within the body) and when there is a moral certainty of causing no harm to the life or the integrity of the embryo or the foetus. The informed consent of the parents, or at least that of the mother, is required prior to any research.
- 6.14 When embryos and fetuses die, they are to be given the same respect as is due to every human being who dies. Researchers may undertake an autopsy, or other forms of research, with the consent of the parents. Research is never to be undertaken on an embryo or foetus, or on tissue from an embryo or foetus, that has been procured through deliberate abortion. Nor is it ever permissible to produce embryos for research purposes or use embryos discarded from IVF programmes for research purposes. Such research is a grave violation of the human dignity of these embryos.

Genetic research

- 6.15 Research in genetic and molecular science is yielding new knowledge which is valuable in itself and has

diagnostic and therapeutic potential. Such research must always be pursued in ways which respect both the fundamental dignity of each human person in his or her uniqueness and the common genetic heritage of the human community. Research must never be premised upon the assumption that a person is wholly reducible to, or determined by, his or her genes. Furthermore, knowledge of the human organism, as distinct from applications of that knowledge, should never be treated as the commercial property of individuals or organisations.

- 6.16 Genetic information may have particular significance to the participant and his or her family (see also 1.10, 1.23 and 1.24). Special protocols may be needed to ensure the appropriate counselling of participants and the confidentiality of records containing genetic information, including family pedigrees.
- 6.17 Genetic research should not be undertaken with a view to changing either the fundamental human nature or the unique identity of an individual person. Rather, research should be directed to applications of diagnostic or therapeutic value. Researchers should seek to avoid contributing



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to the use of genetic information in a way which stigmatises or unjustly discriminates against certain people. Researchers in Catholic facilities should be prepared to explore possibilities which give witness to a respect for human embryos and the human genome.

- 6.18 Genetic research must not involve any techniques that may lead to the asexual creation or reproduction of human embryos or other eventualities that are contrary to respect for human life or human dignity. These techniques currently include: producing, damaging or dismembering a human embryo to remove stem cells or to ensure its truncated development; producing totipotent cells which (without the addition of other genetic material) may be capable of human embryogenesis; introducing the whole or parts of the human genome into animal gametes; forming a chimera with or to create a human embryo; and animal gestation of human embryos.

Health ethics research

- 6.19 Catholic health, aged and community care can make a distinctive contribution through its reflection upon ethical concerns from within the Catholic tradition. In addition to conducting health and medical research, Catholic facilities

should encourage research into the ethics of health care and contribute to the clarification and development of doctrine within the Catholic tradition.

Animal research

- 6.20 At all times animals must be treated with the respect due to them as creatures of God. Research may be conducted on animals only when non-living subjects or experimental models cannot be used to obtain the necessary information. Reasonable care should be taken and needless suffering prevented. Any such research in Catholic facilities should meet all relevant ethical, scientific and legal requirements as determined by the appropriate bodies.

Research ethics committees

- 6.21 Research involving human or animal subjects must be approved by a duly constituted and approved research ethics committee. Several facilities may contribute to the formation of a combined research committee to ensure the relevant expertise. The responsibility of the committee is to ensure that the interests of potential research participants are protected, to ensure that the research is ethically sound, and to audit the scientific, social, and legal validity of the research.



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6.22 Research ethics committees should be constituted in accordance with statutory norms and members should be chosen who are willing to act in accordance with this *Code of Ethical Standards*. The membership should include experts in research, the appropriate sciences that inform the research, health care, moral theology and/or philosophy and the law together with independent

members of the community. The interests of potential research participant groups should also be effectively represented. The independence of the committee should be ensured, for example, by including a sufficient number of members not employed by the facility. Any conflicts of interest must be declared, and researchers should never be involved in the approval of their own projects.

