Health Ethics Guide

Catholic Health Association of Canada

HEALTH ETHICS GUIDE

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PREAMBLE

The 1991 *Health Care Ethics Guide* published by the Catholic Health Association of Canada stated that the guide should be examined and revised at regular intervals as newer insights occur, and in order to respond better to the ethical issues of the day. Continued advances in health care science and technology, and the shift of focus in health care from the institution to the community, highlight the need for such a revision. The increased number of elderly persons in our society, society's rapidly changing social/cultural fabric, as well as years of budget cuts and health care restructuring, have also raised issues that needed to be considered in revising the guide.

One of the most significant factors that has influenced the writing of this new guide is the adoption of a broader concept of health. This approach affirms the importance of sickness care and also of a wider range of determinants of health, including biological factors, lifestyle, physical environment, spiritual well-being, housing, income, education, employment, and social supports. Such a view requires a more holistic approach to health than has existed in the past, one in which the health system comes to be viewed as a continuum of care that includes a variety of services and programs offered in different settings throughout the community. The list of services includes health promotion and disease prevention, social services, acute care, long-term care, chronic care, rehabilitation and home care.

The purpose of the guide is to facilitate sound ethical reflection that leads to informed decision-making. It presents a moral vision reflecting Roman Catholic teaching on health ethics as it applies to contemporary Canadian society. Such a guide can provide a perspective and a general direction. It cannot substitute for organizational responsibility or for the need to follow an informed conscience.

The moral vision of this guide is based on experience and reason, enlivened by Christian faith and taught by the Roman Catholic Church. It is intended to assist a number of different audiences. Most specifically the guide outlines the moral obligations for the sponsors/owners, boards, members of ethics committees and personnel[1] of Catholic health and social service organizations. For Catholics working in health and social service organizations that are not Catholic sponsored, the guide provides valuable assistance. For people who work in Catholic health and social service organizations, regardless of whether they are members of the faith tradition, the guide presents Catholic tradition and outlines the values that are to be respected by those who work within the organization. Finally, the guide can be used by persons receiving care, their families and anyone who seeks a framework to structure and articulate their own decision-making. It also informs them about what to expect from care providers who function according to such a vision of care.

The *Health Ethics Guide* complements other initiatives in the church's healing ministry, such as spiritual/religious care, organizational mission and values integration, ethics committees and centres, and parish-based ministry/nursing, through which caregivers are becoming more aware of the broader aspects of their healing ministry.

Most of the chapters are composed of two parts: introductory comments identifying the values that underlie the treatment of issues discussed in the chapter, and articles that serve as formulations of the contemporary Catholic understanding of how these values are applied in particular circumstances.

1. Throughout this guide the term *personnel* includes all those who serve patients/residents/clients within health and social service organizations, e.g. administrators, physicians, nurses, other health and social service professionals, staff and volunteers.

All the chapters have been expanded to include current ethical issues and themes. The introduction situates the guide within the everyday context of health and community service providers and those receiving care, highlighting the face-to-face encounter of persons as a privileged place for supporting human dignity. The guide also provides an outline of values and principles to assist ethical reflection. Chapter VII, *Governance and Administration,* which is a new addition to the guide, presents an expanded treatment of the many concerns facing boards of trustees and administrators, including issues that have emerged in the restructuring of health care organizations throughout the country. The appendices include a model on how to make an ethical decision or discernment, an explanation of legitimate cooperation, a glossary of terms and a bibliography of important church documents, publications of the Catholic Health Association of Canada, documents consulted and key references on ethics.

Although the guide focuses on ethical issues, many of them have legal ramifications. Where needed, readers are encouraged to refer to the appropriate provincial, territorial and federal legislation.

INTRODUCTION

THE HEALING RELATIONSHIP: THE CONTEXT OF ETHICAL REFLECTION

Imagine for a moment a young person entering an urban drop-in centre, one with health care services. He has fled an abusive family that left him with few of the resources needed to make his way in the world. He arrives with a minor medical problem and, more significantly, critical personal needs.

How are we to relate to such a person? Is he a patient, a client, a consumer, a customer, a disease or condition, or another street person? So many classifications compete for attention.

Not surprisingly, the Catholic Health Association of Canada begins its *Health Ethics Guide* with attention to how health and social service organizations are to welcome people. We draw upon a long Christian tradition of concern for persons as key to our reflection; we do so recognizing the particular challenges and opportunities before us today. The example of Christ and his way of loving others shapes this reflection.

We invite you to consider, within the context of the challenges that lie ahead, how this young man's situation focuses on a need for a relationship of healing. We ask you to consider how the vision and values of the Christian tradition call us to a very particular kind of care for him and for all who come to us, like him, in need; whether we meet them in a community health centre, social service agency, hospital, long-term care centre, residential home, or in their home.

The Call to Respect Dignity

Imagine the care provider[1] *who meets this young man. Where does she begin to address his needs? By caring for the immediate physical problem or by attending to the isolation this young man feels? How does one begin to "heal" the way in which he has become nameless, faceless? This young man is likely doubtful about the willingness or ability of anyone to care or to respond to his real needs.*

Yet, the woman who faces him now sincerely wishes to help and desires to be truly present to this man. As a representative of a community of care, she meets many others like him and is often frustrated by the lack of time she has to give. But, despite the many demands, she reaches out to him and responds to his need for comfort, contact and healing. She struggles to give this young man something more, a reason to hope in the face of so much indifference.

Persons are created to be in relationships that nurture and define them. The tradition upon which we draw sees this encounter between persons as a privileged place for supporting human dignity. Such respect for the dignity of persons is to mark all organizations calling themselves Christian.

- All care is to be marked by attention to the good of the person. Those who come to us are always viewed as persons with whom we are willing to be in relationship. Respect is to be given to the varied communities to which people belong, be they cultural, religious, or linguistic.

1. In the Guide the term *care provider* refers to personnel working within a health or social service organization. It is to be distinguished from *caregiver*, a term which includes care providers as well as those persons who comprise a wider circle of support, e.g. family members, a life partner, close friends or members of the broader community.

- Healing occurs best when people experience that they belong to communities of compassion. Faith communities have a special role in nurturing people and in attending to the spiritual/religious dimension of care.
- Prejudice of any kind represents a fundamental denial of our commitment to the gospel message.
- Health and social service organizations must respect the dignity of personnel in the same way that personnel are expected to respect the dignity of those in their care.

The Call to Promote Justice

For the care provider, treating the young man's medical needs is quite possible. The reality is, however, that the same needs are likely to re-emerge because of the young man's living situation and the injustices that have marked his life.

Both individuals live within a network of communities and institutions which are deeply affected by the social, political and economic structures of society. At times these networks experience stress and limitations. This particular young man knows society as a place of violence. He has become used to seeing resources and services upon which he once depended disappear. A group of his peers has banded together to provide whatever comfort and hope they can. They have become "family." This care provider experiences the demands of many unmet needs as a strain on the resources she has to offer. For her, another support network exists, that of professionals, a faith community, and ties of family and friends upon which she can draw as she seeks to show compassion.

Neither can take such networks for granted; they are increasingly fragile. The economic insecurities facing both persons make their situations all the more vulnerable. Like so many individuals today, they feel stretched to their limits. How can justice be fostered in such circumstances?

Promoting and restoring wholeness of life means not only treating symptoms but also being attentive to the causes of suffering and injustice. The Christian tradition sees the quality of relationships and the protection of individual human rights within community as basic to a healthy, just society. It emphasizes the link between promoting health and working to overcome injustice.

- Respect for the rights of persons and communities is basic to any sense of justice. Such rights are an expression of respect for human dignity.
- The needs of the most vulnerable or abandoned are to be given preferential attention. Their well-being measures the moral quality of any community or organization. This special love of the poor, of those most likely to be excluded, is at the heart of the gospel message and the building of God's Kingdom.
- Health, fully considered, necessarily includes physiological, psychological, spiritual, social, economic, and ecological dimensions. The promotion of justice includes attending to all these dimensions of health.
- Health and social service organizations have a distinctive role within their communities. This role provides them with an opportunity to effect or influence structural changes for the promotion of social justice.
- We recognize that we serve the well-being of each person by seeking the good of all. Our tradition knows this as the call to foster the common good. It can only emerge within communities dedicated to dialogue, interdependence and concern.

The Call to Foster Trust

Imagine now the administrator of the drop-in centre. The young man and the care provider we have met, like so many whose lives have

been stretched to the breaking point in this age, feel frustration, indeed anger at those "in charge." Organizations and decision-makers are a logical target for that anger.

All who bear decision-making responsibility today know this tension well. Supervisors, administrators and board members all feel the pinch. They know, often personally, the limits faced by care providers and the vulnerable, and feel a sense of responsibility for both.

The administrator recognizes that her organization, as a community of service, is directed to providing excellent care for persons in a compassionate and just manner. Its ability to provide this care is determined and shaped by decisions made at the municipal, provincial and national levels. As an administrator, she finds herself caught between the expectations of society and the reality of necessarily limited resources.

She also knows that her organization, as a community of work recognizing the personal dignity and needs of the personnel, must develop and maintain employer-staff relationships which are characterized by trust and mutual accountability. All persons within the organization have a role to play in its effort to become a healing community.

The tradition upon which we draw holds that healing is best effected in an atmosphere of trust.

- Organizations devoted to care in the community are to embody a trust rooted in dialogue and mutual respect. Those in need of care must be able to trust that decision-makers at all levels are committed to their well-being.
- The compassion and trust that are characteristic of health and social services protect society against a growing depersonalization.

- Attentiveness to the well-being of co-workers adds to the quality of care they provide to others; this requires a special effort to develop structures that foster co-responsibility, accountability, and communication.
- Those in positions of leadership must recognize their role is, first of all, a ministry of loving service and stewardship. A commitment to share power and to develop participative processes for decision-making, planning and policy formation is essential to developing higher levels of trust and tolerance.

We have focussed on three persons who face each other with real strengths and potential. Each has something to give and to receive. Health is nurtured and healing occurs in the context of such relationships.

Through this narrative and reflection we have introduced a series of values. The values of the gospel of Jesus Christ, especially dignity, justice and trust, play an important role in shaping our efforts toward health and healing. They underlie the very identity of all Christian service in fidelity to the Lord who "had compassion on the multitudes." In the remainder of this Introduction we look at the tradition out of which our reflection is drawn, and we state more explicitly the values and principles that guide our ethical reflection.

THE ROOTS OF CHRISTIAN SERVICE

Christians look to the example of Jesus Christ as their model and inspiration. His life illustrates his concern for the physical, mental and spiritual health of others.

> *When Jesus heals a leper or proclaims the parable of the Good Samaritan, it is an obvious sign of His compassion for*

> *those in suffering. But even more it points to the new life of the Kingdom: the total and permanent healing of the human person in all [the person's] dimensions and relationships. Jesus' healing Word of power reaches the whole person.*[2]

Jesus identifies with those who are ill or suffering:

> *[He] shows His power over suffering and death not only by taking it away but by entering into our suffering and thus overcoming it from within. By taking it upon Himself, He heals it.*[3]

Through the centuries the church has responded to persons in need. Motivated by their faith, Christians have brought to the fields of education, social services and health care a tradition of dedicated service, loving care and a high degree of excellence, often performed with little material remuneration.

THE CATHOLIC HEALTH ORGANIZATION

The ministry of Catholic organizations is one of the visible expressions of the ministry of Christ. As creatures of body and spirit, we need visible, tangible human institutions to assist us to live as a believing community bearing witness to the Good News as expressed in the Catholic faith. Catholic organizations fulfil this important role by being present to people at the critical points where life can be fostered, where people are born and die, where they learn and are taught, where they are cured and healed, and where they are assisted when in trouble. Catholics see this concrete involvement as a sacramental presence, an encounter with Christ.

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2. *New Hope in Christ: A Pastoral Message on Sickness and Healing.* Canadian Conference of Catholic Bishops, 1983, p. 10, no. 11.

3. *Ibid.*, p. 11, no. 14.

Catholic health organizations have a distinct spiritual vision and culture that directs them to attend to the needs of the poor and vulnerable with compassion and dignity. It is that vision which defines the quality of their relationship with those in need of care.

> *Our distinctive vocation in Christian health care is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life. The ultimate goal of our care is to give those who are ill, through our care, a reason to hope.*[4]

Among the tangible signs that should identify Catholic organizations are the following: Catholic sponsorship and management; quality care; proper stewardship of resources for the community served; a culture that supports Christian ethical values and spiritual beliefs; recognition by the bishop of the diocese as an integral part of the apostolate; promotion of spiritual/religious care; mission and values integration; just working conditions; the availability of the sacraments, and the prominence of various Christian symbols.

