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Ethical issues in health care near the end of life

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In this issue

The first article in this issue is a version of the talk given by Mary Byrne at the *Intensive Bioethics Course* we held for secondary school teachers earlier in the year.

The second is a review article of a book that we recommend to our readers: *Healthcare Allocation: an ethical framework for public policy* contains both a readable and useful summary of the main arguments in this contested area of public policy and a set of positive proposals as to how decisions about allocation should be made.

Two legal cases from Britain involving decisions about health care near the end of life were reported in the press earlier this year. In March 2002 a woman identified only as Miss B appealed to the High Court in the United Kingdom seeking a ruling that would allow her to refuse the ongoing use of a ventilator. She was paralysed from the neck down following the rupture of a blood vessel in her neck and needed the ventilator, as she was unable to breathe unaided. The ruling of the court was that Miss B had the 'necessary mental capacity' to determine which treatment to accept and which to refuse.

In April 2002 Dianna Pretty appealed to the European Court of Human Rights requesting that her husband be allowed to assist her to commit suicide without facing the risk of prosecution. She was suffering from motor neurone disease and was physically unable to perform the actions that would enable her to take her own life. The European Court of Human Rights rejected the claim on the basis that the right to life did not create an opposite right to die and hence support to attain that right. At the time that this second case was

reported there was some confusion in the public discussion about the distinction between the cases. Both were described as instances of a person's 'right to die'. However, there is an essential difference between them, which will be discussed later in this paper.

The focus of this paper is health care near the end of life. A fundamental ethical issue in such health care is the determination of appropriate and inappropriate treatment options, treatment which should be commenced or continued and treatment which may be refused, withheld or withdrawn. I will discuss these issues in the light of a Christian understanding of the gift of life and the purpose and value of life, and then apply this understanding to determining health care near the end of life. In the second section two more specific sub issues – euthanasia and the provision of nutrition and hydration – will also be discussed.

The basis of this paper will be convictions about life as a gift and the purpose of life as they are expressed in the Catholic tradition. There are other ways to express similar principles, deriving from different religious traditions and human philosophies. The practical applications will result in similar decisions. There are also other approaches to these issues at the end of life that lead to different practical decisions. A comparison of all of these is beyond the scope of this paper.

Convictions about life

Life and health care are intimately connected. Health care may be needed by a person to sustain her or his life and, therefore, can have an impact both on the continuance of life and the quality or vigour of the life of that person. It is now medically possible to sustain the life of a person in the face of grave illness or severe traumatic injury. To enable reflection on what would be an appropriate level of health care it is important to consider three convictions about life: (1) life is a gift, (2) life has a purpose, and (3) the Christian meaning of death in light of the resurrection.

Life is a gift

The first fundamental conviction about life is that life is a gift. Many people may acknowledge this simply because no-one can control or choose when her or his life will begin and hence life is 'given' to us. However, within the Christian tradition the conviction that life is a gift is much richer. Each life is a gift given by God and has an intrinsic inviolability or unconditional worth derived from God who created it and sustains it. God as the source of life and the end of life is the Lord of life. We should not deprive another person of her or his life or seek to end our own life. Such an action is a grave violation of the sacredness of the gift of life and of each person as well as a rejection of God as the Lord of life. Furthermore, we are not the masters of our life, but the stewards of it. Our life is a gift that we hold in trust. This means that we have an obligation to care for our life taking all reasonable measures to ensure our health (*Code of Ethical Standards, Principle 1*).

Life has a purpose

The second fundamental conviction about life is that life has a purpose. We believe that we are created and loved by God and so we are called to respond to that love. That is, we are created to love God, to love others and to love self. In this we become fully human and fully the person that God has created. Life is essential for achieving these purposes, but life itself is not the ultimate goal. In other words, life is good and should not be intentionally destroyed, even for something else that is good. However, it does not follow from this that life has to be sustained at all costs. In 1957 Pope Pius XII claimed that: "Life, health, all temporal activities are in fact subordinated to spiritual ends." The consequence of this is that where it is not possible for a person to continue fulfilling the purpose of her or his life, the obligation to seek healthcare treatment to sustain life is lessened. It is important to note that fulfilling the purpose of life does not require a certain level of skill or functional capability. Each person, uniquely created by

God, will have a unique way of living her or his purpose.

