
BIOETHICS OUTLOOK

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The ethics of care for those with post-coma unresponsiveness and related conditions

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In this issue

Bishop Anthony Fisher distinguishes four attitudes on the feeding of people who are at a very low ebb: the never feed view, the always feed view, the seldom feed view and the usually feed view.

Dr. Helen McCabe argues that the increasing penetration of the "free market" into the provision of health care threatens to dilute the therapeutic and caring values which have animated Catholic and other humane health care institutions.

The Plunkett Centre Annual Report for 2004 is now available upon request from the Administrative Officer.

In *The Gospel of Life* (1995) Pope John Paul II wrote of the 'intolerable' neglect that some of the elderly, handicapped and dying experience even in affluent nations. He exhorts us "to preserve, or to re-establish where it has been lost, a sort of covenant between the generations", a relationship of acceptance and solidarity, closeness and service. In his recent *Address to a Congress on Life-sustaining Treatments and the 'Vegetative' State* (20 March 2004) he drew out the implications of this covenant promise by considering how we should regard and care for the persistently unconscious – whether they are of an older generation than ourselves or not. His principles clearly have wider application than just the so-called 'vegetative' patient, to include other patients in comas, advanced dementia, late stages of cancers or other conditions. How are we to show love, care and respect for such people in the context of our Catholic health and aged care mission, and our range of opportunities and responsibilities?

There are I think four positions commonly adopted by ethicists, health professionals and others on the question of whether people who are at a very low ebb, especially those unlikely ever again to recover consciousness, should be fed with medical or nursing assistance.

The Never Feed View

The first position I will call the "Never Feed View". It says, quite simply, don't feed such people. If you have started feeding artificially in the hope of recovery of consciousness and – after a prudent period – you find the patient has not recovered, you should stop feeding them artificially. Otherwise you are simply drawing out their dying process or creating a rod for your back in terms of the care they will require in the future and a rod for the family's back as they become increasingly exhausted by how long their loved one is taking to die. Life in that state is not worth living. There are no human, intellectual, spiritual acts. Whatever of the assisted feeding, the life itself is futile or burdensome both to the patient and to others around her.

On this view there is nothing wrong with allowing the natural dying process to proceed unimpeded in such cases; indeed it would be an offence to human dignity, even torture, to extend the life of such a person; the sooner they are with God the better. People should be encouraged to make declarations early that if they were ever in the future to be in this situation they do not want to be fed; other people should be encouraged to respect such declarations or, in the absence of them, to assume they would have been made had the patient had the opportunity.

The Always Feed View

An opposite view – which I will call the "Always Feed View" – runs something like this: no human being is ever a vegetable or in a vegetative state; no human life is ever useless or worthless. Human dignity is inalienable; we cannot lose it or give it away, no matter how low an ebb we are at. This is the long Judeo-Christian tradition.

In the face of trends of thought demeaning the dignity of the person suffering 'PVS', I strongly reaffirm "that the intrinsic value and personal dignity of every human being do not change, no matter what their concrete circumstances". Even if seriously ill or disabled "a person is and always will be a man, not a 'vegetable' or an 'animal'. Our brothers and sisters in the condition clinicians call a 'vegetative state' retain their human dignity in all its fullness. The loving gaze of God the Father continues to fall upon them, acknowledging them as his sons and daughters, especially in need of help." (John Paul II, Address on Life-Sustaining Treatment and the 'Vegetative', §3)

Furthermore, supporters of the Always Feed View argue, brain-injured people are entitled to appropriate health service and support, including palliative and nursing care, addressing their individual needs. Not to feed them would be discrimination on the basis of disability and eventually homicide by neglect of reasonable care.

Just because the chances of recovery are judged small and waning, when the 'vegetative' state lasts more than a year, does not justify withdrawing minimal care for the patient, including nutrition and hydration. Death by starvation or thirst is, in fact, the only possible outcome of such a withdrawal. If done knowingly and willingly, this ends up being euthanasia by omission. (John Paul II, Address on Life-Sustaining Treatment and the 'Vegetative', §4)

On this view we should be especially vigilant not to abandon patients in the face of economic pressures to be rid of certain patients or to clear beds for others, of physical and emotional exhaustion of bystanders, and of an advancing culture of death sometimes found even in our own ranks. Any policy not to feed or not to feed artificially whole classes of patients or all those in certain institutions should be regarded with suspicion. Advanced

directives encouraging such a course could very well be suicidal in their intent and should not be offered to people, let alone respected if they are given.

