
BIOETHICS OUTLOOK

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In this issue

◆ In the first article in this issue Gerald Gleeson begins by summarizing the main points made by the American Bishops in the recent revision of their Ethical Directives for Health Care. (The Directives were published in full in *Origins*, the CNS Documentary Service, on 15 December 1995.) He goes on to discuss in some technical detail the Appendix to the Directives which sets out the principles according to which individuals or institutions may cooperate in the wrongful activities of other individuals or institutions. Though these Directives apply only to Catholic individuals and institutions in the United States, they will no doubt be of interest to our Australian readers.

◆ In the second article, Bernadette Tobin begins by trying to bring some clarity into the contemporary discussion of euthanasia. (Given the widespread confusion about what is and what is not euthanasia, an apt subtitle to the first part of her paper might be "But that's not euthanasia!".) In second part of her article, she draws on a paper given by John Quilter at a recent public seminar sponsored by the Plunkett Centre to argue that, for at least two reasons, no compassionate society should remove the legal prohibition on euthanasia as the Northern Territory Parliament is currently considering so doing.

US Catholic Bishops revise health care directives

Gerald Gleeson

On November 17 of last year, the United States Catholic Bishops Conference approved a revision of their ethical directives for health care, previously issued in 1971 and revised in 1975.¹ Drafting of this revision has taken several years, and has been subject to scrutiny both by the bishops themselves and by the Vatican's Congregation for the Doctrine of the Faith.

With the exception of a few sections, the new document reads well. It has the sound of a single voice, rather than that of a committee. It would be wrong to expect these directives to alter the fundamental moral convictions of the Catholic tradition. However they have a fresh emphasis and tone and an insightful arrangement of material, together with development in the application of the teaching to the ethics of health care in the 1990s.

The title "directives" may sound a little authoritarian, by contrast with "code" or "guidelines". Still, it is appropriate for the bishops to acknowledge explicitly their responsibility to ensure that health care services provided in the name of the Catholic Church are consistent with the Catholic moral tradition.

In this regard, possibly the most significant section of these directives concerns cooperation between Catholic and non-Catholic health care providers. After commenting briefly on the document as a whole, I will consider this issue in some detail and offer supplementary remarks on some directives.

Overview

Through six major parts these Directives move from a consideration of the social and religious context of health care provision, to consideration of the relationship between the patient and the health care professional, to consideration of specific issues related to the beginning and ending of life, and finally to collaboration with non-Catholic providers.

Part 1: The Social Responsibility of Catholic Health Care Services.

The Directives are concerned primarily with institutionally-based Catholic health care services. The bishops note that (as in Australia) these Catholic institutions are part of the nation's health care system as a whole. Catholic institutions are said to be guided by five normative principles:

- 1) the commitment to promote and defend human dignity;
- 2) the biblical mandate to care for the poor - which in the US context requires particular attention to the uninsured and underinsured;
- 3) the contribution to the common good;
- 4) the responsible stewardship of available health care resources; and
- 5) the recognition of a pluralistic society, without compromising Catholic convictions.

The following Directives from Part I are noteworthy:

Directive No. 3: A Catholic institution "should distinguish itself by service to and advocacy for those people whose social

condition puts them at the margins of society and makes them particularly vulnerable to discrimination".

Directive No. 5: "Catholic health care services must adopt these directives as policy" and require adherence to them within the institution. This requires education for staff at all levels.

Directive No. 6: "Collaboration with other health care providers" in ways that do not compromise Catholic teaching can be an effective means of stewardship of limited health care resources.

Part 2: Pastoral and Spiritual Responsibility of Catholic Health Care

The bishops next look to the religious context of health care, and the link between physical healing and the spiritual dimensions of human life. Illness often leads a person to appreciate the deeper spiritual aspects of human existence. Given the reduced length of stay in hospital, these days, the pastoral care of patients will often be provided at the parish level. Nonetheless, institutions must provide pastoral care services to minister to the religious and spiritual needs of those it serves.

Part 3: The Professional-Patient Relationship

It is in the context of the professional-patient relationship of "trust, honesty and confidentiality" that the bishops begin to address the particular ethical issues which arise in health care today. They recognise that often a patient is cared for by a "team" of health care professionals, but this should not alter "the personal character of the interaction" between patient and provider.

