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In Life and Death: How do we honour the Patient's Autonomy and the Doctor's Conscience?

The Sandra David Oration
Fr Frank Brennan SJ AO

Joe David was born in the Hunter Valley of Lebanese parents who migrated to Australia in 1900. He worked in the coal mines and later as a hawker throughout the Hunter Valley. He opened his first grocery store in Woolloomooloo in 1927. He married Edith Harper of Paddington in 1930. Edith's ancestors migrated to Australia from Edinburgh in 1820. Joe and Edith raised a family of 12 children, 8 boys and 4 girls. Sandra was the eldest daughter.

Family life and Christian values were very strong within the David Family and Sandra, who was educated by the Sisters of Charity at St Vincent's College, Potts Point, then entered the Congregation. She spent some years teaching in Australia and then joined her brother, Max, in missionary work as a teacher in the Highlands of New Guinea. Following her father's death, Sandra felt committed to care for her mother and joined the family company working with two of her brothers, John and Peter.

Her endurance, her devotion to duty and her commitment were always demonstrated through the values she held dearly. Those characteristics were particularly noted during the long illness she endured suffering from cancer. Sandra died peacefully on 13 September 1994. I think she would have espoused both the doctor's conscience and the patient's autonomy.

While preparing this lecture, I had cause to reflect on the gospel for Monday, the 23rd week in Ordinary time:

In this Issue

Frank Brennan, SJ, AO, recently gave the prestigious Sandra David Oration at St Vincent's Private Hospital in Sydney. We are delighted to offer our friends and subscribers the text of the address he gave on that occasion.

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On the sabbath Jesus went into the synagogue and taught, and there was a man there whose right hand was withered. The scribes and the Pharisees watched him closely to see if he would cure on the sabbath so that they might discover a reason to accuse him. But he realized their intentions and said to the man with the withered hand, "Come up and stand before us." And he rose and stood there. Then Jesus said to them, "I ask you, is it lawful to do good on the sabbath rather than to do evil, to save life rather than to destroy it?" Looking around at them all, he then said to him, "Stretch out your hand." He did so and his hand was restored. But they became enraged and discussed together what they might do to Jesus. (Lk 6:6-11)

I thought Jesus had it easy on one count. The autonomous man with the withered hand wanted Jesus the conscientious healer to do good rather than evil, to save life rather than destroy it. The legalism of the religious authorities could be readily disregarded because the patient's autonomy and the healer's conscience could be honoured by the performance of an agreed healing. But what of the case when the autonomous patient wants the conscientious doctor to perform an action which the doctor thinks wrong and death dealing? And what of the case when the autonomous patient wants the conscientious doctor to desist from doing what the doctor thinks is good and life giving?

The consideration of medico-legal problems in the public square of a pluralistic democratic society keeping pace with profound technological change is often marked by simplistic assertions, precluding considerations of comprehensive world views, whether religious or philosophical. It is now commonplace for doctors to be told to leave their consciences at the door, as their patients are consumers and they are suppliers and of course the market decides. It is suggested that the doctor has a stark choice: "What's to come first, the patient or the ethics?" Debates about law and policy are often resolved with simplistic assertions about individual rights and autonomy, with little consideration for the public interest, the common good, and the doctor-patient relationship. Even conscience is said to be a matter for contracting out.

This evening I ask whether there are more compelling ways to resolve these problems, while conceding a limited role for law in determining the range of acceptable answers. Do we not need to accord a higher value to the formed and informed conscience of the individual medical practitioner?

Do we not need to maintain a high regard for the common good (including the doctor-patient relationship) and the needs of the vulnerable as we circumscribe the realm of personal liberty especially when considering laws dealing with end of life decisions? Do we not need to re-assert the place for basic Christian charity?

In my last book *Acting on Conscience* I write at length about the place of religion in law and public policy. Suffice to say, I think it neither sufficient nor useful to quote Vatican declarations in the public square as if such declarations could settle any controversy, except perhaps with some of my fellow believers and religious adherents. Rational dialogue without too ready recourse to authority is a fine solvent to further the search for the true, the good and the beautiful.

