BIOETHICS OUTLOOK

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In this issue

◆ The publication of the encyclical "*Veritatis Splendor*" late last year gave new life to the concept of intrinsic evil. No doubt people can readily recognize the evil of many of the activities the Pope mentions as examples of intrinsic evils: in the economic domain he talks of theft, the deliberate retention of goods lent or objects lost, business fraud, unjust wages, forcing up prices by trading on the ignorance or hardship of another, the misappropriation and private use of the corporate property of an enterprise, work badly done, tax fraud, forgery of cheques and invoices, excessive expenses, and waste. Nonetheless many people are puzzled by what it means to call such activities as these intrinsic evils. In our leading article, Gerald Gleeson elucidates this notion and shows how central it is in a debate about what it means to say that certain moral norms are absolute.

◆ In the last issue Keith Joseph set out the main issues in the contemporary debate about justice in the allocation of resources to health care. In this issue he outlines the actual history of the allocation of resources to health care in Australia.

◆ The Voluntary and Natural Death Bill, introduced into the Legislative Assembly of the Australian Capital Territory last year, now seems unlikely to be enacted, at least in its present form. Bernadette Tobin argues that the Bill confused two quite distinct notions: the withholding or withdrawal of life-sustaining treatment when that has become medically futile or overly burdensome on the one hand and the deliberate and intentional inducement of death on the other.

Just what is an "intrinsic evil"?

Gerald P. Gleeson

One of the most controversial themes in the encyclical *Veritatis Splendor* is that of "intrinsic evil". To many people the expression "intrinsic evil" suggests evil of the very worst kind, an evil like genocide (one of the Pope's examples), and they wonder how genocide can be grouped with deportation and contraception (two of the Pope's other examples).

The category of "intrinsic evil" has become the slogan and focus for current debates in Catholic moral theology about the *absoluteness* of moral norms. In this article (Part I of a two-part study) I outline this current debate. In a second article (Part II) I shall suggest one way in which it might be resolved.

In a sense, every moral theory recognises some kind of intrinsic evil, some point at which a judgment about wrongdoing is "definitive". Moral theories differ over when and how this judgment is to be made, about what constitutes intrinsic evil. For a consequentialist, it would be "intrinsically evil" to bring about more harm than good, either by some a particular action or by some class of actions. For a non-consequentialist, there is more to moral evaluation than consequences: in some instances, at least, the wrong of an action can be identified definitively prior to the assessment of overall harms and benefits ("consequences").

In our consequentialist culture this must seem a bizarre claim: how could we be sure that some action (e.g. lying, killing an innocent person) is inherently wrong and could never be permitted, *in advance* of considering its consequences in a given situation, and/or the ultimate purposes of the agent? Yet, as Jean Porter remarks, the assertion that some actions are intrinsically evil is "one ... we seem unable either to accept or to do without".[1] It is hard to accept because we suppose that in extreme but imaginable circumstances, killing an innocent person, for example, might bring about much more good than harm, and so be justified; on the other hand, it is hard to believe that some kinds of actions, for example, rape and torture, could ever be justified no matter what the circumstances.

If there are kinds of action whose wrongdoing can be identified in advance of all future situations, they will be the subject of exceptionless prohibitions: Never lie; never kill the innocent, never commit adultery, etc., no matter what the consequences. Exceptionless prohibitions presuppose that we can explain why the wrongdoing of a certain kind of action is "intrinsic" and therefore "transcends" all possible variations of circumstance and purpose. The evil of these kinds of action must have a special character all its own, which cannot simply be weighed in the scales against the various goods and evils a particular act will occasion. In order to appreciate how this kind of evil might be possible, it will be helpful to review the use of the term "intrinsic evil" in the Catholic moral tradition.

Stealing $5

First, it is important to note that intrinsic evil is a *technical classification* which does not tell us how serious a particular evil is. Stealing $5 is an intrinsic evil! Secondly, by "evil" is meant *human wrongdoing*, not any of the various other kinds of evil we encounter (natural disasters, accidents, physical handicaps, etc.). Thirdly, as a technical classification, intrinsic evil involves a contrast with, presumably, "extrinsic" evil. In the history of Catholic moral theology, at least two different contrasts have been made in terms of "intrinsic" and "extrinsic".