The Seldom Feed View

A third view, which might be called the "Seldom Feed View", has much in common with the Never Feed View. It argues that while it is normally inappropriate to feed patients in PVS or like situations, there will be some exceptions, e.g. where the diagnosis or prognosis is still in some doubt, or where organs are marked for harvest, or where relatives are returning from overseas and would like the patient to be alive to say goodbye, or where the patient's family have peculiar religious beliefs which require that everything possible be done. Some institutions and professionals might have a 'No PEGs' or 'No tube feeding for PVS' policy, others might not, and families should be free to choose. But overall health professionals should discourage assisted feeding unless there is a fair prospect of return to a reasonable quality of life.

The Usually Feed View

A fourth view, which was taken by Pope John Paul in his address and which I will call the "Usually Feed View", has much in common with the Always Feed View as it proposes a presumption in favour of feeding to which there will be some exceptions. Everyone is entitled at least to food, clothing, shelter, sanitation, company and prayer. So if they need artificial nutrition or hydration they should normally be given it.

The sick person in a 'vegetative' state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc), and to the prevention of complications related to his confinement to bed. He also has the right to appropriate rehabilitative care and to be monitored for clinical signs of eventual recovery.

I want particularly to emphasize that the administration of water and food, even when provided by artificial means, always

represents a natural means of preserving life, not a medical act. Its use should be considered, in principle, ordinary and proportionate, and thus morally obligatory, insofar as and until it attains its proper goal of nourishing the patient and alleviating his suffering. (John Paul II, Address on Life-Sustaining Treatment and the 'Vegetative', §4)

But as John Paul points out, this kind of care is (only) 'in principle' obligatory: if it can no longer achieve its proper goal it is no longer required. Thus assisted feeding and hydration will not be appropriate

- Ø where the patient is imminently dying or already dead;
- Ø where the delivery of such nutrition and hydration is futile: i.e. it is ineffective in feeding, hydrating or comforting the patient;
- Ø where the mode of delivery is too burdensome for the patient; or
- Ø where the mode of delivery places an unreasonable burden upon others.

This means that sometimes it *will* be appropriate to withhold, reduce or withdraw assisted nutrition and hydration. But it also means that *prima facie* such care should be given to those with post-coma unresponsiveness. After all, despite some sloppy talk, they are not dead, not dying, not burdened by assisted feeding; it does work for them in the same way that it works for anyone else; and tube-feeding is usually relatively easily and inexpensively provided in this country. One way of examining our intentions here might be to ask: if PVS or demented or other patients could be adequately fed and hydrated by spoon or with a simple and cheap patch, would we? If our instinct is still 'no' then our reason for withholding tube feeding is not one of the ones traditionally recognised medicine and nursing.

In other places I have argued that to label post-coma unresponsive and like patients as 'dying' or as having a 'lethal pathology' and to call withholding food and water from them 'allowing a natural dying process to proceed' is often confused and inclines people to unethical behaviour. How can someone who, if fed, will live for weeks or years (as the doctors said 'BWV' would do in the Victorian case last year) be said to be dying? Is this simply a tag we apply to create a special class of patients who will, once so labelled, be denied even fairly basic care? After all, everyone suffers from the 'life-threatening condition' so-called that if we are denied nourishment and water, we will undergo a 'natural dying process'; and some people are more dependent than others upon technology or other people's energies for the satisfaction of such basic needs: babies, for instance, and the severely handicapped.

The conference which occasioned the recent papal speech demonstrated that the jury is out on just what, if anything, PVS is and how it is best diagnosed and treated, and just how much instinct and sensation survive even in those suffering very severe post-coma unresponsiveness. It seems that such categorisations are rough at best, describe a wide range of conditions, are sometimes though rarely recovered from (if the patients are not starved first), and involve *some* responsiveness to *some* stimuli. Just what might be experienced by the person is in doubt. But that such patients are often sedated or restrained suggests that they are far from 'vegetative' even from a purely biological point of view. And even if they cannot *experience* the agonies of death by starvation and thirst or react to them, it does not follow that it is morally permissible deliberately to induce that state or that they are no longer the proper subjects of human dignity and the proper objects of human care. Many an illness and many an injustice are suffered unawares but are no less serious for that; and many a person, indeed whole class of person, has been deemed unworthy of care and respect in the past out of what we later came to realize was simple prejudice.