The bishops speak not of the patient's "autonomy" - as is fashionable in much bioethical writing but of the "reciprocal" relationship between patient and professional in

which each collaborates with the other within the context of the Catholic facility.

Directive No. 24 requires Catholic facilities to "make available to patients information about their rights, under the laws of the state, to make an advance directive for their medical treatment" - advance directives that will be honoured provided they do not conflict with Catholic teaching.

Directive No. 25 requires that patients be able to identify "representatives" to make health care decisions for them should they become incapable of doing so.

Directive No. 31 notes that in the case of nontherapeutic experimentation, a "surrogate can give consent only if the experiment entails no significant risk to the person's well-being".

Directive No. 35 requires health care professionals to "be educated to recognize the symptoms of abuse and violence" and to report cases of abuse to the authorities.

Sexual Assault

Directive No. 36 concerns the care of victims of sexual assault, in particular that of females who have been raped. The bishops uphold the principle that a victim of rape "should be able to defend herself against a potential conception from the sexual assault". Accordingly, they direct that "If, after appropriate testing, there is not evidence that conception has already occurred, she may be treated with medications that would prevent ovulation, sperm capacitation or fertilization. It is not permissible ... to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction or interference with the implantation of a fertilized ovum".

That is, a Catholic facility treating a victim of rape cannot administer medications which, if they were to be effective at all, will be abortifacient (because they will take effect after conception has occurred).³

The Structure of the Directives

◆ A *Preamble* notes the changed context of health care delivery in the United States.

◆ A *General Introduction* introduces the fundamental theological principles which underlie the Catholic Church's commitment to the ministry of healing. It notes that this ministry is now exercised mostly by lay people who have inherited the mission of various religious communities. The bishops affirm the fundamental coherence of faith and science, both "grounded in respect for truth and freedom".

◆ The *Six Parts* consider the major areas in which ethical issues arise. Each begins with an introductory discussion, which is followed by numbered 'directives'.

- 1 The social responsibility of Catholic health care services
- 2 Pastoral and spiritual responsibility of Catholic health care
- 3 The professional-patient relationship
- 4 Issues in care for the beginning of life
- 5 Issues in care for the dying
- 6 Forming new partnerships with health care organisations and providers

◆ The brief *Conclusion* sums up the Directives by returning to the theme of the significance for Christians of human suffering.

◆ An *Appendix* sets out the "principles governing cooperation". (This is reprinted in full on page 6 of this edition of *Bioethics Outlook*.)

Directive No. 37 requires that an ethics committee be available to advise on particular situations and to assist with educational opportunities.

Part 4: Issues in Care for the Beginning of Life

The next two parts deal with the beginning and the end of life, those times at which the "sanctity" of life is most likely to be called into question. Within the Catholic tradition, the beginning of life is especially associated with marriage and the care of women and children. The bishops speak consistently of the "marriage act" rather than of sexual intercourse. This is not prudery, but rather the basis for important moral distinctions. Thus, whereas preventing conception that might result from sexual violence is legitimate self-defence, preventing conception as the fruit of faithful marital intercourse freely engaged in by husband and wife contradicts the meaning of their intercourse as both unitive and procreative.

The bishops approve methods of assisted reproduction which do not separate the unitive and procreative ends of the marital act, and do not substitute for the act (no. 38). They forbid artificial fertilisation which involves fertilisation outside the body, and/or the absence of sexual union (no. 41), as well as surrogate motherhood (no. 42).

Directive No. 48 simply states that "In the case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion". It can be argued that the moral objective in the standard treatment of ectopic pregnancies - removing a pregnancy which cannot develop to viability and which threatens a mother's health and future reproductive capacity - does not involve the moral objective of direct abortion.

Directive No. 49 permits the induction of labour after the foetus is viable, for a proportionate reason, e.g. a grave risk to the physical or psychological health of the mother.

Directive No. 51 prohibits nontherapeutic experiments on a living embryo or foetus, even with the consent of the parents. However, "medical research that will not harm the life or physical integrity of an unborn child is permitted with parental consent" (presuming, one supposes from Directive No. 31 above, that the research involves no significant risk, that is, a risk so insignificant as to be non-existent).