"Morally wrong" v "In breach of a positive law"

The first contrast is between whether conduct is held to be wrong "in itself" or wrong because of some positive law. Thus, stealing and adultery are wrong in themselves, whereas eating meat on Good Friday (if a Catholic), or driving on the right hand side of the road (in Australia), are not actions which are wrong in themselves, but only wrong (and in normal circumstances) in virtue of the rules of the Church or State, rules which could be changed. In this first contrast, intrinsic evil means "morally wrong" as distinct from "in breach of a positive law". (Of course, some actions are both morally wrong and in breach of a law.) This distinction is important: a sound moral education should lead a person to understand the difference between the wrong of harming one's neighbour and the wrong of eating meat on Good Friday!

One implication of this contrast between intrinsic and extrinsic wrongdoing is that the latter is subservient to the principle of equity (*epikeia*): i.e. an action which is only extrinsically wrong may cease to be wrong when greater ("intrinsic") goods are at stake. Thus, while one is never permitted to harm one's neighbour (an intrinsic evil), one may well be obliged to miss Sunday Mass in order to care for a sick friend. Likewise, one ought never drive in such a way as to endanger human life - that would be morally wrong, but one may need to drive (safely) on the right in order to avoid dangerous road conditions on the left!

This first contrast urges us to go beyond a legalistic approach to morality. Genuine (moral) wrongdoing derives from the nature of things (e.g. from what truly harms one's neighbour), not from positive, and therefore changeable, human or ecclesiastical rules.

Actions and Purposes

In this first contrast "intrinsic evil" characterises a course of action taken as a whole as wrong in itself. This raises the obvious question of what it is for an action to be wrong in itself, but that question needs to be sharpened by distinguishing various aspects of one's action as whole. Clearly, not all aspects of one's action need be wrong for a course of action as a whole to be wrong. Thus, in giving to charity, *what* one does is not wrong in itself, but one's *so doing* would be wrong ("extrinsically") if one's only purpose was to curry favour and gain an undeserved promotion. Conversely, lying is in itself ("intrinsically") wrong, even if one's further intention is good, viz. to spare someone's feelings, or to avoid embarrassment - factors "extrinsic"to what one actually does.

"What one actually does" v Goals, Consequences, Motives and Purposes

Accordingly, a second use of the terms "intrinsic" and "extrinsic" relies on the contrast between "what one actually does" (in itself), and the goals, consequences, circumstances, motives, and purposes associated with what one does. This second contrast connects the concept of intrinsic evil with the distinction between the means and the ends of human action, and so to the great ethical question *whether a good end ever justifies an evil means*?

The choice of a wrongful means, even in the pursuit of noble goals, damages and compromises the moral integrity of the agent.

While a complete moral evaluation concerns itself both with what we choose as our goals, and with what we choose as our means to those goals, the Catholic moral tradition (reasserted in *Veritatis Splendor*) holds that these are distinct items for evaluation: it is one question whether we employ right or wrong means, and another question whether we pursue right or wrong goals. To be upright, both the means and the goals of one's action must be right. It follows that if one's action (what one actually does, even if only as a means) is intrinsically evil, then it can never be made right by some other ("extrinsic") factor - not by circumstances, not by consequences or purposes. Hence if the evil of certain kinds of action (e.g. murder, adultery, torture) is "intrinsic", the norms prohibiting them must be absolute, admitting of no exception.[2]

Against this account it might be argued that *intrinsically* wrong need not imply *always* wrong. The fact that the evil of a certain kind of action (e.g. lying) is "intrinsic" might have only *prima facie* import, since this evil might in a particular context be outweighed by the good consequences of one's action. On this view, lying would be an "intrinsic evil" - wrong not just because of its consequences or as a matter of general policy, but simply because of what it is (knowingly speaking falsely); still, one would be permitted to tell a small lie in order to achieve a much greater good. (And so on, for the other instances of intrinsic evil: adultery, murder, stealing, etc.). The prohibitions of these actions will be at best "virtually exceptionless".

Those who reject this "prima facie" account of intrinsic evil maintain that it fails to recognise the way human beings are affected by the wrong choices they make. The choice of an intrinsic evil (even as merely a means to a good end) is *always*, not just *prima facie*, wrong because at the very least it harms the person who makes that choice. People who tell lies, who commit adultery or murder, thereby embrace wrongdoing as a means to their end, make this wrong their own, and so wrong themselves, irrespective of any good consequences which may result. On this account, a utilitarian ethical approach which ignores the distinction between means and goals and just assesses all the consequences of an action fails to note the special way in which actions impact upon their agents: the difference between *doing* evil and *suffering* evil.

