
BIOETHICS OUTLOOK

Plunkett Centre for Ethics in Health Care

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Responsibilities to those who are dying

Plunkett Centre's submission to NSW Health Department's review of "Dying with Dignity" Guidelines

In this issue

It is now less than two months to our Intensive Bioethics Course for 2001. This year we are holding it over one and a half days on the first weekend in June. The location is Anderley Lodge in the Mary McKillop Centre in the heart of North Sydney: if you have been to a conference there, you'll know what a lovely location it is. The registration form contained within this copy of *Bioethics Outlook* gives details of the program. In addition to speakers who have participated in previous IBCs, this year we are pleased to announce that the well-known and well-respected philosopher, Dr Stephen Buckle, will give the keynote address: *Is science really ahead of ethics?*

There are two articles in this issue. The first is an edited version of the submission we made to the Review of NSW's Dying with Dignity Guidelines.

The second is a review by Sr Mary Byrne of Helen Watt's recently-published introduction to the ethics of health care.

In 1993, the NSW Health Department issued guidelines on the treatment and care of people who are dying. The guidelines were called '*Dying with Dignity: Interim Guidelines on Management*'. Their purpose was to assist health care workers in making decisions about the care of dying patients. Whereas some Australian states had enacted specific legislation to ensure that people receive (only) those kinds of medical treatment which they wish to have administered to them in the last part of their lives, in particular in circumstances in which they are not able to speak for themselves, New South Wales had addressed the question by way of guidelines to health care practitioners which were intended to clarify good clinical conduct within the context of existing law.

During the course of last year, the NSW Health Department began the process of revising and updating its guidelines. Each Area Health Service in the State was asked to nominate someone with 'expertise in the management of dying patients' to comment on the *Interim Guidelines* and to suggest ways in which they might be improved. Their comments were summarized and circulated widely towards the end of the year in the form of a *Revised Draft*. The draft was organized into the following sections:

background, aims, principles for the care of dying patients, developing and documenting a management plan, related issues, glossary and references.

In order to prepare a submission on the proposed *Revised Draft*, the Plunkett Centre, along with the Bioethics Consultative Committee of St Vincent's Hospital and the hospital itself, sponsored a well-attended public seminar at which the Health Department's proposals were discussed. Our joint submission was greatly informed by the views of clinicians and other health care practitioners who attended the seminar. What follows here is an edited version of that submission.

Title

We urged that the title of the guidelines be changed. The *Interim Guidelines* were called 'Dying with Dignity', an expression coined by the movement of people in favour of legalizing euthanasia as a slogan to convey a particular view about the role of the law. However, since a primary purpose of New South Wales' guidelines is to assist practitioners comply with the *existing* legal framework in which euthanasia (understood as the intentional hastening of death in order to relieve the patient's suffering) is illegal, the title was apt to confuse health care practitioners.

And we argued that the title should underscore the fact that the document is addressed in the first place to health care practitioners (even though it may serve a secondary purpose of helping to inform members of the public of their legitimate expectations, responsibilities and rights as patients in hospitals or residents in aged care facilities). The emphasis in the title should be on the responsibilities of healthcare practitioners. We suggested that a suitable title might be: *Responsibilities to those who are dying*. Given the desirability of a short and memorable title, we added that it should be accompanied by an accurate and informative sub-title: for example *Guidelines on the treatment and care of people who are nearing the end of their lives*.

We also recommended that the fact that the guidelines are intended to clarify the existing legal framework, which does not permit euthanasia, should be reinforced in the following way:

These guidelines do not endorse euthanasia, that is, any action or omission which of itself and by intention causes death with the purpose of eliminating all suffering.

Euthanasia must be distinguished from other care decisions which sometimes risk or have the effect of shortening life but which are not intended to hasten death (eg the giving of appropriate pain relief, the withdrawal of futile or burdensome treatments, etc). The withdrawal or withholding of inappropriate treatment is not euthanasia.

Aims

The *Revised Draft* proposed three aims: that the guidelines should 'provide assistance in making appropriate decisions relating to the management of dying patients', that they should 'increase awareness of the issue in the community', and that they should 'stimulate wide discussion'. We recommended that these aims should be revised in the following way:

- 1 *To set out the principles according to which medical treatment and health and nursing care should be provided to people who are nearing the end of their lives.*
- 2 *To set out the process for decision-making about medical treatment and health and nursing care at the end of life.*
- 3 *To assist health care practitioners to comply with the law in New South Wales with respect to end of life treatment, care and decision-making.*

We also recommended that a proposal about limiting the scope of the guidelines, in particular a proposal to say that they concerned only those patients whose death was imminent, should not be adopted. The kinds of thinking and planning and decision-making explained in them are relevant to the care of patients long before death may be judged to be imminent: the kinds of conduct they recommend should be associated with diagnosis rather than prognosis since they concern sorting out in advance the levels of care that will be appropriate at various stages.

