
Bioethics Outlook

Plunkett Centre for Ethics

A joint centre of Australian Catholic University and St Vincent's Health Australia (Sydney)

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Vale Nicholas Tonti-Filippini

Nick was all that a friendly colleague ought to be: helpful when needed, cooperative in joint endeavours, penetrating in his evaluation of ideas and their expression, amused at and amusing about the intellectual and practical challenges in healthcare today. Another colleague said that, when he sought Nick's advice, it was always prompt and deep. What an accolade that is for someone in our line of work!

In 1982 Nick established one of the first bioethical research centres around the world. History should record our debt to Dr Joe Santamaria, Sisters Rose Holman rsc and Maureen Walters rsc at St Vincent's Hospital –and the other Catholic intellectuals in Melbourne - who first identified the need for that work of the Church, found the money to set it up, and engaged the young Nick to be researcher, organizer, teacher, adviser. For many years Nick (as the face of the St Vincent's Bioethics Centre) and Peter Singer (as the face of the Monash Bioethics Centre) led a robust and courteous debate about bioethical issues - addressing both the fundamentals and the current issues - from which a most diverse audience, here and overseas, Catholic and non-Catholic, has long benefitted.

Nick's contribution to the now-essential tool for doctors, nurses, managers, members of boards – the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* - was invaluable. Of course, Nick had written an important source document for us - an account of the philosophy of health care of the Sisters of Charity in Australia. But he also actively engaged in the discussions of the Steering Committee about the content and style of the *Code* (from memory he also threw in an occasional opinion about some of the arguments which were so ably refereed by Bishop Michael Putney!), and made a critical contribution to our careful consideration of the very many suggestions we received on the two occasions on which we went out to public consultation. And the same can be said of the calibre of his more recent contributions to the development of Catholic Health Australia's tools for good advance care planning.

It is in no small part because of Nick's insistence that responding to the needs of the donor's grieving family – in particular their need for assurance that the person who will be the donor truly is dead - that transplantation here in Australia is conducted according to the highest ethical standards. And, thank God, he has left us with his multi-volume series *About Bioethics*. We shall miss Nick enormously, as a colleague and as a friend. Our heartfelt condolences go to Mary and the family.

May dear Nick rest in peace!

How did patients become ‘consumers’?

Bernadette Tobin

A couple of years ago, the *New York Times* columnist Paul Klugman drew attention to the fact that, in the debate about the introduction of the *Affordable Care Act*, a budget proposal was recommended on the grounds that it would ‘make health care programs more responsive to consumer choice’.¹ Klugman asked: “How did it become normal, or for that matter even acceptable, to refer to medical patients as ‘consumers’? The relationship between patient and doctor used to be considered something special, almost sacred. Now politicians and supposed reformers talk about the act of receiving care as if it were no different from a commercial transaction, like buying a car – and their only complaint is that it isn’t commercial enough.”

Perhaps it became ‘normal’ with the recovery – in the second half of the twentieth century - of the idea that the patient is the person with the primary responsibility for decision-making in healthcare, an idea which is often referred to as the ‘principle’ of respect for patient autonomy. On some crude versions of this idea, the patient is to be treated as customer, able not only to refuse treatments but also to demand them! On more reasonable versions, the patient (and his or her family and carers) needs to be involved in decision-making, encouraged to engage actively in the doctor-patient relationship, relying on the knowledge, expertise and experience of the doctor but also identifying - in advance of emergencies- his or her priorities for and hopes of treatment.

Or perhaps it came with the introduction – from the USA - of the language of the market into the provision of healthcare. Or with the need, in countries in which health care is a publicly-funded good, to keep the costs of healthcare down, as though sending a price signal to ‘consumers’ might help in that regard!

My own view is that, in Australia at least, the *motivation* for this change in language has been the admirable one of trying to encourage healthcare practitioners to fulfil their duty adequately to inform patients and their families of the burdens and risks, as well as the hoped-for benefits, of prospective treatments. That certainly seems to be what lies behind the use of this language in the *National Safety and Quality Health Service Standards* which were published in 2011 by the Australian Commission on Safety and Quality in Healthcare.

