
Bioethics Outlook

News from the Centre for Studies in Bioethics –
Catholic College of Education Sydney

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Profile on Father Tom Connolly

I thought it appropriate for the first edition of our newsletter to include an interview with Father Tom Connolly. Tom was one of the first to be involved in the education and exploration of bioethical ideas in New South Wales. For many years he taught philosophy, moral theology and canon law at Manly Seminary before specialising in Bioethics. Tom has also advised many Catholic hospitals on bioethical issues and is the Director of the Laurdel Bioethics Foundation which he founded.

The interview took place in Tom's study – a comfortable, book-lined room. He pointed out three etchings on the wall which represented to him the principal elements of bioethics – church, law, and medicine. The first picture was of St James' Church in Sydney, the

second, the Law Courts and the third was of Sydney Hospital.

Tom Connolly's priesthood is lived out in active scholarship with the world of ideas and the issues of the day. His bioethical vision flows from his belief in the relevance of the Christian message.

He quoted Cardinal Medeiros:

"A Christian faith that ignores or disregards the marvels of scientific technology in agriculture, medicine and energy is unworthy of the Mystery of the Incarnation."

"Our need for bioethics has grown out of a weakening of faith and an increasing dependence upon technology," he told me, adding that it is through God that relevance comes, and in particular through the incarnation of Christ. "We have lost our sense of the mystery of the human being and of creation," he said. "The element of faith is the element of thinking that is missing. Deduction alone is not enough."

He also spoke of the human dimension, of the need to be aware of the suffering people experience in their lives.

"The term 'bioethics' will not live, it's perishing already," Tom said, describing it as a "catchphrase" to attract popular attention. "You cannot discuss bioethics without philosophy," he added, and stressed the need for sound training in philosophy if people were to be able to discuss these issues properly. "Becoming an ethicist is a lot of hard work," he warned me.

"There is no longer enough attention paid to the development of the imagination in tertiary education. And we need imagination to solve our problems." Tom Connolly shook his head sadly. "The Dawkins Report is a prime example. It's about money." He pointed to the three etchings on the wall. "I'm tempted to add a fourth picture. The Centrepont tower looming over church, law court and hospital to represent the forces of commerce."

It is important to educate people properly. "Education," he told me, "is about the development of the whole person."

Tom spoke of his experiences in teaching bioethics to nursing students, and of his dealings with medical practitioners, scientists and lawyers. Much of his awareness of issues developed from his own pastoral experiences as a Catholic priest. He mentioned the areas of respect for patient rights, confidentiality, con-

sent, and in particular a need to be aware of what the people involved were experiencing.

"There is often a tension between pragmatism and respect for individual rights," Tom said. "Pragmatism is not the only value," he stressed. "For example, when I was involved in the 1977 Federal Law Commission into Human Tissue Transplants, the original proposal was that people would have to opt out of being donors, rather than opting in. There is no doubt that such a system would be easier to administer," he said, "but I pointed out that the doctor is there for the patient, not the patient for the doctor." He smiled. "We were successful and it was changed. That's what's on drivers' licences today."

Tom spoke of the importance of sufficient funding for bioethics. "The first big debate I was involved in was about abortion," he said. "Because the funds dried up for our research the battle was joined before we were completely ready."

In 1981, Tom organised a national bioethics conference with contributions from different religious and philosophical backgrounds. Some of those who contributed were Rabbi Michael Aloney, Reverend Daniel Overduin, Helga Kuhse and Peter Singer.

These speakers come from different backgrounds and traditions, but they share Tom's commitment to the rigorous scholarship and free discussion needed to deal with these problems.

SD

Before I Go ...

This is the first issue of "Bioethics Outlook" and also my last. I have been offered and accepted a position at the University of New South Wales as a Research Assistant into Medical Ethics in the Department of Community Medicine.

The Centre for Studies in Bioethics has expanded since I began in September 1988 and I have grown with it. It has given me the opportunity to develop my knowledge in the area of bioethics.