In addition, the principles in the document should be expressed in such a way as to be applicable to any health care scenario (intensive care unit, hospice, home, community health service, etc) and to all kinds of patients, residents and sick people (eg to elderly people who are no longer able to care for themselves, to those who are subject to accidental or traumatic death, to the persistently unconscious (those in a so-called 'persistent vegetative state' ('pvs')). Of course, health care practitioners working in each of these area may need to develop their own specific protocols to apply the principles and procedures sketched in the guidelines to the care of the particular kind of patient for whom they are responsible.

Principles

The *Interim Guidelines* of 1993 listed five principles as setting the framework for consideration of decisions appropriate to patients who are dying: respect for life, patient autonomy, consultation, access and professionalism.

The principles set out in the *Revised Draft* may be summarized in the following way: patients have a right to be fully informed of their condition and progress ... ; competent patients have a legal right to accept or refuse medical treatment; where a person is unable to consent to medical treatment; the clinicians are to discuss care and treatment options with the 'person responsible' for giving 'substitute consent'; a holistic approach that integrates social, cultural, psychological and spiritual

factors is taken to care for the dying patient ... ; care for the dying patient should affirm life and support them to live as actively as possible until death ... ; decisions made about treatment during the dying process are reviewed and discussed with the patient and family regularly as changes occur ... ; care of the dying patients should include support for the family and significant others ... ; guidance, support and counselling are provided for health professionals who are involved in the care of patients... .

We thought that the principles cited in the *Revised Draft* represented an improvement on those in the *Interim Guidelines* of 1993. For it is appropriate to emphasise the right to refuse any form of treatment. Because of the emphasis in society on autonomy, and the awareness of cultural differences about the desirability of being informed, the principles in the *Revised Draft* may readily spring to mind as first principles.

However, we argued that it was nonetheless wrong to start with the idea of the patient's right to be informed, and that in so doing *Revised Draft* omits the *key* idea which frames this part of medicine and health care. Health care practitioners need to understand clearly what the point is of all their interventions, etc, at what they are aimed. They need to know this very clearly because it is this concept which explains why medicine has its own proper limits, what it means to say that even a life-prolonging treatment may be futile, why futile treatment should not be offered or administered, why overly-burdensome treatment should not be offered or administered, why pain and other symptoms should be effectively relieved, and how requests for unreasonable treatment should be handled. Understanding the purpose of medicine clarifies the scope of medical and healthcare practice. So, it is absolutely crucial that the principles begin with the idea that health care has its own 'ends' or 'purposes' or 'goals': otherwise the value of a principles-based approach will be lost. We therefore set out what we thought the principles should be and suggested how they might be worded. Our proposals were as follows:

1 Goals of healthcare, in particular at the end of life

Healthcare interventions ought to be oriented to the health and well-being of the patient or resident. They should aim to provide diagnostic or prognostic information, to improve or maintain a person's health by curing an illness or slowing the course of an illness or stabilizing the patient in a reasonably satisfactory condition, to relieve pain or other symptoms of illness, and to nourish and sustain the patient.

Good health care treats a person rather than a condition. When a patient is nearing the end of his or her life, two extremes should be avoided: on the one hand, over-treatment (an insistence on futile and overly-burdensome treatments which merely obstruct death) and, on the other hand, under-treatment (the deliberate withdrawal of treatment in order to bring about death).

2 Legitimacy of withdrawing or withholding futile or overly-burdensome treatment

Treatment may be legitimately withdrawn or withheld if it is either therapeutically futile (that is, makes no significant contribution to cure or improvement) or overly-burdensome (that is, the benefits hoped for do not justify the foreseeable burdens of treatment).

The benefits of treatment include preservation of life, maintenance or improvement of health, relief of discomfort. The burdens of treatment include pain, discomfort, loss of lucidity, breathlessness, extreme agitation, alienation, repugnance, cost to the patient. In some cases the burdens of treatment may also include excessive demands on family, carers or healthcare resources.