References

Research: *Gaudium et Spes* 15; *Evangelium Vitae* 26; *Populorum Progressio* 20; *Donum Vitae* 1-3; *Catechism* 159, 283, 2293-94; *Charter* 75-6

Research involving humans: Pope Pius XII, *The Moral Limits of Medical Research and Treatment*, Address given to the First International Congress on the Histopathology of the Nervous System (1952); *Catechism* 2295, 2301, 2375; *Charter* 75-81

Research involving human embryos and foetuses: *Evangelium Vitae* 14, 44-5, 63; *Donum Vitae* 1-5, I:1, I:3-6, III; *Catechism* 2271, 2275, 2323; Pope John Paul II, *Address to the 18th International Congress of the Transplantation Society* (2000);

Charter 82; Australian Catholic Bishops Conference, “Cloning” (2000)

Genetic research: *Gaudium et Spes* 14; Pope John Paul II, *Dangers of Genetic Manipulation*, Address given to the Members of the World Medical Association (1983); *Catechism* 2275; Secretariat of State, *Observations on the Universal Declaration on the Human Genome and Human Rights* (1997); Pontifical Academy for Life, *Concluding Remarks of the Fourth Plenary Assembly* (1998)

Animal research: *Catechism* 2415-18, 2456-57



7. Healthcare institutions

Catholic healthcare institutions as communities of service

- 7.1 The human person is an inherently social being for whom life in society, relationships with others, and collaboration in significant endeavours contribute to human fulfilment. While individual Catholic healthcare professionals may achieve much within their own spheres of activity, they can often achieve more when they unite their efforts with others under the auspices of a Catholic organisation and so become a distinctive “community of service” to those in need. A Catholic healthcare institution or organisation is always more than the sum of its parts, with its own identity, mission, and “institutional conscience”, above and beyond the identity, mission and conscience of its individual members.
- 7.2 A healthcare organisation bearing the name “Catholic” has a special responsibility to witness to the presence of Christ and to Catholic teachings about the value of human life and the dignity and destiny of the human person. Tangible signs of the Catholic identity of an organisation include: sponsorship, ownership, governance and/or management by the

local church or by a religious congregation; recognition by the bishop of the diocese; priority given to pastoral care and mission integration; availability of the sacraments and the prominence of Christian symbols; acceptance of Catholic teachings and observance of canonical requirements. All who work in and for Catholic health care should be united by their adherence not only to the ethical standards of their respective professions but also by a willingness to embrace the ethical standards of Catholic health care.

- 7.3 Catholic health and aged care is not confined to those who accept Catholic beliefs. Indeed, Catholic health care should respect the different cultures and religious traditions of all whom it serves and of those who work within its organisations; it should value this diversity and strive to learn from it. At times a Catholic healthcare institution may be faced with difficult prudential decisions when Catholic beliefs differ either from those of staff members or from those the institution is asked to serve. Catholic teaching on cooperation with others gives guidance about how to resolve complex questions in this regard. (See also chapter 8)



*Catholic health care
in the Australian context*
.....

- 7.4 Public and private Catholic health-care institutions have long been integral to the provision of health, aged and community care services in Australia. Collaboration between providers has increased in recent years in an effort to use limited resources more effectively.
- 7.5 Australia's federal system of government, in which responsibilities and funding are shared between the States and the Commonwealth, has a range of implications for the integration of healthcare services. While national structures help to sustain Catholic health care, state-based and more local forms of collaboration between Catholic facilities and services are also appropriate, in keeping with Catholic teaching on the principle of subsidiarity. (See also principle 5)
- 7.6 As recipients of public funding, Catholic healthcare organisations should recognise their responsibility to use public monies wisely, effectively and accountably. When a publicly funded institution is linked to a privately funded institution, there may be scope for resource sharing, provided public funds are never used to subsidise the private

institution. There should always be a transparent use of public monies for publicly provided services. (See also 7.23 and 7.24)

*Issues of governance and
institutional responsibility*
.....