I would like to thank the people who have been of help and encouragement to me during my period here, both within and outside the College.

I look forward to continuing my association with the Centre and with many of the people and organisations with which I have been involved.

Susanna Davis

Quality of Life and the Limitation of Life-Sustaining Treatment

Written by Peter G. Woolcock

Introduction

In its discussion paper "On the Ethics of Limiting Life-Sustaining Treatment", the National Health and Medical Research Council (NH & MRC) describes a number of cases of limiting life-sustaining treatment. These pose dilemmas about whose responsibility it is to decide between various courses of action and by what criteria. The main issue with respect to responsibility is whether the decision should lie with the doctor or with the patient (or his or her proxy). The main issue raised with respect to the criteria of choice between individuals is whether one of those criteria should ever be the quality of life of individuals. I will be arguing that the professional expertise of the doctor is such that he or she has only a limited role to play in deciding who should receive life-sustaining treatment and who should not. I will also be arguing that we should not choose the recipients of life-sustaining treatment on the basis of quality of life.

The Cases

The NH & MRC paper gives two pairs of cases. The first involves James and Matthew who are both 16 weeks premature and will die without life-support treatment. The case is chosen because James and Matthew are identical on every medical factor. The only morally relevant differences between them are their "quality of life" prospects. James' parents keenly want a child, are in their mid-thirties, emotionally stable, devoted and wealthy. They have no other children. Both want treatment continued even though there is a 30% chance of intellectual handicap. Matthew's parents did not plan to have Matthew. They are both 26, with 4 other children, one of whom has cerebral palsy. They are both unemployed, living in rental accommodation in the outer suburbs.

The second case involves two elderly, sick people. Mr J.G.S. is 97 years old, socially isolated, unable to communicate, requiring total nursing care and with no apparent awareness of the world around him. When he catches flu, he is given increased fluids and aspirin but not antibiotics. He dies of pneumonia four days later. Mrs R.M., by contrast, is a socially active 74 year old who suffers a heart attack then a stroke necessitating ventilation in intensive care. The NH & MRC paper asks, "if she shows no improvement in mental function over the next 4 weeks should ventilation be continued? Would the patient wish to continue living like this?" (p. 6)

Quality of Life

Should young James receive life-sustaining treatment rather than young Matthew on the grounds that James is likely to have the better quality of life? A useful device to help clarify our thinking on this issue is John Rawls' "veil of ignorance" (Rawls 1973). Rawls asks us to reason as if we could be any of the parties affected by the decision but we do not know which that is; it is as if a veil is drawn over which role in the scenario we actually occupy. The function of this device is to eliminate bias in favour of our own characteristics or values. In this scenario we know that James will be richer, healthier and more loved than Matthew and we must reason as if we were one of James or Matthew but we do not know which. Would we agree to save James rather than Matthew on the grounds of James' better quality of life, even though we are just as likely to find when the veil is lifted that we are Matthew and we have just condemned ourselves to death? It seems to me that we would not do so. Even if Matthew's life is not as happy as James', it is the only life he has, and therefore the only life we will have if we turn out to be Matthew. In this sense, each life has equal worth. There is no reason to believe that Matthew's desire to live is any less than James' just because James is happier than Matthew. Matthew, in fact, may feel that his greater misery means that he has more to demand from the remainder of his life than James does, rather than that his life should be shortened because of his misery. Just because we may believe that quality of life is a ground for choosing between James and Matthew does not show that Matthew would choose such a ground. To let Matthew die, therefore, as a consequence of our view of what makes a worthwhile life from our point of view is to adopt an unwarranted moral superiority. By what right do we assume that a point of view is to be preferred just because it is ours, when the person most affected may hold a quite different perspective?

The decision above has been based on the assumption that James and Matthew are both adults. Does the fact that they are neonates affect the conclusions reached? I would suggest not. After all, we are not choosing between James and Matthew on the basis of factors relevant to their life as neonates but on the basis of facts that will make a difference to them once they become adults. However, as we have seen, the difference in quality of life between them even when they are adults does not justify preferring one of them over the other. How, then, can it do so when they are not yet adults?