When considering the question: "Should euthanasia be legalized?", I seek to distinguish between questions of law, public policy and morality. Many persons of a religious persuasion may reason morally from presumptions such that life is a gift given by God and that it is not for any person including the suffering self to take away that life. Such presumptions cannot ground public policy and law, at least in a society where those presumptions do not enjoy uncontroversial, broad public support.

Those who support the legalization of euthanasia usually proceed by quoting cases of mentally competent patients who are not depressed but who are suffering unbearable pain, facing terminal illness. The easiest and most compelling case to consider is the patient whose relatives fully support the proposed euthanasia. There is no suggestion that the relatives are exerting undue influence on the patient for their own self-interested reasons. There are good palliative care facilities available so it is not as if the patient is under duress, feeling that she has no option but death. The patient has a good and trusting relationship with her medical team. Under existing law and policy, there is already the possibility that such a patient will be euthanized or at least given increased doses of pain which will hasten death. A 1997 study on "End of life decisions in Australian medical practice" published in the *Medical Journal of Australia* by Peter Baume and Peter Singer et al claimed that "while 30% of all Australian deaths were preceded by an action or omission explicitly intended to end the patient's life, in only 4% was the decision taken in response to an explicit request from the patient."¹

In the United Kingdom, Lord Joffe has made a number of attempts to have the House of Lords pass his *Assisted Dying for the Terminally Ill Bill*. When last introducing the bill in May 2006, he insisted the bill was restricted to competent and terminally ill adults. He told the House that he intended an "explicit prohibition against ending a patient's life by lethal injection or act of euthanasia" and that the patient would be required herself to ingest orally the prescribed medication. If the patient were unable to swallow, they would be still required to self-administer the poison by pouring the medication into their feeding tubeⁱⁱ. Under Lord Joffe's bill, the patient must not only be suffering a terminal illness but the treating physician must have "concluded that the patient is suffering unbearably as a result of that terminal illness" (Cl. 2(2)(d)).

Once the law and policy move over the "do no harm" divide, are there rational and fair criteria which can be applied? In recent times, the UK has focused on the cases of the 23 year old rugby player Daniel James and the 45 year old MS sufferer Debbie Purdy. Daniel would be ineligible for assistance with dying under Lord Joffe's bill and Debbie may have to avail herself of it long before she is ready to die. She would prefer to have her husband and doctor euthanase her after she has lost control. Daniel was the 23 years old rugby player who was rendered quadriplegic.

He was not suffering a terminal disease. Why should euthanasia be denied him if it be available to the person with the terminal illness? Is not such a law discriminatory? Is it fair? Does it accord equal protection of the law to the liberty interests of Daniel as well as to the person suffering a terminal illness? And if euthanasia is to be available to the quadriplegic who otherwise is healthy, why not extend it to the young person who says, "I am not clinically depressed; I am just sick of living; I want to die. Give me an injection." There would not be many such persons. But they do exist. Once we cross the Rubicon of "Do no harm", don't we set out on the road of voluntary euthanasia such that the only coherent approach ultimately is to make the lethal injection or ingestion available to the self-determining, autonomous person who freely seeks it provided only they are diagnosed as not being clinically depressed? Then why not make it available to the person who is perpetually depressed but who seeks the community endorsement and support of physician-assisted suicide rather than the loneliness and indignity of unassisted suicide?

On 9 December 2008 the Director of Public

Prosecutions decided not to prosecute the parents and a family friend of Daniel James after they accompanied him to Switzerland to assist with his death there at the hands of Dignitas. There have been 115 cases reported of persons in the UK accompanying loved ones overseas to avail themselves of legal assisted death. The DPP has not prosecuted any of them. In the case of Daniel James's parents, the Director publicly declined to prosecute "on the ground that a prosecution was not needed in the public interest. He took this decision personally, he gave his reasons in writing for having done so and he made those reasons available to the public."ⁱⁱⁱ Debbie Purdy then commenced a case which went ultimately to the House of Lords, seeking clarification of the Director's prosecution policy, given that she wanted her husband to assist her travel to Switzerland without any prospect of his being prosecuted. The House of Lords delivered a unanimous judgment on 30 July 2009 requiring the Director of Public Prosecutions to clarify publicly the circumstances in which he would judge a prosecution to be in the public interest "where the offence in contemplation is aiding or abetting the suicide of a person who is terminally ill or severely and incurably disabled, who wishes to be helped to travel to a country where assisted suicide is lawful and who, having the capacity to take such a decision, does so freely and with a full understanding of the consequences".

