
BIOETHICS OUTLOOK

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“We want everything done.”

Jonathan Gillis

In this issue

Jonathan Gillis, a Paediatric Intensivist at the Children’s Hospital at Westmead in Sydney, is Visiting Scholar at the Plunkett Centre in 2008.

In the first article he reflects on what parents really mean when they say that they want ‘everything done’ for their sick child.

In the next article, Bernadette Tobin identifies some of the ethical challenges in a ‘new’ pathway to donation and suggests ways in which these might be met.

And Bernadette Tobin then suggests that it is just as difficult to *understand* the ethics of the mission of a Catholic health care facility as it is to ‘do’ the ethics of mission.

A final note. This is the last issue of *Bioethics Outlook* that has been prepared and distributed by Linda Purves. After ten years as Administrative Officer of the Plunkett Centre, Linda is about to retire. We wish her a happy and successful retirement and express the hope that the person who replaces her is as cheerful and hardworking as she has been ... and that that person is as good a cook!

Despite a great deal of effort and many articles addressing the end-of-life care of children and adults in intensive care units,^{1 2} paediatricians continue to be confronted by parents wanting “everything done”. Such an appeal is often construed by nursing and medical staff as an unreasonable demand and generates emotion and resentment in all parties. Indeed discussion of end-of-life care of children in intensive care is now so coloured by such experiences that it is dominated by words of negativity such as failure, futility, withdrawing and withholding. The grand tradition of paediatric medicine and nursing, however, is that of positive caring for children and families in just these circumstances; in the words of William Osler: “Amid an eternal heritage of sorrow and suffering our work is laid”.³ It is in this context that I would suggest that there needs to be a reframing of the way we talk about and understand the experience of these children and their families. One approach is to use the language of palliative care in which such care is more than symptom control, comfort and terminal care but instead a credible way of being able to confront the plea for “everything to be done” with an answer, not of negativity, but of affirmation and commitment. Although this way of thinking and talking will not resolve

all conflict, it does bring with it the possibility of bringing these discussions out of the cul-de-sac of anger and frustration in which they seem to be trapped.

To understand how this way of thinking might be applied, it is instructive to recognise the attitude and approach of staff as it begins to be obvious to them that a cure is no longer possible. In this situation the treating strategy tends to follow this sequence:

No cure -> continue to try and cure ->
futility, failure, withdrawal of care.

Such a pattern is perceived by patients and families, and probably subconsciously by staff, as:

Treatment equals a cure, which equals care.

Therefore no cure equals no treatment, which equals no care, which equals abandonment.

It is my contention that when families say: "We want everything done", they are really responding to this perceived paradigm by saying:

Care about us and our child.

Care for us and our child.

Don't abandon us and our child.

These sentiments are driven ultimately by the profound emotion of parental love, which neither abandons nor ceases to care.⁴ For the medical and nursing staff, the language and framework of palliative care can provide an

answer to this plea, with treatment continuing but with different goals in mind.

No cure -> continue treatment with a palliative aim to ensure as good a quality of life for as long as possible.

In this manifestation of palliative care, it is apparent to all that the intensive care staff remain committed to delivering the best care and treatment. If a cure is not possible, the strategic direction has to be reconfigured with an emphasis on quality of life in which active treatment will be delivered with the aim of helping the patient to live as long as possible with as good a quality of life as possible. When the patient is eventually at the end of his or her life, the staff will help to minimise the patient's suffering. The framework adopted here is not primarily directed at terminal care, although it recognises that the patient may be on a trajectory to death over a period of days to years.⁵