Part 5: Issues in Care for the Dying

Fundamental to the care of the dying is the principle that "The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering and death". Such a principle of judgment avoids those extreme positions which either insist on the use of burdensome or useless technology to prolong life, or permit the withdrawal of technology with the intention of causing death.

The Directives take up explicitly the question of "medically assisted nutrition and hydration" - about which several different statements have been issued by American bishops. The Directives note that all the statements by various American bishops and groups of bishops agree on the principle that "hydration and nutrition are not morally obligatory either when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person's body".

They then remark that a distinction must be made between questions already resolved by the teaching authority of the Church and "those requiring further reflection, as, for example, the morality of withdrawing medically assisted hydration and nutrition from a person who is in the condition which is recognised by physicians as the "persistent vegetative state".

Patients who are in a persistently vegetative state

Accordingly, Directive No. 58 holds that "There should be a presumption in favour of providing nutrition and hydration to all

patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient".

Clearly, these principles - and the crucial recognition that this is a matter of prudential judgment, about which reasonable people may differ - permit the conclusion that nutrition and hydration is not always obligatory in the case of patients who are in a persistently vegetative state .

Directive No. 61 repeats the principle that medicines to alleviate pain may be administered even if they indirectly shorten a person's life, provided the intent is not to hasten death. It is important to reaffirm this general principle even though properly administered, analgesic medications do not shorten life.

Part 6: Forming New Partnerships with Health Care Organisations and Providers.

The final part of the Directives addresses one of the most critical issues for Catholic health care, here in Australia as well as in the US. Health care services today involve the "joint purchase of technology and services with other local facilities or physicians groups", "joining or co-sponsoring integrated delivery networks or managed-care organisations", sponsored health care plans, and also situations in which the Catholic institution is left as the sole provider of health care services in an area.

The bishops affirm that

"new partnerships can be viewed as opportunities for Catholic health care institutions ... to witness to their religious and ethical commitments and so influence the healing profession".

New partnerships can promote better stewardship of resources and more equitable access for the poor.

However, these ventures can also challenge

"the viability of the identity of Catholic health care institutions ... and their ability to implement these directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles".

There is a risk of scandal when partnerships are not built on common values and principles. Financial considerations may even threaten the viability of the Catholic institutions. The bishops recommend "increased collaboration among Catholic-sponsored health care institutions" in the first instance.

Having acknowledged the benefits and dangers of partnerships, the bishops state that

"The significant challenges that new partnerships may pose ... do not necessarily preclude their possibility on moral grounds."

There must be

"systematic and objective moral analysis which takes into account the various factors that often pressure institutions and services into new partnerships that can diminish the autonomy and ministry of the Catholic partner".

Directive No. 67 requires the local bishop to be consulted in the case of partnerships which may entail the risk of scandal, and Directive No. 68 requires the bishop's approval for partnerships entered into.

Directive No. 69 states that where a partnership involves activities judged morally wrong by the Catholic church, "the Catholic institution should limit its involvement in accord with the moral principles governing cooperation".

But even cooperation that would be in all other respects appropriate, may have to be refused because of the scandal that would be caused in particular circumstances (Directive No. 70).

These principles clearly need elaboration - and some is provided in the **Appendix** which I will discuss shortly. The point here is that the Directives encourage Catholic Health Care providers to explore positively the possibilities of collaborative arrangements. Provided they are armed with a sound grasp of the ethical principles about legitimate cooperation, they will not need to retreat from collaboration out of moral squeamishness or anxiety.

The **Conclusion** notes that sickness speaks to us of our limitations and human frailty, which the follower of Jesus faces in the hope of that final healing in the new creation. In the meantime, Catholic health care services respond to Jesus' challenge to bring healing compassion to those most in need.

The Principles Governing Cooperation

"The principles governing cooperation differentiate the action of the wrongdoer from the action of the cooperator through two major distinctions. The first is between formal and material cooperation. If the cooperator intends the object of the wrongdoer's activity, then the cooperation is formal and, therefore, morally wrong. Since intention is not simply an explicit act of the will, formal cooperation can also be implicit. Implicit formal cooperation is attributed when, even though the cooperator denies intending the wrongdoer's object, no other explanation can distinguish the cooperator's object from the wrongdoer's object. If the cooperator does not intend the object of the wrongdoer's activity, the cooperation is material and can be morally licit.