Vitalism

Considering two positions which both contrast with this view may further illuminate this conviction about the purpose of life. The first position is 'vitalism'. Vitalism is the claim that life is to be preserved if at all possible. It is quite clear that a Christian understanding is different from this. The purpose of life is not simply life itself. Rather, the purpose of life is the achievement of the spiritual goods of life. Hence there is a point where prolonging life using healthcare treatments and technologies may no longer morally be appropriate.

Value as quality

A second position is that life is worth conserving only if it is of a certain value or worth. This presumes that the value of a person's life can be measured either in comparison with another person or in comparison with objective criteria, such as the possession of self consciousness or the ability to live independently. On this view, where a person's life does not have this value, there is no moral obligation to strive to sustain life. This second position may appear to be similar to the Christian conviction discussed above. However, there is a fundamental difference. This position denies the intrinsic worth of every person, a worth that derives from the unique creation by God and the final destiny in God. It also implies that it is possible to judge that some lives have no value at all and hence that some people could be considered as 'better off dead' (cf. *Code of Ethical Standards*, 1.15).

Christian meaning of death

Life is temporal and will end in death. Another fundamental conviction that should inform considerations of health care near the end of life is the meaning found in death, the

significance of death. The Christian hope of resurrection transforms the mystery and pain of death with the promise of eternal life. Thus, death is not a total obliteration of the person. Such a hope does not deny that death puts an end to the goodness of our temporal life (*Code of Ethical Standards*, Principle 7). It simply removes some of the tragedy of death and again shows why Christians do not need to demand an endless effort to sustain life.

We are called to both celebrate the wonderful gift of life and accept the end of this life when achieving the earthly purpose of life is no longer possible. I will now use these Christian convictions about life and the end of life to address the issues that can arise when considering health care treatment options near the end of life.

Determining appropriate health care

As stated above the fundamental ethical issue in health care near the end of life is the determination of appropriate care in the face of multiple healthcare treatment options. The decision about accepting or refusing health care is irreducibly personal and it is important to recognise that, where possible, such decisions are the responsibility of the person concerned. In this section I will discuss some basic grounds for such decision making in light of Christian convictions about life.

In 1995 Pope John Paul II wrote:

Euthanasia must be distinguished from the decision to forgo so-called 'aggressive medical treatment', in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. ... Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the

means of treatment available are objectively proportionate to the prospects for improvement. (Evangelium Vitae n. 65)

Pope John Paul II has highlighted two aspects of any treatment which need to be considered: the results or benefit which can be expected and the burden the treatment will impose. Treatment that does not offer a reasonable possibility of benefit or imposes an excessive burden on a person is treatment that can reasonably be forgone.

Futile treatment

Treatment that will not provide benefit is often called 'futile' treatment (*Code of Ethical Standards*, 1.13). At times a treatment will be unambiguously futile, such as the use of antibiotics to treat a viral cold. At other times the utility of a treatment may be less clear, as for example when the doctor is not sure that a proposed treatment would be effective for a certain patient, despite such treatment being effective in other patients with the same condition. This is a question of the probability that the treatment will provide benefit.

In other circumstances treatment has been labelled 'futile' when the focus is actually on the degree of benefit rather than whether the treatment will provide benefit. In these cases it is not a question of futility but rather a question of whether the benefit is in proportion to the burden of the treatment or the overall condition of the patient. Where the proposed benefit is not in proportion it is more appropriately described as burdensome.

Overly burdensome treatment

Treatment that imposes a grave burden (or is 'extraordinary') can also be described as 'overly burdensome' (*Code of Ethical Standards*, 1.13). To determine whether or not a treatment is overly burdensome the impact the treatment will have on the life of the person and on the person's ability to achieve the goals or purposes of her or his life needs to be assessed. Where the impact of the

treatment is so great that it severely affects the person's ability to attend to the other aspects of her or his life, then such treatment can reasonably be refused or forgone. These are not easy decisions. Such a determination has to be made in the context of each person's life, including the other responsibilities a person may have and the strength a person has to face the impact of illness. Where possible, the person affected should make the decision. Where this is not possible, the people assisting in making the decision, family, friends and healthcare workers, should seek to make the decision as far as possible from the perspective of the person affected.