The work of Catholic health organizations is a particular expression of the healing ministry of Christ. The physical, emotional and spiritual healing experienced by those cared for within these organizations is a sign of the presence and compassion of Christ the healer. Such organizations offer a privileged opportunity to provide the best possible care in a manner and atmosphere fully inspired by the gospel.

The basic orientation of Catholic health organizations and their personnel is respect for the dignity of every person and concern for the total well-being of persons receiving care. These organizations

4. Joseph Cardinal Bernadin, "What Makes a Hospital Catholic – A Response," *America*, Vol. 174, no. 15 (May 4, 1996), 9.

affirm the importance of family, friends and the community in the promotion of health. They also strive to provide for their personnel a milieu that is conducive to personal fulfilment.

As part of the history of health care institutions in Canada, religiously-based organizations have earned their rightful place in our country through their pioneering efforts, often undertaken in very demanding circumstances. Such centres continue to make a distinctive contribution to health care in Canada.

ETHICAL REFLECTION AND DECISION-MAKING

To witness to the teachings and values of Jesus Christ requires sound moral reflection and judgement. This is especially true in our technological world where there is an ever-increasing danger of reducing persons to objects. Judgements of what is right or wrong are ethical or moral decisions. Especially when rights, duties, or values appear to conflict, ethical reflection and discernment can assist everyone concerned.

The quality of ethical decisions depends not merely on abstract reasoning, but also on the lived faith, prudence and virtue of the decision-maker. The Catholic moral tradition is the fruit of an on-going dialogue between our understanding of human nature and our experience of God as revealed in Jesus Christ. It develops through prayer, study, reflection and the recognition of the Holy Spirit at work through various sources. Such sources include health and social service providers, the experience of the Christian community, moral theologians, ethicists, pastoral care workers, the local bishop, church teachings, and especially Sacred Scripture. No source of knowledge pertinent to the issue at hand should be neglected in the making of moral decisions.

The Catholic moral tradition presents a number of theological foundations that guide ethical reflection. These include a belief in the presence of God in human experience; the conviction that all of creation is to be regarded as a gift of God's love; an awareness that we have a responsibility to work to eliminate sickness and suffering; an acknowledgement that, at times, there can be growth through suffering; and the recognition that the moral dimension of human existence requires that we act from an informed conscience.

The local bishop has the responsibility to provide leadership and to collaborate with the mission of Catholic organizations. In fulfiling his role as the primary teacher and pastor of the community, with the assistance of specialists in different disciplines, he has the task to ensure that the teaching of the church is reflected faithfully in the context of rapidly developing medical advances and of the increasing complexity of the human sciences. In order to truly respect dignity, promote justice and foster trust, the church must itself witness to these values.

Since the Christian moral tradition is a living tradition, our formulations of it are necessarily the product of a grasp of reality that is constantly being refined, of historically conditioned attitudes, and of limited philosophical concepts and language. At any given time in history, a particular formulation is only more or less adequate. Continued faithfulness to this living tradition presupposes growth in understanding of moral principles and their implications. It is also important to remember that Catholic teaching maintains a hierarchy of truths and values. This means that specific teachings have varying degrees of importance concerning one's faith and moral life.

The tradition is not always clear or unanimous concerning all moral issues. In such cases, it is the teaching of the Catholic Church that obligations are not to be imposed unless they are certain. Thus, in moral questions debated by moral theologians in the church, Catholic

tradition upholds a person's liberty to follow those opinions that seem to be consistent with the wishes of the person receiving care and with the best standards of good care.

CHRISTIAN MORAL VALUES

Christian ethical reasoning is based upon a world view contained in the gospel as interpreted by the church. This world view gives rise to values and principles that direct ethical decision-making and that enable us to respond to the call to respect dignity, promote justice and foster trust.

Two fundamental values underlie the discussion of values in this guide.

1. **Dignity of every human person** — All persons possess an intrinsic dignity and worth that is independent of what any other person thinks or says about them.[5] The basis for this dignity, in the Judeo-Christian tradition, is the belief that every human being is made in the image of God.
2. **The interconnectedness of every human being** — Human persons are social beings and cannot live or develop their potential outside of human relationships and community.[6] This fundamental value affirms the interconnectedness of every human being with all persons, with all of creation, and with God.

From these two fundamental values flow a number of related values.

3. **Stewardship and creativity** — The scriptures present a view of creation as both gift and responsibility. We share a responsibility

5. *Pastoral Constitution of the Church in the Modern World,* Vatican Council II: Constitutions, Decrees, Declarations, Austin Flannery (ed.), New York, American Press, 1996, nos. 27, 29.
6. *Ibid.*, nos. 12, 25.

to respect, protect and care for all of creation and for ourselves. We are to use our own free and intelligent creativity to fashion a better world while respecting its true nature, appreciating its benefits and accepting its limitations.

4. **Respect for human life** — Human life is sacred and inviolable in all of its phases and in every situation.[7] Human life is a gift of God's love and the basis for all other human goods. Nevertheless, human bodily life is not an absolute good but is subordinated to the good of the whole person.

5. **The common good —** Every individual has a duty to share in promoting the well-being of the community as well as a right to benefit from being a member of the community. Respect for human freedom necessitates that society seeks to enable men and women to assume responsibility for their own lives, and to encourage them to cooperate with each other in pursuit of the common good – the building of a just and compassionate social order in which true human growth for all persons is encouraged. By extension, the common good includes environmental concerns that have a direct relationship to the good of individuals and of society.

6. **Charity or solidarity** — Charity is the Christian virtue urging us to respond to the needs of others. Solidarity (which includes empathy and compassion for others) is a contemporary way to express our interconnectedness to all human beings and our obligation to respond with love to their needs. This response is even more explicitly articulated in church teaching which exhorts individuals, organizations and those who develop public policy to a preferential option for the poor and marginalized.

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7. Pontificia Academia Pro Vita, *Final Declaration*, 5th General Assembly (February 24-27) 1999, no. 1.

CHRISTIAN MORAL PRINCIPLES

1. **Totality and integrity** — All our physical and psychological functions are to be developed, used, and cared for to protect our human dignity. Therefore, no human function can ever be sacrificed except for the saving or better functioning of the whole person. Basic human capacities may not be sacrificed if more harm than good would result to that person.
2. **Double effect** — When an action may have both beneficial and harmful consequences, such as pain relief treatment for a terminally ill person – treatment that might shorten life – the action may be pursued if the following conditions are fulfiled:
    i. the directly intended object of the act must not be intrinsically evil, i.e. contrary to one's fundamental commitment to God, neighbour or oneself;
    ii. the intention of the agent must be to achieve the beneficial effects and to avoid the harmful effects as far as possible (i.e. the harmful effects should not be wanted, but only allowed);
    iii. the foreseen beneficial effects are not achieved by means of the foreseen harmful effects; rather, the beneficial effects are inextricably and unavoidably linked to the harmful effects;
    iv. the foreseen beneficial effects must be equal to or greater than the foreseen harmful effects.
3. **Legitimate cooperation** — This principle applies to situations where an action involves more than one person, and sometimes when the persons have different intentions. It is unethical to cooperate *formally* with an immoral act, i.e. directly to intend the evil act itself. But sometimes it may be an ethical duty to cooperate *materially* with an immoral act, i.e. one does not intend the evil effects, but only the good effects, when only in this way can a

greater harm be prevented. Two provisions must be considered, namely, (1) the cooperation is not immediate and, (2) the degree of cooperation and the danger of scandal is taken into account. (Refer to Appendix II, "The Principle of Legitimate Cooperation")

4. **Subsidiarity** — According to this principle, decisions should be taken as close to the grass roots as possible. As applied to health needs, the principle suggests that the first responsibility for meeting these needs resides with the free and competent individual. Individuals, however, are not self-sufficient. They can achieve health and obtain health care only with the help of the community. The responsibility of fulfiling those needs that the individual cannot achieve alone must be assumed by larger or more complex groups, e.g. community organizations and different levels of government. (Refer to John Paul II, *Centesimus Annus*, no. 12)
5. **Free and informed decision-making** — The person receiving care is the primary decision-maker. No service or treatment is to be provided without his or her free and informed consent. For those not capable of making an informed decision, a proxy[8] shall act for the person in accordance with their personal care directives. If an advance health care directive is inapplicable or unavailable, a proxy shall act for the person in accordance with their known needs, values and wishes. In emergency situations where the person receiving care is not capable of making an informed decision and a proxy is unavailable, the care provider may act in the proxy's stead.
6. **Confidentiality** — Respect for the dignity of persons insists that persons receiving care be treated with trust, honesty and

8. The term *proxy* is used in this guide to identify those people who are entitled to make a care and treatment decision for an incompetent person. This may or may not be a family member. In some provinces or territories the definition of proxy is provided in legislation.

confidentiality. This includes privacy of personal information and freedom from unnecessary intrusions by others.

In this introductory section of the guide, we have highlighted the values and ethical principles of the Christian tradition that direct our efforts to enter into relationships that respect dignity, promote justice and foster truth. In the remainder of the guide we apply these values and ethical principles to seven key areas related to care in the fields of health and social services.

I

The Communal Nature of Care

INTRODUCTORY COMMENTS

Health and social service organizations operate in societies that are organized into complex networks of social groups, from the smallest family to local, national, international and global systems. These different social structures are contemporary expressions of the basic and diverse social needs of all persons. The interconnectedness of all human beings is a fundamental value.

While each person is unique, no one could exist for long or fulfil their potential apart from the human community. The community gives people opportunities to provide and obtain resources such as food, clothing, shelter and culture that are required to live a truly human life. Through sharing and communicating with others in community persons grow in knowledge and love. They achieve human fulfilment by serving others, since each one receives from and contributes in some way to the individual personal development of others. Indeed, every society in a certain sense is "personal," so that the person is the beginning, the subject and the aim of every social institution.[1]

The individual and social needs of people always must be kept in balance within a social order "founded on truth, built on justice, and animated by love.... Every social group must take account of the needs and legitimate aspirations of other groups, and even of the general welfare of the entire human family."[2] This is achieved through cooperative activity and through social structures that seek to guarantee equity and to overcome domination of one group by another. Through

1. *Pastoral Constitution of the Church in the Modern Work*, Vatican Council II: Constitutions, Decrees, Declarations, Austin Flannery (ed.), New York, American Press, 1996, no. 25.
2. *Ibid.*, no. 26.

such an approach, individuals and groups contribute to the well-being of others and receive from others what is needed to meet their own particular needs.

Christian tradition uses the images of the human body and of the family to emphasize that human beings function often as organs of the greater civil society, united by common ends and using common means. Every person shares responsibility for our society and society has a responsibility for each of its members. As Christians, we also live in society as members of a community of faith. The faith life of the Christian community is shaped by our baptismal call to share God's life and to work for the common good of all peoples. The fundamental law of this community is such that love of self, love of neighbour and love of God should not be separated.

Health care and social support are two of the responsibilities and benefits of society.

> *It is therefore necessary that (governments) give wholehearted and careful attention to the social as well as to the economic progress of the citizens, and to the development* [..]*.of such essential services as* [...] *housing, public health, education* [...][1]

Catholic health and social service organizations function in civil society with a particular identity and mission. The specific way in which this mission is carried out distinguishes the service of Catholic care providers. This service is designated as "ministry" because it is motivated by the gospel and is part of an enduring faith tradition. Such an understanding of ministry challenges any system which might treat a person merely as a case, number or statistic. All those who are engaged in this ministry seek to create a community of compassion.

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3. John XXIII, *Pacem in Terris*, April 11, 1963, no. 63.

They are dedicated to the care of persons in need, especially the most vulnerable, to the promotion of health in all its dimensions, and to forming healing relationships.

In society at large, Catholic health and social service organizations are a voice expressing a vision of life based on the moral and religious values of the Roman Catholic tradition. The care provided by these organizations is one expression within the local church of the healing ministry of Jesus Christ.

> Catholic health and social service providers belong to communities of service dedicated to the promotion of a healthy society. As members of these communities they contribute a perspective inspired by the example of Jesus and guided by the Roman Catholic tradition. Those who exercise this ministry serve others, and themselves require a community of support.