Thus, someone who kills an innocent person in the pursuit of his goals, becomes "a murderer"- that is, acquires a new *moral* "qualification", a changed ethical standing in relationship to the community, which is not reducible to the feelings of regret and discomfort, etc. which may accompany his action. He is held accountable for his murderous act, deserves punishment, etc. (Extreme circumstances might require mitigated punishment, but they never absolve a murderer entirely.) Thus, quite apart from the impracticality of the utilitarian "total assessment of consequences" alone, the utilitarian approach fails to see that even actions chosen as means to an end often have a meaning and moral quality of their own, independent of their circumstances and not reducible to empirical effects on the agent. The choice of a wrongful means, even in the pursuit of noble goals, damages and compromises the moral integrity of the agent.

Proportionalism

Proponents of the *prima facie* view of intrinsic evil might agree that one cannot rightly embrace an intrinsically evil action without doing wrong, without its evil rebounding on oneself. However, they might argue that it is only one's complete course of action which can be evaluated as intrinsically evil, not one of its "parts" (e.g. the means - "the small lie" - one adopts to achieve good ends). This would be the approach taken by those philosophers and theologians who are called "proportionalists". They might deny they are utilitarians or consequentialists, on the grounds that they recognise the intrinsic moral quality of actions as right or wrong, over and above their consequences. They accept that *assessed as a whole* one's course of action can be intrinsically evil, i.e. morally wrong (cf. contrast 1), but they deny that this classification can be applied to one's action ("what one does") apart from a consideration of intention, goals, and circumstances. Prior to this complete evaluation (e.g. of telling this small lie *in these circumstances to achieve these goals*), the claim that what one is doing (e.g. telling a lie) is intrinsically evil (cf. contrast 2) is only presumptive or *prima facie* - in principle open to being overruled by a complete assessment of the circumstances and consequences. This complete assessment may show that the small evil one does as a means is "proportionate" the greater goods one achieves.

Against this, as we have seen, those who argue that certain kinds of (intrinsically evil) actions are prohibited absolutely maintain that within one's overall project, means and ends can be clearly distinguished: for example, that the action which is one's "small lie" can and must be separated from one's overall project of achieving certain goods. In these cases, the choice of an evil means vitiates one's conduct as a whole irrespective of its supposedly good outcomes, e.g. the choice to administer a lethal injection to end someone's life as the means to preventing further suffering. Similarly, if someone cheats in an examination in order to attain a professional qualification, his or her subsequent professional achievements (however great) will always be marred by the flawed way they were attained.

The possibility of separating one's action (in the narrow sense) from one's overall project is also fundamental to the so-called principle of double effect which explains why one may be justified in bringing about evil as a side-effect of one's good action.[3] Thus, the removal of a cancerous uterus is an (intrinsically) good kind of action, separable from its evil side-effects in the case of a pregant woman.

Conclusion

I have sought to explain two ways in which it we can speak of human wrongdoing as "intrinsic" rather than "extrinsic". I have linked these distinctions to the question about kinds of actions being always wrong, and to the question about a good end justifying an evil means. The discussion reveals that the dispute between proportionalists and non-proportionalists really turns on deeper issues of moral agency - how actions and their consequences are to be identified and distinguished, how choices affect the moral character of their agents, and of just what the essence of moral wrongdoing consists in.

It should now be clear why, within the Catholic tradition today, "intrinsic evil" has become the sticking point for rival accounts of the extent to which kinds of human action can be identified and morally evaluated independent of their circumstances and consequences. In Part II of this study I will try to mediate between these rival accounts by asking what, in general, makes a kind of action "intrinsically" wrong.

[1] Jean Porter, *The Recovery of Virtue*, Westminster/John Knox Press: Louisvill, Kent., 1990. p. 141.

[2] E.g. John Paul II in *Veritatis Splendor* and John Finnis in *Moral Absolutes*, Catholic University of America Press: Washington, 1991.

[3] Cf. my "The wisdom of cases and the logic of principles", *Bioethics Outlook* 4/4 (1993): 5-8.

Financing Australian Health Care: *History, current challenges and some proposals for reform*

Keith Joseph

In this article I outline the history of the allocation of health care resources in Australia. My aim is to indicate the problems that our health care system will shortly face and, in so doing, to suggest some practicable and ethical solutions.