However, healthcare is not a consumer good. As Klugman says, you can choose to replace your existing car, and what you spend on it, but generally - because illness, injury, disability are themselves not chosen - whether you need health care is not a choice. You get pneumonia. You find a lump in your breast.

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¹ *New York Times*, 21 April 2011

Do we have a right to assisted suicide?

Frank Brennan, SJ

Physician assisted suicide and euthanasia are back in the courts of Canada and the United Kingdom, and back in the parliaments of the United Kingdom and Australia. Last month, the Supreme Court of Canada finished hearing a case in which the applicants claim that a 1993 Supreme Court decision upholding the criminal ban on euthanasia should be overruled. On Friday, the House of Lords will resume debate on Lord Falconer's *Assisted Dying Bill*.

Their Lordships will be looking forward to what they think is the appropriate law and policy on assisted suicide, while looking back at a recent decision of the UK Supreme Court which has said there is a need to consider the European Convention on Human Rights' requirement that everyone is entitled to respect for their private life. Next Monday, the Australian Senate will receive a committee report on the Greens' appallingly drafted *Medical Services (Dying with Dignity) Exposure Draft Bill 2014*.

A word about each development. No law is ever perfect. Any law can work an injustice in a particular case. That's why we have prosecutors and courts which can exercise discretion. Wherever you draw the line in criminal law, there will always be just and compassionate exceptions you would want to see made on one side of the line, without always moving the line and starting the exercise again. Until 50 years ago, attempted suicide was a criminal offence. Seeing there were better ways to dissuade people from attempting suicide and acknowledging that no purpose was to be served by punishing someone who failed to kill themselves, parliaments abolished the offence of attempted suicide, while retaining the offence of assisting someone else with their own suicide.

With developments in medical technology, patients could avail themselves of life sustaining procedures like respirators. Exercising their autonomy, patients were entitled to ask that the respirator be turned off. If death resulted, the doctor was not liable. In 1993, the Canadian Supreme Court said there was a world of difference between turning off life support at the request of a rational, competent, non-depressed patient and administering a lethal injection to such a patient. The first was allowed; the second was not.

The Canadian Supreme Court has now been asked to rule that the distinction between withdrawing life support and administering a lethal injection is ethically contested and contrary to the Canadian Charter of Rights and Freedoms which guarantees everyone the right to life and the right 'not to be deprived thereof except in accordance with the principles of fundamental justice'. The Charter also guarantees equality before the law without discrimination based on mental or physical disability.

The argument runs like this. Since attempted suicide is no longer a criminal offence, everyone has the *right* to commit suicide. A person with a terminal illness and in great pain can decide to commit suicide whenever they wish. But if that person were suffering increasing disability, they would need to commit suicide earlier, while they are still able to perform the death-dealing act. If they were allowed to get assistance with someone else performing the death dealing act, they could decide to live longer, even as long as a person without disability, before then committing suicide with assistance. Unless they have the *right* to assisted suicide, they are being deprived their full right to life contrary to the principles of fundamental justice, and in a discriminatory way. So a law which bans the provision of assistance with suicide is said to be unconstitutional.

The argument against this proposition is that the law banning such assistance can be 'demonstrably justified in a free and democratic society', being necessary to protect the vulnerable in society (whether abled or disabled) who may feel pressured into seeking such assistance or who may be tricked, cajoled or soothed into seeking such assistance in order to satisfy the needs and desires of others, including selfish relatives and overstretched medical personnel.

There is no *right* to commit suicide with a correlative duty that the state support the person wanting to commit suicide. There is only a *liberty* to commit suicide with an immunity from state interference. It is likely that the fairly 'liberal' Canadian Supreme Court will recognise a constitutional right to commit suicide and cut back the outright legal prohibition on providing assistance with suicide.