HEALTH AND HEALING

1. Health arises from the dynamic balance and harmony of a person's biological, psychological and spiritual energies within a physical, social, cultural and economic environment. Health is no longer understood merely in medical terms as the absence of illness. Increasingly, consideration is given to the person as an integrated whole and to a perspective on health that includes wide-ranging determinants of health. (Refer to article 17)

2. These determinants of health include biological and psychological (mental and emotional) factors, the physical environment, lifestyle, spirituality and religious belief, social interactions and support, economic status, and working conditions. Together, these factors influence the health of an individual or community. (Refer to article 4)

3. Healing is more than simply curing a disease. Healing takes into account the wholeness of the person, recognizing the interrelationship of body, mind and spirit. It involves the restoration of balance and acknowledges the role spirituality and/or religious belief can play in the healing process. A particularly important way to nurture health and healing is to foster prayer, forgiveness and reconciliation. (Refer to article 9)

4. All persons have a responsibility to make lifestyle choices that will have a positive effect on their health and well-being, and to participate in the promotion of the health of the community. (Refer to article 2)

5. There is a fundamental difference between the provision of care and the production and distribution of commodities. The provision of for-profit care can never be the sole purpose or goal of Catholic health and social service organizations. In Canada the not-for-profit

delivery of health care has rightly become the norm and is an essential component of Canada's health care system. (Refer to article 150)

CHRISTIAN HEALING MINISTRY

6. In most cultures, people consider healing to be a spiritual or sacred activity. For Christians, healing is seen as a ministry in which all are called to participate as part of their baptismal commitment. Some people have dedicated themselves to particular expressions of the healing ministry by assuming responsibilities as professionals, support workers and volunteers. These people are a visible sign and reminder to the broader community of this ministry.

MISSION OF CATHOLIC HEALTH AND SOCIAL SERVICE ORGANIZATIONS

7. Every Catholic health and social service organization proclaims a religious identity that reflects a vision of life and of the world that is in accord with human values and is faithful to the Roman Catholic tradition. The organization's mission should be articulated clearly in a mission statement. Such statements should be reviewed regularly, with opportunities for input from all members of the organization. A regular audit to ensure compliance with the mission is necessary. (Refer to articles 131-133, 140, 142)

PRIMARY PURPOSE

8. Whatever its particular objectives, every Catholic health and social service organization aims primarily at the relief of suffering and the promotion of health. The breadth of this mission is demonstrated through the integration of policies and programs that emphasize well-being, the promotion of the health of

individuals and communities, the prevention of disease, rehabilitation, and the care of people with acute, chronic or terminal illnesses. Increasingly, this wellness model necessitates collaboration among a variety of agencies, and interactions between the health care and social service systems and other sectors in society, such as education, housing, religious groups, unions and professional organizations. (Refer to article 132)

AN ATMOSPHERE THAT PROMOTES HEALING

9. Catholic health and social service organizations should be characterized by an atmosphere that promotes healing and by a spirit of compassion that is rooted in human solidarity and in fidelity to the healing mission of Christ. All care providers are to foster an environment that is marked by dignity, justice and trust. (Refer to articles 7, 143)

CREATING AN ETHICAL ENVIRONMENT

10. There is an ethical dimension to all health care and social service decisions. It is important that resources be available to promote sound ethical decision-making by all persons in the organization. This responsibility is frequently facilitated by an ethics committee or by an ethics consultant. As more services are offered in the community, ethical resources will be required at the local and diocesan/parish level to assist personnel, those receiving care and their families, in the discernment of ethical issues. (Refer to articles 129, 136, 154, 155)

11. Where ethics committees are established, a multi-disciplinary membership is recommended. A good ethics committee would include such representation as nurses, physicians, social workers, spiritual/religious care providers, ethicists, moral theologians,

administrators, legal consultants and representatives of persons receiving care.

12. The ethics consultant or committee may advise on particular ethical situations, promote education on ethical issues, and where appropriate, review and recommend organizational policies. They may also be a resource to assist in evaluating systemic issues from the perspective of social justice, and, if necessary, take on an advocacy role.

13. Procedures are to be established to address situations in which there is a need, but inadequate time, for ethics consultation. Such situations should be reviewed later by an ethics committee or consultation service. (Refer to article 137)

RESPECT FOR DIFFERENT CULTURES AND TRADITIONS

14. Health and social service organizations must respect the different cultures and religious traditions of those they serve and of those who work within their organizations. They should value these differences, seeking ways to incorporate them in their working environment and in the care they offer. These various cultural needs should be addressed in ways that respect the dignity of the care provider, the mission of the organization and standards for quality care. (Refer to articles 17, 23, 24, 79, 144)

COMMITMENT TO EDUCATION AND RESEARCH

15. Catholic health and social service organizations recognize the importance of education as part of their mandate, especially in the following areas: care and responsibility for one's health and well-being; staff development; the education of students in the caring professions; and public education in health promotion and disease prevention. This education is marked by ongoing

reflection on the Christian meaning of suffering, illness, health, morality, life and death. (Refer to articles 49, 88)

16. Health and social service organizations, in keeping with their mission and purpose, recognize the importance of research for improving the quality of care. Research activities must be guided by approved ethical standards. (Refer to articles 106-127)

II

Dignity of the Human Person

INTRODUCTORY COMMENTS

A fundamental value underlying ethics in health care and social services is respect for the dignity of each human person. This value aspires to protect the multiple interests of the person – from bodily to psychological to spiritual to cultural integrity. This respect for the dignity of each human person has been acknowledged and enshrined in the United Nations' *Universal Declaration of Human Rights*.

Human dignity is based on the physiological, psychological, social and spiritual uniqueness of being a person. Persons are created with intelligence and free will, with a moral consciousness and a potential for self-fulfilment. They possess the radical capacity to know, to love, to choose freely and to determine the direction of their lives. Each person is irreplaceable, with an intrinsic value and purpose in life. All persons are equal in dignity and, therefore, are to be treated with equal respect.

Our Christian faith holds that all persons are created in the image and likeness of God, and are called to know, love and be in communion with God, with all other persons and creation for all eternity. We believe that God became human in Jesus Christ, enabling all human beings to share the dignity of being daughters or sons of God, sisters or brothers of Jesus Christ.

Respect is due to every person. In light of gospel values, differences of age, sex, race, religion, social and cultural background, health status, sexual orientation, intelligence, economic status, employment, or other qualitative distinctions do not take away from the dignity shared by all persons, whether or not they are aware of their dignity.

The inherent dignity of each person is to be cherished by treating all persons with equal respect.

RESPECT FOR EVERY PERSON

17. All persons have equal value and dignity and are to be treated with respect, especially when they are weak, vulnerable or sick. All persons, therefore, are to be provided with the services they need in the context of the mission and resources of the organization and the common good. (Refer to articles 7, 14, 30, 67, 79, 98, 142, 144)

EMOTIONAL AND FAMILY BONDS

18. Family and close friends are intended to be the privileged bearers of intimacy, loving support, courage and compassion in the face of illness and suffering. This support is an expression of the community's healing presence. For Christians, it is a tangible manifestation of the healing presence of God. Efforts are to be taken to strengthen and support such relationships in their healing and wellness roles. (Refer to articles 84, 89)

19. Each person's emotional, familial and cultural ties are to be respected and fostered. These ties create rights and duties for both the person receiving services and those providing care. Providers are to take these emotional and familial ties into account in the making of treatment and care decisions. (Refer to articles 84)

SEXUALITY AND PERSONS RECEIVING CARE

20. Sexuality is an integral part of being human. Human sexuality is expressed through personal grooming habits, dress, touch,

companionship, the personalization of one's environment, and intimate physical affection. This sacred dimension of the person is to be treated with respect and sensitivity. (Refer to articles 17, 66)

21. In institutional settings, it is crucial to respect the deeply personal nature of sexuality, to balance the needs of the individual with the needs of other members of the institutional community, and to respect the values of the organization. Prejudices that view elderly and disabled persons as not requiring any sexual expression are inappropriate since they impose stereotypes that portray persons as less than human. (Refer to article 66)

22. Guidelines are important for responding to situations when it is determined that an individual who lacks decision-making capacity has entered a sexual relationship with another, or whose sexual activity is causing concern or distress among care providers, family members or other persons receiving care. Such guidelines should seek creative, respectful and ethical resolutions for all concerned.[1]

SPIRITUAL AND RELIGIOUS CARE

23. Spiritual and religious care, often referred to as pastoral care, is integral to the healing process. Catholic health and social service organizations should ensure that such services are provided. Good spiritual and religious care is characterized by sensitivity and respect for the varying spiritual and religious needs of the recipients and for the spiritual suffering that often accompanies sickness. It also provides opportunities to participate in the life of a faith community. Caregivers require a similar kind of support. (Refer to articles 14, 35, 46, 65, 79, 84, 86, 98)

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1. These articles were developed using *Guidelines on Human Sexuality*, Providence Centre, Scarborough, Ontario.

24. Spiritual and religious care is provided in a variety of settings: within institutions, in the community, in parishes, and at home. Such care includes: pastoral visiting, counselling, in-service education, spiritual direction, individual and group prayer, and opportunities for celebrating the sacraments and other religious rites. This care is important in all situations of illness and loss; it is essential in the context of end-of-life care. (Refer to articles 84, 86, 98)

THE PRIMARY ROLE OF THE PERSON RECEIVING CARE

25. The competent person receiving care is the primary decision-maker with respect to proposed treatment and care options. (Refer to articles 67, 89-91)

26. In making decisions about treatment and care options competent persons, or proxies for those who are not competent, are to seek those measures for preserving life that offer a reasonable hope of benefit. (Refer to articles 92-96)

27. The competent person has the right to refuse, or withdraw consent to, any care or treatment, including life-saving or life-sustaining treatment. (Refer to articles 40, 92, 96-97, 105)

MENTAL HEALTH

28. Mental health is fundamental to a person's well-being. There are intimate connections among mental health, one's general attitude to life, and the healing process. Care providers must attend to the mental health needs of the person receiving care. Furthermore, a person's mental state should never be the cause of their not receiving necessary, compassionate care. (Refer to articles 30, 133)

29. Any form of treatment that restricts personal freedom or hinders

a person's mental capacity, such as commitment to a mental institution or the administration of drugs that affect the person's mental functions, are only to be implemented for the good of the person receiving care and/or when the safety of others is in danger. Such treatments should always seek the person's greater freedom and functioning and be done with scrupulous observance of due legal process. (Refer to article 42)

THE NEEDS OF THE MARGINALIZED

30. Persons who are marginalized in society because of a physical or mental condition, or because of social, cultural or economic factors, are frequently stigmatized. They are to be treated with compassion and respect in accordance with their needs and circumstances. (Refer to articles 17, 28, 43. 85)

CARE OF THOSE RAPED, VIOLATED OR ABUSED

31. Care providers are to be trained to recognize the symptoms of violence and abuse and to respond with compassion and sensitivity. A protocol is to be established in conformity with legal requirements to deal with all forms of abuse. Special attention is to be given to groups more vulnerable to abuse. It is recommended that such a protocol also address situations of abuse among care providers and between care providers and those receiving care.

32. A protocol to assist those who have been subjected to rape is to be established. Such a protocol, however, is not to include the use of abortifacients. Persons working in health care and social services, along with the organizations for which they work, must assist in bringing to justice the perpetrators of sexual assault.

KNOWLEDGE OF HEALTH STATUS

33. Persons who require care have a right to expect relationships that

are marked by mutual respect, trust, honesty and confidentiality. They have a right to know the state of their own health. This information should be given with kindness and patience by a health professional skilled in communication who can respond to questions from the person receiving care and their family. Such information, when of a serious nature, should be given face-to-face and in a suitable environment. (Refer to articles 38, 84)

INFORMED DECISION-MAKING

34. Except in certain emergency situations, the informed consent of a person receiving care is necessary for any health care procedure. Informed consent requires that the person be provided with all the information necessary for making a sound decision. This includes information about the benefits, risks and any potential harm of a proposed treatment, possible alternatives and the option of no treatment at all. Care providers should confirm that the person receiving care understands and appreciates the information being conveyed and, thus, is capable of making a decision. For those who do not have decision-making capacity, informed consent is to be obtained from a proxy. (Refer to articles 44, 46, 67, 68, 70, 84, 89, 90, 113, 121)

WELL-FORMED CONSCIENCE

35. Health and social service organizations have a responsibility to provide persons receiving care and care providers with the necessary information, counselling and spiritual support required to make decisions according to a well-formed conscience, i.e. their best judgement of what is right or wrong. Care providers should not be expected to participate in procedures that are contrary to their professional judgement or to their personal moral

values or that are contrary to the values or mission of their organization. (Refer to articles 23, 45, 46, 92)

PRIVACY

36. Every person has the right to privacy. This includes privacy of personal information, confidentiality, and freedom from the unwanted intrusions of others in their immediate situation. This privacy must be carefully respected by care providers in their professional and informal conversations. (Refer to articles 38, 44, 84, 115, 121)

37. Exceptions to the right of privacy must be clearly justified by those claiming them. Exceptions may be justified in situations where the right to privacy is limited by the demands of the common good. (Refer to article 121)

CONFIDENTIALITY OF INFORMATION

38. Every person has a right to confidentiality concerning all personal information. In particular, special precautions are to be taken to protect the confidentiality of records, files, computer data and other information that could pose a serious threat of discrimination or other adverse social consequences. Care must be taken to restrict the availability of such records only to authorized persons. Such confidentiality is limited when it endangers the health and well-being of others or when the law requires disclosure. (Refer to articles 33, 36, 44, 83, 84, 115, 121)