3 Responsibility for health care decisions

The person who is ill or dying is primarily responsible for making decisions about his or her health care. People are competent to make such decisions if they are able to understand their own condition and what is proposed and to evaluate healthcare options. Since people sometimes need to seek help and advice in making these decisions, particularly where they have serious consequences, this responsibility may at times best be exercised in consultation with others.

4 Responsibility to provide adequate information

To enable patients and residents to make healthcare decisions, practitioners should take care to explain clearly and accurately the person's condition, the nature of the treatment options, the person's prognosis with or without treatment, and the risks and harms inherent in any proposed treatment which the person would be likely to think significant in making a decision. This information-giving process may, however, need to take place over a period of time and the healthcare practitioner needs to be sensitive to individual and cultural difference)

5 Refusals of treatment must be respected

Since treatment may not be imposed upon a competent patient, any refusal of treatment must be respected. Healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, whether or not they agree with the patient's refusal.

6 No obligation to comply with unreasonable requests

Sometimes patients or relatives may request a test or treatment or place conditions on treatment which a practitioner or facility judges to be unreasonable. Practitioners should try to explain to the patient or relative(s) why they think the test, treatment or conditions are unreasonable and thus why they are not obliged to comply with the request. They should offer the patient or relative(s) the opportunity of a second opinion and, if appropriate, arrange for the patient to be cared for by another suitable practitioner.

7 Consent is always required for treatment

Except in the case of an emergency, tests or treatment should not be administered to any competent patient until all relevant information has been disclosed and considered and the patient's free and adequately-informed consent has been given. Care must be taken to ensure that the patient is competent to consent, and is not being coerced or intimidated.

Except in the case of an emergency, tests or treatment should not be administered to any incompetent patient until all relevant information has been disclosed and considered by the patient's legitimate guardian or representative, and the consent of that person has been given.

The decision of the patient's representative should be based on a judgment about what is in the patient's best interests. In making these decisions, those concerned should take into account (a) the patient's medical condition and prognosis, (b) the patient's previously expressed wishes (if any), (c) the capacity of the family to care for the person, and (d) the views of those who are caring for the person.

8 Responsibilities to families and others

Health care practitioners, in particular the senior clinician, have responsibilities to families and relevant others. These include respecting their ties to patient/resident, taking their views into consideration when recommending treatment, helping them to reach consensus when conflict arises and supporting them during illness and subsequent bereavement.

9 Responsibilities to colleagues

Health care practitioners, in particular the senior clinician, have obligations to those responsible for the care of the patient/resident. Those caring for the patient or resident have the right to appropriate information about the rationale of interventions to be undertaken. Decisions about treatment and care should be communicated and explained to allied health practitioners, documented clearly, and reviewed regularly.

10 Privacy of patient and resident must always be respected

The privacy and confidentiality of the patient's relationship with a healthcare professional is integral to any healthcare relationship. Information gained in the course of a health care relationship should only be shared with those in a therapeutic relationship with the patient on a 'need to know' basis. Respect for confidentiality will not normally inhibit/exclude the patient's family and/or friends from participating in the care of the patient. Health care professionals should not fail to respect the patient's right to decide who shall be privy to such information. Conversations with family and other carers should give priority to the patient's wishes and must not exclude the patient from discussions or decisions about his or her own health care. However, divulging of confidential information may sometimes be necessary in order to prevent serious harm to the patient or to others.

Developing and documenting a management plan

This section of the *Interim Guidelines* had canvassed the following issues: discussion with the patient, documentation of discussions in the patient's notes, decision making, evaluation of the patient's condition, documentation of decisions made, implementation of the management plan, palliative care, and quality assurance.

The corresponding section of the *Revised Draft* has the following headings: multidisciplinary team and the role of the clinician with overall responsibility for the health care of the patient; assessing the patient; discussions with the patient about the type and extent of medical treatment; discussions with staff involved in the care of dying patients; documentation of discussions and decisions made; resolving conflict in regard to the treatment plan.

Here we pointed out that employing the notion idea of a treatment 'team' is often inappropriate, since the group of people involved in the care of a person will very often change from day to day. We recommended that the guidelines refer more flexibly to 'those involved in the care of the person'.

We argued that the paragraph (4.3) which specifically addresses the forgoability of life-prolonging treatment should restate the principle that treatment may be legitimately withdrawn or withheld if it is either therapeutically futile (that is, makes no significant contribution to cure or improvement) or overly-burdensome (that is, the benefits hoped for do not justify the foreseeable burdens of treatment).