- 7.7 Until recently institutional Catholic health care was chiefly the responsibility of women and men religious. This ministry is now being assumed by lay people, for whom the small remaining numbers of dedicated religious sisters, brothers and priests are still a significant inspiration. When employing staff, particularly in executive positions, Catholic healthcare organisations should ensure that those employed are familiar with and supportive of this *Code of Ethical Standards*, and of Catholic teachings more generally. Support for Catholic teaching and tradition is critically important for those in leadership positions, and people known to be antithetical or indifferent to Catholic teachings should not be employed in these positions.
- 7.8 As a moral community, a Catholic healthcare organisation must always address the ethical dimension of decisions related to governance, management and administrative policy, and strive for



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effective communication and consultation with its staff. As an occupational community, a Catholic healthcare organisation should provide its employees with a context in which they can find personal and professional fulfilment and a means of earning a living. Staff are to be treated with respect and justice, and there should be mutual accountability between the organisation (represented by the board, executive and administration) and those who work in it.

- 7.9 There are various forms of governance and management in Catholic healthcare institutions in Australia today. Where the ministry of a diocese or religious congregation has been incorporated under a governing board, that board is to act in accordance with its mandate from the diocese or congregation. Owners and sponsors should seriously consider the long-term strategies and management policies established by their boards. Board members and executives should attend to the ethical dimensions of all board decisions, especially in financial considerations, and in setting policies and priorities. To this end competent ethical advice should be sought.
- Collaborative relationships*
.....
- 7.10 Collaboration and/or integration with another healthcare provider may be necessary or desirable if a particular institution is to continue or extend its ministry. The development of collaborative ventures should involve the owners and sponsors of the Catholic institution, along with the advice of Catholic ethicists and consultation with the diocesan bishop.
- 7.11 Catholic institutions should, in the first instance, seek collaborative relationships with other Catholic institutions and agencies. If no exclusively Catholic relationship is possible, Catholic institutions may look to forming partnerships with other church or “community benefit” (“not for profit”) organisations and institutions, or with publicly funded health services. In rare cases, collaborative relationships between Catholic organisations and “for profit” private organisations may be appropriate.
- 7.12 Contracting for specific services, rather than entering into commercial arrangements such as alliances or joint management, will often provide more appropriate forms of collaboration with an organisation



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whose identity, history, sponsorship and mission are markedly different from that of the Catholic entity. Care should always be taken to ensure that arrangements deriving from contracts with other parties are in accord with Catholic moral and social teachings.

- 7.13 In some cases, independent healthcare practitioners, consultants, groups and companies may be attached to, or may operate under the auspices of, a Catholic institution or organisation. At least to the extent that their practice and presence is identified as part of, or as linked with, the Catholic entity, these practitioners, groups and companies should agree to abide by this *Code of Ethical Standards*.
- 7.14 Every proposal to enter into a collaborative relationship with a non-Catholic provider must be closely evaluated to ensure that it would not compromise the identity, the mission or the ethical standards of the Catholic institution. Indeed, the collaborative relationship should enhance the Catholic healthcare apostolate by helping to implement the Church's moral and social teachings, furthering the provision of health care for the community,

and ensuring the responsible stewardship of resources. The collaborative arrangements must not involve the Catholic institution in “formal cooperation”, nor in unjustified “material cooperation”, with activities contrary to Catholic teaching. (See also chapter 8) The diocesan bishop shall be informed of any proposed collaborative relationship as soon as possible, and his approval must be obtained prior to finalisation of the arrangements.

- 7.15 In some instances the changed circumstances of healthcare delivery and/or the lack of suitable partners may require a Catholic entity to reassess its involvement in some or all aspects of its existing apostolate, and even to withdraw from those aspects which cannot be undertaken in keeping with the standards of Catholic health care. The diocesan bishop should be consulted in relation to these issues.

Pastoral Care

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- 7.16 Catholic health care affirms that spiritual care is integral to the healing process. Pastoral care services should ensure that patients and clients are given the opportunity to reflect on and to engage with the spiritual and emotional



7. HEALTHCARE INSTITUTIONS

dimensions of their healthcare needs, and to renew or reaffirm their religious beliefs.