The second distinction deals with the object of the action and is expressed by immediate and mediate material cooperation. Material cooperation is immediate when the object of the

cooperation is the same as the object of the wrongdoer. Immediate material cooperation is wrong, except in some instances of duress. The matter of duress distinguishes immediate material cooperation from implicit formal cooperation. But immediate material cooperation - without duress - is equivalent to implicit formal cooperation and, therefore, is morally wrong. When the object of the cooperator's action remains distinguishable from that of the wrongdoer's, material cooperation is mediate and can be morally licit.

Moral theologians recommend two other considerations for the proper evaluation of material cooperation. First, the object of material cooperation should be as distant as possible from the wrongdoer's act. Second, any act of material cooperation requires a proportionately grave reason.

Prudence guides those involved in cooperation to estimate questions of intention, duress, distance, necessity and gravity. In making a judgement about cooperation, it is essential that the possibility of scandal should be eliminated. Appropriate consideration should also be given to the church's prophetic responsibility."

This is the full statement of the principles of cooperation as they have been established in the tradition of Catholic moral theology. If we ask why we should ever cooperate with a wrongdoer in any way at all, the fundamental answer is that sometimes it is only by cooperating that we can minimise evil and wrongdoing; not to cooperate would be to stand by and allow greater evil to occur. Jesuit moral theologian James Keenan illustrates the moral wisdom of legitimate cooperation with the case of the wife who sees that her brutal husband is about to hit their child with a bat, and unable to restrain him - grabs a belt, gives it to her husband and says, "Here, use this".

But once we accept that sometimes it is better to provide assistance to a wrongdoer than not to, the question arises as to which forms of assistance are permissible and which are not. Clearly, it cannot be right to cooperate if

cooperation means intending and participating directly in the other's wrongdoing, as for instance by driving the get-away car for a gang of bank robbers. Some cooperation makes the cooperators wrongdoers; some enables them to minimise evil, without themselves doing wrong. While this distinction is obviously valid, spelling out the criteria for legitimate cooperation has been held to be the most difficult problem in all of moral theology!

Two Distinctions

As the Appendix notes, Catholic theology has explained the difference between the action of the wrongdoer and the action of the cooperator in terms of two distinctions: first, between "formal" and "material" cooperation, secondly, between "immediate" and "mediate" cooperation.

The formal/material distinction concerns the intention with which one acts. The driver of the get-away car intends the bank robbery just as much as the robbers in the bank do. His cooperation is "formal". The wife who gives her brutal husband the belt in place of the bat does not intend the child to be hit; she intends to lessen the injury. Her cooperation is "material" - it directly contributes to her husband's wrongful act - for he hits the child *with a belt*, - but far from being wrong, her "assistance" is praiseworthy. Likewise the nurse who gives a determined IV drug user a clean needle and says, "Here, if you must inject, use this" provides legitimate material cooperation in order to minimise evil.

The immediate/mediate distinction concerns the "object" of the action, what exactly is being done in a particular case. Driving the get-away car is "immediate" cooperation - i.e. it is a part of the series of actions which constitute the robbery itself. Hiding the robbers after their get-away is "mediate" cooperation - wrong, of course, but not a part of the robbery itself.

Combining these two distinction, a further classification and principle emerges: **immediate material cooperation** may constitute **implicit**

formal cooperation. This occurs when what a person does - irrespective of his or her stated intentions - is immediately involved in the wrongdoing, so that the person must also be held accountable for the wrongdoing. For example, the assisting surgeon at an abortion can be held to be "immediately" assisting the very actions which constitute the wrongdoing. Any claim he makes that he does not intend the abortion is empty. If someone willingly acts as assistant surgeon, he cannot but be intending the abortion. By contrast, a nurse assisting at an abortion may be providing only "mediate" assistance. Whether the nurse "formally" intends the abortion is another matter; clearly he might, but it does not follow from his actions that he must intend this (as it does in the case of the surgeon), for this intention is not *implicitly embodied* in his actions.