Suppose a woman loves two cups equally because they were given to her by each of her two children. One is a piece of high quality china whereas the other is a piece of rough clay. Suppose now she is taken back in time to the moment just before each cup is created and, knowing what the cups will become, is asked to choose between the two piles of ceramic material. Given that the two cups are of equal worth to her, she will be

unable to choose between the two piles of constituents, even though one is of a finer quality than the other. Likewise, the equal worth of James' and Matthew's lives as adults makes it impossible to choose between them as babies even though the quality of their lives will differ.

Medical Professional Expertise

The Mr J.C.S. case raises the issue of the role of the doctor in deciding whether patients should receive life-sustaining treatment. I will argue that the doctor's role here should be limited solely to his or her area of expertise. Merely in his or her capacity as a doctor, a person does not have any special expertise about which of two patients is most worthy of living, even when resources are so scarce that only one of these patients can be saved. The doctor's expertise is in how to maximise a patient's chances of life or how best to return a patient to the maximal degree of normal physical functioning. There are considerable dangers in extending this role to judgments of who shall die in order that someone else can live. In particular, it threatens the public's confidence in the hospital system. People want to be assured that, if they enter an emergency ward in a coma, everything will be done to save their lives. They do not want there to be any chance that doctors will decide to let them die so that their body can be used for spare parts for some more "deserving" case, for example. Unless there is this absolute trust in the intentions and procedures of hospitals we are likely to find far more cases of the kind reported to me by one of my students. She reports nursing an old lady in a nursing home who "every night when we put her to bed would scream 'you're not going to kill me, are you? Please don't kill me.' It was terrible!"

The crucial point I wish to make here is that doctors should have a very narrow discretion in what they can do for the patient's good, or in his or her "best interests". It must be restricted solely to their expertise as doctors, that is, to their role in saving life or returning patients to maximal normal functioning. They should not legally be empowered to decide as the nurses and consultant did in the case of Mr Derek Page. Mr Page was a single man with a mental age of three who was on a dialysis machine. As Justice Kirby (1985, p. 71) puts it, "At times he was violent, generally uncooperative, dirty, incontinent of urine and faeces, unable to take medication reliably and he could not adhere to a prescribed diet. He exposed himself and masturbated while being examined. A great part of his life was spent under sedation, particularly when he was being dialysed. His blood pressure was not properly controlled." Mr Page was taken off the dialysis machine by medical and nursing staff on the grounds that it was in his "best interests" (Kirby 1985, p. 71). Now, decisions by medical and nursing staff about what is in Mr Page's best interest should be restricted solely to questions about what is in his best interests from the view-

point of keeping him alive or returning him to maximal normal physical functioning. This is their role as health professionals and it is their area of expertise. It is almost impossible to see how taking Mr Page off the dialysis machine can have been in his best interests in either of these senses, given that it would lead to his quicker death and his quicker physical deterioration. This explanation of their action, therefore, should have been a legally culpable one. What they rightfully could have said, provided they genuinely believed it to be true, was that Mr Page's situation meant that his being on the dialysis machine could neither prolong his life nor improve his physical condition. As it happens, they could not offer this justification because it was not plausibly supportable by the facts and they would have placed their reputation as medical experts in jeopardy to have offered it.

The reason why I stress this question of the interpretation of "best interests" is that the NH & MRC Discussion Paper states that it is a right of the patient "to be treated in his/her best interests" (p. 8) and that parents (in the case of children), relatives, close friends, physicians and members of the helping professions all have a right to "assist in judgments about the best interests of the patient" (p. 8). My point is that, as far as the role of hospitals, doctors etc. is concerned, the best interests of the patient are already determined, namely, maintenance of life and restoration of health. Discretion to doctors in this matter not only results in the kind of discrimination against the weak and unattractive, as was practised on Mr Page, it also leads to the Lord Dawson Case. Lord Dawson, physician to the King, shortened George VI's life so that news of his death would be reported in the respectable morning papers rather than in the evening scandal sheets (Wilson 1989, p. 244). Whether or not Lord Dawson had the King's wishes right, it was not his prerogative as a doctor to make such a decision nor should the laws be modified in any way that might lead doctors to think it is. Equally, it is not part of the doctor's role to decide that Mr J.G.S.' best interests are served by letting him die. If competent medical opinion would have agreed that Mr J.G.S. needed antibiotics to live or be restored to normal physical health then this is what the doctor should have prescribed.