I will start by looking briefly at the historical development of the Australian health care system from colonial times to the present. I shall then look at the problems which will soon face the Australian health care system. Like the rest of the developed world, we have an ageing population, and more and more we rely on expensive technology as part of our health care. Together, these factors will increase the cost of health care, both in real terms and as a percentage of our Gross Domestic Product. I will conclude by looking briefly at some of the suggested solutions to these problems.

The Development of the Australian Health Care System

Under our Federal system of government, the constitutional responsibility for health care and prevention rests largely with the States. This has its historical origins in the system of health care developed by the colonial authorities in the nineteenth century which consisted of State-run institutions and institutions operated by religious bodies and private charities. The largest non-government institution involved in health care was (and remains) the Catholic Church. Much of what can be termed "preventative" or "public" health measures such as control of animals and water supply and sewerage was devolved to local government, though usually under guidelines set by the State authorities.

Following Federation in 1901, the Commonwealth assumed responsibility for quarantine and defence, and it was in these two areas that most Commonwealth activities in health were concentrated. The Commonwealth Department of Health was started in 1921. For many years its prime concern was quarantine. Following the First World War there was also established a network of hospitals to care for servicemen returning from the war, hospitals which eventually came under the control of the Department of Veteran Affairs.

Decentralised Origins

Thus until the 1970s the Australian health care system was relatively decentralised. Apart from the Veteran Affairs network, the health care system was controlled by the State or Territory authorities. Usually each hospital was run by its own Board which was composed of members of the community it served. The hospital's services were developed in response to the demands of its community. Most hospitals were general hospitals, providing a broad range of services. There were very few specialist hospitals, and most of these were in inner city areas.

The system was essentially a "fee-for-service" system. For treatment by a medical practitioner, or as a hospital patient, a person was required to pay fees for services provided. This was regardless of whether or not the patient was cared for in a state-owned hospital or a private or religious hospital. A system of private insurance developed, and the poor could usually rely on charity, either private or state[1].

After the Second World War, as part of the post-war reconstruction effort, Commonwealth involvement in the health care system increased. The Commonwealth *National Health Act, 1953* provided some limited benefits: in particular, the Pharmaceutical Benefits Scheme was introduced, and provision was made for the supply of hearing aids. The Act also allowed for the regulation of private health funds by the Commonwealth.

However, in general, the system continued to develop under the control of the States, with fee-for-service supplemented by charity[2]. This was not, at the time, an unreasonable basis for the provision of health care: times were prosperous, private insurance relatively cheap, and the services available were fairly limited.

Golden Age Wanes

However, this golden age began to wane in the 1960s as new and expensive technologies became available. In 1972 a Labor government under E.G. Whitlam was elected: part of its platform was the provision of universal health care. The election of the Labor government also coincided with the start of a period of significant growth in the national health care bill, the increased use of new technologies, and the end of full employment.

On 1st July 1975 Medibank, the system of universal and non-contributory medical and hospital care, was begun. However, with the success of the Liberal Party in the December elections of 1975, the scheme came under review. Medibank was whittled away. First contributions were changed, then people were allowed to opt out if they joined a private health fund, and finally universal insurance was abolished altogether. By September 1981 only pensioners and the poor were provided with non-contributory hospital and medical services. For others it was either self-funding or private insurance: in short, a structure of health care funding similar to that obtaining in the USA.

There are problems already present, or soon to be present, in the health care system: essentially there will not be enough resources, especially at Government level, to cope with the demands that will be placed upon the health care system.

When Labor returned to office in 1983 Universal Health Insurance was once again introduced, effective from 1st February 1984. The new scheme was known as Medicare but, unlike the United States scheme of the same name which mainly covers the elderly, it was (and still is) both universal and financed through the taxation system. Private insurance to cover admission to private hospitals (or as a private patient in a public hospital) and ancillary services also became available.

Under the various agreements reached between the States and the Commonwealth, public hospitals provide free accommodation to all public patients who belong to Medicare. The services of medical practitioners are still paid for on a fee-for-service basis, reimbursed by insurance. The result now is that we have a modified two-tier system, both in structure and funding, with private and public sectors operating under Commonwealth and State guidelines.