7.17 Pastoral support is of crucial importance in the context of both aged care and palliative care. The shorter length of stay within many healthcare institutions means that the pastoral care of sick people is now often the responsibility of parishes and local communities, as it has long been in the case of the elderly. Where practicable Catholic healthcare institutions should support this development by collaborating with parish and community based carers. They should also provide pastoral visits, counselling, group prayer, and opportunities for celebrating the sacraments and other religious rites within the institution.

Care of staff

7.18 Catholic healthcare institutions should be marked by a spirit of mutual respect and support among staff members, which promotes the healing and well-being of the whole person. Staff at all levels should be offered appropriate education and formation in the culture and traditions of Catholic health care. Student practitioners, in particular, should be able to draw upon the experience and wisdom of their teachers. Health-

care educators, in their turn, should ensure that students are treated justly and that their insights and contributions are respected.

7.19 No staff member may be required to participate in an activity that in conscience the person considers to be wrong. A Catholic organisation should ensure that conscientious objection may be exercised without threat of penalty. The exercise of conscientious objection should never put the person receiving care at risk of harm or abandonment, nor conflict with the ethical standards of the Catholic organisation.

7.20 While protecting the Catholic identity of an institution or organisation (see also 7.15) and the requirements for individual positions, there must be no unjust discrimination in employment decisions. All staff are entitled to just remuneration. Workers should be treated as persons and never as mere commodities. The rights and responsibilities of staff who belong to trade unions should be respected.

7.21 Boards and executives are responsible for ensuring staff have a safe working environment, and that staff concerns are heard and justly acted upon. Employers should



recognise the right of employees to form associations to engage in collective bargaining, to provide various benefits for their members and to work for a better society. All members of healthcare organisations should take a collaborative approach to relations between unions and administration.

- 7.22 Respect for individuals and their participation in decision making requires that Catholic organisations develop guidelines for situations in which it becomes necessary to dismiss workers or reduce staff numbers. This implies consultation with those affected, examination of alternatives, open communication, and a willingness to honour the special needs of individuals. Staff retrenchment should be a last resort. Employees who are not members of a union should not be treated differently from those who are. Similarly, staff who are made redundant because of structural changes must receive their statutory entitlements and should not be treated differently from those who leave voluntarily. Staff who are dismissed with cause should be treated with compassion and respect.

Financial considerations

- 7.23 Many Catholic health and aged care organisations need to generate a reasonable surplus in order to fulfil their total mission, which includes caring for those who are unable to pay for services, providing services which may not, in themselves, be financially viable, and supporting sponsoring bodies, including their retired members. The pursuit of a surplus should never compromise quality of care nor the mission to those in need. To this end, Catholic institutions and services should be able to demonstrate the various social benefits they are providing to the community.
- 7.24 Transactions with third parties, including suppliers, contractors and funding bodies, should be conducted justly. The investment of an organisation's funds is to be consistent with the mission and values of a Catholic organisation. Referral of persons by a health-care professional to facilities in which the referring professional has a financial investment is, in so far as it involves a conflict of interest, generally unethical.



Ethical review and formation

- 7.25 Catholic organisations should ensure that those with management responsibility reflect on the ethical and Christian dimensions of their work. This may be done through special seminars or as a routine part of a regular business agenda. Clinicians and other healthcare professionals should also be encouraged to participate in continuing education in the ethical aspects of their work. It is imperative that board members regularly reflect on the mission and values of their organisation and on their implication for policy and priorities.
- 7.26 Catholic healthcare facilities should have, or have access to, the expertise of clinical ethicists and/or a clinical ethics committee. Such committees need a sufficient number of competent and independent members to

ensure freedom of discussion and objectivity of their judgments, their ability to make suggestions on behalf of patients and staff, to advise governing boards on the ethics of proposed and current clinical practices, and to assist with the professional development of staff in relation to ethics and Catholic teaching.