How, then, do we limit life-sustaining treatment if not by giving discretion to doctors? Are there moral experts we can turn to for an answer? I would suggest not. Rather, we must publicly debate these matters to arrive at processes that we would regard as reasonable if applied to our own cases and to the cases of others who may not share our particular idea of what makes a life worthwhile. Some situations will be relatively straightforward, for example, those where people have indicated their preferences while cool, calm, collected and healthy, for example, through the use of living wills. The law should be modified to accommodate these innovations. The real difficulty remains the case of the people who cannot consent. If there genuinely

is a shortage of resources then we seem to be left with the current model – first come, first served. Anything else introduces highly contentious claims about the superior worth of some lives over others, and this should be anathema to democracy.

References

- Kirby, M. (1985), George Judah Cohen Lecture, *Australian Health Review*.
National Health and Medical Research Council (1988), Discussion Paper on the Ethics of Limiting Life-Sustaining Treatment.
Rawls, J. (1972), *Theory of Justice*, OUP.
Wilson, I. (1989), *The After Death Experience*, Corgi.

Ethical Issues in the Care and Treatment of People with AIDS

On February 9 this year the Centre for Studies in Bioethics organised a one-day conference at Calvary Hospital, Kogarah to consider the ethical issues that arise in the context of caring for people who are sick with AIDS. The issues were addressed from medical, nursing, theological and pastoral care perspectives.

Dr Furner, Medical Officer at the Albion Street Clinic, was the first speaker. In Dr Furner's opinion there was minimal risk to doctors and nurses in caring for antibody-positive patients but she recognised that there was a significant level of discrimination towards people with AIDS from the medical and nursing community in general. Dr Furner, in response to a question, made the interesting comparison between abortion rates for women who are IV drug users and HIV positive and women who are HIV negative. Only 40% of female intravenous drug users in New York who are diagnosed as HIV positive will proceed to abortion compared with fifty % in the population in general who will have an abortion but are HIV negative. It would be wrong for the medical profession to consider abortion the answer for women who are HIV antibody positive.

Peter Boswarva RN from the St Vincent's AIDS unit concentrated on the issues that arise from nursing people with AIDS. In a review of the literature Mr Boswarva established that there was widespread fear amongst nurses in relation to antibody-positive patients and AIDS and that this was often coupled with prejudice and antipathy towards homosexuals and IV drug users. Notwithstanding these findings Mr Boswarva could see no reason for nurses refusing to care for people with AIDS and regarded such refusal as unethical on the grounds that the patients are sick with

minimal risk to the nurse. With appropriate precaution Mr Boswarva could see very little danger to any nurse whatever their immune competency or pregnancy status. Mr Boswarva also regarded the issue of confidentiality and partner notification a non-issue in that the experience of the Unit at St Vincent's has been entirely positive. Patients with appropriate counselling and support have been willing to give consent for notification without exception. It has never been necessary to breach confidentiality without the consent of the patient.

Fr Philip Malone MSC presented a paper on the contributions that theology could make to the debate. Fr Malone was at pains to establish the field of morality and moral judgments. It was important that morality is not about setting rules but about a vision of what it is to be human. It is a futile activity to keep asserting what others should do. To have any practicality, moral theology and ethics must address the motivation of human beings. It is this vision of becoming a compassionate and a caring community that theology has to offer. Theology, according to Fr Malone, has the task of promoting ways of living that are in accord with human values and good living.