The two-tier nature of our present funding arrangement can be illustrated by looking at how acute hospital inpatients are now covered. The Commonwealth is responsible for the provision of medical benefits, either directly through Medicare, or indirectly through regulation of private insurers. It is also responsible for pharmaceutical costs through the Pharmaceutical Benefits Scheme (PBS). In addition the Commonwealth is responsible for the health care of veterans, though it should be noted that Veterans' hospitals are being progressively handed over to the States. The States have responsibility for determining the mix and location of services, and for the regulation and licensing of hospitals. The setting of private fees and funding of hospitals is a mixed Commonwealth/State responsibility. In 1989/90 40% of funding came directly from the Commonwealth, 48% from the States, and 12% from private insurers.[3]

The result is a public hospital system made up mainly of hospitals owned and financed by State governments, supplemented by not-for-profit non-government hospitals which are also funded by the State. In most States, control of hospitals and other government health services has been largely devolved by State Departments of Health to Area Health Services. Independent of the public system is a private system, consisting of for-profit and not-for-profit institutions. These institutions are financed by Medicare reimbursements (to 75% of scheduled fees for medical procedures), private insurance (covering accommodation, the "gap" between Medicare reimbursement and the schedule fee, and ancillary services) and payments by patients (for fees over the schedule).

Your Local GP

This fairly complex arrangement is reflected in other areas of health care provision and funding. Take, for example, your GP: he or she is licensed by a State government authority, but his or her fees are paid by Medicare to 85% of the schedule. Any further fees are paid by you. If you are prescribed pharmaceuticals, the regulation of the dispensing of the pharmaceuticals is controlled by the State Department of Health. The Commonwealth, however, regulates funding through the Pharmaceutical Benefits Scheme (PBS), for which you pay part and the Commonwealth pays the rest - unless, of course, you have been prescribed drugs not covered by the PBS, in which case you pay for them, (though you may receive partial reimbursement from a private insurer).

So, we have a system in which the States have most of the responsibility for administering and regulating the health system and the Commonwealth has most of the responsibility for the provision of funds (though these are often spent at the discretion of the States). This government structure is supplemented by a private structure: private hospitals, insurers, and providers such as GPs. Funding in the private sector is on a fee-for-service basis.

Future Crisis ?

By and large, at present, the system works. However, there are many problems looming which will demand an intelligent and ethically-informed response. Several government[4] and private[5] reports have examined these problems which may be summarised as follows:

- Increasing costs of the Pharmaceutical Benefit Scheme and Medicare - leading to a diversion of Commonwealth funding away from other health care priorities, such as mental illness, Home and Community Care schemes, and preventative health measures;
- Demographic changes, with an increasing proportion of the population being aged - leading to an increased proportion of the population with disabilities and requiring expensive medical care;
- Declining government funding, as government at all levels (Commonwealth, State and Local) attempts to control expenditure and reduce deficits;
- Overlapping of services between Commonwealth, State (and Territory) and Local Government authorities;
- Declining proportion of the population covered by private insurance, coupled with increases in the cost of private insurance - leading to added pressures upon the public system;
- Increasing expenditure on technologies, especially diagnostic technologies;
- Problems in access to public hospitals for elective procedures - "waiting lists", "queue jumping" by privately insured patients, etc.;
- Poor co-ordination of hospital services, especially in metropolitan areas;
- Requirements for increased capital expenditure in the 1990s following a period of restraint and cost-cutting in the 1980s;
- Historical funding of hospitals: inequity in the distribution of funds.

This list is not exhaustive. However, it indicates that there are problems already present, or soon to be present, in the health care system: essentially there will not be enough resources, especially at Government level, to cope with the demands that will be placed upon the health care system. It is this perception of impending crisis which has been part of the motivation for the present Commonwealth Minister of Health, Senator Graham Richardson, to push forward with fairly radical reforms in the private insurance and hospital sector.[6]

One obvious solution to problems of insufficient resources is to cut costs and make the system more efficient. Indeed, this was the response of the 1980s. However, it would seem that we have reached the point where there is little more that can be done within the structure of the present system. Thus we must now look at changing the structure of the system: a large range of proposals has been made, from moderate proposals for reform through to some quite radical changes.

In general, it can be said that there is widespread agreement that we ought to avoid the United States system. Even a body such as the Committee for Economic Development of Australia (which is largely sponsored by business interests) stresses the need for universal cover of basic health care. However, given that caveat, there are many radical proposals for reform.

Proposals for reform

Some of these proposals are targeted at the supply of services. For example, privatisation of hospitals, audits of the quality of service associated with the accreditation process, and the use of Diagnosis Related Groups (DRGs) are all aimed at increasing the efficiency of services provided.

Other proposals concentrate on the funding of services, usually with the intent of reducing demand (as with co-payments) or that of inducing suppliers of services to be more efficient (DRGs). Many proposals, such as those for rationing of health services or limiting the public funding available, cover both supply and funding.

