



Editor's Forum

Paul Byrne, MB, ChB, FRCPC

Interim Director and Clinical Professor, John Dossetor Health Ethics Centre, University of Alberta
Staff Neonatologist, Stollery Children's Hospital

Discussion of dignity in the context of health care delivery has become a rarity and restricted to end-of-life situations. It appears that the importance of personal dignity has been relegated and seems somewhat old fashioned in our modern Health Science Centers' culture. Similar to traditional views of virtue and character as being core requirements of the "Good Doctor", discussions of dignity appear as footnotes in medical literature. The exception appears to be in palliative care. In this final chapter of care, attention to dignity comes to the fore in research and practice.

The papers in this issue of *Health Ethics Today* illustrate how much ethical importance we risk losing when we ignore or neglect the inherent dignity of individuals, groups, or even entire populations in our care. Doris Kieser describes first-hand experiences of care in an outpatient clinic. Her insightful observations on the "small acts" involved in patient care show vividly how impersonal and undignified routines can become, even when health care practitioners (HCPs) are trying to be professional. Her descriptions make us cringe because they are so familiar. And yet HCPs rarely question the adverse effects of new "Policy & Procedure" initiatives on the dignity of those in our care.

Heidi Janz's paper is more highly charged as it describes her experience of a policy to change governance, conditions and control of user-run home care services required by groups of disabled and dependent adults in Edmonton. It is clear that the dignity of those whose lives were most affected was not considered by this policy change. While we must accept the need to review and improve how

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care is provided in terms of quality, efficiency and cost, the processes involved cannot ignore basic ethical principles such as autonomy, privacy and dignity. Janz suggests that there did not appear to be any effort to have face-to-face meetings about how these most vulnerable people would be affected by the proposed changes in care delivery. If that had occurred, the innovative model of care already in place, one that evolved over decades, might have been better appreciated. Her story forces us to consider the humanity of the “other” and illustrates how economically driven administrative decisions may seriously affect the care of individuals and groups. For Janz, resolution was positive when Alberta’s Premier Redford became involved directly and reinstated the original contracts.

Dick Sobsey’s paper on direct-to-consumer (DTC) genetic testing and the consequences involving interpretation of results shows how impersonal this process has become. Although DTC genetic data may be highly personal in nature, the DTC process is devoid of professional - client involvement. Sobsey describes the four main areas currently involved in DTC genetic testing but it would seem that this will expand rapidly in the near future as it has become so

economically profitable. While impressive efficiency and low cost make DTC testing across a wide spectrum of health care issues attractive, the absence of standards for discussion and interpretation of results are a cause for concern. In this way DTC genetic testing is not different from other health information in that it requires an explanation of meaning in context for a specific person.

In the article by Kate Holt, she describes Austin Mardon’s achievements, advocacy, and the recently established Catherine & Austin Mardon, CM Schizophrenia Award for people afflicted by mental illness. Mardon’s tireless work on behalf of people with mental illness reminds us of how an individual whom the majority in society may regard derogatively as “other”, can be a shining example to all of us as one giving service to those most vulnerable and is cause for celebration.

Each of these very different papers suggests that we need to be wary of moving towards models of care that are impersonal and that risk objectifying individuals as data points. This approach to clinical situations treats those in our care as machines rather than people.

Reclaiming Dignity in Healthcare: Small Gestures of Caring

Doris M. Kieser, PhD

Assistant Professor, St. Joseph’s College and
Assistant Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

Use of the term *dignity* in healthcare and ethics has, of late, been the subject of scrutiny; Ruth Macklin’s (2003) short and critical dissection of the term in global bioethics, for example, launched an ongoing discussion in bioethics literature. Does dignity remain useful in ethical discourse and application? Is it subject to definition and, if so, by whom? Macklin’s basic thesis is that dignity falls under the realms of respect and autonomy, and

therefore unnecessarily muddies ethical waters. One problem with dignity is its ambiguity in the face of human difference – a legitimate concern. What constitutes dignity in death, for instance, is an unsettled question. Another problem with dignity is that it tends to emerge predominantly in high stakes ethical scenarios: end-of-life discussions (e.g., the ethics of euthanasia, assisted-suicide, and end-of-life treatment) and nascent human life discussions (e.g.,

the ethics of embryonic research, genetic cloning, and fetal right-to-life). As legitimate and complex as these various issues are, they tend to escalate differences and disintegrate helpful dialogue.