Treatment may also be overly burdensome on others. That is, the provision of and requirements for a certain treatment may cause disproportionate hardship to others (*Code of Ethical Standards*, 1.14 & 5.9). Pius XII indicated that the "circumstances of persons, places, times, and culture" are important spheres of consideration when determining burden. An example could be the burden on a family from a remote area of Australia when one member of the family requires radiotherapy. Such treatment may require that the patient, and another person to support the patient, reside in a major city for six weeks or more. This may have a major impact on any farming family or in any situation where the main wage earner has to leave the family for that length of time.

Consideration of the gift of life and the purpose or goals of life sets the context for the determination of both benefit and burden and the assessment of appropriate health care near the end of life. Treatment should enable or sustain life so that a person may continue to live the purpose of her or his life.

Sometime the withdrawal of certain treatment is misunderstood, and taken to justify the cessation of all health care. Even when treatment is refused or withdrawn, good basic care in response to the needs and symptoms of the person should still be given (*Code of Ethical Standards*, 5.12).

Euthanasia

Euthanasia can be defined as an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering (*Evangelium Vitae* 65). Two important components in this definition are that the action (or omission) (a) caused the death and (b) was intended to cause death. Hence, euthanasia involves deliberately ending the life of another person.

Some of the debate over euthanasia centres on the legitimacy of a distinction between allowing a person to die and intending the death of a person. While the expression 'allowing to die' is still used, it is not a very helpful term. It is possible maliciously to 'allow' a person to die by not providing the care or help a person reasonably needs. The expression 'allowing to die' does not easily highlight how it is different from intending to kill a person and generally refers to accepting the inevitability of death for a person who is terminally ill while seeking to relieve some of the pain caused by the burden of treatment.

Intending and foreseeing

The critical distinction in the debate over accepting and intending death is between intending the outcome of an action and foreseeing but not intending that outcome. Some people do not accept this distinction between intending and foreseeing but not intending. Hence (they argue) anything that we can reasonably foresee will happen if we act in a certain way, we intend to have happen. From this perspective, foreseeing that a person will die after ceasing life-sustaining treatment means intending that the person would die.

But this very inclusive definition of intent (that includes everything that can be reasonably foreseen) is implausible. It would imply that a doctor who prescribes medications to relieve a condition in a patient intends both the relief of the condition and any side effects of the medication. It makes better sense to say that the doctor intends the relief of the condition and merely foresees and tolerates but does not intend the side effects.

When a person is terminally ill treatment that will not provide benefit may be

withdrawn or withheld. The intention of the healthcare professional who withdraws or withholds such treatment is to relieve the person of pain and distress. Accepting our inability to halt a person's dying in such circumstances need not be intending or desiring that the person die.

In the situation where a person refuses life sustaining treatment, developments in medical knowledge mean that it is possible at times to foresee that a person could die within a reasonably short time after the treatment is ceased. However, the intention of the person refusing such treatment need not be a wish to die. Rather it may be the desire to be relieved of treatment that is overly burdensome.

Stewards of life

In light of the Christian convictions about life, it can be seen that euthanasia and assisted suicide are choices to reject and violate the gift of life as given by God. They are also contrary to the purpose or goal of life, love of God, of others and of self. As stewards of our lives we should not seek to end our lives.

The difference between the two cases discussed at the beginning of the article is highlighted by the difference between euthanasia and refusing overly burdensome treatment. Miss B requested the removal of treatment, a ventilator, that she considered too burdensome. Dianna Pretty requested assistance to end her life. Her action would directly intend her death while Miss B sadly accepted that death was a most likely consequence of refusing ventilation but was not seeking death.¹

The provision of nutrition and hydration

The provision of nutrition and hydration to people who are seriously ill has been the source of some considerable debate. Questions about the continued provision of nutrition and hydration may arise when a

person is terminally ill or when a person is deeply unconscious and is unlikely to regain consciousness. There are two main views in the debate.

Medical treatment

On the one hand, some people classify the provision of nutrition and hydration as medical treatment. Continuing such treatment, therefore, is to be determined by a consideration of the benefit it provides and the burdens it imposes. The benefit should be an improvement in the medical condition of the person so that she or he can continue to pursue the (spiritual) purposes of life. On this view, a person who is persistently unconscious has totally lost the ability to pursue such purposes in life. So, on this view, there is no moral obligation to continue the treatment of nutrition and hydration to a person who is persistently unconscious, as it is merely prolonging life (Panicola, 2001, p.21).