The answers that Christians are looking for will not be found in cloisters or seminaries but in going out and helping, in taking the initiative and being with people rather than holding back and being careful. Theology's contributions to the care of people with AIDS should be one of empowering Christians to care and to act. It should also be one of reflecting upon our image of God.

Fr Hugh Murray cm spoke on being a chaplain to people with AIDS. In a very frank discussion Fr Murray addressed the issues that confronted him as a Catholic priest mainly working with homosexual men. In such a ministry there is a constant tension between the pastoral care of the Church and its official teaching on sexual morality. Fr Murray's personal impression is that there is a much greater understanding of homosexual people within the Catholic Church and less prejudicial judgments. As a chaplain he has found that suicide in the context of euthanasia is a troubling pastoral problem as well as the conflict between relatives and homosexual friends and companions over funeral arrangements. One of the more piercing messages of Fr Murray's talk as well as comments by participants is that it is very patronising for the Catholic Church to have shunned homosexual men while they were healthy but once sick with AIDS they become deserving of the Church's attention.

The conference highlighted the need for constant education of all staff in health institutions about the facts of HIV transmission. Secondly, the conference addressed the particular concerns of Catholic Institutions. A pertinent challenge was given to Catholic theology and pastoral care to find a vision of care that improved upon the maxim: 'love the sinner, hate the sin'. Although the maxim encapsulates a Church that

wishes to care as well as teach, it carries with it undertones of patronage and prejudice when applied to homosexuals. Homosexuals appreciate the care being offered by Catholic institutions but are disappointed that they have become visible to Christians only when sick with AIDS.

Such was the interest in the topic that the Centre for Studies in Bioethics will run the conference again in the latter half of the year. A transcript of most of the talks is available for a small cost.

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Calendar -1990

July 13-15

A Christian Conference on the Environment
Sydney

Enquiries phone: (02) 956 5811

December 12-14

"Out of the Crucible: Science, Creativity and the
Human Condition"

Conference hosted by CHAST (Centre for
Human Aspects of Science and Technology)
University of Sydney

Enquiries phone: (02) 692 2172

August 5-8

"AIDS in Asia and the Pacific"
Canberra

Enquiries phone (062) 285 3000

August 8-11

"4th National Conference on AIDS"
Canberra

Enquiries phone (062) 285 3000

Conference at St Margaret's Darlinghurst

In October 1989 a conference was organised by the Centre to consider the implications of the early diagnosis of the anencephalic infant. Fr Bill Daniel SJ and Sr Diedre Gardiner RSM were our speakers for the day. Fr Daniel's views of this topic were already published in the *Australasian Catholic Record*.

As Fr Daniel pointed out, the problem of the anencephalic fetus is a new one for Catholic moralists because of the fact that such a fetus is now able to be diagnosed early in the pregnancy. The termination of such a pregnancy is medically advisable because of the dangers an anencephalic fetus poses to the mother at birth.

The speakers addressed the issues from a number of moral principles including the principle of double effect and ordinary and extraordinary means. The following is a summary of their thoughtful, complex arguments.

Sr Gardiner established that the principle of double effect was of little help in this particular situation and preferred to analyse the situation under the aegis of proportionality. Was the continuation of uterine life of benefit to the anencephalic fetus and mother, or a burden? Since we cannot speak of viability with an anencephalic fetus, the early induction of labour is no more fatal for the fetus at 16 weeks than it is at 40 weeks. Therefore, since the continuation of uterine life is of no benefit to the anencephalic fetus the question must be considered from the perspective of benefit and burden to the mother.

Fr Daniel followed a similar line of reasoning. He considers the limits of charity and the teaching of Pius XII on the question of burden and benefit when assessing medical treatment. These principles were applied to a consideration of the duty of a woman to her unborn, based on respect for life. As a positive duty there are limits to what a woman must do to preserve the well-being of the unborn. The suggestion was then made that there are limits to the duty a woman has to her fetus when anencephaly is diagnosed. The delicate problem of scandal in this matter was analysed by Fr Daniel. He did not see the case of the anencephalic fetus undermining the pro-life mission of the Catholic hospital. A careful presentation of the case should avoid scandal and women who come to Catholic hospitals suffering the tragedy of an anencephalic pregnancy need the support of a hospital where they can expect wise and sympathetic guidance in the formation of their consciences.