In this short piece, I consider dignity in its somewhat more mundane manifestation: the sense of respect for individuals seeking basic care – their privacy, their agency, their bodies, and their integrity – within structures created for efficiency and best practices. I do so because dignity, however one understands it, is at least as ethically weighty in the smaller gestures of care for one another as it is in high stakes ethical scenarios. In the Roman Catholic/Christian tradition, within which I work, dignity is understood as inherent to every person *prior to* any social assessment of his/her value, by virtue of our shared creation in God’s image (Catholic Health Alliance of Canada, 2012, p. 14). Beyond any religious commitment, however, we share a commonsense understanding of dignity that invites us to be mindful of care beyond cure: we respect privacy and confidentiality, we are gentle while relaying difficult news, and we are particularly attentive to the vulnerable among us, whose decision-making capacities might be compromised. Contrary to Macklin, therefore, I suggest that dignity remains an important concept in ethical dialogue and in practice.

Case in point: While recently seeking outpatient care at a hospital clinic, I received, for the most part, professional and skilled care from people who facilitated follow-up care as well as possible. I assume that my caregivers were vaguely mindful of the dignity of their incoming patients. More ethically curious to me was the structure and processes through which care occurred and in which dignity was possibly recognized but attentive only to the basic norms of respect, privacy, and confidentiality.

Over three visits to the clinic, I witnessed troubling structural and process-driven management of personal aspects of dignity. For instance, mobility-compromised patients using walkers, canes, or crutches, many of whom were elderly, were required to carry their belongings (including winter attire) around in a large plastic bag, once they had

changed for x-rays. Such a scenario assumes, of course, that said patients were making their way through the public corridors of the building in scant cotton gowns.



I also witnessed an odd demonstration of confidentiality policies at work. Patients were required to wait behind the line on the floor in the interests of privacy while persons ahead gave personal information at the various check-in desks. Following that, patients were identified in the small waiting area and, if mobility limited, the nurses would come to them to discuss their health issues and the procedure for the day. While staff were quite considerably taking pains to ease the burden for some patients, they were also having easily overheard private confidential conversations in a crowded waiting area. Interestingly, in a small UK study on healthcare practice and human dignity, this practice was specifically noted as a common breach of patient dignity (Baillie & Gallagher, 2012). Attention to such aspects of patient care would likely reveal more respectful and dignified means of moving patients efficiently through their appointments and tests.

All this is to say that respect for privacy and confidentiality seems implemented in basic ways to assure policies are being met and due diligence is undertaken, particularly with respect to legal requirements, but the policies themselves are incapable of meeting a more robust perception of intrinsic worth and our ethical requirements therein. Patients are left subject to the revelation of personal, private information, bodily diminishment



(scrubs always trump hospital gowns in healthcare encounters), and the struggle to transport their possessions with them through the institution.

As noted above, the concept of dignity has in recent decades been co-opted by pressing, high-profile issues within healthcare ethics; assisted death, stem cell procurement, and genetic testing, for example. Perhaps more proactive attention to the implementation of dignity in the smaller, subtler actions within healthcare and in the physical structuring of care, could better facilitate the flourishing of every patient in our midst. Small initiatives aimed at alleviating patients' experiences of indignity or diminishment, like storage space for belongings or designated space for confidential

discussions, would be more attentive to patient dignity. This would also be attentive and respectful to the professional standards and interests of care providers, without necessarily reducing efficiency.