LEGITIMATE HEALTH INTERVENTIONS

39. Medical interventions and therapies are justified only if the intended benefit for the person receiving care outweighs the foreseeable

harm or risks of harm. (Refer to the principle of double effect, page 13 and to articles 44, 45, 70, 92-94, 97, 108)

ADVANCE HEALTH CARE DIRECTIVES

40. Advance health care directives enable a person to communicate their directions concerning the type of treatment they desire should they lose their decision-making capacity. Persons are encouraged to discuss these directives with their family and care providers, and, if appropriate, to appoint a proxy before crisis situations arise. A statement of philosophy or beliefs, when included as part of a written advance health care directive, assists family and care providers to carry out the wishes of the person receiving care. (Refer to articles 25, 27, 91, 92, 97)

41. A person's written or oral directives are to be respected and followed when those directives do not conflict with the mission of the organization. Advance directives which seek to clarify issues surrounding end-of-life treatment are to be discussed and carried out in a compassionate and sensitive manner. (Refer to articles 25, 27, 91, 92, 97)

RESTRAINTS

42. Since the use of restraints can be an infringement of a person's dignity, a policy of least restraint should be adopted. Restraints may be necessary when behaviour presents an unacceptable potential for injury to the person receiving care or to others. Such measures should only be undertaken if all other alternative safety measures have proven ineffective, the right of freedom of movement of the individual has been taken into consideration, and the safety needs of the person receiving care outweigh the potential negative effects of restraint use.[2] (Refer to articles 17, 29)

2. This article was developed using *Use of Restraints Policy*, St. Mary's of the Lake Hospital, Kingston, Ontario.

DISCHARGE

43. Persons receiving care should not be discharged by the care provider until there is assurance that the person is safe in leaving the service, either because they are able to care for themselves or because adequate supports have been put in place. Similarly, those who no longer require the level of care provided by a given organization should be transferred to a more appropriate place of care when it is available. (Refer to articles 9, 30)

III

Human Reproduction

INTRODUCTORY COMMENTS

Human sexuality is a personal aspect of our identity that gives beauty, pleasure, power and mystery to our lives. Because we are created in the image and likeness of God, human sexuality is good in all its dimensions: physical, psychological, spiritual and social.

Human sexuality has an interpersonal purpose. It is rooted in our basic human need to love and be loved, to live and grow through human relationships, to preserve and perpetuate society. The wonders of sexuality and birth are best shared in the family setting, and should be supported by instruction in both the parish and school.

Human sexuality is meant to nurture and sustain a woman's and a man's free gift of themselves in a permanent, loving and fruitful commitment of marriage. For Christians, this covenant of human love is a symbol of that faithful love existing between Christ and the church.

The love between a woman and a man is experienced in a unique way and completed through the marital act of sexual intercourse. This act can deepen the union of love, enabling the couple to share with God in the creation of human life. Men and women are called to be responsible stewards of God's gifts, always treating each other with loving respect. The unitive and procreative aspects of sexual intercourse are not to be separated.

Responsible parenthood requires that decisions about having children be made in a prayerful and discerning manner, considering what is most loving and life-giving and what is best for the overall welfare of the family.

Christianity looks upon the beginnings of human life with particular wonder and reverence. Catholic health care providers, therefore, are

to surround obstetrical and perinatal care with an atmosphere respectful of human life, mindful of the parents' special circumstances and needs.

> Human sexuality has a special significance and sacredness given by the Creator. This sacred dimension of the person is to be treated with respect and sensitivity.

CONDITIONS FOR PARTICIPATION IN GENETIC SCREENING PROGRAMS

44. Individuals may participate voluntarily in a genetic screening program for research, education or genetic counselling, as long as their informed consent is obtained and there are no disproportionate risks involved. They must understand the consequences of testing and the implications for themselves and their families so that they are able to make informed decisions as a result. The principle of informed consent must also apply to any subsequent treatment decisions. Confidentiality of data must be maintained given the risk of discrimination. (Refer to articles 34-39, 45, 46, 108)

PRENATAL DIAGNOSIS AND TREATMENT

45. Prenatal diagnostic procedures with the informed and free consent of the parents are permitted as long as they respect the life and integrity of the embryo or fetus and are directed toward its protection or healing. The anticipated benefits for both the parents and the unborn must outweigh the risks involved in the diagnostic procedures. (Refer to articles 34, 39, 44)

46. The presentation of any diagnostic information is to be complete and objective. It is to be communicated in a supportive manner with no attempt to link prenatal diagnosis to direct abortion. Counselling and pastoral support are to be made available for the parents. (Refer to articles 23, 35, 44)

DISEASE TREATMENT OF PREGNANT WOMEN

47. Medical treatment is permitted to prevent or cure a grave illness in a pregnant woman that cannot be deferred until the unborn child is viable even though the pregnancy may be endangered.

RESPONSIBLE PARENTHOOD TO BE FOSTERED

48. Health and social service organizations are encouraged to foster responsible parenthood and to promote the various methods of the regulation of conception that respect a woman's natural fertility cycles.

49. Educators and health professionals in relevant programs are to be well-informed on natural family planning methods. They are to provide instruction honestly and objectively about these and other methods so that couples can make free and informed decisions for responsible parenthood. (Refer to article 15)

50. Means that deliberately and intentionally interfere with the procreative aspect in sexual intercourse are morally unacceptable. Reference should be made to the Canadian Bishops' 1968, 1969 and 1973 documents on the pastoral application of this norm. (Refer to Appendix IV, "Selected Bibliography")

STERILIZATION

51. Direct sterilization, whether it is permanent or temporary, for a man or a woman, may not be used for the regulation of conception.

52. Concerning the conditions of material co-operation regarding sterilization procedures, one should consult the values and principles in the Introduction. (Refer to page 13 and Appendix II, "The Principle of Legitimate Cooperation")

ACCEPTABLE ARTIFICIAL INSEMINATION AND FERTILIZATION

53. Artificial insemination by the husband (AIH) may be used appropriately within marriage as long as its use is to facilitate the natural act of marital intercourse in order to maintain the unitive and procreative meanings of marriage.

54. *In vivo* fertilization procedures that respect the personal dimension of marital intercourse and protect every embryo, e.g. tubal ovum transfer (TOT), may be used to assist a married couple to achieve pregnancy.

UNACCEPTABLE ARTIFICIAL INSEMINATION AND FERTILIZATION

55. Artificial insemination by a donor (AID), i.e. insemination of a married woman with the sperm of a donor who is not her husband, or fertilization with the husband's sperm of an ovum not from his wife, is contrary to the covenant and unity of marriage.

56. *In vitro* fertilization is not permitted because it separates procreation from the personal, sexual act of love of the couple and because it can lead to the deliberate destruction of embryos.

57. Fertilization using the sperm and/or ovum from a deceased spouse(s) violates the natural aspect of the conjugal act as well as the dignity of the child by deliberately separating the child from the bonding and nurturing normally coming from the biological parent(s).

CRYOPRESERVATION

58. The freezing of embryos constitutes an offence against the respect due to human beings by exposing them to grave risks of death or harm to their physical integrity, and by depriving them, at least temporarily, of maternal shelter and gestation, thus placing them in a situation in which further offences and manipulation are possible. (Refer to articles 60, 118)

SURROGACY

59. Embryo or male gamete transfers to "surrogate mothers" are not permitted because such procedures violate the unity and dignity

of marriage and can lead to the commercialization of human reproduction.

RESPECT FOR EMBRYOS AND FETUSES

60. All embryos and fetuses, including those that are malformed, deserve the same respect owed to any human being. (Refer to articles 58, 116-118)

61. Direct abortion, i.e. any deliberate action with the primary purpose of depriving an embryo or a fetus of its life, is never permitted. (Refer to article 62)

EXTRAUTERINE PREGNANCIES

62. In cases of extrauterine pregnancy, no intervention is permitted which constitutes a direct abortion. (Refer to article 61)

CARE OF HUMAN REMAINS

63. A policy should be in place to ensure that all aborted embryos and fetuses, and the remains of miscarriages and stillbirths, are buried or cremated in a respectful manner and place. (Refer to article 79)

CARE OF PARENTS IN DISTRESS

64. Compassionate care is to be provided to parents of malformed embryos, to parents who have given birth to malformed or disabled children, and to those who lose a child through a miscarriage or stillbirth. (Refer to article 23)

65. Catholic health and social service organizations are to provide compassionate physical, psychological, emotional and spiritual care for those women and men who are distressed due to their involvement in abortions. (Refer to article 23)

SEXUALITY AND PUBLIC HEALTH

66. Health care organizations, parishes and schools should assist families to provide education concerning sexuality and public health, including information about sexually transmitted diseases. They should also provide compassionate care for those who suffer from these diseases. (Refer to articles 21, 22)

IV

Organ and Tissue Donation and Transplantation

INTRODUCTORY COMMENTS

Human beings live and grow in mutual dependence with other members of the human community. Advances in medicine have made organ, blood and other tissue transplants a way to improve health and to give new life to countless people. Organ and tissue donation is an expression of respect for the dignity of persons, solidarity with other members of the human community, and charity in response to the needs and suffering of others.

From a Christian perspective, as members of the human community, we are co-creators and stewards of God's creation. We are to use our gifts to benefit ourselves, other individuals and the common good. In honouring the sacredness of every human life, Christians are encouraged to be generous in their response to God's call to love through the self-giving that comes from volunteering to be an organ donor.[1]

In applying its ethical principles to the issue of organ and tissue donation and transplantation, the church teaches that transplanting organs and tissues from a dead person to a living person, and transplanting organs and tissues from a living person to another, are ethically acceptable, provided that the following criteria are met: there is a serious need on the part of the recipient that cannot usually be fulfiled in any other way; the functional integrity of the living donor as a human person is not impaired; the risk taken by the living donor as an act of charity is proportionate to the good resulting for the recipient; the donor's and the recipient's consent are free and informed.

Many Catholic health care organizations provide a crucial link in the donation and transplantation of organs and tissues. They have a

1. John Paul II, *Evangelium Vitae*, no. 86.

responsibility to provide this service with respect. Health care professionals are ideally suited for promoting organ donation and for educating the public about the subject.

Schools, parishes and community organizations should highlight the merits of organ and tissue donation and transplantation. Such activities would help to bring this issue into peoples' homes and encourage them to express their wishes to family and care providers.

> Participation in organ and tissue donation and transplantation is strongly encouraged as an expression of solidarity, charity and respect for human dignity. In the donation and transplantation of human organs the functional integrity of the living donors involved is to be maintained.

RESPECT FOR DONOR AND RECIPIENT

67. In the donation and transplantation of human organs and tissues, respect is to be given to the donor and to the recipient. In transplantation (allo-geneic, auto-logous) the functional integrity of the living donor concerned is always to be maintained. The free and informed consent of both donor and recipient must be ensured. Organ or tissue donation by minors or others lacking decision-making capacity may be permitted in certain rare circumstances. (Refer to articles 17, 25, 34)

68. Any use of human tissue (e.g. placentas, cell lines) without the informed consent of the person from whom the tissue is obtained is contrary to respect for the dignity of persons. (Refer to articles 17, 34)

ELIGIBILITY FOR BEING A RECIPIENT

69. The choice of transplant recipients should reflect the equality of all people and should not be based on criteria of personal or social worth. The recipients of organs are to be chosen according to principles of distributive justice, with consideration of the urgency of need, the capacity of the recipient to meet the demands of post-transplant care, and the foreseeable outcomes. (Refer to article 17)

LIVING DONORS

70. The transplantation of an organ from one person to another is justified only if the good to be derived by the recipient is in proportion to the foreseeable risk to the donor. This requires that donors not be deprived of life or of the integrity of their bodily functions, that the transplanted organ be donated without coercion, and that the donor's consent or that of the family or other proxy, be free and informed. (Refer to articles 34, 39)

HUMAN CADAVER DONORS

71. The retrieval of organs from human cadavers is permissible when it is based on the donor's previously expressed wish. In the absence of the donor's consent, the consent of the family or other proxy is required. The previously expressed objections of the deceased are to be respected.

72. Care providers are to ensure that the compassionate care available to any dying person is provided to a dying patient who is a potential donor. No removal of organs or other invasive activity for the purpose of organ or tissue donation may begin until the death of the donor has been authenticated by two physicians, neither of whom is related to a transplant program or to any person likely to become a recipient of organs or tissues provided by the donor. (Refer to the definition of *death* in "Glossary" and article 73)

DISTINCT HEALTH CARE AND TRANSPLANTATION TEAMS

73. The team providing care to the donor should not overlap with members of the transplant team so that potential conflict of interest can be avoided. (Refer to article 72)

MONETARY REMUNERATION

74. Monetary remuneration for tissue or organ donations contradicts the principle of charity or altruism which is part of the necessary justification for such transplantations. Organs, blood and other tissues, therefore, should not be bought or sold. However, compensation for health care or other costs incurred by the donor or donor's family can be provided.