Ideas of abandonment and non-abandonment are not new,^{6,7} but seem to have lost currency in the ongoing literature on end-of-life and futility issues in intensive care. The day-to-day symptom-control aspects of palliative care, however, have been practiced with varying quality in intensive care units since their inception. Indeed a whole supplement of the journal *Critical Care Medicine* was recently devoted to the application of palliative-care principles in the critical care environment.⁸ Palliative care has been very useful in intensive care. Renewed emphasis on pain, and especially other symptom control, psychological and spiritual issues has improved terminal care and increased compassionate awareness of the importance of these issues for staff caring for dying patients. But the present deployment of palliative care does not address the many issues that arise during the period before end-of-life seems imminent. It is often, however, during this indefinite interlude that conflict arises and patients and families want more time to live, when they "rage, rage against the

dying of the light".⁹ Nursing and medical intensive care staff often seem to be surprised in their own endeavour to provide comfort care and the "good death" that people do not want to die and do not want their loved ones to die. The enormity of the parental experience and the fundamental nature of parental love dictate that parents will instinctively ask for "everything to be done", irrespective of any rational medical argument.⁴ Thus it is in this penultimate period that fear of abandonment is most palpable and when patients and families demand what is often considered futile treatment. Such misalignment and conflict can be addressed by palliative care when it is conceived as more than terminal care, which in this model can provide a new language, a new framework and an attitude of mind that can enable all of us to break out of this seemingly false dichotomy of cure and terminal care.

The application of palliative care here is about a coherent and encompassing treatment strategy that makes sense to the patient, family and health team. It is active not passive, profoundly positive, not abandonment, and can never be futile.

Such an attitude of mind emphasises that curative and palliative care are not really two models of care. It removes comparisons and stops the splitting of aspects of care so that one inevitably looks better or more weighty than the other, if only unspoken. There is no switch to "comfort" care, words which although compassionate evoke a negativity, a passivity and a trace of being the opposite to the timely, efficient and vigorous intensive care approach. Palliative and curative care are both elements of good nursing and medical practice, one encompassing practice with goals changing continuously within total care. By evoking the profoundly positive nature of all care (including palliative care) the fundamental fear of all patients and families is addressed: fear of abandonment. For the nursing and medical staff, the plea for

"everything to be done" was about avoidance of inevitable death, for the patient and family it was about their perception that to be cared for was dependent on the staff being able to provide a cure. This application of palliative care fulfils the WHO definition: "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual... [It] will enhance quality of life, and may also positively influence the course of illness".^{10 11}

There are a number of issues with the model I am suggesting here. Firstly, many intensivists will contend that parents do not fear abandonment but simply are not willing to realise that their child is dying. Secondly, if ventilation and inotropic support are withdrawn the child may die immediately, leaving no time for a palliative-care period. Thirdly, many will make the obvious comment that palliative care thus defined is simply good medical practice. But my contention here is about language and an attitude of mind, about how we talk between ourselves and with parents. Conflict arises when languages are misaligned: intensive care staff, whether intentionally or not, often imply abandonment, and parents, whether consciously or not, believe that the only way to prevent this is to demand that "everything be done." Palliative care provides the intensive-care staff with a framework and common language with which to reflect on and institute care for these children and their families. Such an approach should be articulated and commenced well before the terminal period. It builds an early connection and trust with parents. Parents and staff can commit to a mutual understanding that there will be a totality of care within which there is a dynamic relationship between curative and palliative strategies. This will not of course resolve all

conflict, but it does attempt to approach these situations with a foundation based on recognition of parental love and an ongoing credible commitment to care for the child and family. Children and families need to know the strategic direction of treatment, but should be guaranteed that, whether curative therapy is or is not possible, there will be an overriding commitment to treatment. They can know that full appropriate therapy will always be delivered, that everything appropriate will be done.