To be sure, there are logistical details that are prohibitive across the health care spectrum. However, taking the notion of dignity seriously seems to be the *care* aspect of healthcare that we are providing. In turn, a personal and embodied sense of respect includes attending to the various small ways that dignity is compromised for individuals, even when not confronted with the seemingly weightier healthcare issues at the beginning and end of life.

Enacting a more robust sense of dignity in the smaller acts of care could also facilitate the habit of mindful attention to shared human dignity in more pressing circumstances. If we acknowledge the diminishment of dignity and authority that comes with wearing a flimsy gown through the public corridors of a hospital, we might be more acutely aware of its diminishment in larger spheres.

Most healthcare providers are committed to giving competent and compassionate patient care. They work hard in difficult circumstances that are often beyond their control. Dignity, as a component of care, is the very least we can offer when pain and suffering are inevitable. It invites us to be intentional about the ways in which we offer care to the persons before us, and their experiences in our midst. It invites us to understand that privacy and confidentiality go beyond lines on the floor, privacy notices and signs, files in locked drawers, and that respect extends beyond the beginnings and ends of lives. *Dignity is more commonly enacted in small ethical moments of caring in mundane circumstances; moments that, in fact, define the nature of our practice.*

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Where Have All the Ethics Gone?: Our Nineteen-Day Battle with Alberta Health Services to Save Our (Independent) Lives

Heidi Janz, PhD

Assistant Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

As someone who has studied and worked in the field of Disability Ethics for over ten years, I *thought* I was thoroughly aware of all the contemporary ethical issues related to disability. These issues remain active fronts on which people with disabilities must wage ongoing battles in order to preserve our fundamental human rights. Beginning-of-life and end-of-life issues, such as selective abortion and euthanasia/assisted suicide on the basis of disability, access to appropriate medical care, and full inclusion in public discourse on the allocation of health resources – those were, to me, the readily-identifiably areas in which people with disabilities and their allies still had much work to do and many battles to fight. But the right to self-determination through living independently in the community, with appropriate supports? The right to direct one’s own personal care? Those, thankfully, were *old* battles, battles that had been hard-fought, but eventually won, by previous generations of Canadians with disabilities in the 1970s and 80s. Now, they were “givens,” assumed rights, on the basis of which I, like many other Canadians with disabilities, had been able to build a career, a home, a life.

But that seemingly solid foundation on which my current life and lifestyle had been built suffered a seismic shock in late May of this year. It came in the form of a letter from Alberta Health Services (AHS) to Creekside Support Services (CSS), the user-run homecare service provider at Creekside Condominiums, where I and fourteen other individuals with disabilities live. This letter informed us that the proposal for a renewed contract which we had submitted back in February was not among

those selected to be awarded a homecare contract by AHS. Consequently, “Representatives from Zone Operations will begin contacting service providers the week of June 3rd to discuss next steps, contract terms, and transition planning for home care clients... The care of Albertans is our first concern.” The letter concluded: “Home care is a growing need across the province and *we want to ensure there is a fair and transparent process for contracted home care services*. We are grateful to you for your compassion and dedication in providing home care services to Albertans. We will work closely with you during this transition to ensure individuals continue to receive the care they need. Thanks again for your continued support to make sure clients continue to receive the care they need throughout the transition.”

Potentially lost in the banality of the Ra!-Ra! Client-Centred Care jargon is the fact that, with this letter (and identical letters received by the two other user-run homecare service providers in Edmonton: Abby Road and Artspace), AHS was announcing its decision to arbitrarily set the clock back 30 years for Albertans with disabilities. No longer were we to have any say at all in where, when, or by whom our personal care was provided. Within the next four to six weeks, we were going to lose all of our current health care aides – many of whom had worked with us for six years or more. Our aides were to be replaced by workers from a third-party, for-profit homecare provider. We were going to be forced to relinquish absolutely all control over who we would allow into our homes to provide us with essential, personal intimate care.