Each of these proposals has certain ideological presuppositions, and indeed different ethical implications. So, how do we proceed from here?

Firstly, we need clearly to establish those values which will guide us in the selection of solutions to the problems we face. In a practical sense, we need to establish the ethical basis on which we will approach the allocation of health care resources. I would suggest that prime among these values will be equity, justice, love, and stewardship. In other words, we need to allocate our health care resources in a just, beneficial and efficient manner.

The last sentence, of course, could justly be called a "motherhood" statement. We need to be able to relate these values to the real problems of our health care system. This requires an analysis of these values, and of their relation to the real world. It also requires an analysis of the proposed solutions in the light of these ethical values.

In future articles I hope to contribute to this project; that is, to examine values such as justice in relation to the perceived problems and the suggested solutions in the allocation of health care resources. In the next issue the reforms currently being proposed by the Commonwealth Government in relation to private health insurance will be examined.

1 Evans, David "'Abusing Charity' - Hospitalization and the care of the sick in 20th Century Victoria", in John Pearn and Catherine O'Carrigan (eds) *Australia's Quest for Colonial Health: Some influences on early health and medicine in Australia*, Department of Child Health, Royal Children's Hospital, Brisbane, 1983.

2 An exception to this was Queensland. There free health care in public hospitals was provided by the state government until the introduction of Medicare.

3 National Health Strategy, Issues Paper No. 1: *The Australian Health Jigsaw: Integration of Health Care Delivery*, July 1991, pp. 38-39.

4 National Health Strategy, Issues Paper No. 2: *Hospital Services in Australia - Access and Financing*, September 1991.

5 Committee for Eonomic Development of Australia: *A Plan for Health Policy Reform*, December 1993.

6 *Sun Herald*, 5 Dec 1993, "$2b Medicare blowout", p.2; Speech to Doctors Reform Society, 18 Nov 93, by Senator Richardson.

7 CEDA, op. cit., p. 36.

The distinction between foregoing life-sustaining treatment and directly inducing death

Bernadette Tobin

> *"An Act to make provision with respect to the withholding or withdrawing of medical treatment from, and the administration or provision of drugs to induce the death of, persons who are terminally ill".*

It now seems unlikely that the Voluntary and Natural Death Bill, introduced into the Legislative Assembly of the Australian Capital Territory last year, will be enacted, at least in its present form. Nonetheless the underlying philosophy of this Bill is worth examining. One element of that philosophy consists in the equating of two morally-distinct activities. This mistaken equation, and the confusion it generates, is to be found not only in this Bill but also in the thinking of many people. It is worth trying to dissolve this confusion.

First, a few words about the purpose of this Bill. The Voluntary and Natural Death Bill is intended to clarify the law as it relates to the medical treatment of people who are seriously ill or dying and in particular to give legal sanction to the refusal of life-sustaining treatment. Such refusals might be made by a patient himself (where the patient is competent) or by another person on a patient's behalf (where the patient is incompetent). One of the proponents of the Bill described the present situation as "chaotic and unregulated" and open to abuse. Another said: "You get to a stage where life support systems are not an option. If you turn it off, the person dies, and we have to have a way of dealing with this."[1] The Voluntary and Natural Death Bill is thus one of a series of recent legislative and non-legislative attempts in the Australian states to enshrine the right of a person to refuse treatment, even when that treatment is life-sustaining. Each of these laws and sets of guidelines, though they generally have features in common, needs to be considered independently.

Section 15 of this Bill says: *"A person who is of sound mind and has attained the age of 18 years may make a direction that in the event he or she suffers a terminal illness (a) extraordinary measures shall not be applied to him or her, or (b) a drug for the purpose of inducing his or her death shall be administered or provided to him or her."*

In passing, the sloppiness with which some of the key terms are defined in the Bill should be noted. "Extraordinary measures" are said to be *"medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation"*. On this definition the cardio-pulmonary resuscitation of someone whose heart stops beating after routine, curative surgery would be an extraordinary measure ! "Terminal illness" is defined as *"any illness, injury or degeneration of mental or physical faculties such that (a) death would, if extraordinary measures were not undertaken, be imminent; or (b) there is an absence of thought or perception from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken"*. On this definition, people who suffer from dementia are categorized as terminally ill !