Duress

If *immediate material* cooperation may amount to *implicit formal* cooperation, what is the point of retaining two separate descriptions? What distinguishes the two descriptions is the presence or absence of duress. If someone drives the get-away car because he is threatened with death to himself or his family, his cooperation is immediate, but it is not formal at all. The possibility of duress means that when we simply observe a person's actions (e.g. driving the get-away car; providing nursing care) we cannot always be sure whether or not the person formally intends wrongdoing. Thus, the presence of force which takes away a person's freedom of action may change what would otherwise be formal (even implicitly formal) cooperation into material cooperation.

Once cooperation is recognised as material, rather than formal, then it may be permissible, given the further condition that there is a proportionately grave reason for the cooperation, i.e. that the benefits of cooperation minimise evil and outweigh the harms of not cooperating, harms which may include scandal. The more "remote" the cooperator's actions are from the wrongdoing, the easier it is to establish the proportionate reason.

The point of this somewhat technical discussion is that sometimes a Catholic facility which is locked into collaborative arrangement with the government or with other health care providers may find that its freedom of action is limited. The very existence of the Catholic facility may be threatened if it is unable to cooperate with others, or if it is unable provide services required of it as the sole provider of health care services in a particular area. Under such duress, what would otherwise be immediate (and so implicitly formal) cooperation, may become material cooperation. That cooperation is material does not of itself make it permissible; it does mean that such cooperation may be permissible, if the conditions on proportionality and absence of scandal can be met. Even under duress, such immediate material cooperation would never be permissible in the matter of abortion where the life of an innocent third party is at stake. In other situations of duress it may be permissible.

Of course, these implications are not mentioned in the bishops' directives. What matters is that the principles - utterly traditional in Catholic theology - are set out so clearly. Their application in particular situations will be a matter for theological analysis under the direction of the local bishop.

Notes

1 Ethical and Religious Directives for Catholic Health Facilities, *Origins*, CNS Documentary Service, Vol. 24, No. 27, December 15, 1994.

2 *Origins*, 15: no. 39 (1986), pp. 633, 635-638; 16: (1986) pp. 237-238.

3 While the principles invoked here are traditional ones, the formulation is somewhat ambiguous. What, for instance, would constitute 'appropriate testing'? On this particular issue, the directives of the Joint Committee on Bioethical Issues of the British and Irish Bishops are more helpful. It need not be a matter of establishing whether or not pregnancy has occurred. What is relevant to the prudent judgment whether a woman may rightly choose to prevent ovulation (and conception) is what can be known about the timing of ovulation, in particular whether ovulation has taken place, or is about to take place. If, on the basis of reasonable inquiry, it can be concluded that ovulation has not occurred, and will not coincide with the administration of the medication (to prevent ovulation, capacitation or fertilisation), then "hormonal postcoital contraception after insemination by sexual assault" may be administered, provided it can be administered urgently, within about a day. Where it is impossible to determine the likely timing of ovulation, the British Report - having detailed the statistical probabilities that the medication may be abortifacient, - "leaves to the conscience of upright Catholic medical practitioners the judgment whether, given these probabilities, it could be right to administer the pill in such a case."

Notes on the Centre

◆ The first Chairman of the Management Committee of the John Plunkett Centre, Professor Muredach Dynan, has recently been appointed Pro Vice-Chancellor (for Quality Assurance) at Australian Catholic University. The position is to be located on the McAuley Campus of Australian Catholic University in Brisbane.

◆ Mr John Quilter is on leave for the first semester in 1995. He is currently in Pittsburgh where he is completing his PhD thesis. The subject of his thesis is "The Happy-Go-Lucky Person: Moral Luck, Personalism and the Foundations of Eudaemonism". His supervisor is Professor John McDowell.

◆ Mr Keith Joseph is currently on a one-year contract at Australian Catholic University. His time is divided relatively evenly between teaching philosophy at the North Sydney and Strathfield

Campuses of the University and working in the John Plunkett Centre. Keith has recently returned from a visit to Canada where he continued his research in the areas of resource allocation and genetic engineering.

◆ Dr Martin Kelly is spending one full day a week at the Plunkett Centre this year. The rest of his time is being spent completing his studies in philosophy and theology and working part-time in Accident and Emergency at St Vincent's Hospital in Sydney.