- 7.27 Consultation with clinical ethicists should be at the invitation of a patient, the patient's representative(s) or a clinician. Referral of particular cases to ethics committees should respect patient privacy and professional privilege and not identify particular patients. Advice given by ethics committees in response to particular cases should be in terms of general protocols applicable to like cases and in terms of the ethical principles relevant to them.

References

Catholic Health Association of Canada, *Health Ethics Guide* (2000), Chapters 2 and 4; *Ethical and Religious Directives* Parts 1, 2, 6; Archdiocese of Philadelphia, "Catholic Health Care Collaborative Relationships", *Origins* 28(38) (1999) 657, 659-60



8. Cooperation with others

Introduction

- 8.1 For Catholic healthcare practitioners, institutions and organisations, collaboration with others and the sharing of resources provides an opportunity to extend their mission, to witness to their ethical commitments, and to promote the common good and a responsible stewardship of limited resources. At the same time, cooperative arrangements may pose challenges for the identity and mission of Catholic health care if the arrangements involve cooperation with those who endorse procedures or treatments which Catholic teaching holds to be wrong. As a result, Catholic healthcare organisations, and the individuals working within them, may face difficult decisions about the extent to which they should be involved in cooperative relationships with certain individuals, funding bodies, or governments.
- 8.2 The executives and governing boards of Catholic healthcare facilities are responsible for ensuring that decisions about cooperation are made in accordance with Catholic teachings. Because of the complexity of these issues, the advice of Catholic ethicists should normally be sought before any

such cooperative arrangement is considered. In the case of institutional cooperation, especially when there is risk of public scandal, the guidance of the Diocesan Bishop, and, if appropriate, of the Australian Catholic Bishops' Committee for Doctrine and Morals, should also be sought.

- 8.3 The Church has a long-standing tradition of ethical reflection on the conditions under which cooperation with others is legitimate. Although different theologians have articulated this tradition in slightly different ways, their formulations have the common aim of explaining why, on some occasions at least, it may be permissible to cooperate with those whom one believes to be acting wrongly.

Identifying issues of cooperation

- 8.4 In the context of health care provision, questions of cooperation concern the extent to which individual practitioners, and those responsible for the identity and mission of a Catholic facility or service, may or should do something which facilitates conduct by another party which is not in accord with Catholic teaching. Thus, for example, a question of whether it would be permissible to cooperate with others arises



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when a Catholic facility provides goods or services to another facility who then uses them to an unethical end.

- 8.5 One can facilitate another’s conduct either by a positive action or by a decision to refrain from doing something one could do to influence or prevent the other’s conduct (e.g. by “turning a blind eye” to a colleague’s unethical practices that one ought to report to the appropriate authority).
- 8.6 When morally evaluating actions which assist another’s wrongdoing, it is essential firstly that one is able to distinguish one’s own potentially cooperative action from the conduct of the other party. The object of one’s own action must not be unethical or wrong in itself, and must be distinct from the object of the other’s conduct. The key question here is: What is the precise nature of one’s cooperative action or omission, that is to say, what is its “object” or intrinsic moral meaning as one’s proposed course of action?
- 8.7 Having distinguished one’s own action from that of the other party, one must then examine the way in which these actions are nonetheless cooperatively linked.

Some key questions here are: Is it one’s intention to assist the other’s wrongdoing, or is this assistance merely a side-effect of one’s action? Does one’s cooperation amount to an endorsement of the other’s wrongdoing?

Formal cooperation in wrongdoing

- 8.8 On the basis of reflection on questions like these, the Church has come to distinguish between “formal” and “material” cooperation. Cooperation is *formal* if the intended “object” or “end” (including the chosen means) of one’s action is precisely to contribute to the other’s wrongful conduct, or if one otherwise shares in the other party’s “bad will”. For example, if a Catholic facility refers patients to another facility *intending* that they undergo abortions there rather than on its own premises, such a referral would involve formal cooperation in abortion. Likewise, if a Catholic institution entered into a contractual arrangement with another party, with the intention of providing some services prohibited by Catholic teaching, such a contract would involve formal cooperation in those prohibited services. Formal cooperation in wrongdoing is never morally permissible.