FROM ABORTED FETUSES

75. Transplantations using organs and tissues from deliberately aborted fetuses are ethically objectionable insofar as this practice

may legitimate abortions. No human life is ever to be conceived or used simply as a means to obtain tissues/organs for transplant purposes.

BRAIN CELL TRANSPLANTATIONS

76. Transplantations to the brain in order to restore functions lost through disease are permitted if the personal identity and abilities of the recipient are not essentially compromised.

ANENCEPHALIC INFANTS AS CADAVER DONORS

77. The use of organs or tissues from an anencephalic infant after brain death has occurred is justified. Great care should be taken, however, to avoid any action that could compromise the dignity of the infant as a person. In particular, no intervention for the purpose of obtaining tissues or organs for transplantation should be carried out if it would harm, increase the risk of harm, or hasten the death of the infant.

78. Coercion, or even the appearance of coercion, in suggesting this donation option to parents, must be carefully avoided. (Refer to article 34)

DISPOSAL OF HUMAN ORGANS AND TISSUES

79. The dignity of the human person requires that human organs and tissues be treated with respect. They are not to be considered as simply pathological or biomedical waste. Institutions must develop a protocol for their proper disposal. The faith traditions and cultural practices of the persons involved are to be respected. (Refer to articles 14, 63)

USE OF ANIMALS

80. The use of animal parts for transplantations, such as replacement

heart valves from pigs, is permissible as long as these can fulfil an essentially beneficial human function in the recipient.

81. Transplantation of animal cells, tissues or organs into humans (xenotransplantation) is increasingly viewed as one possibility for overcoming human organ shortages. However, such transplantations might transmit an infected agent to a recipient and in turn to others. Such risks, together with the ethical implications, should be clearly understood and consented to by recipients and others involved. Those who wish to undertake xenotransplantation have the burden to show that the procedure is both safe and ethical.

82. In the case of xenotransplantation, any careless or cruel use of animals being prepared as sources for transplantable organs or tissues is to be avoided.

EVALUATION OF NEW PROCEDURES

83. Proposals for new kinds of transplant procedures or for significant changes in current transplant protocol are to be submitted for medical, ethical and financial review and evaluation, always respecting patient confidentiality. (Refer to article 38)

V

Care of the Dying Person

INTRODUCTORY COMMENTS

Because of the inherent dignity and value of the person, all human beings are to be respected at every stage of life.

Sickness, suffering and dying are an inevitable part of human experience. Although the harshness of these realities can be eased by medical and psychological advances, nonetheless, they are a reminder of the limits of human existence and they lead human beings to ask more profound questions about the meaning of life and the mystery of death.

Dying can be a time of deeper self-awareness and not merely an inevitable process to which persons must passively submit. It can be a time in which persons freely and consciously affirm the meaning of their lives. It can also be an occasion of profound reconciliation with family and friends. In the time between the diagnosis of a terminal illness and death many losses occur which affect both the dying person and family members. These losses may be physical, psychological, social, or spiritual in nature. Grief is an important dimension of the dying process. Spiritual and religious care, therefore, is an essential element of care for those who are dying.

As Christians, what may seem meaningless takes on new meaning when we walk with Jesus Christ in faith through his life, death and resurrection. Death is the end of life on earth and the beginning of an eternal life with God. This conviction has moved Christians throughout history to regard death with awe and profound respect. When suffering and sickness do occur, they can have a positive meaning in a person's life. They do not represent a punishment or curse. On the contrary, accepted as a means of drawing closer to Christ, they can be an aid to spiritual growth.

Advances in science and technology are dramatically improving our ability to cure illness, ease suffering and prolong life. Concerted efforts must be taken to alleviate sickness and suffering.

These advances also raise new ethical questions concerning end-of-life care, particularly around life-sustaining treatment. There are occasions when prolonging life by artificial means places onerous burdens on dying persons and their families. In the face of such issues, it is necessary to maintain a balance between two important obligations. We are obliged not to intentionally kill someone; assisted suicide and euthanasia are not acceptable options. At the same time, we are not obliged to use life-sustaining procedures which would impose burdens out of proportion with the benefits to be gained from such procedures.

Catholic health and social service organizations, along with local parish communities, should surround dying persons and their families with all the care resources available.

> The human person is to be respected through every stage of life. At the end of life, dying persons and their families and friends are to be surrounded by all appropriate medical and pastoral care.

CARE OF THE DYING PERSON

84. Dying persons are to be provided with care, compassion and comfort. This should include the following: appropriate medical care; pain and symptom management; social, emotional, spiritual and religious support; full information about their condition; the opportunity for discussion with health care personnel; full disclosure to any family member or other person authorized by the dying person to receive this information; and a degree of privacy that ensures death with dignity and peace. (Refer to articles 17-19, 23, 24, 33-38, 85, 98)

85. Infectious diseases, especially those with fatal outcomes or that stigmatize, place special demands on care providers and require concerted efforts in education and prevention. Individuals with such infectious diseases deserve the same standards of care as other persons receiving care; they are to be treated with compassion and respect. (Refer to articles 17, 30)

PALLIATIVE CARE

86. The physical, emotional and spiritual care that characterizes palliative care should be available to all who require it. It should be provided in the home as well as in institutional settings. Health care and social service providers, along with parish communities, are encouraged to be actively involved in securing palliative care for those persons and families in need of it. (Refer to articles 23, 24)

87. A person receiving care should be given sufficient pain management to lessen pain and suffering, even if such pain management could shorten life, though not intentionally. The goal of such care is to alleviate pain and suffering while minimizing the potential side effects of medication. Persons receiving care

have a right to be cared for by care providers who have sufficient expertise in pain and symptom management.

EDUCATION ABOUT CARE OF THE DYING PERSON

88. Health and social service organizations are to provide education and special training to those who care for dying persons, especially because society has difficulty dealing with death. Parish communities, as well, should offer programs on care of those who are dying. (Refer to article 15)

DECISION-MAKING AND THE DYING PERSON

89. In making decisions about the treatment of the dying person, the needs, values and wishes of the person receiving care should be the primary consideration. Treatment decisions should reflect an agreement among all those involved in the care of the person, including family members and those who are significant in the person's life. (Refer to articles 18, 19, 25, 34, 91, 97)

90. The informed and voluntary decisions of a competent person, in consultation with those providing care, should determine whether life-sustaining treatment is to be undertaken or continued. Care providers are to promote understanding of treatment and care options that are available to dying persons, and enable them to make decisions on their own. (Refer to articles 25, 34, 97)

91. When a person is not competent, that is, lacks adequate decision-making capacity with respect to treatment, every effort is to be made to ensure that the choice of health care treatment is consistent with the person's known wishes. Health care treatment choices are to be made by a proxy who, if the person's directives are not known or are inapplicable, must make treatment decisions

based upon the dying person's known needs, values and wishes. (Refer to articles 25, 40, 41, 89, 97)

CRITERIA FOR DECISION-MAKING

92. Decisions about end-of-life care often require weighing the benefits and burdens of treatment options for the person receiving care. In some situations a decision to undertake or to continue life-sustaining treatment is appropriate. In other situations such a decision would not be respectful of the person's dignity and well-being. Such decisions should take into account the person's past and present expressed wishes; his or her physical and emotional condition, including excessive pain, suffering, expense or other serious inconvenience; as well as the person's culture, religion, personal goals, relationships, values and beliefs. Decisions about end-of-life care are not concerned only with the person receiving care; the concerns of care givers and the community must also be considered. (Refer to articles 26, 27, 39-41, 100)

THE OBLIGATION TO SEEK TREATMENT

93. Competent persons receiving care, and proxies of persons who are not competent, are to seek those measures that offer a reasonable hope of benefit and that can be obtained and used without excessive pain, expense or other serious inconvenience. (Refer to articles 26, 39, 89)

NO OBLIGATION TO SEEK OR PROVIDE TREATMENT

94. Persons receiving care are not obliged to seek treatment when it is of no benefit or when the burdens resulting from treatment are clearly disproportionate to the benefits hoped for or obtained. (Refer to articles 26, 27, 39, 96)

95. There is no obligation to provide treatment when it is of no benefit or when the burdens resulting from treatment are disproportionate to the benefits hoped for or obtained. (Refer to articles 26, 27, 96)

REFUSING AND STOPPING TREATMENT

96. Morally, a person can refuse life-sustaining treatment when it is determined that the procedure would impose strain or suffering out of proportion with the benefits to be gained from the procedure. (Refer to articles 25-27, 95, 100)

97. Even when life-sustaining treatment has been undertaken, this treatment may be interrupted when the burdens outweigh the benefits. The competent person receiving care makes this decision. When such a decision is being made for a non-competent person, his or her known needs, values and wishes are to be followed. (Refer to articles 25, 27, 39-41, 89-91)

98. A decision to forgo useless or burdensome treatment must not mean abandonment of the person receiving care. In all cases, the dignity of the person is to be respected. The person's comfort, as well as social, emotional and spiritual support, must be maintained. (Refer to articles 23, 24, 84)

ARTIFICIAL NUTRITION AND HYDRATION

99. Artificially provided nutrition and hydration raises issues related to such fundamental human realities as basic nourishment, mutual interdependence, and faithfulness to those who are vulnerable and dependent. Artificial nutrition and hydration requires special training and serious attention to the human and ethical issues involved.

100. The moral value of these procedures depends upon the benefits

they provide and the burdens they place upon the person receiving care. Where the burdens are disproportionate to the benefits, or where there is no benefit from the procedure, it should not be initiated, or if already initiated, should be withdrawn. The criteria on which to base any decision to withhold or discontinue artificial nutrition or hydration are to follow the needs, values and wishes of the person receiving care. The intent must never be to hasten death. (Refer to the principle of double effect, page 13 and articles 92, 96)

101. Since some pathological conditions experienced by those who are dying prevent normal food ingestion, a decision to forgo or stop artificial nutrition and hydration can allow the pathology to run its course without prolonging the dying process. Such a decision is not the same as "hastening death."

CARDIOPULMONARY RESUSCITATION

102. Cardiopulmonary resuscitation (CPR) is an aggressive treatment used in situations of unexpected cardiac arrest. It is not indicated for use with dying persons.

SUICIDE AND EUTHANASIA

103. Treatment decisions for the person receiving care are never to include actions or omissions that intentionally cause death (euthanasia).

104. Intentionally causing one's own death (suicide), or directly assisting in such an action (assisted suicide), are morally wrong.

105. Refusal to begin or to continue to use a medical procedure where the burdens, harm and risks of harm are out of proportion to any anticipated benefit is not the equivalent of suicide or euthanasia. (Refer to article 27)

VI

Research on Human Subjects

INTRODUCTORY COMMENTS

Research in the human sciences provides significant benefits for the human community. New knowledge and understanding in health care, the social sciences and technology help alleviate human suffering, improve treatments for illnesses and enhance health status. The findings of research involving human subjects can offer creative solutions and hope for research subjects, particular groups and society as a whole. The participation of individuals in research studies, as investigators or as subjects, is an affirmation of solidarity with others. The way research is carried out must always respect the dignity and integrity of the persons involved and serve the common good.

Our Christian faith gives us an increased awareness of solidarity with others and challenges us to exercise leadership through participation in research. As co-creators with God, we are to use our gifts of intelligence and freedom to improve our bodies and to develop health care and social services that will benefit humankind, including medical technologies, methodologies and basic sciences.

Catholic health and social service organizations, as well as educational institutions engaged in research involving human subjects, have a responsibility to communicate and foster a respectful ethical attitude toward such research.

> Research should be directed to the benefit of persons, the common good and the natural environment. Researchers are to conduct their studies with the highest respect for the dignity of the persons involved. Catholic individuals and organizations should provide leadership through participation in such research.

PURPOSE OF RESEARCH

106. Research involving human subjects must be directed toward the benefit of humanity and the advancement of knowledge. Researchers are to conduct their research as critical and responsible professionals, accountable to those people participating in the research, to the society that supports them, as well as to their colleagues, students and research institutions.

CRITERIA FOR RESEARCH STUDIES

107. The methodology for ethically justifiable research on human subjects must be scientifically sound.

108. The benefits expected from the research must be proportionate to the risks incurred by the subjects. (Refer to articles 39, 44)

109. Commitments made to participants must be honoured.

110. Researchers have a duty to disseminate the analysis and interpretation of any significant results to the research community. Silence on negative research outcomes may foster potentially harmful clinical practices or wasteful duplication.

111. All research projects involving human subjects must be submitted to an authorized research ethics board for approval.