My initial reaction to this letter was complete and total shock. For the first few minutes and hours, I kept having thoughts like: *Canada is still a free, democratic country, isn't it? I'm still a tax-paying Canadian citizen! How then, could AHS be on the verge of annihilating my basic right to self-determination?!* If CCS was going to launch any kind of campaign to try to stop this ill-conceived plan, which would place our way of living – and, indeed, our very lives – in jeopardy, we had to begin that campaign *immediately*.

So, we hit the ground running – or at least with our wheelchairs driving in high gear! The morning after the meeting that plunged us into battle-mode, we launched our campaign to try and affect a reversal of this AHS plan. Our primary weapons in this campaign were traditional news and social media. I set up a Facebook page entitled “Stop the Alberta Government’s Home Invasion and Assault on People with Disabilities”. This Facebook page served as a repository for a collection of news articles, blog posts, and online discussions about AHS’ decision to change homecare. My friend and neighbour, Cam Tait, a former reporter with the *Edmonton Journal*, dedicated his already-established blog to features, interviews, and posts by guest bloggers (including myself) about



the impact that AHS’ decision to arbitrarily change homecare providers would have on service-users and current homecare staff alike. Disturbingly, we kept discovering new angles to explore from how things were unfolding at Abby Road, which was about two weeks ahead of us in the “transition process.” At the first meeting between homecare service users at Abby Road and representatives from their new service provider, Rivera, residents were told that, while workers from Rivera would still assist people to eat, they would not have time to do meal preparation. Abby Road residents who required meal preparation were consequently advised to look into getting Meals on Wheels. As many homecare users in this situation are totally unable to prepare meals, this on-site meal preparation was an essential part of our life supporting conditions. The more we learned about what life after the change in homecare providers would look like, the more fearful we were all becoming.

Then came the Monday morning, a week into our campaign, when Cam Tait and I shared a DATS bus. “Heidi, what do you think--” Cam asked me, “What do you think of inviting Allison Redford for coffee on the blog?”

It took me a second or two to realize that he was serious. I shrugged, “Sure, why not? – it certainly can’t hurt!” Cam composed the invitation and posted it on the blog that afternoon. The next morning, I had an idea and emailed Cam: “Hey, do you think maybe I should email the invitation you posted on the blog directly to Redford’s office?” Cam’s reply was almost instantaneous: “Not now, but RIGHT NOW!” Within five minutes, the coffee invitation was emailed to the Premier’s office and cc’d to the Health Minister, Fred Horne.

Late that afternoon, the homecare service users at Creekside had a meeting with representatives of AHS Homecare to discuss the transition. A long-time friend of mine attended the meeting with me, both to help facilitate others’ understanding of my speech and to offer me moral support. After the meeting was adjourned, my friend turned to me and declared, “If I hadn’t actually been here myself, I think I would

have had a hard time believing what went down here!” He was referring to the through-the-looking-glass moments of illogic, indifference and arrogance that had characterized the response we received from AHS Homecare. Over and over again throughout the hour-and-a-half-long meeting, representatives of AHS Homecare repeated their mantra: “Your care-plans will continue to be followed to the letter; *the quality of your care WILL NOT CHANGE.*” Indeed, when pressed to answer specific questions, such as, “How would an outside homecare provider be able to provide 24/7 service, when the bylaws of our condo board would prohibit them, as ‘outsiders,’ from using the office and staff room space currently used by our ‘in-house’ support services?”, the only response offered by the representatives of AHS Homecare, who grudgingly admitted that they were not aware of this Condo Board policy, was, “*The quality of your care WILL NOT CHANGE.*” Ultimately, we insisted that we were simply unwilling to proceed with any further talks about transition unless or until the question of 24-hour care was satisfactorily addressed.

Disturbingly, this prompted the following response, “Unfortunately, the contract starts August 1st, the longer we take in getting [the new service provider] ready, the more problematic the transition will be.”