Underlying the Church's concerns here is the long philosophical and theological tradition that human life is of intrinsic value, a 'basic human good'. It is an idea presumed in, until recently, both law and healthcare practice. An increasingly popular alternative, however, is to say that people below a certain quality-of-life threshold do not command the same respect and care as those above it; in particular, their lives are not inviolable and they are not necessarily worthy of medical, nursing and other care. Post-coma unresponsive people need not be fed—whether by tube or otherwise—because they lack the capacity to achieve life's purpose, however this is characterised. Such a view is common amongst those who support the Never Feed and Seldom Feed approaches.

"Quality of life" considerations, often actually dictated by psychological, social and economic pressures, cannot take precedence over general principles. No evaluation of costs can outweigh the value of the fundamental good of human life. Moreover, to make decisions regarding a person's life on the basis of someone's external evaluation of its quality amounts to attributing more or less dignity to that particular person, thus introducing into social relations a discriminatory and eugenic principle. (John Paul II, Address on Life-Sustaining Treatment and the 'Vegetative', §5)

The problems with this sort of thinking have been exposed many times before and I will not rehearse the arguments here. Suffice it to ask why we will not actively kill, or remove vital organs from, or experiment upon, or otherwise subject to indignity people who we think 'as good as dead'? Surely it is because they are not yet dead. Or to ask whether we regard it as irrational or cruel that a woman goes day by day to hold the hand and spoon soup into the mouth and pray with and for her long-demented husband? Such care will make sense to those who understand the preciousness of life and love, even for the profoundly handicapped, but may be mysterious to quality-of-life thinkers.

In the quality of life mind-set there is, as John Paul II observes, a tendency to value life 'only to the extent that it brings pleasure and well-being', to view all suffering as 'an unbearable setback, something from which one must be freed at all costs' and to view 'the growing number of elderly and disabled people as intolerable and too burdensome' — ideas all too familiar in the feeding debate. 'In this context,' the Pope notes, 'the temptation grows to take control of death and bring it about before its time, "gently" ending another's life.' Whether motivated by a selfish refusal to be burdened with another person or by a nobler but misguided mercy, it is 'the height of arbitrariness and injustice' to take it upon ourselves to judge 'who ought to live and who ought to die'.

The Pope's teaching on this matter in his recent *Allocution* should have surprised no-one. It was in keeping with the US Bishops' Committee for Pro-Life Activities *Statement on Nutrition and Hydration* in 1992, the US *Ethical and Religious Directives for Catholic Health Care Services* in 1994, the Vatican *Charter for Health Professionals* in the same year and the Australian *Code of Ethical Standards for Catholic Health and Aged Care Services* in 2001. All supported what I have described as the Usually Feed View. Several bishops and Catholic organisations have taken a similar position, such as Archbishop Hart of Melbourne and Catholic Health Australia when they sought to speak for feeding BWV in the Federal Court last year.

We must promote positive action as a stand against pressures to withdraw hydration and nutrition and so put an end to patients' lives. It is necessary, above all, to support the families of those suffering this terrible condition. They must not be left alone with their heavy human, psychological and financial burden. Although the care for these patients is not, in general, particularly costly, society must allot sufficient resources for this care. There must be appropriate, concrete initiatives such as: a network of 'awakening centres', with specialized treatment and

*rehabilitation programmes; financial support and home assistance for families; facilities to accommodate those who cannot be cared for at home; and respite for families at risk of psychological and moral burn-out... Spiritual counselling and pastoral aid are particularly important as they help the family find meaning in this apparently hopeless situation. (John Paul II, *Address on Life-Sustaining Treatment and the 'Vegetative'*, §6)*

Rather than the positions of those who say 'always feed', 'seldom feed' or 'never feed', the Church proposes that feeding and hydrating, even by artificial means, is a kind of basic caring which should be given unless there are very strong reasons against it in a particular case. This means we should revisit any policies like "we don't accept patients with PEGs" or "we don't use artificial life-sustaining measures" and that we must resist recent proposals to offer patients advanced directives which exclude artificial feeding. We need to offer positive alternatives such as those listed here by the Pope. Some of our institutions should have a specialty in the care of patients suffering post-coma unresponsiveness as some would undoubtedly improve. But even when we cannot cure we can always care. The covenant between the generations demands that at least we try.