References

1. Royal College of Paediatrics and Child Health *Withholding or withdrawing life sustaining treatment in children: a framework for practice, 2nd edition, 2004.* <http://www.rcpch.ac.uk/Publications/Publications-list-by-date> (accessed 3 Jan 2008).
2. Committee on Bioethics. American Academy of Pediatrics. Guidelines on forgoing life-sustaining medical treatment. *Pediatrics* 1994;93:532-6.
3. Osler, W. The Student Life. In: *Osler W. Aequanimitas with other addresses to Medical students, nurses and practitioners of medicine. 3rd ed.* Philadelphia: P. Blakiston's Son, 1932.
4. Gillis J, Rennick J. Affirming parental love in the pediatric intensive care unit. *Pediatric Critical Care Med*. 2006; 7: 165-8.
5. Lynn J. Serving patients who may die soon and their families: the role of hospice and other services. *JAMA* 2001;285:925-32.

6. Schneiderman L, Faber-Langendoen K, Jecker NS. Beyond futility to an ethic of care. *Am J Med* 1994;96:1104.
7. Quill TE, Cassel CK. Nonabandonment: a central obligation for physicians. *Ann Int Med* 1995;122:368-74.
8. Levy MM, Carlet JM, eds. Compassionate end-of-life-care in the intensive care unit. *Crit Care Med* 2001;29:N1-61.
9. Thomas D. Do not go gentle into that good night. In *Thomas D: Collected poems.* New York, New Directions: 1971.
10. *World Health Organisations, 2007.* <http://www.who.int/cancer/palliative/definition/en/>.
11. Fox E. Predominance of the curative model of care: a residual problem. *JAMA* 1997;278:761-4.

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Donation after Cardiac Death: Ethical challenges in a 'new' pathway to donation

Bernadette Tobin

Donation of organs and tissues – both from living donors and from donors who have deceased – is now a widespread and well-accepted part of modern medicine. The *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* is unambiguous about donation being a good thing. It says:

*"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."*¹

The *Code* goes on to emphasize the ethical importance of ensuring that what is said to potential recipients about the benefits and burdens of transplantation is realistic and that their consent is truly voluntary. It points out that parts of the body should not be treated as commodities. And it reminds us that there should be no unjust discrimination in the allocation of organs and tissue.

The *Code* then distinguishes living donation from deceased (or 'cadaveric') donation. The *Code* reminds us that 'cadaveric' donation is an act of generosity, that death must be established 'with moral certainty' before vital organs are removed for transplant, that organs and tissues may only be removed when the deceased person has bequeathed them verbally or in writing or with the permission of the family, that even in the face of a clear expression on the part of the deceased person to donate organs at death the wishes of those grieving the person's death should be taken into account, and that the grieving family should be given sufficient time and information to comprehend the situation

before things proceed. Indeed those grieving should be given 'adequate evidence' to provide them with 'appropriate assurance that death has taken place'.

The fundamental ethical requirement in all deceased donation is, therefore, that the donor has died. In bioethics, that is sometimes crudely called the 'dead donor' rule.²

Donation after 'brain death' is still the more common scenario for deceased organ donation today. Death is determined on neurological criteria: the complete cessation of all function of the brain. But the law in Australia, as elsewhere, recognizes that there are two ways in which death may be determined: firstly, by the permanent loss of brain function and, secondly, by the permanent loss of circulation of blood in the body. These are two ways of finding out the answer to the same question: is the person dead? The first has long been known called 'brain death', the second is now called 'cardiac death'.

Donation after cardiac death is not really new. It was the normal pathway to donation when transplantation was introduced in the sixties: the first famous transplantation undertaken by Dr Christian Barnard in South Africa made use of organs donated after cardiac death. But once the concept of 'brain death' gained general acceptance, most deceased donation (except in Japan and the Netherlands) has followed 'brain death'.

However, the donor rate in Australia is static: many people on waiting lists for transplants are not receiving donor organs; there is a direct correlation between mortality on a waiting list and the number of available donors. Developments in medicine mean that

it is now possible for older people to be organ donors: what matters is not the age of the donor so much as the health status of that person before he or she dies. And increasingly families of very sick people are raising the possibility of donation with professionals, both with staff in intensive care wards and with donor co-coordinators at the state level. So, recently, in Australia as well as elsewhere, there has been a resurgence of interest in donation after cardiac death.