Over in London, Lord Joffe has four times introduced bills to the House of Lords seeking some form of legalised assistance with dying. Each bill has failed. He has passed the baton to Lord Falconer, who is now making his second attempt with his *Assisted Dying Bill*. Lords Joffe and Falconer were amongst the 42 lords who debated the measure in July. When debate resumes on Friday, the lords will be considering a bill which restricts the assistance by a medical practitioner to preparing medicine for self-administration or preparing a device like one of Philip Nitschke's machines for self-administration of the medicine. The bill specifies that 'the decision to self-administer the medicine and the final act of doing so must be taken by the person for whom the medicine has been prescribed'.

In July, Lord Falconer told the House of Lords, '*I have built on the Oregon model, but with more safeguards. I reject the Belgian and Dutch approach.*' He is anxious to avoid arguments about slippery slopes and developments in Belgium and the Netherlands where doctors have performed euthanasia on non-competent patients and on patients who are not suffering terminal illness. To get his bill through, Lord Falconer is even prepared to consider further safeguards. Looking to the UK Supreme Court's recent decision, he has favourably quoted the Chief Justice Lord Neuberger who wrote:

A system whereby a judge or other independent assessor is satisfied in advance that someone has a voluntary, clear, settled, and informed wish to die and for his suicide then to be organised in an open and professional way, would, at least in my current view, provide greater and more satisfactory protection for the weak and vulnerable, than a system which involves a lawyer from the DPP's office inquiring, after the event, whether the person who had killed himself had such a wish, and also to investigate the actions and motives of any assister, who would, by definition, be emotionally involved and scarcely able to take, or even to have taken, an objective view.

Lord Falconer has told the Lords:

'Some say that the courts should be involved as an additional safeguard before an assisted death occurs. We should constructively consider that issue in Committee.'

Meanwhile the Australian Senate is considering a much broader proposal than Lord Falconer's bill. The Greens have formulated the fuzzy notion of a medical practitioner providing 'dying with dignity medical services' including the administration of a lethal substance to a patient at their request. Their bill, unlike the UK bill, would allow Philip Nitschke to administer the fatal injection. Their bill includes the form to be filled in by the patient seeking dying with dignity medical services. The form is so shoddily drafted that it does not even specify a request for any particular services. It is simply a blank cheque given to the doctor stating: 'I am satisfied that there is no medical treatment reasonably available that is acceptable to me in my circumstances.'

The Bill provides: 'No civil, criminal or disciplinary action lies, and proceedings must not be brought, against a person in relation to an act done, or omitted to be done, if the act is done, or omitted to be done' in accordance with the proposed Commonwealth law. This is a constitutional nightmare and a federal mess-up of truly Green proportions. The criminal law in this area is a matter for the States. If you want certainty in the criminal law, which you do, you change the criminal law in question. You amend the State laws on assisted suicide. You do not have the Commonwealth coming in over the top to offer immunity from prosecution for an action which is still a criminal offence in the States.

More problematic is the doubt about the constitutional power of the Commonwealth even to make such a law. It would be like the Commonwealth legislating a new criminal law in relation to abortion. It is a State issue, not a Commonwealth issue. The only time the Commonwealth bought into euthanasia was when the Commonwealth Parliament overrode a law of the Northern Territory. There has never been any suggestion that it would or could override a law of the States. The Greens have not helped anyone with this half-baked exercise.

Lord Sumption stated the issues well in the UK Supreme Court:

There is no complete solution to the problem of protecting vulnerable people against an over-ready resort to suicide...The real question about all of these possibilities is how much risk to the vulnerable are we prepared to accept in this area in order to facilitate suicide for the invulnerable...There is an important element of social policy and moral value-judgment involved. The relative importance of the right to commit suicide and the right of the vulnerable to be protected from overt or covert pressure to kill themselves is inevitably sensitive to a state's most fundamental collective moral and social values.

Keeping an eye on developments in Canada and the UK, we Australians need to be clear about the social, philosophical, legal and constitutional issues involved when contemplating our own amendments to the law and practice of assisted suicide.