This article was originally a paper presented at the National Conference of Catholic Health Australia on 8th September 2004 in Adelaide

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Science with humanity

Helen McCabe

*'One of the salient features of the modern world is the growing interdependence of men one on the other, a development very largely promoted by modern technical advances. Nevertheless, brotherly dialogue among men does not reach its perfection on the level of technical progress, but on the deeper level of interpersonal relationships. These demand a mutual respect for the full spiritual dignity of the person.'*¹

I have been asked to say a few words on this particular paragraph from *Gaudium et Spes*. In attempting to make comment, I will focus on one key concept employed in this paragraph, a concept which, I shall propose, is less readily understood in a world ideologically and morally far removed from the world out of which this encyclical emanated. The concept is: respect for the full spiritual dignity of the human person. In focusing on *this* concept and the values it expresses, I hope to show, in contrast, how the philosophical and ideological influences which have emerged since the promulgation of *Gaudium et Spes* confound not only the aspirations of this document, but, more seriously, threaten to render this concept unintelligible. This development, in turn, has given rise to an array of ethical problems in the field of medical science, in particular, and in the provision of health care more generally. For the sake of brevity, I will attempt to demonstrate how, as a consequence of losing hold of the values which underlie talk of respecting the full spiritual dignity of the human person, we are no longer able to administer and finance health care services in ways that are either just or compassionate. Consequently, we fail the human person.

Gaudium et Spes articulates an understanding of the very preciousness of human life according to which every human

person has intrinsic, equal and inalienable dignity or worth and, therefore, deserves uncompromising reverence and respect regardless of race, gender, social status, personal wealth or other arbitrary factors. Accordingly, it is the individual person who is central to the social and political order,² the creation and maintenance of which is ultimately for the purpose of promoting human good or human fulfilment. In other words, the existence of a political order, or a common good, reflects our social and interdependent nature; when we work towards promoting the common good of our communities, we also act to uphold the dignity of each member of that community. For instance, on thinking about the need for health care in the contemporary world, much of what comprises this good is beyond our personal capacities to provide. Therefore, we must collaborate and cooperate with others in order to fulfil our needs for health, life and the relief of suffering associated with illness and injury.³

Recent history has shown that the development of vaccines, pharmaceuticals, and of scientific knowledge and technological know-how is better achieved through scientists collaborating on an international scale. At the same time, in order to render the benefits of medical advances accessible to all

in health care need, it is also necessary to cooperate with others in raising and distributing the requisite financial and administrative means for doing so; the advent of universal health insurance schemes, both in Australia and in many other nations, including some poorer nations, has enabled the realisation of such aspirations. In this sense, individual flourishing is realised through the sharing of life, of activity and of material goods in community with others.⁴ At least, it is these conceptions of the human person and of the common good which are central to *Gaudium et Spes*.

However, in ways unforeseen at the time of this encyclical, the rise of an atomistic form of individualism now acts to undermine the very notion of the common good in which to respond to human need. In its place, we find an encroaching so-called 'free' market where, according to the proponents of a more radical expression of liberalism, the autonomous individual may make his or her way in the world unencumbered by obligations to others. This autonomous being is respected not as one created in the image of God, not as one in need of community, and not as one who bears actual needs, but as one whose individual interests are to be sought through the expression of choice. That is, on a more radical liberal worldview (one that originates in the work of John Stuart Mill), the basis of morality is founded on individual preference, or individual choice itself. It is individual choice, then, which is the supreme good or ultimate value and it is valued, moreover, regardless of the moral worth, or otherwise, of what is actually chosen; for what an individual has chosen becomes 'good' simply because she has chosen it.⁵

The political correlate of this worldview is the State as a device *not* for meeting human need but, instead, a device for maximising choices; in this respect, the contemporary State gives way to, or grants a less bridled expression of, the norms, values and purposes of the 'free' market where individual choice is granted free reign. For this reason, we

increasingly look to the market as the social realm in which to provide health care services; thus negotiations can occur around price, as distinct from human need.