In discussion with participants the question of the use of anencephalic organs was raised. Fr Daniel replied to the question by saying that he was very unhappy with the pressure to redefine death in the case of the anencephalic infant for reasons other than

the good of the infant. Also, the idea of maintaining the infant's life to allow the salvage of organs was not a procedure that appealed to Fr Daniel for the same reason, i.e. that it was of no benefit to the infant.

CR

News Update

Research on Human Embryos

The British House of Lords voted 234 to 84 in February in favour of allowing research on human embryos up to 14 days after fertilisation.

The Human Fertilisation and Embryology Bill still has to be passed by the House of Commons.

Tasmanian Catholic Health Care Association

The Inaugural Mass for the Tasmanian Catholic Health Care Association was said in Hobart on 17 May 1990 by Archbishop Darcy.

Sister Juliana Coulson LCM, Sister Administrator of Calvary Hospital, Hobart, said that it would be part of the Association's brief to address bioethical issues within the Archdiocese.

St Margaret's Hospital to Relocate

St Margaret's Hospital Darlinghurst will relocate to the Liverpool Hospital site.

The move was decided on in response to the need for obstetric beds in that region as highlighted in the 1989 Shearman Report on "Maternity Services in New South Wales".

Mr John O'Neill, Chairman of the Board of Management of the St Margaret's Hospital complex said that the Sisters of Saint Joseph saw the relocation as an ideal opportunity for St Margaret's to "provide the wonderful care it is renowned for to families in the South Western area of Sydney".

St Margaret's at Liverpool is not expected to open until 1993.

Northern Sydney Public Health Unit

The Northern Sydney Area Health Service recently received funding from the New South Wales Department of Health to establish a Public Health Unit.

Based at Hornsby Hospital, the Unit commenced operation in February 1990.

According to the Deputy Director of the Unit, Dr

Michael Stanford, the Unit has four main areas of activity. They are environmental health, the control of communicable diseases, prevention programs, and health surveillance.

Dr Stanford said the Unit aims to improve the health of the public in the Northern Sydney region by encouraging health care professionals and managers to think in terms of outcome instead of just activity.

Housing Conditions Affect AIDS

A British study on the housing needs of people with HIV/AIDS has shown that the stress of poor housing conditions could accelerate the rate at which people with the virus become ill.

Of those interviewed, 30% had had to find other accommodation because of harassment. They cited dampness and lack of heating as major problems.

Increase of AIDS in UK

The British publication, *Nursing Times*, predicted that by 1993, more than half those diagnosed with HIV/AIDS will have contracted the virus through heterosexual sexual activity or through intravenous drug use. This compares with 7% in the first nine months of 1979.

The spread of AIDS in Britain has not been as rapid as originally estimated, probably because of the response of the homosexual community. However, the importance of educating the homosexual community was emphasised.

Australia Joins Boycott of AIDS Conference

Australian non-government organisations will boycott the Sixth International Conference on AIDS unless the US Government removes restrictions on travel for people with HIV/AIDS, reported "Front-line", newsletter of the AIDS Council of New South Wales.

The Australian Federation of AIDS Organisations (AFAO) joins other overseas organisations in the boycott. They include:

- Action AID (UK)
- Action Health 2000 (Britain)
- AHRTAG (UK)
- AIDES Solidarite Plus (France)
- AIDS Council of New South Wales (Australia)
- APARTS Solidarity Plus (France)
- Australian Federation of AIDS Organisations (AFAO)
- Austrian AIDS Help
- Brazilian Interdisciplinary AIDS Association (ABIA)
- British Hemophilia Society
- British Medical Association
- British Red Cross