112. The research ethics board is to reflect the values of the organization in which the research is taking place. Its membership should include clinical staff, ethicists/moral theologians, experts in law and in the appropriate sciences, and representatives of the general public.

ISSUES OF CONSENT

113. In all research involving competent individuals, subjects must have provided free and informed consent for their involvement.

This can be achieved by candidly providing to the participants beforehand accurate and understandable information, including all benefits and risks, as well as realistic expectations. Volunteers who decline or withdraw from participation in experiments must be assured that their health care needs and employment relationships will not be compromised because of their decision. (Refer to article 34)

114. Researchers have an obligation to be aware of factors which reduce participants' competence or reduce their ability to consent freely. Research with children, and with subjects whose lack of competence has been established, requires special considerations.

- For research that is of potentially direct benefit to the subject, consent must be given by the subject to the extent possible, and where impossible, consent is to be obtained from the appropriate proxy.
- For research that does not offer a potentially direct benefit to the subject, the following conditions are to be met: there is no valid alternative to the specific population involved; the research involves minimal risk; to the extent possible, the subject consents, and where impossible, appropriate substitute consent is obtained.
- In all situations, a subject's refusal to participate must be respected. (Refer to articles 25, 34)
- Any inducements or payments offered to individuals may limit the freedom of consent.

PROTECTION OF PERSONAL HEALTH INFORMATION

115. The goals of research do not justify automatic and unrestricted access to confidential records or other sources of personal health information. Protecting the privacy of individuals is essential.

Research organizations must have a clear protocol in place concerning access to and use of information. Such a protocol must be communicated to research subjects. (Refer to articles 36-38)

RESEARCH ON EMBRYOS AND FETUSES

116. Experimentation on embryos and fetuses, whether viable or not, must respect them as human beings. Experimental manipulations of embryos and fetuses are not permitted unless the manipulations are therapeutic. (Refer to *Donum Vitae*, I:4 and article 60)

117. Researchers must not carry out interventions on live embryos and fetuses, unless there is a moral certainty of benefit to them and of not causing disproportionate harm to the life or integrity of the unborn child and the mother, and on condition that the parents have given their free and informed consent to the procedure. (Refer to articles 34, 60)

118. Researchers must not produce or keep alive human embryos for a scientific, commercial or other purpose because these practices treat a human subject as an object. (Refer to article 58, 60)

EXPERIMENTATION WITH GAMETES

119. Attempts to combine a human gamete with that of an animal are immoral because they constitute the brutalization of humankind.

CLONING OF HUMAN LIFE

120. Researchers must never reproduce a human person through cloning. This practice violates the fundamental integrity of what it means to be a person by transforming both the person from whom the clone is derived and the person resulting from the cloning into objects and treats them as instruments of production. Moreover, to reproduce asexually violates the fundamental nature of human sexuality and procreation.

GENETIC RESEARCH

121. The fact that genetic research leads to a shift in medical therapy from detecting and testing to predicting and preventing raises a number of ethical concerns. Of particular concern are the potential harm to future generations, respect for the privacy and confidentiality of personal genetic information, and the requirements of voluntary and informed consent. (Refer to articles 34, 36-38)

122. Attempts to influence chromosomatic or genetic inheritance that are not therapeutic but that are aimed at the selection of human beings according to predetermined categories, such as gender, are manipulations contrary to the personal dignity, integrity and identity of the human being. Such attempts are immoral and cannot be justified on the grounds of possible beneficial consequences for future humanity.

GENE PATENTING

123. Researchers should be able to patent the intellectual processes used in their research.

124. Genetic material should not be considered a marketable commodity. The elemental ingredients of life (the human genome) should be regarded as the communal property of humankind. The patenting of human genes, cell lines and other genetic materials raises serious ethical questions related to:

- the increased risk of dehumanizing and exploiting human persons;
- access to products created from patented materials;
- the further commercialization of research;
- ensuring that genetic material is not taken from persons without their informed consent.

HEALTH CARE WORKERS AS RESEARCH SUBJECTS

125. The participation of health care workers as subjects in research presupposes their willingness to participate, as documented by approved consent procedures, and their freedom to withdraw at any time during the research project. Health care workers who decline participation or who choose to withdraw during any phase of the research project must not suffer any compromise of their conditions of employment because of their refusal or withdrawal. (Refer to article 139)

CONFLICT OF INTEREST IN RESEARCH

126. All contracts between researchers and commercial sponsors should be reviewed by the organization for possible conflicts of interest. (Refer to article 148)

RESEARCH ON ANIMALS

127. Research on animals often precedes treatment for human subjects. Proper respect surrounding the use of these animals is to be given. When research on animals is justified, pain relief must be used in order to reduce suffering.

VII

Governance and Administration

INTRODUCTORY COMMENTS

Catholic health and social service organizations are communities of service, united through collaborative activities and inspired by Roman Catholic moral principles for the purpose of providing an optimum level of care for those who are sick or in need, and promoting a healthy society. At the same time, they are occupational communities providing for personnel a means of personal and professional fulfilment and a means of earning a living.

To meet these obligations, the organization is called upon to act as a moral community by addressing the ethical dimension of decisions related to governance and administration, and by striving for effective communication and consultation with all members of the organization.

As a community of service that receives funds from the public to carry out its mission, the organization acts to meet obligations that correspond to its several roles:

- as an agency commissioned to provide services to the public;
- as a human community of service expressing solidarity with those in need of care;
- as a Christian community acting as a careful steward of God's gifts;
- as a church community committed to a preferential option for those who are poor and marginalized.

Work is a dimension of a person's creativity; it provides a community and a sense of meaning and purpose. As a community of work, the organization seeks to create an atmosphere within which work is viewed as more than an economic function. The personnel, in turn, are expected to carry out the mission of the organization. In their life and work

personnel are guided by personal values that go beyond their role as employees. Personnel should be treated accordingly.

As communities of service, Catholic health and social service organizations are dedicated to providing an optimum level of care and promoting a healthy society. As occupational communities, these organizations provide for employees an atmosphere for personal and professional fulfilment and a means of earning a living. In meeting such obligations, these organizations recognize the need to address the ethical dimension of decisions related to governance and administration.

GOVERNANCE

128. Board members and senior administration are responsible for creating a healing atmosphere that is sensitive to the needs of the persons they serve, as inspired by the mission of their organization. This requires respect and compassion for those receiving care and their families, and for those providing care, while seeking to be effective and efficient within the constraints imposed by limited resources. (Refer to articles 7, 9, 154)

129. Responsible stewardship requires that board members and senior administration attend to the ethical dimension of all board decisions. This includes financial considerations, just wages and treatment of personnel, planning and priority setting, and policy development. Those chosen to serve as board members should appreciate the importance of this ethical dimension of governance. (Refer to articles 10-13, 154)

ADMINISTRATION

130. The administration coordinates the multiple functions of the organization in a way that encourages personnel and those receiving care to form a community of compassion and care.

131. In conformity with the organization's mission and purpose, administrative decision-making, planning and policy formation should be participative processes, involving input from managers, health care and social service professionals, other staff and representatives of the community served. (Refer to articles 7, 8, 154)

PARTNERSHIPS

132. Circumstances sometimes dictate that Catholic organizations enter into a variety of partnership arrangements. The resulting alliances,

which may be voluntary or mandated by civil authorities, bring both opportunities and risks. In creating such partnerships the following guidelines should be attended to:

- the mission and ethical values of Catholic organizations are to be affirmed and protected;
- the board, and governance and administrative structures, should ensure effective promotion of the organization's mission and values;
- the development of any collaborative venture should proceed with the continued active involvement of the board of trustees and the sponsor/owner of the Catholic organization. When a partnership has a significant impact on mission and values, the local bishop should be informed and consulted;
- the principle of legitimate cooperation, when appropriate, should form the ethical context for such partnerships. (Refer to Appendix II and to articles 7-9, 128)

ALLOCATION OF RESOURCES

133. The careful stewardship of resources should be guided by the mission and values of the organization. Catholic organizations fulfil their responsibilities concerning resource allocation in a variety of ways, such as:

- active participation in the formulation of federal, provincial and local policy directions for the equitable distribution of funds;
- cooperation with other organizations to make limited resources available to more people;
- planning and distributing funds appropriately among programs and services within the organization;

- active concern for the special needs of the most disadvantaged among those receiving care and those in the larger community. (Refer to articles 7, 8, 28, 30, 31, 129)

134. Basic health care needs are not to be overlooked when allocating resources for procedures involving expensive, scarce medical services.

RATIONING OF RESOURCES

135. When the resources available for health care and social services are not sufficient to meet the needs of those seeking care, those who have the responsibility for rationing these limited resources are to consider the ethical dimension of any decisions to deny services or to select some individuals over others for services. Organizations are encouraged to develop a suitable protocol to address the rationing of resources.

ADDRESSING ETHICAL DIFFERENCES

136. Each organization is to set up a conflict resolution process to address ethical differences that arise among care providers, persons receiving care, and/or the organization. (Refer to articles 10-13)

137. Situations arise in which care options are limited by the organization because of economic factors. This may conflict with a care provider's best judgement about a treatment or service they consider indispensable to the health or well-being of a particular person. In rare circumstances, it may be justified for the care provider to challenge the imposed constraints by carrying out the necessary treatment or service, and then informing the appropriate authority concerning the action taken. (Refer to articles 13, 133-135)

138. Care providers often play multiple roles and express multiple loyalties in the same situation. For example, caregivers might be called upon to be a patient advocate and a gatekeeper to services. Efforts should be made to reduce the occasions in which providers must play conflicting roles. The education of all care providers should address the ethical conflicts that can arise in playing such conflicting roles. (Refer to articles 10-13)

CONSCIENTIOUS OBJECTION

139. No one may be required to participate in an activity that in conscience the person considers to be immoral. While continuing to fulfil its mission, the organization is to provide for and to facilitate the exercise of conscientious objection without threat of reprisals. The exercise of conscientious objection must not put the person receiving care at risk of harm or abandonment. (Refer to article 125)

EMPLOYER/EMPLOYEE RELATIONSHIPS

140. All members of the organization are to respect and act in accordance with the organization's mission. The primary responsibility of everyone in the organization is the person receiving care. To enhance the mission and the care, employees should exercise respect for one another. (Refer to articles 7, 8)

141. The organization should treat personnel respectfully and justly. The employer/employee relationship calls for fairness and mutual accountability from both the organization (represented by the board and administration) and from those who work in the organization. (Refer to articles 17, 128, 129)

142. Those who give direct care and those whose work enables care providers to function effectively should be valued as providing

different but important aspects of the mission and operation within the organization. All persons are to be treated with respect and equal consideration in employment practices. (Refer to articles 14, 17)

143. The expertise and experienced judgement of care providers are to be acknowledged in their individual areas of competency. Similarly, teams of care providers should respect the diverse expertise of their members in providing consultation, making decisions and delivering services. (Refer to articles 89, 90)

144. Equal opportunity for employment and career development should be available to all irrespective of gender, race, age, national origin, sexual orientation, religion, disability, or other differences. All are entitled to fair compensation for their work. (Refer to articles 14, 17)

145. The employer must recognize 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 the organization are to encourage a collaborative approach between unions and administration based on the good of the person receiving care.

146. In light of its commitment to respect individuals and its recognition of the value of involving all levels of staff in planning and decision-making, organizations should develop explicit guidelines for situations in which it becomes necessary to lay off workers. This implies consultation with those affected, examination of alternatives, open communication, and a flexible approach to honour the uniqueness of each individual. Staff layoffs should be a last resort; one that is used only after all other alternatives have been seriously tried. Treatment of non-unionized employees

should be as consistent as possible with that of unionized employees. Similarly, treatment of employees terminated as a result of downsizing or program changes should be as consistent as possible with treatment of those leaving voluntarily. Those who are terminated with cause should be treated with compassion and respect.

147. When contracting out work, care should be taken to ensure that all contracting out arrangements respect the rights and responsibilities of unions, provide just wages, not treat work as a commodity and not endanger the sense of community within the organization.

CONFLICT OF INTEREST

148. Pursuit of wealth by care providers and organizations should always be secondary to their primary responsibility to promote health and relieve suffering. (Refer to article 126)

149. Referral of persons to organizations in which the referring professional has an investment interest is usually a conflict of interest and is, therefore, ethically inappropriate.

ALTERNATIVE SOURCES OF REVENUE

150. In seeking additional or supplemental sources of revenue, health and social service organizations are to establish guidelines to ensure that such activities are undertaken in an ethical manner.

- In the direct solicitation of donations, policies should be developed that ensure there is no coercion and/or breach of patient/client confidentiality.
- Funds received for specific purposes should be devoted to those goals.