The question arises: is donation after cardiac death ethically-acceptable? In this article I shall try to do two things: to show, why this pathway to donation raises so many ethical questions and, to identify the ethical issues that need to be addressed if hospitals are to use this pathway to donation in an ethically-sound way.³

Donation after cardiac death has three main elements: (1) life-sustaining treatment is withdrawn; (2) measures are taken to prepare for organ retrieval; and (3) if the person dies, as expected, within a defined period of time, then the organ/s are removed.

Preliminary

Donation after cardiac death follows on from a decision to discontinue 'extraordinary' life-sustaining treatment. 'Extraordinary' treatment is treatment which is either futile or overly-burdensome. A decision to forgo extraordinary life-sustaining treatment (to withhold it or to withdraw it) reflects a judgment about *the value of that treatment for the patient himself or herself*: the reason for the withdrawal of 'extraordinary' treatment must not be to bring about death. It is never permissible deliberately to end a person's life (for whatever reason, whether to relieve that person's suffering by euthanasia, to procure organs for transplantation into others, to vacate a bed, etc). So the first thing to be said about donation after cardiac death is that the decision to withdraw 'extraordinary' treatment must be independent of, and prior to, any decision to remove organs for transplantation.⁴

Are present arrangements for consent ethically-adequate?

To be genuine donation, organ donation should reflect a decision on the part of one person to make her organs available to others for the benefit of their health and even life. Given that deceased organ donation takes place after the person has died, what kind of evidence of the desire to make this donation is ethically-required? What kind of consent is ethically adequate? Must the person have anticipated this specific kind of donation? Must the person have anticipated that organs would be retrieved after a decision had been made that life-sustaining treatment would be ceased because it was judged extraordinary? Must the person have anticipated that procedures, from the taking of blood for tissue typing to the use of drugs to stabilize the organs, might be done for the sake of the potential recipient? Must the person have specifically authorized this particular pathway to donation? Or it is ethically sufficient that he or she has decided to be an organ donor and the family have authorized the process involved in this pathway to donation?

Guidelines from the National Health and Medical Research Council says the following: *'Where the law permits, it is ethical to proceed with these interventions if: (a) there is evidence that the patient would have wanted to be a donor; (b) the patient or family have sufficient information to make informed decisions about ante-mortem interventions; (c) the patient, if competent, has given proper consent or, if the patient is not competent, the family gives permission based on there being reasonable grounds for believing that the patient would have consented; (d) interventions will not contribute to the cause of death or compromise the continuing care of the patient; and (e) measures are taken to prevent any associated pain or discomfort.'*⁵

This is a reasonable view of the ethics of the matter. The patient must have wanted to be a donor; there must be evidence of that desire; and the family must be given adequate information about the process of donation, in particular that it could involve procedures done on the patient for the sake of the recipient

(blood tests for tissue-typing, the use of drugs to preserve organ function in the recipient, etc.), and that, if the patient dies within a set time after the discontinuation of life-sustaining treatment (in Australia, one hour) then there will be only a very short time (in Australia, five minutes) after which they will have to leave the bedside. For many people, that will be too much to ask, even if they know that they will be able to return to the bedside after the organs have been removed.

The insight here is that, to be ethically-sound, the whole process must be explained, in advance, clearly and simply to the family, and that their permission must be based on an accurate awareness of the processes involved. Good ethics requires not only the prior consent of the patient but also the present permission of the family: if at any time the family withdraws that permission, organ retrieval should not go ahead.

NSW Health makes an additional point. In its guidelines, the NSW Department says that implied donor consent (to pre-mortem procedures) can only be presumed when the person has consented to organ donation while alive ... *in the context of adequate awareness of the procedures involved in donation after cardiac death.*⁶ For this reason, the NSW Guidelines limit the permissible pre-mortem procedures to the 'routine' taking of blood for testing for disease and to allow matching of a potential recipient to the donor's organs. They point out that the use of drugs to preserve organ function in the recipient, and the pre-mortem insertion of a femoral cannula to enable rapid cooling of the organs after death, are presently not legally permitted in New South Wales at least, and that (again in New South Wales) substitute decision-makers are not legally empowered to make those decisions. So in New South Wales at least, pre-mortem procedures are presently limited to the 'routine' taking of blood.