Frank Brennan SJ, Professor of Law at Australian Catholic University, is presently Gasson Professor at the Boston College Law School. This opinion piece first appeared in Eureka Street. Fr Brennan tweets at @Brenna1n

How did patients become 'consumers' ? Continued from page 2

You are involved in a car accident. When you develop a medical problem, you *need* health care, and generally you will not be able to compare prices as savvy consumers can. So the decision to have genuinely-needed healthcare is not discretionary in the way that buying clothes or a new car is. (That said, the *timing* of a so-called 'elective' procedure may be related to capacity to pay. If is an emergency the public purse will provide it immediately; otherwise you may have to wait.)

The distinction between genuinely-needed health care on the one hand and cosmetic interventions on the other is generally clear. Most breast augmentation, face lifting, surgical alteration of the feet, etc, has nothing to do with the restoration or maintenance of health or the relief of symptoms of ill health. So the doctors who use the knowledge and expertise they acquired in medical school for these purposes do stand in a relation of 'provider' to 'consumer' rather than 'doctor' to 'patient'. But it would be regrettable if all healthcare were assimilated to that model. People who seek relief from illness, pain, disability, anxiety, depression are patients in the original sense of that word: they suffer from something that has happened to them, a *pathos*, and they seek help from someone they trust is committed to their health and organic well-being.

And, finally, what does a conception of patients as 'consumers' imply about justice in the allocation of a society's health care resources? It seems to suggest that we should allocate healthcare as we do cars: Lamborghinis for some and FJ Holdens for others. Would that be just? Surely genuine healthcare ought to be allocated on the basis of sheer need, regardless of capacity to pay. In the end that is why we should reject the language of the market in healthcare. It corrupts a Hippocratic commitment, on the part of the doctor and the nurse, to the well-being of the sick person.

In Memory of

Nicholas Tonti-Filippini

Raymond Campbell

I am greatly honored to have been asked to speak of my dear friend and colleague Nicholas today. I am also a little wary. I am afraid that if I get something wrong Nick will still find some way of correcting me!

I dare say that not a few of us have had that experience of being chided by Nicholas, but always done in the interest of pursuing what was true and good.

It would be impossible to do justice to Nick's career in the short time allowed. Fortunately I don't have to because Nick has done it for me in the Preface to his first volume of *About Bioethics*.² So I recommend it to you. But I want to highlight some of the ways in which Nick has contributed to Bioethics in Australia and around the world.

Service to bioethics

In 2009 Pope Benedict XVI appointed Nick a Knight Commander of St Gregory the Great for services to Bioethics and the Church. That word, "service", sums up Nick's approach to all that he did and sets an example for us all. For Nick ethics was not an academic discipline. It was not a career. It was a vocation, and it was a vocation of service. He never set out to build a career. He set out to be of service -- whether it was at St Vincent's Hospital and the Bioethics Centre, working for the bishops, working as a private consultant, or as a member of the staff at the John Paul II Institute for Marriage and Family.

Nicholas also tried to instill into his students that same idea of being of service through rigorous but sensitive thought and argument.

St Vincent's Bioethics Centre, Melbourne

I first met Nick over the phone in the latter part of 1982. A mutual acquaintance had mentioned to Nick that I had just returned after three years overseas studying Moral Philosophy. I was living in Sydney and Nick rang up and introduced himself, told me a little

² Nicholas Tonti-Filippini. *About Bioethics: Philosophical and Theological Approaches*, Vols 1-4. Connor Court Publishing, Ballan, 2011

about the St Vincent's Bioethics Centre which had just been established, and asked if I would be involved from a distance.

Little did I realize that phone call would be the start of over thirty years of friendship and collaboration.

Reflecting upon that phone call leading up to today I realized that that call in itself displayed part of Nick's character and his contribution to bioethics – his willingness to reach out to others and engage them, whether it be in a joint project, or in a conversation to clarify some issue in the search for truth. I would guess there are many people who have received such phone calls or emails, and have been enriched because of it.