We also suggested that something should be said here about complex treatments such as intravenous therapy, nasogastric feeding, etc, and offered the following wording:

Though artificial means of life-support (including dialysis, ventilation, etc.) are often appropriate, cases do arise in

which patients/residents decide that the burdens of using a life-support to themselves or to others are too onerous. In such cases a decision to withdraw or withhold a complex means of life support may be appropriate.

Nutrition and hydration should be provided to those who need them. However they are not appropriate when they cannot be assimilated by a person's body, when they do not promote health and well-being, and/or when the mode of delivery imposes grave burdens on the patient/resident or others.

When treatments are withheld or withdrawn because they are therapeutically futile or overly-burdensome, other forms of care such as appropriate feeding, hydration, comfort care and hygiene should be continued.

We also thought that, in this section, some mention should be made of the need to respect the privacy of the patient/resident.

We did not think it is advisable that these guidelines recommend referral of difficult or contested cases to an expert tribunal. What the guidelines should do is give more help in the matter of resolving differences (eg (a) help those who are related to the patient by ties of family, friendship or care to understand the issues; (b) promote communication among them, encourage them to express their feelings; (c) try to identify what is common in the fears and hopes of the parties in conflict; (d) give people more time; (e) recommend the getting of a second opinion; (f) seek advice from the chief executive of the hospital/hospice/nursing home; (g) be clear about who has ultimate responsibility for decisions about withdrawing or withholding of life-

prolonging treatment (viz, the senior clinician)).

Finally, we said that we thought that a special section with respect to the care of children would be a good idea. We recommended that a paediatric physician should be consulted about wording, and offered the following as a starting point for consideration:

Children and babies have special needs when they are sick. Pain and other symptoms of illness can be overwhelming for them. As far as is practicable, families should be enabled to remain with a sick child, in facilities designed for children. (If it is necessary to accommodate a child in an adult ward every effort should be made to ensure the child has private space and is screened and sheltered from the other activities of the ward.)

Parents have the primary responsibility for the health and well-being of their children, young infants and adolescents. Until a child comes to have legal and moral responsibilities for his or her own healthcare decisions, treatment should not be administered (except in the case of emergency treatment) without consultation with, and the consent of, the child's parent(s) or other duly-appointed guardian(s). A child's ability to understand healthcare decisions, and thus to agree to treatment, depends on his or her level of understanding and maturity. This competence normally develops over time and thus must be (re)assessed in relation to each proposed medical intervention. Whenever possible, healthcare professionals should assist both parents and child to understand proposed treatment options and their consequences and

implications. Where appropriate, the agreement of a child to treatment should be sought. If parents refuse life-saving treatment for a child, emergency treatment should be given and it may be appropriate to seek a court order or the appointment of a guardian.

Related issues

In the *Interim Guidelines*, the following issues were discussed under this heading: cardiopulmonary resuscitation status and palliative care status; admission and discharge policy for specialist units including special care units; drugs which ameliorate symptoms but present a risk of shortening life; identification of the responsible attending medical officer; advance directives; differing opinions regarding management plan; support services for friends and family. In the *Revised Draft* only the appointment of guardians and the writing of advance directives (or 'living wills') are addressed.

We recommended that something be added here about the desirability of people looking ahead, anticipating their need for someone to collaborate with health care practitioners in decision-making and in particular to consent to treatments, and thus the desirability of appointing someone as their 'representative'. This is a more useful idea than recommending written 'advance directives'. There are practical drawbacks to written advance directives. A written document may be a clumsy tool for determining the prior wishes of a currently-incompetent person. The language used and the circumstances described may not accurately anticipate the circumstances in which decisions about the appropriateness of further treatment need to be made. It is common for doctors to say that they would much prefer to consult a person who can truly represent the prior wishes of the patient than to read what has been said in a formal document.

However, since people will want to know whether there is any point in preparing a written advance directive, we also

recommended that the guidelines say something to the effect that such a written advance directive would constitute evidence of the person's previously expressed wishes and thus would be taken into consideration along with the other things set out in the last paragraph of our suggested principle 7.

We expressed the view that we do not think specific legislation is needed to enable a competent adult to appoint someone to make health care decisions of these kinds. Such legislation would be unlikely to be marked by the flexibility provided by these guidelines especially if they were to be revised along the lines set out in our submission.

However since an advance directive or 'living will' constitutes evidence of previously expressed wishes, we suggested that the guidelines should (1) encourage health care practitioners to help their patients to undertake such thinking and planning, etc, and (2) state that existing law allows the responsible clinician to take such evidence into consideration in deliberations about appropriate levels of care, etc.