◆ Dr Gerald Gleeson has returned from his short sabbatical leave in the last few months of last year. Dr Gleeson worked with the Jesuit moral theologian, James Keenan, at Weston Jesuit School of Theology, Cambridge, Massachusetts. His research included study of 'the moral object of human action'.

Euthanasia Bill puts vulnerable people at risk

Bernadette Tobin

In February this year, the Honorable Marshall Perron introduced into the Northern Territory Parliament a Bill (entitled the Rights of the Terminally Bill) which, if passed, would legalize the practise of euthanasia in the Northern Territory. The Bill will be debated by the Parliament in during its sittings in May. In the following article Bernadette Tobin argues against any proposal - including that in the Northern Territory - to legalize euthanasia. However, since most debates about the wisdom of removing the legal prohibition on euthanasia are bedevilled by misunderstanding about key terms, she begins by setting out what is, and what is not, euthanasia.

I

Euthanasia is the intentional hastening of a person's death in order to relieve that person's suffering. In other words, it is the direct and deliberate hastening of death motivated by concern for that individual person's suffering.

Several things need to be noticed about this definition:

♦ Without the idea that the hastening of death is **intentional**, we could not distinguish euthanasia from other acts which are different human acts even though they have the same consequence: for instance

- (a) the withdrawing or withholding of life-sustaining treatment because that treatment is itself judged to be either medically futile or overly-burdensome for the patient, and
- (b) the administration of a treatment with the intention of relieving the symptoms of illness and in the foreknowledge that this may or will hasten death.

In the appropriate circumstances, **both** (a) and (b) are perfectly good medical conduct. In addition, **both** (a) and (b) are perfectly legal everywhere in Australia. And **neither** (a) nor (b) constitutes euthanasia.

♦ To understand the importance of clarifying the intention implicit in an act, think of the difference between the act of a careful and sympathetic doctor who in immunizing a child by injection knowingly causes that child pain and a callous person who deliberately inflicts pain on a child. We could not express our understanding of the moral difference between what the good doctor does and what the callous person does without reference to the intention with which each of them acts.

♦ To understand the importance of the object of an act (or the motivation with which it is done), think of the difference between deliberately hastening someone's death in order to relieve the person from suffering and deliberately hastening someone's death in order to inherit sooner rather than latter. The former is euthanasia; the latter is killing (or letting die, as the case may be) of a different moral kind - it is a different human act - one which requires its own moral justification.¹

Euthanasia may be either 'active' or 'passive'. That is to say, it may be brought about by active means (for instance, by the use of a lethal injection) or by passive means (for instance, by the failure to treat an infection in order to hasten the patient's death).

The term 'passive euthanasia' is surrounded by perhaps the deepest confusion. Some people are under the mistaken impression that any case of letting someone die is a case of euthanasia. That this is not so ought by now to be clear. Passive euthanasia is the intentional hastening of a person's death (in order to relieve the person's suffering) by an omission (for instance, the omission of antibiotics), **where the purpose of omitting the antibiotics is to bring about the patient's death**. However, if in the presence of a life-threatening infection antibiotics are omitted because they are judged to be medically

futile or over-burdensome, that case of 'letting the person die' is not euthanasia. For, as we have seen, the forgoing of life-sustaining treatment (either by withdrawing it or by withholding it) which is judged to be medically-futile or overly-burdensome is not euthanasia.

Finally, a patient may be euthanatized in accordance with his or her request (voluntary euthanasia) or in the absence of a request from him or her (non voluntary euthanasia).

II

No truly compassionate society should legalize euthanasia for it would put at risk the lives of many vulnerable people.² There are two reasons for this. On the one hand, the mere expression of a wish to die, even by someone who (to quote from the current Northern Territory proposal) is 'suffering from a terminal illness and is likely to die within twelve months as a result of the illness', is not sufficient justification for an individual doctor to accede to such a request let alone to justify legalizing the practice of voluntary euthanasia. On the other, if voluntary euthanasia is legalized, doctors and other health care professionals will be further encouraged to practice it on patients who have not even expressed such a wish. Since neither of these ideas is self-evident, I need to explain them. Let me begin with the idea that certain wishes to die should be resisted.