Despite the tough front we maintained throughout this meeting with AHS Homecare, its conclusion left us all feeling, not triumphant, but rather immensely drained, and, indeed, bullied. It seemed as though, no matter what we said or did, AHS was going to force this change upon us – consequences, and our lives, be damned. But by mid-morning the next day came game-changing news: Cam got an email from Premier Redford’s office; she and Dave Hancock, Minister of Human Services, wanted to meet with us that Sunday morning. Once again, we were in shock. But, for the first time since this whole nightmare began, we felt real hope that there could yet be a positive conclusion to all this.

So it was that on the following Sunday morning, Larry Pempeit (the Founder and President of CSS), Cam Tait, and I went to the Legislature to meet with Premier Redford and Minister Hancock. (Personally, I was especially grateful that this miraculous meeting



was taking place on a Sunday morning because it meant that the congregation of my church was providing us with real-time prayer backup!) During the meeting, we shared our concerns about the heavy-handed way in which AHS was changing our homecare provider without including us in any sort of consultations. Premier Redford was especially interested in how this was handled. “I want to make sure I understand this,” she said several times while her aides were busy taking notes. She said she was unaware of how things were handled, especially when we service users have had direct input in the care we get. We told her we planned to fight the battle to the end, July 31, when our contract was due to expire. Premier Redford said she would look into the Creekside situation as well as that of Abby Road and Art Space. “We have work to do,” she said near the end of the meeting. As we left the meeting, we couldn’t help but feel a new sense of hope for our situation.

In the end, the resolution of our battle came much sooner than any of us had dared even dream. Two days after our meeting with Ms. Redford, came the announcement by AHS that they were reinstating the contracts of Creekside, Abby Road, and Art Space. While this battle ended happily for us, my personal sense of security as a disabled Albertan is still not what it was before this battle to overturn AHS’ unilateral decision to dismantle our user-run homecare services.

As I reflect on the events which led up to, and transpired during, our battle with AHS to save our user-run homecare services, I remain most disturbed by the way in which the political priorities of cost-saving and efficiency – both of which seemed to be defined with only the short-term gains in mind, without a thought to the long-term consequences – totally eclipsed any consideration of the ethics involved in implementing an arbitrary policy change on a vulnerable constituency. At one point during Creekside’s meeting with representatives from AHS Homecare, I asked this question: *“The first principle in AHS’ Code of Conduct is: “Treat people with respect, compassion, dignity and fairness.” Please explain to us how AHS’ decision to unilaterally impose its will on Albertans with disabilities without any form of consultation whatsoever complies with this principle?”* The only responses I received were several blank stares. It reminded me of debates I’ve had with my teenaged niece, who, when confronted with an aspect of an issue that she hadn’t considered, will simply roll her eyes and say, “Whatever!” I

cannot help but remain fearful of a healthcare system that can so easily ignore or dismiss basic ethical principles, such as beneficence and respect for patient/client autonomy, when implanting policies it deems to be “fiscally-responsible.”

There is no guarantee that similar breaches of ethics and common sense will not recur. In fact, at the time of this writing (almost two months after their reinstatement was announced), the three user-run homecare service providers in Edmonton have yet to receive long-term contracts from AHS, and are currently still only operating on month-to-month provisional contracts. This is indicative of the enduring need to keep asking the question of a healthcare system which seems to have developed a propensity for riding roughshod over the basic rights of some of its most vulnerable constituents: Where *have* all the ethics gone?

A similar version of this article first appeared in the Canadian Journal of Disability Studies: cjds.uwaterloo.ca

Direct-to-Consumer Genetic Testing

Dick Sobsey, EdD

Professor Emeritus, Educational Psychology and John Dossetor Health Ethics Centre, University of Alberta

In November 2007, the genomics and biotechnology company, 23andMe, began accepting clients, offering direct-to-consumer (DTC) DNA analysis to any Americans willing to pay \$999 for the information amid howls of criticism. A lot has changed since then.

Other companies, such as deCODEme, Navigenics, Pathway Genomics, and Knome, also began offering DTC genetic health screenings. In early 2008, 23andMe made their service available to Canadians. The number of genetic probes sampled by 23andMe has increased from about 30,000 to more than 500,000. The cost of genetic screening has dropped from \$999 or higher to just \$99. The number of

individuals tested has increased from a few to hundreds of thousands, and continues to grow.