Basic care

On the other hand, some people classify the provision of nutrition and hydration as basic care. On this view, food and water are fundamental requirements for living, which sustain life and promote the inherent dignity of the person. Therefore, it is still possible, and at times necessary, to assess the benefit and burden of such care. The sustaining of life is itself considered a benefit, as life is a good in itself. Furthermore, on this view, feeding is an expression of solidarity with the person being fed and, therefore, is a social sign of the value of people in the society because the weakest and most vulnerable are cared for and protected.

There is a risk with this second view. It could be used to claim that nutrition and hydration should never be ceased, a position similar to vitalism. However, in the situation of a terminally ill person the provision of nutrition and hydration may well be futile, such as when it cannot be assimilated or absorbed. It may also be burdensome if the means of providing the nutrition and hydration causes undue pain and/or distress.

The person who is persistently unconscious

There is little disagreement that it may be appropriate to cease the provision of nutrition and hydration to a person who is terminally ill, using the criteria of futility and burdensomeness. There is a much greater level of disagreement over the care of the person who is persistently unconscious. According to the first view such people do not receive benefit from the provision of nutrition and hydration and, therefore, such treatment should be ceased and the person allowed to die.

There are two flaws in this view - the emphasis on the lack of ability to pursue the (spiritual) purposes of life and the claim that withdrawing nutrition and hydration is simply withdrawing futile or burdensome treatment. The situation of the person who is persistently unconscious but not terminally ill does challenge our understanding of how such a person could continue to achieve the purpose of life. However, we have no basis for claiming that such a person has lost the ability to continue striving for this achievement. All that it is possible to claim is that we do not know if this person is still achieving a purpose in life. Importantly, as we discussed above, there are no functional criteria attached to achieving the purpose of life. (While the common term persistently 'unconscious' has been used it may be more accurate to acknowledge that such people are persistently 'unresponsive' and, hence, the level of consciousness cannot be determined.)

The second flaw is confusion about the intention behind withdrawing the nutrition and hydration. Again, if the person is persistently unconscious it is not obvious that the withdrawal is a withdrawal of futile treatment. The nutrition and hydration is sustaining life rather than treating a medical condition. Hence ceasing the nutrition and hydration may be intending that life cease. The interpretation of burden and benefit may have moved from the treatment being a burden to the life itself having no benefit and hence being a burden. In such cases, the person will die from lack of nutrition and

hydration rather than any underlying terminal disease.

According to the second view it is still necessary to assess the ongoing provision of nutrition and hydration, and the burdens and benefits of such provision. However, there is a presumption towards life where the provision of nutrition and hydration itself is not burdensome or futile.

The inviolable dignity of every person

While there is an emphasis on the purpose of life in the Christian convictions about life, there is a strong emphasis on the gift of life which must never intentionally be ended. While it is hard to understand how a person can continue to achieve the purpose of her or his life when persistently unconscious, it is clear that the person has an inviolable dignity which may not be gravely violated by intentionally ending the life. Hence, in questions over nutrition and hydration, the focus needs to be on the benefit and burden of the provision of nutrition and hydration with a presumption towards supporting life unless there is obviously futility or burden (*Code of Ethical Standards*, 5.12).

Conclusion

We have been given a gift of life. We are the stewards of this life and we therefore must care for it, including seeking and accepting health care as needed. But for a Christian life is to be understood in the light of the spiritual purposes or goals of life. We should not determine when our life will end as is the case with euthanasia, but we do not need to accept care that will frustrate our attaining of this purpose, care that is futile or overly burdensome. God is the creator of our life, Lord of our life and the final destiny of our life.

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Footnote

1. I am not suggesting that Miss B and Dianna Pretty are to be bound by Christian convictions about life. These recent public examples are discussed simply to highlight the different aspects of decision making near the end of life.

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'Healthcare Allocation: an ethical framework for public policy'

Reviewed by Helen McCabe

The title of the book reveals its primary purpose: Fisher and Gormally have offered an important contribution to the ethical debate surrounding the problem of allocating scarce health care resources.¹ Commissioned by the Catholic Bishops' Joint Bioethics Committee, it is presented as a report, the focus of concern being that of the situation in the United Kingdom. Nevertheless, its observations and claims are readily applicable to the Australian health care context, as they may well be internationally. The editors of this book are suitably qualified to speak to this issue: Dr. Anthony Fisher is the Episcopal Vicar for Health Care in the Archdiocese of Melbourne, has completed an Oxford University doctoral thesis on the just distribution of health care resources, and has been a lecturer in Ethics and Moral Theology at the Australian Catholic University. Mr. Luke Gormally was the director of The Linacre Centre for Health Care Ethics in London from 1981 to 2000 and is now Research Professor at The Ave Maria School of Law, Ann Arbor, Michigan.