Three Cases

Consider the following three cases: Imagine an old man who is diagnosed with a cancer which will kill him in less than a year. Like many old people he feels a burden on his family. Feeling guilty about being so sick and so dependent on them, he expresses a wish to be helped to die. Next, imagine a middle-aged woman who suffers from polio and needs a ventilator to help her to breathe at night. Let us say that she becomes so demoralized by the social discrimination she faces every day that she gives up using the ventilator (and so falls into the category of the 'terminally' ill) and expresses a wish to die. Finally, think of a young woman with a fatally progressive form of leukaemia whose self-esteem is so diminished by her worsening appearance that she feels motivated to express the wish to die.

In each of these cases, the proposed legislation to legalize voluntary euthanasia in the Northern Territory would allow and (over time) encourage doctors promptly to accede to such requests for euthanasia. Yet it would be quite wrong for a doctor to accede to any of these requests, from the old man with cancer, from the disabled woman with polio, from the young woman with leukaemia. The fact that each of them requests euthanasia is not justification in itself for someone else - a doctor - deliberately bringing about their deaths. Surveys have repeatedly shown that general practitioners are often unable to distinguish a rational decision from a clinically-depressed one.³ In addition, many are still unaware of the extraordinary advances in the science of palliative care. And so it is not surprising that many people still spend the last stage of their lives in *relievable but unrelieved* pain.

Of course any of the people I have mentioned might in their anguish take their own lives. But the Northern Territory proposal would authorize someone else to kill them, and no amount of talk about 'physician-assisted suicide' can fudge the fact that suicide and euthanasia are morally-distinct human acts. It does not follow from the fact that you think you have reason enough to commit suicide that I thereby have a sound reason for euthanatizing you. Respect for personal autonomy does not trump all other considerations - as the Northern Territory proposal implicitly acknowledges when it insists that the request must come from someone who is (in the sense stipulated) to be regarded as 'terminally' ill.

The other reason why a compassionate society ought not to legalize voluntary euthanasia has to do with the fact that legalization of voluntary euthanasia will inevitably lead to the *de facto* acceptance of non-voluntary euthanasia amongst both doctors and the wider community. We know that legal reform has a causative effect on human behaviour. We should be honest enough to admit that legalizing voluntary euthanasia will not only make it more likely that doctors will accede to requests that are inadequately based: in time it will encourage doctors to expect such requests and even to ascribe them to incompetent patients who cannot make a request.

Already we hear a lot of glib talk about 'what the patient would have wanted' if only he or she could have told us before becoming unconscious. No doubt the belief that one is acting in accordance with what the patient would have wanted is a powerful defence mechanism which helps doctors make difficult treatment decisions. But in the absence of explicit and unambiguous written or oral directions, the notion of an 'ascribed autonomous wish' is a mere projection of the doctor's (or the family's) own preferences. Legalizing voluntary euthanasia on the grounds that respect for personal autonomy is the fundamental moral imperative will encourage the emerging idea that we can ascribe 'autonomous requests' for euthanasia to incompetent patients who cannot make explicit requests.

There is much else to be said about the Northern Territory proposal to legalize euthanasia. Often support for such proposals comes from people who have had first-hand experience of a loved one suffering intensely as he or she dies. It is not good enough to say to such a person that there are centres of excellence in palliative care in some parts of Australia. We ought to recognize a moral responsibility to ensure that such care is available to every Australian regardless of where he or she lives. We ought also to recognize that, in a small number of cases, even the best palliative care cannot relieve the pain of 'terminal' illness. In these rare cases, other measures (of which sedation is only one) need to be taken. And physical pain is only one of the things from which people who know they are dying suffer. Feelings of worthlessness, of guilt and of being a burden on others, the deep desire to make amends for something in the past, are just some of the other forms their suffering takes. There are many ways in which we can better serve dying people than by agreeing with their self-assessment and extinguishing their lives.

It is sometimes said that a majority of doctors would welcome such a change in the law: but Australian surveys of their attitudes and practices are flawed by the general failure of the researchers to distinguish between the direct and deliberate hastening of death on the one hand and the forgoing of life-sustaining

treatment when that is judged to be therapeutically futile or overly-burdensome on the other.⁴ The former is euthanasia (whether 'active' or 'passive'), the latter is no more than good medical care and is perfectly legal everywhere in Australia.