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8.9 Care must be taken to ensure that arrangements which are claimed to distance a Catholic provider from the provision of prohibited services do not implicitly involve *formal* cooperation. Sometimes there is no reasonable explanation for one's cooperation other than that one endorses the other's wrongdoing.

***Material cooperation
in wrongdoing***
.....

8.10 *Material* cooperation in another's wrongdoing occurs when, although one's cooperative action is not unethical in itself, and although one does not intend to assist the wrongdoing of others, one's own behaviour does (foreseeably) have that effect. For example, if a Catholic facility were to arrange transportation to another facility for a patient who had chosen to go there to undergo a procedure prohibited in a Catholic facility, such cooperation may be material rather than formal. Likewise, in a situation in which a medical practitioner gives a patient advice or information on the basis of which the patient makes decisions not in accord with Catholic teaching, this may involve material, rather than formal, cooperation.

8.11 For cooperation to be merely material, the cooperative action must not be wrong in itself and must not endorse the wrongdoing of the other party. However, the fact that cooperation is material, rather than formal, does not of itself mean that it is permissible. There must always be serious reasons to justify material cooperation in someone else's wrongdoing.

***Determining whether
material cooperation is justified***
.....

8.12 A well-informed and prudent agent will only choose to provide material cooperation when the legitimate benefits and prospective harms of cooperation are to be preferred to the legitimate benefits and prospective harms of non-cooperation. In reaching a judgment on this question, one should consider carefully and objectively how important is the good one is pursuing and whether there are other ways of pursuing it; how serious are the evils to which one's cooperation would contribute, and the necessity and proximity of one's contribution to the success of the other's action; the foreseeable benefits and harms that would result from cooperating and from not cooperating, including any injustice one's cooperation would occasion.



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8.13 Where there are foreseeable harms from material cooperation, Catholic healthcare facilities and professionals should always try to minimise those harms. The graver the foreseeable harms of cooperation, the more significant must be the morally permissible and expected benefits of the cooperation or the expected harms of non-cooperation if such cooperation is to be justified. While the expected benefits of material cooperation are often easy to identify, the harmful effects may be less apparent and so are noted below.

Harmful effects of material cooperation
.....

- 8.14 The principal ill-effect of material cooperation in wrongdoing is that it facilitates someone else's wrongful conduct. Catholic healthcare facilities and professionals should be reluctant to assist others, even materially, in any conduct which is contrary to sound ethics and the Christian gospel. Where possible, one should try to avoid or minimise this harm by persuading the other party not to engage in the wrongful activity.
- 8.15 Another potential ill-effect of material cooperation in wrongdoing is on the cooperating person or facility itself. Despite not

sharing the wrongful object(s) or bad will of the person with whom one is cooperating materially, there is a danger that one may become less sensitive to the wrongdoing, and may unjustifiably place such things as a desire to work well as a team, or a desire to succeed in one's joint projects, ahead of a concern for sound ethics and moral teaching. The normal way to minimise this risk is to examine one's own objects and motives carefully, to recommit oneself to the highest ethical standards, and to discourage the wrongful practice with which a person or group find themselves cooperating.

Scandal
.....

- 8.16 The possibility of "scandal"—both in the ordinary sense of that which causes people shock or dismay and especially in the theological sense of that which leads others to act wrongly—is another harm that may result from cooperation. At times, the true nature of one's material cooperation may not be apparent to all, particularly to people outside the Catholic institution. As far as practicable, one should try to minimise scandal by explaining clearly to staff, patients, and the wider public the reasons for one's cooperation and why the proposed cooperation is permis-



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sible according to Catholic principles. Secrecy about legitimate cooperation is inappropriate. It may undermine the integrity of the institution and increase the risk of scandal if the cooperation becomes known and it is perceived that the institution tried to hide the practice. The diocesan bishop has the ultimate responsibility for judgments about such scandal in the context of the local church.