- Canadian AIDS Advisory Council
- Canadian AIDS Society
- Canadian Hemophilia Society
- Canadian Red Cross
- Christian Aid (UK)
- Comite Ciudadano Anti-SIDA (Spain)
- Deutsche AIDS Hilfe (West Germany)
- Dutch Association of People with AIDS
- ECHO (UK)
- European Parliament
- GAPA - Grupo de Apoio a Prevencao a AIDS (Brazil)
- Government of Switzerland
- Grupo Autoapoyo/EK Ciempies (Spain)
- Grupa Pela VIDDA (Brazil)
- French Red Cross
- Frontliners (UK)
- International Association of People with AIDS
- International League of Red Cross and Red Crescent Societies
- International Planned Parenthood Foundation
- Latin American Network of AIDS Service Organizations
- London Lighthouse (UK)
- The NAMES Project International AIDS Memorial Quilt (USA)
- National Association of People with AIDS (USA)
- National Gay and Lesbian Task Force (USA)
- National Institute of Public Health (Norway)
- Native American AIDS Prevention Center (USA)
- New Zealand AIDS Foundation
- Noah's Ark (Sweden)
- Norwegian AIDS Association
- Norwegian Educational Association
- Norwegian Red Cross
- Norwegian Union for Teachers
- People with HIV in Sweden Group
- PLUSS (Norway)
- Positivigruppen (Denmark)
- PostiviLeben (Austria)
- RFSL HIV Kansliet (Sweden)
- Save the Children (UK)
- Shanti Project (USA)
- Swiss AIDS Help
- Terrance Higgins Trust (UK)
- Township AIDS Project (South Africa)
- Oxfam (UK)

(As of April 5, 1990 -- List courtesy of the NAMES Project AIDS Memorial Quilt)

Bioethics Forum

The first in a series of monthly forums on "bioethics and Life Manipulation" took place on Tuesday 27 March at the University of Sydney.

The forums are organised jointly by CHAST (Centre for Human Aspects of Science and Technology) and the Australian Institute of Biology.

Enquiries may be directed to Professor Alex Reichel, Director of CHAST, on (02) 692 2172.

St Vincent's Bioethics Centre 8th Annual Conference

St Vincent's Bioethics Centre hosted its eighth annual bioethics conference at St Vincent's Hospital Melbourne from Monday 7 to Thursday 10 May.

Subjects addressed included an economic overview of health resources in the 1990s, government policy and Health Services Agreements, reproductive technology and HIV/AIDS.

Graduate Diploma for Catholic College

The Catholic College of Education Sydney received unconditional accreditation for its new Graduate Diploma of Health Science (Palliative Care Nursing). This is in addition to the Graduate Diploma of Health Science (Gerontic Nursing).

SD

Cocktail Launch for WA Ethics Centre

The battle for sound business ethics commenced at a Cocktail Party in Perth on Saturday 12 May. Director of the Centre, Mr Colin Honey, launched an appeal for one million dollars to cover the running costs of the Centre, which will conduct courses for young professionals.

Professor Max Charlesworth delivered the inaugural lecture. "We can no longer pretend that business is a world of its own laws and rules," he said.

I was unable to attend the opening - our budget wouldn't cover the taxi fare - but would like to take this opportunity to wish Colin and the staff of the Centre every success.

SD

Bioethics Centres around Australia

The field of bioethics is much more active across Australia than I realised, as I found when researching this newsletter.

I decided it might be useful to compile a list of the various centres. Please let us know of any changes or additions so we can keep this information up to date

SD

New South Wales

Centre for Studies in Bioethics [Est. 1988]
Catholic College of Education Sydney
PO Box 968
NORTH SYDNEY NSW 2059
Phone: (02) 929 0199

Coordinator: Mr Chris Rigby
Administrator: Ms Susanna Davis

Begun as a joint initiative between the Catholic College of Education Sydney and religious orders and Catholic hospitals in Sydney. Runs seminars, workshops and conferences on bioethical issues aimed at the health profession. Is building up an extensive collection of research material and library resources.