- Financial investments are to be consistent with the mission and values of the organization. (Refer to articles 7, 8, 129, 133, 135)

ABUSE OF CARE PROVIDERS

151. Health and social service organizations are to develop policies and guidelines that recognize the obligation to provide care in situations of risk, set limits concerning the level of care to be provided in such situations, and provide mechanisms for protecting the safety of care providers.

152. The organization must make it clear that it will not tolerate racism or bigotry toward care providers, and should establish guidelines for addressing such situations. Care providers should receive education on how to deal with bigotry.

DEALING WITH COMPLAINTS

153. Organizations should have a well publicized process for responding to complaints regarding personal or corporate misconduct. This process should include:

- the naming of an office within the organization to receive and investigate complaints;
- mechanisms for assuring a prompt investigation;
- the naming of an impartial person to adjudicate the claims;
- full opportunity for all parties to present their positions;
- protection from reprisals for the person reporting misconduct in good faith, and for witnesses.

ESTABLISHING A PROCESS FOR ETHICAL REFLECTION BY MANAGEMENT

154. Organizations should encourage a forum for those with management responsibilities to reflect on the ethical dimension of their work. (Refer to articles 10-13, 128-131)

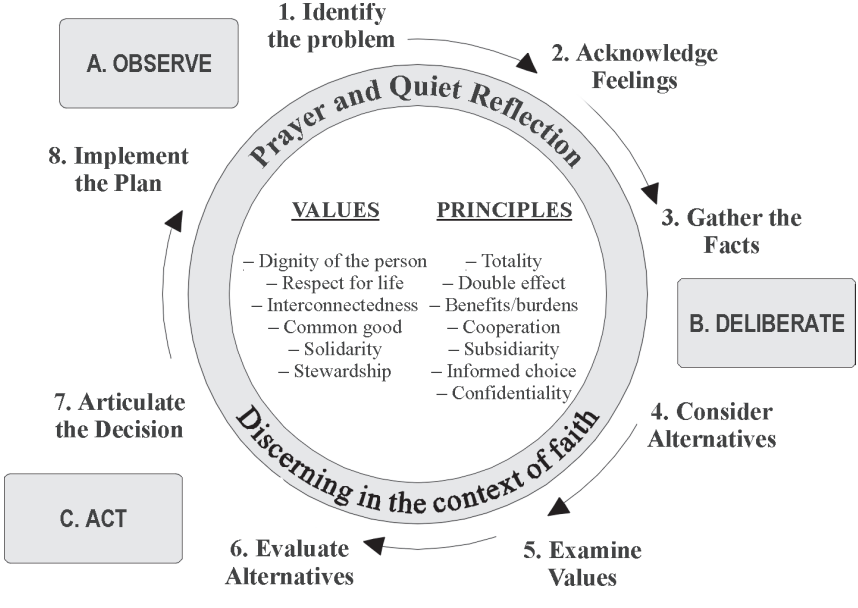
155. The ultimate goal of all ethical reflection by management, and indeed, by all those involved in these ethical processes, is to bring the healing, compassion and reconciliation of Jesus to all who form the health and social service communities.

VIII

Appendices

APPENDIX I

A Framework for Ethical Discernment[1]



1. The framework in Appendix I is adapted from "A Framework for Ethical Decisions in Health Care," Dr. Michael D. Coughlin, Ethics Service, St. Joseph's Hospital, Hamilton, Ontario, and includes elements from "An Ethics Work-up or Work-out," Dr. George C. Webster, Health Care Ethics Service, St. Boniface General Hospital, Winnipeg, Manitoba.

GENERAL GUIDELINES

These eleven observations will aid those making ethical decisions.

1. The Catholic tradition has always respected the role of both faith and reason in ethical discernment. The teachings of the faith are not contrary to reason, nor is the use of reason a denial of the need of faith for deeper spiritual insight and significance. The use of reason insists on using rational understanding, the logic of consistency, clarity of terms, and transparency of information and process.

2. There is an uncompromising recognition of both the equal dignity of all human life as a gift from God and the social nature of human persons.

3. No human being is to be treated simply as a means to another end or to be judged on the basis of any qualitative distinction.

4. Since the teachings of the faith are an organic whole, there is a hierarchy of truths and moral values, all interrelated but some of more importance than others, e.g. murder is a greater moral evil than mutilation.

5. When a conflict arises between a formally declared teaching of the church (e.g. innocent human life must be protected) and a possibly compromising procedure, preference must be given to human life unless another human life is equally being threatened, in which case the principle of double effect may be used.

6. When situations arise involving morally controversial treatments or procedures which are supported by reputable ethical opinions and not specifically prohibited by church teachings, such views may be legitimately followed, e.g. some treatments for ectopic

pregnancies, the withholding/withdrawing of nutrition or hydration in some situations.

7. Christian ethical discernment also attends to the moral promptings of God as we experience them internally, e.g. intuition, emotions, imagination and "gut-feelings." These promptings have a legitimate place in ascertaining moral correctness.

8. Feelings of interior harmony and integration can be valid indicators of God's Spirit when informed by objective criteria including medical information, legal obligations, church teaching, Sacred Scripture, and the authority of experts.

9. Sound ethical discernment is usually best made through a team approach which involves the person receiving care, health care and social service professionals and a bioethics consultation.

10. The discernment process can be facilitated best in a prayerful atmosphere where reasoned presentations and adequate time are provided.

11. Every effort should be made to resolve ethical conflicts by using communication and dialogue, remembering that God does not expect the impossible in our efforts to respect the dignity of life.

DISCERNMENT PROCESS

The following model is a framework that identifies the key elements of a discernment process. It offers a way of focussing attention on the questions that should be raised in addressing ethical decisions in health care. It provides a process for integrating into such decisions the values and principles articulated in the Guide.

Prayer and quiet reflection

A. OBSERVE

1. Identify the Problem
Name the problem clearly.
Where is the conflict?

What seems to create difficulty? Is the conflict between individuals?

2. Acknowledge Feelings
What are the "gut" reactions?
biases?, loyalties?

What are the initial feelings about the case?

3. Gather the Facts
Issues to consider:
a. Clinical factors:
(diagnosis, prognosis, certainty?)
b. Psycho-social factors:
(history, family situation?)

What are the ethically relevant facts?
Whose account of the "facts" counts?
Have all relevant perspectives been obtained?

B. DELIBERATE

4. Consider Alternatives

Issues to consider:

a. What are the alternative courses of action? *All options should be seriously considered before eliminating any*.

b. What are the likely consequences?

e.g. – medical
– quality of life
– relationships
– legal
– moral/spiritual

What are the alternatives?
Probable consequences?

Alternative 1.

Alternative 2.

Alternative 3.

5. Examine Values

Issues to consider:

a. Preferences of the person receiving care:
– wishes, values, beliefs?

b. Are others' values relevant?

c. What beliefs/values of the Christian community are relevant?

d. Which of the values are in conflict?
– What is the problem?
– Whose values conflict?
– Economics involved?

What are the important values?

Whose?

What is the good we seek?

6. Evaluate Alternatives

Issues to consider:

a. Identify the decision-maker(s).
- Who speaks for the person receiving care?

b. Rank values.
- Dignity of the person;
- Respect for life;
- Interconnectedness of every human being;
- Common good;
- Solidarity;
- Stewardship.

c. Justify ranking. By what principles?
- Totality;
- Double effect;
- Benefits/burdens;
- Legitimate cooperation;
- Subsidiarity;
- Informed choice;
- Confidentiality.

d. Evaluate the consequences of alternatives in terms of principles.

e. What alternatives are excluded?

Who is the appropriate decision maker(s)?

Rank Values

C. ACT

7. Articulate the Decision

Issues to consider:

a. Which alternative best reflects the ranking of values?
b. Which alternative best balances more of the values?
c. Have any other alternatives come to light?

State the decision.

8. Implement the Plan

Issues to consider:

a. How best to communicate the decision?
b. Who needs to know it?
c. How best to document the process?
d. Who needs to act?

How should the decision be carried out?

Concluding Review:

What are the feelings of those involved?
Conclude with a prayer or reflection

Conclusion: *In working through the discernment process, practitioners may gain insight into the decision to be made. The experience may also help them identify opportunities on a wider institutional level for policy change, education and research. Some cases will result in the identification of opportunities for education or collaboration with community agencies, other organizations and persons needing care.*

APPENDIX II

The Principle of Legitimate Cooperation

For Canada, as for many societies at the end of the 20th century, health and social services have become a central forum in which to work out the values, beliefs and principles that will together constitute a new social vision for the decades ahead. In many ways, Canada's moral and ethical fibre is reflected in its health and social service systems.

The history of this country records the many ways in which the church has contributed to the development of these systems. Through its continued presence at critical points in life, where people face the questions of illness, dependence and mortality, the Catholic ministry of care, especially through its hospitals, homes and religious orders, has significantly influenced and shaped public policy.

Today, this ministry continues to provide an opportunity to bring the values of the Catholic moral and social tradition to bear on public policy considerations affecting the life, health, and well-being of persons, communities and the nation as a whole. Sustaining a strong Catholic health and social service presence is particularly important in a society where contrary values such as individualism and consumerism constantly erode respect for the dignity of human life. This presence provides a significant opportunity to respond to the call issued by John Paul II to "Respect, protect, love, and serve every human life."[1] This entails a special commitment to work for social justice and the common good.

Until recently, most health care and social service providers in Canada operated with a degree of independence from one another. Increasingly,

1. John Paul II, *Evangelium Vitae*, April 6, 1995, no. 5.

however, Catholic organizations are working with other organizations and providers who in the past may never have been considered as potential partners.

These new partnerships enable Catholic providers to exercise leadership and to witness to their core values and ethical commitments. Such arrangements offer valuable opportunities for promoting the common good, social justice and responsible stewardship. Catholic presence in health care is especially important in those services which touch people at key moments in their lives, for example, in obstetric and gynecologic services, long-term and chronic care, and in the care of those who are dying.

Promoting justice and the common good in the context of such partnerships can pose a challenge to the identity, mission and ethical integrity of Catholic organizations. Such arrangements may necessitate closer involvement with organizations that do not share Catholic moral principles, and with practices that the Catholic tradition finds morally unacceptable. Such situations create ethical dilemmas that are often difficult to resolve.

The principle of legitimate cooperation in the Catholic moral tradition acknowledges that, in some instances, the good that is sought can be achieved only through cooperation with what we find morally unacceptable. In moral theology, the principle of legitimate cooperation is related to the principles associated with toleration and double effect. In this area, the action of the wrongdoer is differentiated from the action of the cooperator through two major distinctions.[2]

2. See National Conference of Catholic Bishops (U.S.), *Ethical and Religious Directives for Catholic Health Care Services*, Washington, D.C. March, 1995, "Appendix: The Principles Governing Cooperation," p. 29, for the succinct source on which this enlarged section is based.

1. The distinction between formal and material cooperation

Formal cooperation focuses on the intention of the agents. It is *explicit* when the cooperator intends, agrees with or desires the object of the activity of the wrongdoer. In this case, the cooperator's action is morally wrong. Formal cooperation can also be implicit. It is *implicit* when, in spite of denying any agreement with the wrongdoing, no other explanation can distinguish the wrongdoing from the cooperator's involvement.

If the cooperator does not intend the object of the activity of the wrongdoer, but only tolerates it, the cooperation is *material*. Material cooperation can be morally licit.

2. The distinction between immediate and mediate material cooperation

Material cooperation is *immediate* when what the cooperator does is, to all appearances, indistinguishable from what the wrongdoer does. For example, the nurse assisting in a direct abortion is as necessarily involved in the procedure as the surgeon doing the operation.

Immediate material cooperation is wrong except in some instances of duress, e.g. if a surgeon decides to do some illicit procedure during an operation, the assisting nurse, who may oppose such an action, should not walk out of the operating room thereby endangering the life of the patient. It is *duress* that distinguishes immediate material cooperation from implicit formal cooperation. Without duress, they are both morally wrong.

Material cooperation is *mediate* when what the cooperator does remains distinguishable from what the wrongdoer does. Such cooperation can be morally licit. For example, a nurse who prepares an operating room with the surgical supplies that she knows will be used for an abortion is cooperating with the doctor. However,

her action can be distinguished from that of the physician and can be legitimate.

Two general statements can be made about legitimate cooperation:

A. Immediate cooperation is acceptable only in circumstances of duress (e.g. external pressure, extreme financial harm) where the cooperator has lost the freedom to refuse to cooperate lest a greater evil occur.

B. As the gravity of matter increases, the degree of distance between the cooperative action and the wrongdoing must increase.[3]

In summary, moral theology evaluates activities involving material cooperation with the following conditions:

1. what the material cooperator does should be distinguishable from what the wrongdoer does;
2. an act of material cooperation requires a proportionately grave reason;
3. questions of duress, distance, necessity and gravity in making a judgement about cooperation must be guided by the cardinal virtue of prudence;
4. the possibility of scandal, i.e. creating confusion between Catholic moral teaching and involvement in questionable procedures, should be eliminated. Sometimes a prophetic stance in a community may seem to cause scandal to some, but this may be necessary for a greater good.