Engagement with others

This willingness to engage with others was manifested in various ways during his life. He was great at organizing conferences, beginning from the time he was at the St Vincent's Bioethics Centre. These conferences caused consternation amongst some people because Nick was always ready to engage with those with whom he disagreed. He would invite people from "the other side" to speak at those conferences. This displayed both his willingness to try and understand the other point of view, and also his confidence in the position of the Church. In more recent years this continued with the hosting of the Bioethics Colloquium, and I believe that Professor Tracey Rowland, as Dean of the Institute, has received calls from some still wondering whose side Nick was on because of whom he was inviting to speak!

Mention of the Colloquium highlights another example of Nick's desire for collaboration and dialogue. He was the prime mover in setting up the Australian Association of Catholic Bioethicists, under the auspices and with the support of the Order of Malta, of which Nick was an esteemed Knight of Obedience. Nick had earlier played a part in establishing the International Association of Catholic Bioethicists. Both associations were formed to help Catholic Bioethicists meet with each other and with experts in other fields in order to collaborate in the defense of human dignity. So you could sum it up by saying that Nick contributed greatly to the building up of the Bioethics community here in Australia and around the world.

This brings me to Nick's contribution to substantial issues in Bioethics. Once again, how can I list them all? I mention two which I think are particularly significant and which illustrate the different contexts in which he worked.

Involvement here and abroad

Nicholas made a significant contribution to the development of the Church's thinking in regard to Assisted Reproductive Technologies. He was involved in discussions and debates in Rome which preceded the publication of *Donum Vitae*, the Church's first official

document responding to the new reproductive technologies. Secondly, while serving as a member of the Australian Health Ethics Committee, Nick chaired the working committee drawing up guidelines for care of people in what we now call “the unresponsive state”. Those guidelines were a great achievement and owe much to Nick’s contribution both as an ethicist and as Chair.

Both those examples demonstrate Nick’s approach to Bioethics. As he expressed it in his book his approach was straightforward. “It is that every member of the human family possesses inherent dignity and consequently has equal and inalienable rights.” The defense of the dignity of the human person sums up the core of Nicholas’s service to all.

But how he went about doing that changed over the years. Nicholas was never one to stand still and keep on repeating what he had been doing.

Proposing a new approach

Through his experience on government committees, another of his contributions to Bioethics, he began to change his conception of how best to enter into public dialogue. Like many of us in the early days he tended to take a natural law approach, which although not denying his own theological foundations, tended to be predominantly philosophical. Even then Nick had his own way of presenting things. You could never quite push Nick into a particular school of thought. While influenced by the views of others, he was always an independent thinker.

He decided a purely philosophical approach did not really work. Instead he proposed an approach which involved more of a sharing of one’s own personal culture, including one’s religious beliefs, and then looking for values which were common. Nicholas believed that this allowed us to be much more explicit about our theological faith and for a much healthier relationship between our faith and philosophy. Once again this reflected Nick’s own character. Although he was known as a philosopher, Nick was first and foremost a man of faith, and more explicitly, of Catholic faith. You cannot begin to understand Nick without understanding his great faith in and love of God – a faith and love which grew through his marriage to his wife Mary.

Made in the image of God

Nick had always considered our work in Bioethics to be a part of evangelisation. In his latter years he made this more explicit. He moved from speaking about the dignity of the human person in philosophical terms to speaking more and more in terms of the human person as the *imago Dei*, the person made in the image and likeness of God. Nicholas was developing a much more theological approach to Bioethics. During this past year Nick

and I have been team teaching two subjects in Bioethics in Brisbane. If any of you have been courageous enough to team teach with Nick you know that it could be a challenging experience. He could take on the role of the questioning student! But of course he was not your average student.

During one of our conversations I suggested to him that rather than getting involved in arguments about other approaches, he needed to focus upon developing further his theological approach, as there was still much to do. He seemed to accept my advice and said that was what he would do.

He has not been able to complete the task, but whoever has. So he has left us, his colleagues and students with work still to do. But he has given us a rich heritage on which to build.