Christian Centre for Bioethics [Est. 1986]
Sydney Adventist Hospital
185 Fox Valley Road
WAHROONGA NSW 2076
Phone: (02) 487 9289

Director: Dr Tom Ludowici

Based within the Sydney Adventist Hospital it has organised a national bioethics conference each year since 1986. Aims to build up resources and reference material and to service the needs of the hospital and community at large.

Laurdel Bioethics Foundation [Est. 1981]
PO Box 539
BURWOOD NSW 2134
Phone: (02) 745 2364

Director: Fr Tom Connolly

The Director advises several Catholic hospitals on bioethical issues. Has extensive material collected over the years and also provides consultancy and research.

Queensland

Provincial Bioethics Centre for the [Est. 1981]
Queensland Catholic Dioceses
PO Box 343
SOUTH BRISBANE QLD 4101
Phone: (07) 844 8708

Director: Sr Regis Mary Dunne RSM

This Centre aims to service the local community in Brisbane, and in particular the five Queensland Catholic dioceses. It has links with the Mater Hospital in Brisbane and an extensive collection of reference material which is used by professionals, politicians, media, students etc. It employs two full-time staff members plus the help of volunteers.

South Australia

Bioethics Unit [Est. 1989]
Flinders Medical Centre
Flinders Drive
BEDFORD PARK SA 5042
Phone: (08) 275 9911

Director: Dr Brian Stoffel

This is a new Bioethics Unit based within the Flinders Medical Centre and is involved with that Hospital's Ethics Committee. This Unit has an orientation towards research.

The Dietrich Bonhoeffer International
Institute for Bioethical Studies Inc. [Est. 1983]
GPO Box 588
ADELAIDE SA 5001
Phone: (08) 297 0946

Director: Dr D. Overduin

The Institute has links with the Southern Cross Bioethics Institute and publishes a regular newsletter. Principal object is research and education on bioethical issues.

Southern Cross Bioethics Institute [Est. 1987]
"The Pines"
336 Marion Road
PLYMPTON NORTH SA 5037
Phone: (08) 297 0022

Director: Mr John Fleming

Involved in bioethical research and publication of the quarterly "Bioethics Research Notes" in conjunction with the Dietrich Bonhoeffer Institute for Bioethical Studies.

Victoria

Bioethics Department [Est. 1982]
St Vincent's Hospital
41 Victoria Parade
FITZROY VIC 3065
Phone: (03) 418 2453

Director: Dr Bernard Clarke

Situated in St Vincent's Hospital, Melbourne. Hosts annual national bioethics conference and is involved in bioethical research.

Centre for Human Bioethics [Est. 1980]
Monash University
CLAYTON VIC 3168
Phone: (03) 565 4278

Director: Professor Peter Singer

Part of Monash University. Publishes "Bioethics News". Offers the only postgraduate bioethics degree program in Australia. Also has extensive resource material on bioethics.

Centre for Research in Ethics and [Est. 1989]
Health Issues
(Institute of Catholic Education)
PO Box 146
EAST MELBOURNE VIC 3002

Coordinator: Dr Liz Hepburn

Situated on the ICE campus in Melbourne, it publishes a newsletter and is involved in research and education.

Western Australia

The L.J. Goody Bioethics Centre [Est. 1988]
(Catholic Archdiocese of Perth)
20 Prendiville Way
LANGFORD WA 6155
Phone: (09) 458 6094

Director: Fr Walter Black MSC

The Centre has been operating since 1988 producing documents and giving lectures for the Archdiocese. Will be moving into new premises soon with facilities to include a specialised library and public lecture hall.

Kingswood Centre for Applied Ethics [Est. 1989]
(University of Western Australia)
C/- Kingswood College
CRAWLEY WA 6009
Phone: (09) 389 0382

Director: Mr Colin Honey

The Centre's main areas of operation are bioethics, professional ethics and business ethics. It aims to provide a resource centre and a visiting fellow program. According to Mr Honey it is "deliberately broad-based, non-denominational and non-opinionated".

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Centre for Studies in Bioethics
Catholic College of Education
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PO Box 968
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Telephone: 02 929 0199
Facsimile: 02 955 8932