Glossary

A question was raised about the need for a glossary of key terms. We said that the need for such a glossary depends on what is ultimately said in the guidelines themselves. If the key terms (such as 'therapeutically futile' and 'overly-burdensome') are explained in the text - as we have suggested that they ought to be - a glossary may not be needed.

Finally, we suggested that the document address the need for wide community education. Such education needs to be focussed on helping people within the general community become aware of their right to determine the level and type of care they will receive at the end of their lives, an awareness would make people less anxious about the kinds of treatment they may receive then. As well, education could be focussed on encouraging people to begin planning early through open discussions within their families and with their healthcare practitioners.

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Life and Death in Healthcare Ethics: *A Short Introduction by Helen Watt*

Reviewed by Mary Byrne, rsc

In this book Helen Watt (a Research Fellow at the Linacre Centre for Healthcare Ethics in London) sets out, and defends, the approach which she finds most helpful for thinking about ethical problems in health care. In the Introduction she summarises the approach thus:

'The approach I will defend links morality to human fulfilment: to the enjoyment of 'basic human goods' such as life, knowledge and friendship. It gives a central place to human intentions in evaluating means for promoting human well-being. It lays stress on the impact of choices on the agent him- or herself: on the kind of people we make ourselves to be by choosing as we do. There is, I will argue, more to morality than the achievement of good results – to say nothing of 'the best' of all the results we could achieve. While the expected results of our actions are often decisive in judging them right or wrong, we should not attempt to judge our actions simply on the basis of the outcome they produce.'

This approach derives from a virtue or character ethic. Becoming a virtuous person is instrumental to and part of human fulfilment. Rather than acting in accordance with abstract norms or trying to maximise happiness, it is realising human fulfilment that is important. Part of what is important for human fulfilment is the realisation of certain basic human goods. They include life (health), knowledge and friendship. We have an objective interest in these goods. They are good in themselves, not just instrumentally good (although they can also have instrumental value: life is instrumental to

enjoying friendship; health is instrumental to gaining knowledge easily). These basic goods are not derived from something more basic. They are "simply *seen* as good by the person with sufficient experience".

It is not possible to realize each good on every occasion: we cannot both have friendship all the time and gain a maximal amount of knowledge. At times choices have to be made and each choice will harm (in a certain way) the goods that were not chosen at that time. This is one way in which the basic goods shape morality. They help us understand what fulfils a human being.

The choices and actions an agent makes have an impact on that agent. They help form the kind of person the agent comes to be. By making choices an agent shapes the person she or he is becoming since acting can strengthen respective dispositions within a person. The intention of an action is important and is part of what needs to be assessed when evaluating "means for promoting human well-being". As this is the case it is important to look at the actions a person chooses to do, giving some weight to the outcome of an action, but also assessing the action in itself. It is this view of the significance of human action which Watt develops in a range of particular case discussions.

Watt's book has six chapters: (1) homicide: moral approaches; (2) the unconscious patient; (3) the competent patient; (4) abortion; (5) embryo destruction; and (6) cooperation. The first three chapters begin with a sketch of a relevant case.

In Chapter 1 the case of a child born with Down's Syndrome whose parents, on hearing that the child had the condition, said that they did not want the child, is used as a starting point for a discussion of the

distinction between killing and letting die, the role of intention, euthanasia, the relevance of the notion of 'having an interest', the basic human goods (in particular the 'good of life'), and the moral theory known as consequentialism. Watt sets out some of the main objections (agent-relativity, the importance of inputs into action, and the idea of there being moral absolutes) to which consequentialism is subject as a moral theory.

Tony Bland's case sets the scene for the discussion in Chapter 2 of the diagnosis of 'persistent vegetative state', the concept of a 'human person', the goal of medicine, non-voluntary euthanasia and the social significance of tube feeding, and the question of whether tube feeding constitutes medical treatment.

Chapter 3 starts with the case of Dr Nigel Cox who gave one of his patients (who had expressed a wish to die) a lethal injection. Watt asks whether Dr Cox had committed a justified homicide, whether Mrs Boyes' life was 'worthless', what help the principle of 'respect for patient autonomy' provides us, and discusses the distinction between 'ordinary' and 'extraordinary' means. She helpfully distinguishes the two very different views of life which the term 'quality of life' may be used to describe (the view that the patient's life has - in some circumstances *no* value, and the view that, though the patient's life *always* has value, it may not have *enough* value to justify some intervention), briefly explains the point of the principle of double effect, and then brings the discussion back to questions raised about the general approach to thinking about these issues that she endorses.