In consequence of this development, we find a growing disparity between the 'health care haves' and 'have-nots' on a background of diminishing support for publicly funded health care services. In the United States where the most sophisticated medical technology is developed and applied, we find more than 44 million people without access to even a basic level of primary health care while even greater numbers of American citizens lack adequate insurance coverage should they suffer any more serious (or more expensive to treat) medical problems.⁶ Underlying this predicament is a denial of any obligation on the part of the community to provide for the health care needs of those members who lack the pecuniary means for meeting the cost of private health care insurance; as one libertarian proponent of a market in health care says: 'it may be unfortunate that some are denied health care, but it is not unfair'.⁷ In Britain, as is the case in the United States, we discover a newfound avoidance of those patients with more expensive conditions to treat, such as HIV, cancer, schizophrenia and other chronic conditions.⁸ In Sweden, the public health care services originally designed to grant priority of concern to the frail elderly and those more vulnerable members of the community have now been reconfigured to cater to the demands, or choices, of the wealthier middle classes, as are expressed through their greater purchasing power. At the same time, health care professionals are abandoning the public health care system to pursue more lucrative careers available in the commercial private sector.⁹ In other words, access to health care services is now increasingly determined by an individual's place in the market, as distinct from his or her place in a community where systems of health care have formerly enjoyed, on behalf of that community, political protection. In this respect, the dignity of the human person, if such a notion can be contemplated at all, consists in an individual's

choice-bearing capacity, a capacity which, as already suggested, readily finds its expression in the market.

What all this means for the health of large sections of the human family is precisely what the principles enunciated in *Gaudium et Spes* are designed to protect against: the demeaning of the human person. For those who are poor, it seems somewhat nonsensical even to talk of respecting their dignity when, in being excluded from the benefits of health care, they suffer not only harm to their health but, also, as Michael Walzer points out, loss of social standing.¹⁰ That is, they suffer humiliation. In the contemporary world, where the principles of *Gaudium et Spes* are increasingly viewed as anachronistic, respect for the individual person is contingent at best. Indeed, in the absence of a richer conception of the value of the human person, the term 'respect' collapses altogether. Or, at best, respect for persons is changed to respect for autonomy or for individual choice.¹¹ In this sense, those with insufficient means for choosing - children, the unemployed, the unborn, the poor and destitute, the brain impaired or demented, the chronically ill and many others - are in danger of being excluded from both the benefits of scientific medical and economic advances, as well as from that form of friendship found in community.

Instead, our energies and allegiances are increasingly directed towards the market. Market ideology has come to dominate in the contemporary world in ways inconceivable until recently. In addition to its propensity to allow a greater expression of personal choice, another justificatory argument for promoting the market is what some claim to be its ability to achieve greater levels of efficiency. Contemporary market proponents argue that, through the mechanism of competition, the market is able better to distribute goods and services, including the resources of health care, more efficiently than can such bodies as state bureaucracies. For this reason, health care services ought to be provided in a competitive market. We now find a growing number of market-based health care services globally to lend expression to this belief. However,

proponents of competitive markets fail to distinguish between needed goods, such as health care, and commodities. For the competitive market has its own logic and purposes which are contrary to meeting human need; rather, the market's purpose is to pursue profit, not health, or any other needed good. If actual health is achieved in a market, its achievement is merely accidental to the market's purposes. For market efficiency is measured in terms of profit-maximisation, not health benefits.

Distributing health care services

Such talk may sound alarmist. After all, we here in Australia can point to our system of Medicare and assume that everyone has access to a high standard of health care services. And this may, up to a point, still be true. However, the market is sought more often as the favoured realm in which to distribute the resources of health care. This development should concern us greatly.

To talk of a mutual respect for the full spiritual dignity of the human person, as it is articulated in *Gaudium et Spes*, finds us searching, with increasing difficulty, for the means of doing just that in the contemporary world. While the provision of health care has traditionally represented a concrete expression of this principle, it is becoming increasingly difficult to uphold in ways that are respectful of the dignity of all (or even any) human persons. In relation to the health care services provided by the Catholic Church, the U.S. ethicist, Richard McCormick argues that the growing dominance of a competitive market ideology in contemporary culture raises the most direct threat to 'the soul of Catholic health care'. For in order to obtain the means to make available the benefits of modern medical technology, Catholic health care services have little choice but to become full participants in a culture in which the primary purpose of providing such services is to serve the market prior to the patient in health care need. While modern technology can be (and in the spirit of *Gaudium et Spes*

ought to be) employed for the benefit of human persons, it is subsumed, instead, by the prior purpose of the market. Hence, the distribution of health care services is determined by its propensity for procuring profit. Furthermore, health care resources are thought of, less often, as components of the common good and, more often, as individual possessions. This we see in the greater personal (or out-of-pocket) costs for health care, the diminishing support for public health care services, the trend to claim patent protection on scientific and technological developments for longer periods of time, as well as the increasing tendency to privatise health care services. Moreover, if we consider the introduction of a range of private health insurance policies, we will be able to see that the resources of health care are, under the guise of greater efficiency claims, being redirected to benefit the wealthier members of the Australian community at the expense of the poorer. Notably, it is the wealthy who are able better to support the interests of business. This is the case both within and between nations.