3. See "Catholic Health Ministry in a Changing Environment: Maintaining Ethical Integrity," in *Catholic Health Ministry in Transition, A Handbook for Responsible Leadership*, Silver Spring, MD., National Coalition on Catholic Health Care Ministry, 1995 p. 5, for these two articulations.

Taking leadership and influencing public policy in our pluralistic society is a prophetic responsibility to which Catholic individuals and organizations are called. The principle of material cooperation may provide valuable direction not only for individuals but also for organizations under the sponsorship of a specific religious perspective and in partnership with organizations that may not share Catholic moral principles. Such a broadening of the boundaries regarding the use of the principle of legitimate cooperation makes it possible for Catholic organizations to consider entering into new partnership arrangements in order to implement and promote the Church's social teaching, the preferential option for the poor, and the dignity of the human person. In this way, religiously-based health care and social service organizations can continue to provide a powerful presence and voice for these human values within society.

APPENDIX III

GLOSSARY OF TERMS

Abortifacient
Medication or device that intends to induce an abortion.

Abortion
The termination of a pregnancy, spontaneously or by induction, prior to viability. A *direct* abortion is a procedure whose deliberate purpose is to terminate the life of an embryo or a fetus. An *indirect* abortion is a procedure necessary to save the life of the mother in which the death of the fetus is an inevitable result, e.g. the treatment of an ectopic pregnancy.

Advance health care directives (Living will)
A document that is intended to instruct or inform others concerning a person's needs, values and wishes, the identity of the proxy and/or the type of treatment a person desires should they lose their decision-making capacity or be unable to make their wishes known.

AID
Artificial insemination by a donor.

AIH
Artificial insemination by the husband.

Allocation
The designation or the setting aside of resources for specific purposes. (*see* Rationing)

Allo-geneic (Allograft)
The transfer of body organs or tissue, e.g. skin or bone, from one

individual to another individual of the same species.

Anatomical integrity
see Bodily integrity

Artificial fertilization
see In vitro

Artificial insemination
see In vivo

Assisted suicide
Counselling, abetting or aiding someone to kill himself or herself.

Auto-logous (Autograft)
The transfer of body organs or tissue, e.g. skin or bone, from one part to another part of the same individual.

Bioethics
That part of ethics that deals with issues of life in the context of the life and health sciences. This is a word first used by Van Rensselaer Potter in 1971. It is a combination of the two Greek words, "bios" meaning "life" and "ethos" meaning "custom."

Bodily integrity (anatomical/functional)
"Integrity" indicates that the parts of the body are differentiated and developed while each part fits into the whole and harmonizes with the other parts. "Anatomical integrity" refers to the material or physical integrity of the human body. "Functional integrity" refers to the systematic efficiency of the human body, e.g. if one kidney were missing from a person's body, there would be a lack of anatomical integrity but functional integrity would remain since the person would still retain adequate renal function.

Brain death
see Death

Caregiver
Caregiver is a term that includes care providers as well as those persons who comprise a wider circle of support, e.g. family members, a life partner, close friends or members of the broader community.

Care provider
Care provider refers to someone who offers health or social services in a professional or paid capacity within a health or social service organization.

Cloning
In the context of this guide, cloning is the asexual reproduction of an individual by nucleus transplantation that results in a genetic copy of the individual from whom the nucleus was taken.

Common good
The sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfilment more fully and more easily. (*Cathechism of the Catholic Church*, no. 1906)

Competence
Possessing sufficient capacity to make a reasonable decision for one's own best interest.

Confidentiality
Confidentiality is a quality of human communication that protects a person's right to privacy by fostering trust between the care provider and the person receiving care. Confidentiality excludes unauthorized persons from gaining access to information concerning the person receiving care, and requires that people who have such information refrain from communicating it to others.

Conscience
The specifically human capacity to make practical judgements in matters involving ethical issues.

Conscientious objection
Objection to a specific belief or action on moral or religious grounds.

Consent (informed)
Informed consent requires that an individual possess the competence and freedom, as well as understand and appreciate the information needed to make a reasonable decision for their own best interest.

Cooperation (formal, material)
Cooperation with others performing immoral acts can be either formal or material. *Formal cooperation* focuses on the intention of the agents. It is *explicit* when the cooperator intends, agrees with or desires the object of the wrongdoer's activity. In this case, the cooperator's action is morally wrong. Formal cooperation can also be implicit. It is *implicit* when, in spite of denying any agreement with the wrongdoing, no other explanation can distinguish the wrongdoing from the cooperator's involvement. *Material cooperation* occurs when the cooperator does not intend the object of the activity of the wrongdoer, but only tolerates it. Material cooperation can be morally licit. (Refer to Appendix II, "The Principle of Legitimate Cooperation")

Cryopreservation
In the context of this guide, cryopreservation refers to the freezing of gametes and embryos in order to preserve them.

Death
With respect to the biomedical definition of death, persons are dead when they have irreversibly lost all ability to integrate and coordinate the physical and mental functions of the body. In regard to the precise moment of death, death occurs: a) when the spontaneous functions of the heart and breathing have definitively ceased, or b) with "brain death," i.e. the irreversible arrest of all brain activity. In reality, the definitive arrest of cardiorespiratory activity very quickly leads to brain death. (Refer to *Charter for Health Care Workers*, Vatican, 1995, no. 129)

Dignity
The value that recognizes the inherent worth and promotes the multiple interests of the person.

Distributive justice
The obligation of society to distribute the goods of that society equitably to its individual members.

Duress
In the context of the principle of legitimate cooperation, duress refers to those pressures which cause the cooperator to lose the freedom to refuse to cooperate lest a greater evil occur.

Ectopic pregnancy
see Extrauterine pregnancy

Embryo (human)
The unborn child from the time of fertilization until the end of the eighth week of pregnancy.

Ethics
The study of the rightness or wrongness of human choice and behaviour; a set of principles of right conduct; reflection on values.

Euthanasia
The deliberate killing of someone by action or omission, with or without that person's consent, for compassionate reasons.

Experimentation
Any research in which a human being (in the various stages of existence: embryo, fetus, child or adult) represents the object through which or upon which one intends to verify the effect, at present unknown or not sufficiently known, of a given treatment, e.g. pharmacological, teratogenic, surgical, etc. (*Donum Vitae*, footnote 2, page 16) *see* Research.

Extrauterine pregnancy
A pregnancy in which the fertilized ovum is implanted somewhere other than in the uterus, e.g. in a fallopian tube or in the abdomen.

Fetus (human)
The developing child in the uterus from the end of the eighth week of pregnancy until the time of birth.

Functional integrity
see Bodily integrity

Guidelines
Criteria that guide or direct action.

Homograft
The transfer of human tissue or organs from one human being to another.

Human dignity
see Dignity

Illicit
Contrary to the law (divine, ecclesiastical or civil).

***In vitro* fertilization**
Literally meaning "in glass," it is the technique whereby an ovum or egg is fertilized by sperm in a petri dish outside the body of the mother.

***In vivo* fertilization**
Literally meaning "inside a living being," it is a technique whereby an ovum is fertilized, not from sexual intercourse, but as a result of sperm being artificially introduced into the woman. *see* TOT

Licit
According to the law (divine, ecclesiastical or civil).

Living will
see Advance health care directives

Ministry
The specific manner in which the mission to heal is carried out in Christian health and social service organizations. This service is designated as ministry because it is motivated by the gospel and is part of the church's faith tradition.

Moral
This term has a numer of meanings: that free human activity which perfects or fulfils a person's progress toward their ultimate destiny or detracts from it; the judgements of a person's conscience; the choices made and the objective elements of the human act; a system of norms or principles of good conduct for individuals or groups.

Moral certainty
The confidence that all of the conditions required for making an informed decision have been met beyond a reasonable doubt.

Palliative care
Palliative care, as a philosophy of care, is the combination of active and compassionate therapies intended to comfort individuals and their support communities who are facing the reality of impending death. It strives to meet physical, social, and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs and practices.

Person
A being endowed with intelligence and free will, with a moral consciousness and a potential for self-fulfilment in relationship to God and others.

Personnel
In the context of this guide, personnel refers to all those who serve

patients/residents/clients within health and social service organizations (e.g. administrators, physicians, nurses, other health and social service professionals, staff and volunteers).

Principle
A more specific articulation of a value that is used as a starting point or rule of thumb for good ethical reflection and action.

Protocol
The rules or formalities of any procedure or group.

Proxy
Those persons who are entitled to make a care and treatment decision for an incompetent person. This may or may not be a family member. Such a decision should be based on the decision the person would have made for themselves to the best of the proxy's knowledge. If this is unknown, the decision should be made in the person's best interest. In some provinces and territories, the definition of proxy is provided in legislation.

Rationing
The withholding of potentially beneficial services because circumstances, policies and/or practices establish limits on the resources available for health care or social services. This definition is used because it clearly identifies what is of ethical concern (that is, the potential harm that can come from the denial of services) and recognizes that the practices or proposals to ration services must be tested against ethical criteria that assess the need for rationing, the methods proposed and their likely outcomes. *See* Allocation

Religion
The expression of spirituality through traditions, rites and practices usually within the context of an organized faith.

Research (clinical)
Any inductive-deductive process that aims at promoting the systematic observation and understanding of a given phenomenon in the human field or at verifying a hypothesis arising from previous observations. (*Donum Vitae,* footnote 1, page 16) *see* Experimentation

From a moral point of view, clinical research usually refers to relatively untested, and usually innovative medical and surgical procedures. It can be either therapeutic or non-therapeutic:

- *therapeutic:* these procedures are designed and conducted for the benefit of the subject, either to diagnose or to treat their illness;
- *non-therapeutic:* these procedures are often unrelated to the interests of the person but related to the class of which the individual is a member and are applied primarily as a means of contributing to the common good.

Restraint
Any physical, environmental or chemical substance which controls a person's behaviour by preventing or restricting free physical movement to which the person has not consented and/or is unable to remove independently. A *physical* restraint inhibits free physical movement by such means as lap belts, vests/posey jackets, bed rails, mitts, wrist restraints, wheelchair trays and shoulder harnesses. An *environmental* restraint is a barrier to free personal movement which serves to confine a person to a geographic area. A *chemical* restraint is medication given with the sole purpose of altering the specific behaviour or movement that places the person under care or others at risk of injury.

Social justice
The concern to root out social habits, institutions, or structures that harm the common good of society, and to establish structures, ways of acting and attitudes, that promote the common good.

Spiritual and religious care
The activity of chaplains, community clergy, faith leaders and laity in helping persons to discover and deepen life and give expression to their spirituality and/or religion.

Spirituality
The search for the sacred. A conscious striving to move beyond isolation and self-absorption to a deeper awareness of interconnectedness with the self, other human beings and the transcendent.

Stewardship
The appreciation of the giftedness of creation and the exercise of responsibility in relationship to creation.

Surrogate mother
A woman who allows a child to come to term in her womb with the understanding that she will turn the newborn infant over to the party or parties who have used her services.

Therapeutic procedures (*also see* Research)
From a moral point of view, this usually refers to medical and surgical procedures that are related to the life-saving or healing interests of the person receiving care.

TOT
"Tubal Ovum Transfer," a modified version of "low tubal ovum transplant" (LTOT), is a surgical procedure in which the ovum is moved into the lower part of the fallopian tube for the purpose of fertilization. It is done to assist the natural process of fertilization. To date the church has not evaluated the TOT process. *see* in vivo

Transplant
The surgical operation of implanting the donated organ or tissue into the recipient, or the entire process from retrieval through to implantation.

Triage
The assignment of degrees of urgency to decide the order of treatment of those receiving care.

Value
That quality of the goodness of things that motivates human activity.

Vitalism
A doctrine that the functions of a living organism are due to a vital principle totally distinct from physiochemical forces. The moral consequence of this doctrine is that all life has an absolute value that cannot be subordinated to any other end, e.g. human life, in any condition, must be preserved at all costs.

Xenotransplantation (xeno-geneic/heterograft)
The transplantation from one species to another, e.g. animal to human. It is derived from the Greek "xenos" meaning "alien" or "stranger."

Zygote
The fertilized egg before it begins to divide into further cells.

APPENDIX IV

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"I found the guide to be a soulful, compassionate guide to care in today's complex health care arena. It balances the needs prevalent in our multi-cultural, secular society with the desire to remain faithful to Roman Catholic teaching."

Dawn Dudley Oosterhoff, RN, LLB, SJD (Cand.), Faculty of Law and Collaborative Program in Bioethics, University of Toronto

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