In this development of Dr. Fisher's doctoral thesis, the authors draw on a wealth of scholarship and thought-provoking insights to consider, initially, both the ethical merits and deficits within traditional and current policies concerning health care resource allocation. This aspect of their analysis involves well considered, albeit brief, critiques of the more influential philosophical theories of modernity and their application to the

problem of health care resource allocation. Ultimately, the authors conclude that, in holding to impoverished conceptions of justice, the 'answers of modernity' would fail, overall, to distribute resources in ways that can be considered fair. They then go on to remedy this situation by offering an ethical framework in which 'principled resolutions' to the problem of health care resource allocation can be found.

In constructing their ethical framework, the authors draw on both classical and current strands of thought including the Hippocratic medical tradition, Judeo-Christian social and bioethical teaching, the natural law tradition (particularly as developed by, among others, Finnis, Grisez and Boyle), traditional and contemporary virtue ethics, and MacIntyre's 'communitarian' critique of liberalism. The influence of Catholic bioethical and social justice thought is readily discernible throughout the book; for this, there are no apologies offered given the long association of the Church with health care, both in its provision and in addressing relevant ethical dilemmas. However, the authors believe that their contribution, in appealing to reason and experience will, likewise, appeal more generally to include 'people of good will', of 'all faiths and none'.

I

The book is structured around six related parts, the first part attending to a consideration of those matters which have

occupied the contemporary ethical debate, as well as laying out some groundwork for their arguments which are developed in part three.

II

In part two, both unsystematic and principled approaches to health care allocation are addressed. The unsystematic approaches of 'ad hocery' (to do things as we've always done them or 'leave it to the doctors to decide') and the free market are considered: 'ad hocery' is found to give rise to arbitrariness and unpredictable decision-making on the part of managers and other providers, the more powerful gaining at the expense of the less powerful, with some persons being excluded from access to care entirely. The free market approach was found to be both theoretically and practically defective, health care provision being particularly unsuited to the workings of the free market. While the authors find some legitimate (albeit conditional) place for free market approaches within the health care context, they conclude that it cannot be relied upon to distribute resources efficiently or justly. Contemporary principled approaches to resource allocation are then examined: neutral (or 'thin', 'anti-perfectionist') principles, consensus principles (as expressed by the voting majority), arbitrary principles (or the 'principlism' of health care ethics), liberal-welfarist approaches, and utilitarian-economic approaches are each found inadequate to the ethical task of guiding the distribution of the resources of health care. For while each approach contains 'something of importance', taken together these approaches are found to lack, overall, an adequate understanding of the human good, of human persons and what is necessary to their well-being, of human community and of the common good, as well as of health care itself. In general, unreasonable prejudices and arbitrary principles inherent in these approaches are shown to distort decision-making in determining 'what kind of health care to allocate, to whom and on what basis'.

III

In part three, the authors attempt to resolve the problem of resource allocation by constructing an ethical framework to form a basis for moral decision-making. The natural

law notion of basic goods (or aspects of human flourishing), the 'commonsense' morality which gives rise to a range of moral norms, the virtues, and the notion of basic needs form the moral framework, underpinned by a substantive conception of community and the common good. Within this framework, the basic goods of health and life provide (among other things): a) reasons for providing health care, b) an explanation of what kind of good health care is, c) natural limits to how much health care ought (as a matter of duty) be provided, as well as d) determination of what kinds of health care services are required in order to satisfy the demands of justice. Arguing from within this framework, the authors propose that health care is an important human good, its object being that of life and health and, as such, directed toward the living of a fully human life.