Section 15 quoted above clearly refers to competent adults, people who aware of themselves and their circumstances and are able to reflect on and discuss their future medical care. (In this short article, I set aside what the

Bill proposes in respect of people who are incompetent.) If such a person becomes terminally ill, he or she may direct either that extraordinary measures shall not be applied or that a drug for the purpose of inducing death shall be administered or provided to him or her. Neither here, nor in any other part of the Bill, is there a distinction made between the refusal of burdensome (and in that sense "extraordinary") treatment on the one hand and the request for the direct hastening of death on the other. The Bill thus treats as morally-indistinguishable two quite distinct practices.

Of course, in one important respect, the two practices are identical. The outcome will be the same if either life-sustaining measures are foregone or death is directly induced. But, though outcomes matter from a moral point of view, they do not by themselves *determine* the morality of an action. It also matters how an outcome is brought about. The underlying philosophy of this Bill - in treating as alternatives the foregoing life-sustaining treatment and the direct inducement of death - is not simply saying that outcomes matter, but rather that they are all that one needs to take into consideration in assessing the morality of an act.

In order to see why this idea - central to the moral theory called "Utilitarianism" or "Consequentialism" - is mistaken, we need to bring to mind the other facets of our actions which are morally significant. The *intention* with which I act and the *motive* out of which I act are just two of these.[2] If, in administering a dose of morphine to a dying patient, I intend to relieve that person's suffering, I do one thing. If, in administering the same dose, I intend to hasten that person's death, I do another, morally-quite-distinct, thing.[3] If, in giving up my seat on the bus to the old lady, I am motivated by concern for her well-being, my act has quite a different moral value from that which it would have if I did the same thing motivated by the desire to attract the admiration of an onlooker.

Often, in working out what we should do, it would be irresponsible not to take into consideration the likely consequences of our actions: whether or not (for example) to send one's child to a private school so as to enable her to receive a better education than at the local public school. But, given the two examples above which show the importance of both intention and motive, the idea that the outcomes are *all* that matter from a moral point of view is a mistake.

So, even though the outcomes of withdrawing or withholding life-sustaining treatment may be the same as those of directly inducing death, that is not a good reason for treating them as morally equivalent.

The distinction between foregoing life-sustaining treatment and directly inducing death can be illustrated by reference to both traditional Catholic thinking and to the Anglo-Australian legal tradition.

In the Catholic moral tradition, in which there is no place for killing an innocent person (even with the intention of relieving that person's suffering - euthanasia), it has always been held that there is no obligation to accept life-sustaining treatment when either (a) the treatment would be medically futile or (b) the treatment would be disproportionately burdensome. Of course, there is much debate within the tradition about the meaning and extension of the terms "medically futile" and "disproportionately burdensome". And so there should be. For instance, it is not *obvious* whether the provision of food and water to a patient who is in a persistently vegetative state is medically futile. And again, what is tolerable treatment for you may be too burdensome for me; what was tolerable treatment for me a little while ago may have become too burdensome for me now, etc. But the underlying principle is clear: A person may refuse treatment - even treatment which is keeping him or her alive - if it is achieving none of the goals of medical treatment or if it is overly burdensome. Put briefly : a doctor is not morally obliged to keep a person alive at any cost.

In Anglo-Australian law, the distinction is even clearer. The direct, deliberate and intentional hastening of death (euthanasia) is illegal. But the law recognizes the right of any person to refuse any treatment, even treatment which is life-sustaining (except from suicidal motives). If, after having been properly advised about the treatment options and likely outcomes, a patient refuses treatment, his doctor would be neither civilly or criminally liable if the patient were to die. In fact, if a doctor imposes treatment against the wishes of a (competent) patient, the doctor commits the civil wrong of trepass and may commit a crime of assault. And it makes no difference whether or not the doctor thinks the patient is being irrational.

In addition, a doctor is only obliged to provide, or to continue to provide, "reasonable care", a legal formulation which is based on the same idea, that treatment which either has no reasonable chance of benefitting the patient (treatment which is "medically futile") or is excessively ("disproportionately") burdensome may be withdrawn or withheld (even if withdrawing or withholding that treatment will bring about the death of the patient).

There are many other aspects of this Bill which require careful consideration. I have concentrated on just one element in its underlying philosophy. One implication is this: we should reject the idea that the proposals to legalize euthanasia (the direct hastening of a person's death with the intention of relieving that person's suffering) would do no more than to bring the law into line with contemporary medical practice. No doubt some doctors do directly hasten their patients' deaths in order to relieve their suffering: to the extent that they do, they commit euthanasia. But where a doctor withdraws or withholds life-sustaining treatment because it is medically futile or because it is overly-burdensome, he or she does not commit euthanasia. What the doctor does is not only standard and good medical practice: it is perfectly legal.