Chapter Four addresses ethical issues associated with abortion. Watt begins by distinguishing questions of justification from questions of culpability. Arguing that the relationship of dependency involved in pregnancy is not unique, she insists that the foetus cannot be classed as an unjust aggressor. She claims that the ethics of abortion require consideration of the status of the foetus and argues against several views

in the literature which deny that the foetus is a human being. She also discusses a range of responses when there is a need to undertake life-saving treatment for the mother and finally considers whether the notion of a woman's rights might settle the ethical issues.

In Chapter Five the question of whether a human embryo is a 'person' or human moral subject is discussed. Identical twinning, in vitro fertilisation, the status of the embryo, its developmental potential, natural embryo wastage, human cloning, and the possibility of 'abortifacient contraceptives' are all considered.

Chapter Six starts from the phenomenon of moral disagreement and considers the difficulties which face those health care professionals who find themselves 'outside the mainstream position in their profession'. What should a doctor or nurse do if asked to participate in what he or she sees as an immoral procedure? Distinguishing between formal and material cooperation, Watt explains why formal cooperation should be morally excluded and how material cooperation may be justified, a discussion which brings her back to the centrality of moral integrity.

How useful is the book? There are other ethical challenges in health care: 'ownership' of bodies, ethical and unethical uses of genetic information, the allocation of resources. And there will be health care workers who do not have to face the above - admittedly current, pressing and controversial - issues in their day to day practice. So the question arises: Will the value of Watt's discussion be limited to a consideration of the issues that she confronts? The answer is no. The way in which Helen Watt has approached these topics shows that they are not totally separate from everyday more mundane challenges in health care. They are part of a related spectrum of healthcare challenges to which a health care worker is asked to respond compassionately and respectfully. Therefore, the underlying approach presented in this book will be relevant to healthcare workers in many

situations. An ethical framework has been presented which will have application to all healthcare decision making.

Helen Watt has written this book to enable people working in health care to find answers to some very significant questions. She has presented answers and positions that are not held by many healthcare workers today. Part of her intention is to support people who believe that all life must be respected as they continue to face the many challenges to such positions and the ongoing pressure to rescind from such positions: she encourages healthcare workers to act with integrity for it is an essential part of attaining human fulfilment. In addition, she has attempted to provide reasonable arguments which support the positions which she has set out.

Though her approach is one which is at home within the context of a Catholic bioethic, it is set out as a contribution to 'natural philosophy': as she says, 'there are no religious premises in the arguments put forward or discussed'.

Readers will no doubt engage actively with Dr Watt. For example, one interesting, although minor, claim relates to the goals of nursing and medicine. Watt describes the goal of nursing as "to sustain the patient's life" while the goal of medicine is "to promote health, or some approximation to health, or failing that, to palliate the symptoms of disease". She then uses this difference to assess the nature of tube feeding - whether or not it is medical treatment - and to ask whether it can ever be withdrawn.

Two points may be made in reply: Firstly, the issue is not so much whether tube feeding may legitimately be stopped, but whether nutrition and hydration may legitimately be stopped. Part of what is significant in making such a decision is the manner in which the

nutrition and hydration is supplied, whether it be by tube, by intravenous forms or by someone spoon-feeding the patient. The decision has to be made in a particular context. There could possibly be occasions when hand feeding should be stopped, such as when the patient cannot swallow or is not assimilating the food that is being given. Alternatively a well-placed central venous line could cause little distress and provide good nutrition and hydration. Secondly, there are many ways in which "sustaining life" can be understood. It can be understood as doing everything medically possible to preserve life, as maintaining friendship, as describing the way of life of parents caring for young children. The expression seems to have the same problems as those which are associated with describing the goal of nursing (as Watt does) as "caring". A better description of the goal of nursing may be "health, assisting persons to that level of integrity/wholeness/health in which they are unimpaired in doing what is important to them".¹ This understanding of nursing would change the focus of the question in relation to food and water from whether it is medical (or nursing) care to whether such provision of food and water is appropriate to the health of the person.

For people with a stronger interest in these topics or health care ethics more generally, further reading will be needed. Many helpful references are given. However I can recommend this book as a very useful, easily accessible resource book for health care workers.

Helen Watt: *Life and Death in Healthcare Ethics: a short introduction*, Routledge, London and New York, 2000

Reference

¹Taylor, Carol R. (1998), "Reflections on 'Nursing Considered as Moral Practice' " *Kennedy Institute of Ethics Journal* 8 (1) 71-82

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