In this way, the authors reject the egalitarian notion of providing health care for the purpose of enhancing individual opportunity, as well as the utilitarian notion of maximising the overall good (the content of which remains to be determined). At a later stage, they consider the utilitarian concern with 'efficiency and effectiveness' measures, noting that while such measures may assist in the conservation of shared resources, they can never stand alone as a criterion for health care distribution. For, they argue, 'efficiency and effectiveness' are mere 'means to ends which must first be determined', ends without which such measures can be employed all too enthusiastically for achieving that which may well miss the mark. The authors also reject the libertarian free market approach, finding it, generally, in violation of the requirements of fairness. Rather, they uphold a 'thick' conception of health, the care of which is all too morally significant to be left to the whimsy of an unregulated market. However, and while they stress that strong justification is needed for withholding health care, they do locate a range of permissible limits to its provision so that we are not morally required to provide all manner of health care 'in all circumstances', 'all the time', and 'at any cost'. For, on this account, there exist other goods necessary to the flourishing of human life (education, social welfare support, the arts

and so forth) and which claim equal consideration in our moral affairs.

The authors acknowledge that health care is necessary to life and health and, as such, represents a 'basic need of human persons'. As a requirement for participating in aspects of human flourishing, needs provide reasons for action 'which require no further justification', their satisfaction representing no less than a *prima facie* duty. For instance, failing to satisfy the need for health care results not only in harm to the goods of life and health, but, as well, harm to those other goods which 'depend upon long life and good health' if the human person is to flourish at all. That is, the identification of a basic need is, of itself, the identification of a moral claim. Nevertheless, the need for health care is a qualified need: it is a recurrent, or a 'course-of-life' need, as well as being limited to that which explicitly serves the life and health of a person. In employing the concept of basic need, then, the authors distinguish kinds of health care services which constitute mere desires (superior hospital amenities, futile treatments, 'doubtfully effective treatments', and so forth) from those which are essential to life and health. And it is those health services, in meeting genuine basic needs of human persons, which have a stronger claim on the commitments of 'reasonable individuals and communities'. In this way, decisions as to what ought to be provided in the way of health care are further circumscribed.

In strengthening their ethical framework, the authors attend to the relationship between human persons and human communities, a relationship conceived of 'as the moral foundation of duties to meet the healthcare needs of others'. In doing so, they reject atomistic views of human relations, noting, instead, the need for relationships and cooperation with others in order to achieve one's purposes. Moreover, they propose that cooperation and relationships are 'constitutive of the very self which is realised and fulfilled'; ties to family, workplace, neighbourhood and other associations influence, in profound ways, an individual's identity, values, and commitments. And it is these ties which, in

turn, give rise to debts, inheritances and obligations. The conception of the human person employed here is not, however, subsumed to that of the needs of the community. Rather, the common good is that of the good of individuals whose intrinsic dignity must be upheld at all times. Nevertheless, the rights of individuals to make claims on shared health care resources are constrained by the duties of communities to provide that care, duties (on this account) being prior to rights. The authors go on to nominate differing degrees of responsibility for attending to the needs of others based on such considerations as (among other things) proximity, prior commitments, or a person's capacity to respond.

Social responsibilities to provide health care are then ordered by such considerations as degrees of urgency, the importance of health care, the moral norms and virtues which direct decision-making, and the other responsibilities of the community. This part of the framework draws on the 'common humanitarian duty of care' or the duty to be a 'Good Samaritan'. It also addresses the requirements of distributive justice, including the principle of the Golden Rule. In drawing on this principle, the authors propose a test for determining the fairness of health care allocation decisions by asking:

"Would I think the healthcare budget and its distribution was fair if I (or someone I loved) were in healthcare need, especially if I were among the weakest in the community (i.e. sick with a chronic, disabling and expensive ailment, and poor and illiterate)? Would I think it were fair if I were one who would go without under the proposed arrangements? Would I think it fair were I a healthworker, healthplanner, taxpayer and/or insurer?"

In applying this test, the authors suggest that need, compatible with similar and more important needs of others, would form the primary basis of health care distribution and

serve to sort rights-claims to health care. Furthermore, the health care system would serve as a mechanism for redistributing resources from 'those who have more than they need to those who have less than they need'. The Golden Rule lends support, then, to a universal system of health care.

In a more controversial light, the authors note that each community will make such arrangements for providing health care as 'better reflects its temper, history and enduring values': in comparing the universal system of the United Kingdom with the free market arrangements of the United States, they find such differences 'fitting' provided that neither arrangement is 'a necessarily unjust system'.