Currently, the 23andMe screen provides information in each of four major areas (1) Health Risks, (2) Drug Response, (3) Inherited Conditions, and (4) Traits. The Health Risks area lists approximately 120 conditions grouped in to three major categories: (a) increased risk, (b) decreased risk, and (c) typical risk. Links from each condition provide more information about each condition including links to scientific studies and information on possible actions that can be taken to control risks. The information provided is clear and useful, however, it is important to recognize that

additional genetic and environmental risk factors that are not part of this screen may also influence risk.

The Drug Response area provides information about genetic influences on responses to 22 drugs. For example, it provides information about possible Coumadin hypersensitivity, response to beta blockers, and susceptibility to heroin addiction.



The 23andMe Inherited Conditions screening also tests for carrier status for about 50 autosomal diseases, including PKU, Tay-Sachs, type A Neiman-Pick and maple-syrup urine diseases. This is potentially useful information, however, negative results could be misleading in some cases. For example, the tests look for specific variants in the relevant genes, but there may be other known or unknown variants that are not tested. As a result, the lack of identification of a problem with a gene does not guarantee that the gene is properly functioning.

The Traits area provides interesting information but most seems to have limited practical value. For example, one would probably already know if his or her hair was curly without the benefit of genetic testing. In addition to the health-related information, the 23andMe test also provides extensive genealogical information as part of the genetic screening.

Ethicists and healthcare providers have raised many ethical issues with DTC testing. Those getting bad news about their genetic risk for diseases might believe these are inevitable outcomes, and therefore

do less to prevent these problems. People getting good news about their genetic risk factors might assume they have little or no risk and make fewer efforts to control lifestyle factors. Because people access the results of their tests without the assistance of professional healthcare providers, they will be less likely to engage with professional help. People may be devastated to find out that they are at high risk for conditions that they may be unable to do much about. People receiving results from DTC testing may feel less need for contact with the traditional healthcare system. People may have their lives disrupted by unanticipated genetic surprises, for example, some father-child relationships might be genetically contradicted. Without the benefit of professional genetic counselors, information received about genetic risks or conditions is likely to be misunderstood. Because of these and many other concerns, there have been calls for outlawing DTC DNA tests or at least bringing it under the control of the traditional healthcare system.

The concerns are legitimate, but need to be put in perspective. There are also a lot of potential benefits, 23andMe and some other companies have attempted to address many of these issues through education and informed consent procedures, and some potential concerns have been shown to be less problematic than assumed. Overall, research studies have suggested that negative outcomes have been less frequent and less severe than predicted, but also have suggested that the potential benefits have been exaggerated (e.g., Saukko, 2013). Perhaps genetic information is not fundamentally different than other healthcare information available to consumers. Home blood pressure monitors, thermometers, home pregnancy tests and many other products are available to consumers. All can provide real health benefits, but they are not panaceas and can have negative effects, such as diverting some individuals from proper assessment and care.

Some of the identified concerns seem to assume that risks identified in DTC testing don't already exist in the traditional system. For example, without the involvement of healthcare professionals, individuals who are tested may misunderstand test results. This is

true but seems to assume, however, that the traditional health care system consistently provides consumers with information that is accurate, unambiguous, and well-understood. Unfortunately, this is frequently not the case (e.g., Browner et al., 2003).

After six years of rapidly growth practice of DTC genetic testing, it is no longer a question of whether

we should allow it to exist or even whether it should be encouraged or discouraged. It does exist, and the challenge we now face is how do we better incorporate it into our existing healthcare system? This will require additional education for many physicians (e.g., Bernhardt, 2013) and better methods for linking the results of DTC testing to healthcare providers.