Will care of the dying be eroded?

Is it possible or likely that the medical care of the dying will be compromised by the need to retrieve organs as soon after death as possible? Isn't there a very real possibility that

this pathway to donation will erode either the quality of care provided in ICU or the trust of families that the welfare of the sick patient is the paramount concern of the intensivist? Isn't there a very real possibility that families will be prevented from expressing their grief in a way that is both appropriate on the occasion of death and valuable for them in the longer term?

The critical thing here is the patient not be treated merely as the custodian of organs: the patient must be treated with respect for that person's intrinsic human dignity and cared for as should be any person who is dying. 'The care of a potential donor is never to be compromised in favour of the potential organ recipient(s).'

Once again, it will be critical that the family is aware of the processes of donation after cardiac death. If the patient dies within an hour of the discontinuation of life-sustaining treatment, then organ retrieval can go ahead. After death, there will be a 'stand-down' period of five minutes, immediately after which the family will have to leave the bedside. Of course, if the patient does not die within that time, then normal care of the dying will be resumed.

Does the doctor have a conflict of interest?

If the decision to discontinue treatment is to be absolutely independent of any consideration of donation, how is that to be achieved? Is it ethically permissible for the person looking after the severely ill patient, the intensivist, to discuss the possibility of donation with those who are grieving for the sick person? Would that not put the intensivist into a position where she has not just a tolerable 'duality' of interest but an intolerable conflict of interest? For that reason, should not the matter of donation be left to a 'separate requester', someone who is completely independent of the care of the patient? Or is the conversation with the family about the possibility of donation, in circumstances in which they have raised it, better had with someone they have come to know and trust? If so, may she raise the

possibility with them, or must she wait for the family to raise it?

Several things are clear: Those involved in the care of the patient should *not* even discuss the possibility of donation with families who raise this matter themselves until after it has been decided that, for the sake of the patient, life-sustaining treatment is to be withdrawn. Then, they should at least *offer* the family the option of discussing the matter with someone who is completely removed from the care of the patient.

There are different opinions about whether intensive care staff may *raise* the question of donation with the patient's family after a decision has been made to withdraw extraordinary treatment. Some argue that, since the family should have the opportunity to consider whether the patient would have wanted to donate organs in this context, it is permissible for staff to raise the matter with the family after a decision has been understood and accepted by everyone. Others think that it is morally-safer if intensive care staff confine themselves to discussing the matter *only* if it is raised by the family.

Of course, it goes without saying that those who may be involved in the processes of organ recovery or transplant must not be involved in the care of potential donors before they die, nor in discussions with the family.

Are non-therapeutic interventions ethically-permissible?

When life-sustaining treatment is withdrawn, but before the patient has died, are there measures that may legitimately be undertaken to prepare for organ retrieval and transplantation? Or is it unethical to do any pre-mortem procedures on the donor for the sake of the recipient?

Here two questions need to be distinguished: whether the donor has truly consented to pre-mortem procedures and whether it is ever permissible to subject one person to procedures which are not therapeutic for them and which may involve some risk to their own life. We have already touched on

the first. With respect to the second, our *Code* says: 'Persons with 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...'.⁸ Pre-mortem interventions should clearly not harm the patient (for instance, hasten that person's death). Nor should they in any way compromise the end-of-life care that the patient is receiving (for instance, make that person uncomfortable).

Conclusion

Donation after cardiac death requires us to rethink traditional ethical principles in a new context. It is wise for hospitals to prepare their own local protocols to ensure that they conduct donation after cardiac death in an ethically-sound way.