- 8.17 Material cooperation may also compromise one's ability to witness to certain values or principles. Catholic facilities and their professionals share in the Church's "prophetic" calling to witness to the truth of the Gospel, and so they will be wary of doing anything which might compromise the mission of the facility or the Church more broadly. The reasons which would justify cooperation by institutions sponsored by the Church are usually required to be more stringent than they need to be in the case of individuals, since institutions have a higher public profile and a correspondingly greater prophetic responsibility. The best way to avoid compromising that witness is for the facility or individual to

explain their basic commitments clearly and publicly, and to testify to them in ways which help to ensure there is no misunderstanding that they have lessened their commitment to those values.



Case study

8.18 These principles may be illustrated by reflection on the following case of “institutional cooperation”, viz. when a Catholic facility’s pathology service realises that on occasion the information it provides to its clients may be used by them to make decisions not in accord with Catholic teaching (e.g. information about a chromosomal abnormality which is used as the basis for a decision to seek an abortion). Because institutional cooperation is more complex than cooperation by individuals the discussion of this case can only be in general terms, which would need further specification depending on the precise circumstances. Secondly, the relationships of clients to the Catholic facility may vary from their being patients in the Catholic facility to their being patients in another facility. Thirdly, the contractual arrangements involved may be either between facilities or between individuals and facilities.

As in all cases of cooperation, moral evaluation proceeds in two stages: first, it must be established that the cooperation would not be formal; secondly, if the cooperation would be merely material, then the grounds for its justification must be examined.

In establishing that the cooperation would not be formal at least four matters must be clarified.

- First, the overall *purpose* of one’s own service must be morally upright (e.g. to provide information to patients and their doctors that allow them to make informed and ethically sound decisions). When considering whether to provide pathology services for another facility, the nature of the procedures and treatments for which the services are to be provided, will be crucial to determining whether a Catholic facility should be providing such a service.
- Secondly, the *tests* carried out by the Catholic facility must be medically appropriate and ethical in themselves (e.g. not tests which unjustly risk the life or health of the unborn).
- Thirdly, the Catholic facility must not conduct the test with a view to, or as a preliminary to, the immoral procedure (e.g. selective abortion), but simply for the purpose of a sound diagnosis relevant to an ethically sound treatment option.
- Fourthly, any immoral *use* to which the results of the test might be put must not be the object of the



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Catholic service (e.g. to profit from the provision of the prohibited services by others).

In determining whether material cooperation by a pathology service would be morally justified in a case like this, a number of issues must all be addressed:

- First, the morally permissible benefits (and prospective harms) of providing the service must be preferable to the benefits (and prospective harms) of not providing the service at all. For example, if a Catholic facility is the sole provider of pathology services in an isolated town, the non-provision of any services to other providers might seriously delay pathology results for all their patients.
- Secondly, the prospective harms of providing the service (including the likelihood of scandal to staff, patients and others) must be minimised.
- Thirdly, there should be no weakening of witness to Catholic moral teachings, and new ways of affirming Catholic witness should be found.
- Finally, strategies for staff formation and education, and for the

communication of facility policies will usually be required in addressing these issues.

- 8.19 It is possible that in some situations the very nature of the proposed project is such that grave scandal is unavoidable. In such cases, the gravity of this consequence must be taken into account in assessing whether material cooperation would be justified. Likewise, the frequency with which contractual arrangements may involve material cooperation is obviously relevant to whether it is prudent to enter into those arrangements in the first place. Although cooperative relationships between facilities may distance the Catholic facility from prohibited procedures in the other facility, this distance may also limit the Catholic facility's ability to witness to its convictions and to prevent scandal occurring. Great prudence is necessary in the resolution of these difficult cases, and expert advice should always be sought.

References

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General: *Evangelium Vitae* 73-74; Pope John Paul II, *Veritatis Splendor* (On Certain Fundamental Questions of the Church's Moral Teaching) (1993), 28-83



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