There are many things wrong with the drafting of the Northern Territory proposal. But the most expert redrafting could not make this a wise legislative proposal. Even if one assumes that on occasion a case of euthanasia can be morally unobjectionable, there are still deep reasons for maintaining the legal prohibition. The moral and social cost of legalizing the practice would be too high.

Notes

¹ See Suzanne Uniacke and H.J. McCloskey: 'Peter Singer and Non-Voluntary 'Euthanasia': tripping down the slippery slope': *Journal of Applied Philosophy*, Vol. 9, No. 2, 1992.

² The arguments which follow owe much to a paper given by Mr John Quilter at a public seminar on euthanasia sponsored by the John Plunkett Centre in November last year. (The other speakers were Professor Rummelink, former Attorney General of the Netherlands who, as the chief law officer, oversaw the arrangements by which the Netherlands gave *de facto* legal recognition to the practice of euthanasia (without decriminalizing it) and Ms Lyn Gillam of the Centre for Human Bioethics at Monash University.) See Quilter, J: *Against Legal Protection of Voluntary Active Euthanasia*, in Tobin, B (ed): *Euthanasia: Proceedings of a seminar sponsored by the John Plunkett Centre for Ethics in Health Care*, Sydney, 1995 (forthcoming)

³ A.C. Neilsen III and T.A. Williams: 'Depression in ambulatory medical patients: prevalence by self-report questionnaire and recognition by non-psychiatric physicians': *Archives of General Psychiatry*, 37, 1980. E.B. Knights and M.F. Folstein: 'Unsuspected emotional and cognitive disturbance in medical patients': *Annals of Internal Medicine*, 87, 1977. H.S. Moflic and E.S. Paykel: 'Depression in medical in-patients': *British Journal of Psychiatry*, 126, 1975.

⁴ See Tobin, B: 'Euthanasia survey's fatal flaw', *Medical Observer*, 5 August 1994. Kuhse, H: 'Which fatal flaw?', *Medical Observer*, 16 September 1994. 'Dr Tobin replies', *Medical Observer*, 16 September 1994.

NOTEBOOK

Intensive Bioethics Course

The second John Plunkett Centre Intensive Bioethics Course will take place at St Patrick's College, Manly on the weekend of 30 June - 2 July 1995. The Course offers an intensive introduction to ethical issues in health care to anyone interested, including doctors, nurses, social workers, members of institutional ethics committees and board members.

It also provides a suitable background for applicants for the Masters in Applied Ethics (Health Care) at Australian Catholic University who have not undertaken studies in either philosophy or theology.

Plenary and tutorial sessions will cover the topics of Informed Consent, End of Life Decisions, Resource Allocation and the Ethics of Research Using Human Subjects. Participants are encouraged to live in at the College from Friday evening until late Sunday afternoon so as to gain from the opportunity for informal discussions.

Application forms may be obtained by contacting Barbara Reen at the John Plunkett Centre on (02) 361 2869.

Advanced Bioethics Course

The venue for the first John Plunkett Centre Advanced Bioethics Course on the weekend of 15-17 September 1995 will be the Retreat House of the Franciscan Missionaries of Mary at Point Piper.

The Course will consist in an intensive examination of the contribution of Catholic Christian moral theology to the area of health care ethics. Further details will be provided in the next issue of *Bioethics Outlook*.

1995 AHEC Ethics Workshops

In May 1995 the Australian Health Ethics Committee will be conducting a series of workshops to consult with interested organisations and individuals on matters relevant to the operation of institutional ethics committees.

The workshops will be held in the following cities on the dates shown.

Sydney	2 May	Perth	9 May
Brisbane	4 May	Adelaide	11 May
Canberra	9 May	Melbourne	12 May

Issues to be discussed include:

- Options for facilitating the approval of multi-centre research including clinical trials of drugs, epidemiological and social research;
- The role of institutional ethics committees in the monitoring of research and how monitoring can be effective but not too intrusive;
- The role of the Australian Health Ethics Committee in ethics education.

Anyone interested in ethical aspects of research is welcome. This may include members of institutional ethics committees, board members, researchers, participants in research or members of community groups.

For further information contact:

Australian Health Ethics Committee
MDP 33
GPO Box 9848
Canberra ACT 2601
Phone (06) 289 6992
Facsimile (06) 289 7802

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