An important part of such a protocol is that there are procedures in place to make it likely that staff know about, understand and support this 'new' pathway to donation. It is also important that there is the opportunity for any member of staff who has a conscientious objection to donation after cardiac death to be able to exercise that objection without threat of penalty.⁹ However the exercise of conscientious objection should never put the person receiving care at risk of harm or abandonment, nor conflict with the ethical standard of the Catholic organization.

The desire to enable someone who wished to offer a chance of health and even of life itself to other sick people is a generous and worthy desire, one that we should support and enable. But our support should be accomplished by ethically-sound means, means which do not compromise medicine's unique capacity to care for the dying. We need to make sure not only that donation after cardiac death *is* ethical and humane, but also that it is *seen* to be ethical and humane.

Footnotes

1. *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, Catholic Health Australia, 2001, 3.22
2. In passing, it is worth noting that some aspects of donation after 'brain death' remain controversial: the main debate concerns the dead donor rule. Some still think that donation after brain death does not fulfill the 'dead donor' rule. (See Robert Truog: Brain death: too flawed to endure, too ingrained to abandon, *Journal of Law, Medicine and Ethics*, Vol 35, No 2, 2007: 273.281.) They further divide into two sub-groups: those who think we should abandon the requirement that the donor be dead, and those who think that we should abandon organ donation altogether. The ethical prohibition on killing the innocent properly rules out the former position. And acknowledgement of the seriousness of the latter requires hospitals to have a robust respect for conscientious objection. But both of those matters are discussions for another occasion.
3. There is, of course, a prior question: Is it ever ethically-permissible to withdraw life-sustaining treatment from a sick person and let that person die? The traditional Catholic teaching on this subject is abundantly clear. Once again the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* puts things simply and well: 'Decisions about life-sustaining treatments for patients who are terminally ill raise two sorts of challenge: which treatment should be 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 with disproportionate hardship to the patient, carers or others.' (*Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, 5.9) That is to say, futile treatment, overly-burdensome treatment, not reasonably available treatment, are all optional, non-obligatory, or (to use the technical philosophical term) 'extraordinary'. An intervention is futile if it will not work. So futility is always relative to a goal: a treatment will not achieve the goal of curing the patient; a treatment will not achieve the goal of reversing the patient's condition; etc. And it is worth noting that this traditional Catholic teaching, which is good secular ethics as well, and which captures the Hippocratic ethic of using medicine to benefit the sick and to keep them from harm, is well-recognized and well-supported by the law.
4. In this context, the NHMRC Guidelines entitled '*Organ and Tissue Donation after death, for transplantation: guidelines for ethical practice for health professionals*' point out that discontinuation of treatment may only be considered when the competent patient, the family or the legally appointed decision maker has agreed to discontinuation of burdensome treatment, and they helpfully add that treatment which maintains the patient's comfort and dignity must be continued. '*Organ and Tissue Donation after death, for transplantation: guidelines for ethical practice for health professionals*', National Health and Medical Research Council, Australian Government, 2007, p 28
5. *Organ and Tissue Donation after Death, for Transplantation*, National Health and Medical Research Council, Australian Government, 2007, p 29 <http://www.nhrmc.gov.au> The guidelines add that the costs for these interventions must not be charged to the family of the deceased.
6. *Organ Donation after Cardiac Death: NSW Guidelines*, NSW Health, 2007
7. 'Principles surrounding non-heart-beating organ donation: draft of December 2, 2002', Pennsylvania Catholic Health Association, *The National Catholic Bioethics Quarterly*, Vol 6, No 3, Autumn 2007, 563-4
8. *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, 1.21
9. No staff member may be required to participate in an activity that is in conscience the person considers to be wrong. A Catholic organization 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 standard of the Catholic organization.' *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, 7.19