This raises an important question. Given that there is no algorithm for determining a just allocation of resources, and given that a certain responsiveness to local circumstances will legitimately be built into any actual allocation, it seems clear that standards for assessing allocations need to have an in-built flexibility. But how much flexibility? Enough to accommodate the main features of the market-dominated arrangements of the U.S. health care "system"? The authors do not pursue this line of inquiry. It is a fruitful one for students of the moral and political philosophy of health care.

In structuring a moral framework in this way, an analysis of the various criteria recommended for allocating health care resources is, in turn, elaborated. Prior to completing this part of the book, however, reference to the role of the health care professions is considered in relation to its bearing on the problem of resource allocation. The authors conclude that health care professionals have dual responsibilities to their individual patients *as well as* to the common good by practicing wisely (not pursuing treatments which are futile, for instance) and by ensuring the integrity of their professions and of the health care system more generally.

IV

Part four of the book deals with allocation criteria in the light of the requirements of distributive justice, dismissing such criteria as 'to each equally', 'to each according to the free market', 'to each according to their social contribution', and 'to each according to their desert or merit'. Rather, the authors propose a needs-egalitarian criterion (tempered by a preference for the needs of the most disadvantaged), taking into consideration the propensity of needs to conflict, and providing the ethical means for sorting rival claims to health care resources. As well, and beside the requirements of distributive justice, other considerations in the allocation of health care resources are addressed, including the provision of other goods necessary to human flourishing (those goods which promote justice and peace), and the requirement to respect other basic human rights.

V

Part five is devoted to a consideration of Catholic social teaching and Catholic bioethical thought as it bears on the problem of distributing health care resources. In taking the structure of their proposed moral framework, the authors situate it within a contextual understanding provided by divine revelation. In this way, they situate the problem of health care allocation within a theological context. Here the authors may seem to contradict earlier claims as to the universal appeal of their approach. For they say that the full implications of reason and the practical applications of morality are adequately understood in light of a full account of the human situation which, in turn, is 'only adequately and reliably illuminated by the life and teachings of Jesus Christ, mediated to us in the Church's Scriptures and tradition'.

This raises another important question. The authors propose and defend a "natural law" version of the challenges and obligations of morality. That is to say, they believe that the

substantive positions which they endorse can be appreciated by anyone of goodwill in that they reflect what is found in common morality's prohibitions, virtues and obligations. They believe that their conclusions do not rely on acceptance of religious propositions. Of course it is consistent with all of this that the ethic they elaborate may have its best and most characteristic expression in Christianity. But that seems to be different from saying that it is 'only' adequately and reliably illuminated by the life and teachings of Christ.

In drawing on Catholic social justice teachings (as expounded in papal encyclicals) and on Catholic bioethical thought, the authors outline a context in which health care allocation ought to be attended, taking account of

- the dignity of all human persons,
- the right to life and to health care,
- the principle of a preferential option for the poor and sick (especially those who are elderly),
- communal responsibilities to provide health care,
- the limits of property ownership,
- the principle of subsidiarity, and
- the model of the Good Samaritan.

VI

In part six, the implications of the proposed moral framework for public policy are considered. Such matters as 'how much' ought to be allocated to health care, the recognition of rights-claims to health care, distributional criteria, the roles of government and the private sector, and gatekeeping are addressed. This section concludes in noting the need for informed public debate on the above matters.

Overall, the authors are concerned to avoid those approaches to health care allocation which may harm the practice of health care, discriminate against groups of patients, and damage the character of social relations, including those of the health care professions with their patients. In providing a more substantial understanding of the human good, of human persons, of human communities and of the common good, as well as a substantive conception of health care itself, they may well have realised their overall intention.

In noting the necessity of ethical guidance as a determinant of resource allocation policy, the authors stress that ethics is but one determinant; they do not, then, 'aspire to provide a blueprint for resource allocation'. However, this book will appeal, nonetheless, to health care and social welfare policy advisers, health care administrators, clinicians, and interested members of the public. Moreover, the seriousness of its claims cannot be overlooked by anyone engaged in the field of health care ethics. Indeed, healthcare administrators, charged with the responsibility to make wise and just allocations of the community's resources, would do well to make it the subject of sustained reflection.

Helen McCabe, a nurse at St. Vincent's Hospital in Sydney, is undertaking studies towards a PhD in the School of Philosophy at Australian Catholic University

FOOTNOTE

1. *Healthcare Allocation: an ethical framework for public policy*. Edited by Anthony Fisher OP and Luke Gormally, The Linacre Centre, London, 2001.

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