By way of example, if we look to the pharmaceutical industry, we find a proliferation of pharmaceutical agents which offer real benefits for a range of serious and often life-threatening illnesses. For instance, to ameliorate the devastating effects of the HIV pandemic, a range of anti-retroviral agents have been developed. However, pharmaceutical companies, aided and abetted by the power of the WTO, have recently been successful in curtailing any concerted effort on the part of the Indian pharmaceutical industry to continue manufacturing generic drugs so as to provide them at affordable rates to the poor. Previously, Indian companies, in developing generic brands of anti-retroviral agents, have been able to provide those agents to individuals at a cost of \$US200 per person, compared with \$US15,000 per person by those companies which hold the patents. However, according to the rules of the WTO, the development of generic brands of these drugs will not be allowed in the future so that, as resistance to existing anti-retrovirals occurs (as it inevitably does), these drugs will be

unavailable to the poor.¹² The beneficiaries here, of course, are the pharmaceutical companies.

Closer to home, as a successful outcome of the lobbying efforts of increasing numbers of commercial health insurers entering Australia's insurance market, we find a range of policies to boost private insurance membership. The most contentious policy involves the re-introduction of a 30% rebate for holders of private health insurance coverage. The cost of this rebate to government amounts to more than \$2.19 billion annually, representing an equivalent amount being withdrawn from public health care services. Consequently, approximately one-third of the cost of private health insurance is now met from public funds.¹³ Moreover, as premiums rise, the cost of the public rebate increases accordingly. This development threatens equity in both access to health care and in the quality of care received. As the subsidy is also applied to ancillary services, the cost to government for dental care of *privately* insured individuals presently amounts to \$300 million annually.¹⁴ Yet, a decision was taken in 1996 to abolish the *public* dental health scheme for very low-income persons, a scheme which cost government only \$54 million annually.

In poorer nations, governments are being forced to give up responsibility for attending to the needs of people in order to service foreign debt. If we consider Latin America for instance, we find that, under the direction of the World Bank and the IMF, governments have been forced to privatise their health services and open up the market to competition from American managed care organisations. Prior to this imposition, the public health care systems of Latin America ensured broad access to basic health care services so that significant improvements in life expectancy rates were realised, together with reductions in maternal and infant mortality rates. Indeed, the disease profile in Latin America came to emulate that of developed nations, with the rate of childhood immunisation in Costa Rica and Argentina exceeding that of the United States. However,

investor-owned, foreign managed care companies have now entered a largely unregulated market where they are at liberty to pursue profit-making unimpeded by obligations to support the poorer members of society who are left with no obvious recourse.¹⁵ And this is the case even though the poor contribute disproportionate amounts of funding to the pool of health care financing to which these managed care companies have access. As a consequence, the progress made in improving the health status of Latin Americans is being undermined.

Overall, what these few examples point to is a loss of respect for the full spiritual dignity of the person. They also reveal an alienation of individuals from each other with marked disparities between those who benefit from scientific progress and those who are excluded from its benefits. In upholding this rather slippery notion of individual choice, human dignity is offended in other respects as well: high rates of abortion and embryonic stem cell experimentation and destruction are but two instances to consider. And if individual choice is the supreme good, as is claimed, then it will be increasingly difficult to avoid the legalisation of euthanasia. And if access to health care is to be determined by the purchasing power of individuals who 'desire' or 'prefer' particular health care services, then Catholic health care services, in the absence of any funding sources alternative to what currently exist, must refuse care to those who can ill afford it. Rather, Catholic health care services will be granting a preferential option for the well-off.

This is not the time, however, for the Church to abandon the sick and the injured. Indeed, it has been a long time since there has been such a need of the health care services of the Church, particularly for those who are, or will be, finding themselves estranged from the benefits of health care. What is needed, then, is a creative approach on the part of the Church to stand outside the ideology of the post-modern culture in which it finds itself so as to honour the full spiritual dignity of the person in times of health care need. This may call for a re-think on how best to fund Catholic health care services. Most importantly, the more serious challenge facing the Church is to find a language in which to speak to the world of what it really means to respect human dignity. For if we are to engage in meaningful brotherly dialogue, we must endeavour to promote, in ways that are intelligible, the true value of the human person in the public realm, to rescue those vulnerable concepts which express that very value, and to demonstrate in our actions that, in our hearts and in our minds, we really mean it.

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