Doing the ethics of mission

Bernadette Tobin

What are the challenges that face those who have to 'do' the ethics of mission? In a recent article in *The Weekend Australian* on conscience, the journalist Greg Sheridan expressed the following view: 'The knowing is seldom the problem, despite the many excuses the mind can invent for itself. It's the doing that's the hard bit.'¹ Why 'the doing' should be hard for us is interesting. Socrates, who thought that no one does wrong willingly, found it a real puzzle. Aristotle thought that the answer lay in some deficiency in our upbringing, that moral development (which requires development in our feelings and our will as well as in our knowledge and understanding) can be unbalanced: unless our 'affective' and 'conative' capacities are properly developed, we will find it hard to feel and to act as a truly good person does. But, that said, the *knowing* is sometimes a challenge.

Recently, when a young Indonesian woman in Bali, and six children in Australia, died from complications of influenza, one of our state premiers called for flu vaccines from the national stockpile to be made available to residents of aged-care facilities. The then Commonwealth Minister for Health ruled this out on the grounds that the national stockpile was there for emergencies and 'while this has been a worse flu season than we have experienced for three or four years, it would not qualify as a national emergency.'² I was struck by the terms in which a colleague criticized this decision. She said: "He put the common good ahead of the good of individuals." Did he? Answering that

involves *knowing*, in particular knowing what constitutes the common good, together with judging what it requires of a person with a significant public responsibility for promoting the common good in the particular circumstances of last winter's flu.

It is a misunderstanding of the common good to think of it as 'the greatest happiness of the greatest number'. This utilitarian goal is unworkable and incoherent: for what is 'happiness' and how can we weigh one person's happiness against another's? Rather, the common good is to be understood as (in the words of John Finnis) a 'set of conditions which enables the members of a community to attain for themselves the values(s) for the sake of which they have reason to collaborate with each other (positively or negatively) in a community'.³

Notice the emphasis on *individual* well-being in community: the common good is fundamentally the good of individuals: it is the *condition* for the good of individuals. Seeking it involves us in thinking of common enterprises (eg stockpiling of flu vaccines) as ways of helping individuals 'help themselves'. It involves us in thinking of what responsibilities we have by virtue of our voluntary commitments, our past or present receipts of benefits from others, the dependence of others on us, and by virtue of the network of relationships that exist amongst families, members of the same

political community, indeed between the communities which make up the whole of mankind. So, properly understood, the common good is not the kind of thing that can be put ahead of the good of individuals!

Indeed, the common good requires that we distribute our health care resources (like flu vaccines) in an appropriate way, that is to say, on the basis of need rather than on the basis of capacity to pay or provider whim. But it also requires that we provide for basic public health measures, for forms of care which express our solidarity with the frail elderly, the handicapped, the mentally ill and the poor, ... and that we make adequate provision for emergency care! So, if there are good reasons for having a stockpile of flu vaccines (for use in the emergency of a pandemic), and if it is reasonable to judge that the conditions last winter did not truly constitute an emergency, then it seems that it may well have been his convictions about what are the conditions for the good of *individuals* that led the Minister of Health to decide as he did!

Doing the ethics of our mission requires us to *understand* the elements our ethics: its goal (I think Aristotle's way of putting it - 'human flourishing' - hasn't been bettered), its precepts both negative and positive, and how it is best realized in actual circumstances. Of course, knowledge of ethical principles (available to any person of good will) needs to be accompanied by prudent judgment if we are truly to 'do' the ethics of mission in the circumstances of contemporary life: but, again, that too is a matter of knowledge!

Doing the ethics of mission certainly has its challenges. So, too, in my view, has *knowing* the ethics of mission.⁴

Footnotes

¹ *The Weekend Australian*, 18th-19th August 2007, p40

² *The Australian*, 15th August 2007

³ John Finnis: *Natural Law and Natural Rights*, Clarendon Press, Oxford, 1980

⁴ This article is based on the talk given at the Annual Conference of Catholic Health, Australia, 2007. It is reprinted, with permission, from *Health Matters*, Vol 43, October 2007, 26-27

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