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Dr. Austin Mardon: Living Well with Schizophrenia

Kate Holt

Stewardship Officer, Office of Advancement, University of Alberta

“Life is what happens to you while you are making other plans,” said Dr. Austin Mardon during his convocation address in June of 2011. Austin should know. A promising geographer from a family of academics, Austin participated in a meteorite recovery expedition to the South Pole, became a successful writer, and obtained two master’s degrees before being diagnosed with schizophrenia at age 30.

Schizophrenia affects one percent of people over the age of 18, with symptoms typically appearing in the late teenage and early adult years. Last year, Austin and his wife, Dr. Catherine Mardon – both of whom are strong advocates for the mentally ill – established The Catherine & Austin Mardon, CM Schizophrenia Award. Funded by Janssen, Inc. as well as friends and associates of the Mardons, the scholarship is the first post-secondary award in Canada for a student, or a student with a family member, who has been diagnosed with schizophrenia.

Austin was only 24 years old and a graduate of the University of Lethbridge when he travelled to the South Pole on a meteorite recovery expedition sponsored by NASA and the National Science Federation. Austin successfully recovered 700 meteorites and received the U.S. Antarctic Service Medal for his work, but the extreme hardships of the journey took a toll both mentally and physically. He went on to earn masters degrees in both science and education and became a published author, but his health issues persisted. His subsequent diagnosis of schizophrenia in 1992 came as a shock. “I thought my life was over,” he recalls. Thankfully, he was wrong. “Ultimately it’s how you rise to the challenges put before you, how you give back to society and how happy you choose to be in the life you were given that matters.”

He and his wife, Catherine, have been widely recognized both provincially and nationally for their advocacy efforts. In 2007, Austin was the first person

with schizophrenia to become a member of the Order of Canada. He is also a recipient of an honorary doctorate from the University of Alberta. Although some of his abilities were compromised by the disease, Austin earned a PhD in geography from Greenwich University, Australia; continued to publish, including articles in both *Science* and *Nature*; was elected an International Fellow and Corresponding Fellow of the Explorers Club of New York; and was inducted into the International Academy of Astronautics. Austin is currently an Assistant Adjunct Professor at the John Dossetor Health Ethics Centre.



“Schizophrenia throws up so many barriers in life – especially in pursuing education. Money should never be one of those barriers. It is our hope that this scholarship will help in a small way,” said the Mardons when they established their award.

“This scholarship is a wonderful opportunity and an example of the great work Austin and Catherine are doing to create opportunities for people living with mental health challenges,” says Lieutenant Governor of Alberta, Donald S. Ethell. “I trust that it will help current and future recipients complete the education they need to fully maximize their potential.” His Honour is the founding patron of the Lieutenant

Governor’s Circle on Mental Health and Addiction. His interest in and support for mental health initiatives grew out of his own experience with PTSD, which he developed following his long military career.

Applications for the Mardons’ scholarship are available through the University’s Specialized Support and Disability Services (SSDS); the annual deadline is Sept. 30. For information on how to apply, go to: <https://www.registrar.ualberta.ca/ro.cfm?id=574> For information on Austin’s published work, visit his website at www.austinmardon.org.

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Phone: 780-492-6676 Fax: 780-492-0673

Mail: John Dossetor Health Ethics Centre, 5-16 University Terrace,
University of Alberta, Edmonton, Alberta T6G 2T4

Best regards,

John Dossetor Health Ethics Centre

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RETURN UNDELIVERABLE CANADIAN ADDRESSES TO
University of Alberta
John Dossetor Health Ethics Centre
5-16 University Terrace
EDMONTON, AB T6G 2T4
Email: dossetor.centre@ualberta.ca

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Editor • Paul Byrne

Assistant Editor • Carol Nahorniak

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John Dossetor
Health Ethics
Centre



John Dossetor Health Ethics Centre
University of Alberta
5-16 University Terrace
Edmonton, Alberta, Canada T6G 2T4
Telephone: (780) 492-6676 • Fax: (780) 492-0673
Website: www.bioethics.ualberta.ca/
Email: dossetor.centre@ualberta.ca

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