Teacher

The final contribution I would like to mention is Nick's contribution to the teaching of Bioethics. Nick loved being part of the John Paul II Institute for Marriage and Family. In many ways, it was just made for him. It brought together the things he was passionate about. I know he was loved and respected by his peers and students. Even here Nick would not stand still. He was always probing for better ways to help the students learn and develop their thinking. He undertook and completed a fellowship with the Higher Education Research and Development Society of Australasia and encouraged his fellow lecturers to do something similar. Once again he has left us some of his reflections in his first volume.

There is so much more I could say, and I know there are people who could add so much more. We will find ways to pay our tributes to this great man.

Family

I cannot finish without paying tribute to Nick's wife Mary and his family. As I searched for the words to say, I realised that once again Nick had done it for me. In the Preface I have referred to Nick wrote: "With my illnesses, Mary has had much to endure, and if I have achieved anything worthwhile it is because she has provided so much love and support, including having given me four children, Claire, Lucianne, Justin and John. My education owes much to them."

I think many of us can say that our education owes much to Nicholas. He was a good and faithful servant who did not hide his light under a bushel. I thank God he was my friend.

This eulogy was given at the Requiem for Nicholas Tonti Filippini, Melbourne, 18 November, 2014.

Give the ill help to die well – not lethal doses

Anthony Fisher, op

On Wednesday, a Senate Committee will hear evidence on a euthanasia bill that would allow some people to be given a lethal injection on compassionate grounds. I understand why some people want this.

It's often because someone they've known and loved has had a "hard dying". Or because they are exhausted from caring for someone who is dying very slowly. Or because they are afraid of their own decline. I sympathise with these reasons. I know that those who support euthanasia are not all grizzly Dr Deaths. This challenges me to think about what "a good death" means and how our community responds to the elderly, frail, disabled and dying.

But, however well-meaning, I don't think giving people a lethal dose is the answer. Reason and experience show that euthanasia cannot be made safe, because no law can prevent abuse in this area. In places such as the Netherlands and Belgium the numbers being medically killed are escalating and the range of cases keeps expanding beyond the "last resorts" for which euthanasia was first sold to the public.

Now people who are not terminally ill, or even physically ill, people who haven't volunteered or can't volunteer, can legally be killed in those places and some want to extend it further – for example, to long-term prisoners and children.

Attempts to limit euthanasia by legalising and then regulating it have failed. You can't prevent the subtle or overt pressure to request euthanasia. You can't stop people feeling or being made to feel they are a burden. You can't stop bean counters thinking some people should just hurry up and die.

Euthanasia is not just a private matter, because it draws medical professionals, regulators and the whole community to the bedside. It makes us all complicit. It asks us all to agree that some people are better off dead and that our laws and health professionals should make them dead.

Once we've accepted that some old people can be killed, why not some others? Why should it be restricted to the very sick? What about younger people who want it? People who are just sick of life? People who are unconscious or too young or disabled to consent?

It's not that I'm a nervous "slippery-slope", it's just a matter of following the logic of the argument for giving some people a lethal dose. Having undermined the principles that doctors never kill patients and that our state will not sanction killing, we will have changed what doctors are and what our justice system is. We will have changed how we relate to the "unwanted" people.

“Of course he’d say that, he’s a bishop”. But it’s not just Christian leaders who worry about these things. Many believers, many secular thinkers, share the idea you should never kill innocent people.

Human dignity, human rights, human “unkillability”, can’t be lost or volunteered away. They don’t depend on how healthy, useful or wanted you are. Palliative Care Australia says that, were all people given good palliative care, they would be able not only to live well in their illness, but to die well, too.

My pastoral experience concurs: instead of signalling to people that their life is not worth living, we should ease their sense of meaninglessness in suffering. Sadly, many people lack such care at the end. Compassion demands we offer everyone real care, even when it’s hard, rather than a lethal injection.

Euthanasia cannot be made safe. It makes vulnerable people more vulnerable and suffering people suffer more. Surely we can do better in Australia than inviting them to “volunteer” for early death.

This opinion piece first appeared in the *Sydney Morning Herald* on 15 October, 2014. Anthony Fisher op, then the Bishop of Parramatta, has since been installed as the ninth Archbishop of Sydney

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