[1] As quoted in the Canberra Times, 30 June 1993, p.20.

[2] There are others: for instance, the kind of act I choose; the wider circumstances in which it is done.

[3] Here I do not want to lend support to the idea that pain-relief in dying patients cannot be accomplished without hastening their deaths. Specialists in palliative care are able these days to relieve painful symptoms of (say) advanced cancer in all but a small percentage of cases. Other measures need to be taken in those few cases, but these need not involve the hastening of death.

John Plunkett Centre Philosophy Colloquia Programme, 1994

Mar 25	JPCE	"Patients who express a wish to die: What do they want?" Bernadette Tobin, JPCE and Paul Glare, Royal Prince Alfred Hospital
April 15	ACU, MK	"A values-based approach to the ethics of genetic engineering" Keith Joseph, JPCE
May 13	JPCE, SVH	Topic to be announced Reneé Fox, Annenberg Professor of the Social Sciences, University of Pennsylvania
July 15	JPCE	"Epistemology of person perception" Derek Brookes, Philosophy, ANU
Aug 15	JCPE	"Heidegger and Democracy" Simon Longstaff, St James Ethics Centre

All Colloquia commence at 2.15 pm. Colloquia to be held at the John Plunkett Centre (JPCE) will be at 17 Leichhardt Street, Darlinghurst. Colloquia to be held at ACU, MK, will be held at the MacKillop Campus of Australian Catholic University in the Carroll Building, 40 Edward Street, North Sydney. Further details of the venue for Professor Reneé Fox's colloquium are available from the John Plunkett Centre.

Dates to keep free for the remaining presentations in the Colloquium series are September 2, October 7, November 18 and December 2. Details will be publised in the next issue of *Bioethics Outlook*. For further information, contact John Quilter at the John Plunkett Centre or at Australian Catholic University, PO Box 968 North Sydney NSW 2060.

NOTEBOOK

Intensive Bioethics Course

The first Intensive Bioethics Course to be sponsored by the John Plunkett Centre for Ethics in Health Care will be held at Manly College on the weekend of 17 to 19 June this year.

This weekend course will provide an intensive introduction to the philosophical, theological, legal and economic aspects of the provision of health care.

The faculty will include staff at the John Plunkett Centre, together with prominent clinicians and philosophers from around Australia.

The Intensive Bioethics Course will provide a suitable background in bioethics for applicants for the Masters in Applied Ethics (Health Care) at Australian Catholic University who have not undertaken studies in either philosophy or theology.

The weekend programme will be made up of lectures, seminars and informal dicussions. Participants will be encouraged to live in at the College from Friday evening until late Sunday afternoon.

For further details of this weekend, contact Barbara Reen at the John Plunkett Centre.

Conference Proceedings Now Available

The first Philosophy and Applied Ethics Conference was held at the University of Newcastle in August 1993. Papers were given by Cliff Hooker, Paul Crittenden, Richard Sylvan, Jane Bryson, Keith Joseph, Peter Isaacs and David Massey, Lynn Gillam, Hiram Caton and Jeffrey Minson, Howard Whitton, Andrew Alexandra and Seamus Miller, Udo Schuklenk, Leslie Cannold, John Quilter and Bernadette Tobin.

Proceedings of the Conference are now available from Mr Keith Joseph at the Department of Philosophy at the University of Newcastle, NSW, 2308.

The cost is $16.00 each, with air mail postage and handling as follows (additional copies in brackets):

- within NSW $5.00 ($2.00 for additional copies)
- rest of Australia $8.00 ($3.00)
- New Zealand $17.00 ($7.00)
- other overseas countries $26.00 ($15.00).

Please make cheques payable in Australian dollars to *Philosophy Conference Committee*. For further details contact Keith Joseph at the John Plunkett Centre on Tuesdays or Wednesdays.

Graduate Certificate and Master of Arts in Applied Ethics (Health Care)

Brochures for the Graduate Certificate in Applied Ethics (Health Care) and for the Master of Arts in Applied Ethics (Health Care) are included in this issue of *Bioethics Outlook*. These courses are offered by Australian Catholic University. The deadline for applications has been extended. Applications are welcome for mid-year commencement in 1994.

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