The 45-year-old Debbie Purdy has been confined to a wheelchair since 2001 having been diagnosed with MS in 1995. Last October when first going to court to seek the order clarifying that the Director of Public Prosecutions would not prosecute her husband if he were to assist with her suicide once she could no longer control her bodily functions, she said: "We are not asking for the law to be changed for it to be made compulsory for people at the end of their lives to be dragged off to the knacker's yard. But this should be one of the choices available and for it to be available we need to be clear on the law." She told the court:^{iv}

My dearest wish would be to die with dignity in my own home, with my husband and other loved ones around me. I hate the idea of having to travel to another country when I will be at my weakest and most vulnerable, both emotionally and physically. Going to another country also means that I have to go earlier, because being able to travel such a distance and to make all the arrangements in a foreign country will require me to be physically and mentally

capable so that too will mean that my life is further shortened as a result of the lack of a humane law in this country. I hope that one day the law will recognise that this is inhumane and that the law should be changed. My husband has said that he would assist me, and if necessary face a prison sentence, but I am not prepared to put him in this position for a number of reasons. I love him and do not want him to risk ending up in prison. As long as the DPP will not clarify his policy on prosecutions in these circumstances, I worry that as my husband is black and a foreigner, this makes him a more likely target for prosecution.

Given that some medical practitioners presently practice euthanasia when the law prohibits same, is there any point in changing the law? The usual reasons for legal change include the claims that some jurisdictions have been able to develop sufficient safeguards to ensure that only the competent, self-determining patient can avail the service of physician assisted suicide and that without such a change to the law, competent, self-determining citizens have to opt for earlier suicide when they are still able to self-administer the suicide cocktail.

If there is to be any move towards the legalization of euthanasia, there will be considerable difficulty in setting criteria and safeguards. It is all very well restricting its availability to the competent, but what of the claim of the person who says, "I am now competent but I am not yet ready to die. Soon I will be incompetent and I want to have made a binding decision consenting to euthanasia once I have lost my competence. I do not want to go earlier than I need. But I do want to go once I am no longer competent." Inevitably there will be some individuals who in the transition to incompetence or dementia will have changed their flickering minds and decided to cling to life for all that it is worth. At their moment of greatest vulnerability, the law will be invoked with a presumption that their earlier option for death is now binding and unreviewable.

I acknowledge that many ageing persons could autonomously decide to end their own lives according to their own sense of a good life and a good death, whatever the law was. But what of vulnerable groups such as Aborigines in the Northern Territory who were not adequately consulted and who were terrified by the 1997 Northern Territory euthanasia law? Many of them were suspicious of, or alienated from, the healthcare

system, having been told that non-Aboriginal doctors would be able to kill them in certain circumstances without fear of prosecution.

There are many other individuals who might be vulnerable though they do not fit any minority group profile – those like the late Alzheimer's sufferer Graeme Wylie and his daughters. When sentencing Shirley Justins for providing Wylie with a lethal dose of the veterinary drug Nembutal, the judge observed that it was cruel for those involved in the euthanasia to deny Mr Wylie's daughters an opportunity to say farewell. Given Dr Philip Nitschke's involvement in that case, there would be every chance of there being more Graeme Wylies who would never come to our attention once euthanasia was legalised and doctors like Nitschke were free to practise euthanasia more than they presently do.

Many voluntary euthanasia supporters may enjoy a good death regardless of the law. There are some "oldies" who will be vulnerable if euthanasia is legalised. Not all oldies are vulnerable; but some are. In shaping laws and policies (rather than moral codes), we need to have a care for them, regardless of our religious or atheistic beliefs.

Earlier this year, voluntary euthanasia advocates joined issue with my description of Graeme Wylie's death. Not having attended the trial of Shirley Justins, I have confined myself to facts on the public record. There was a family dispute about the belated changes made to his will – a not unfamiliar occurrence in Australia. Wylie had previously sought the services of Dignitas in Switzerland but been rejected because he was judged not competent. But letter writers to the *Sydney Morning Herald* (which has a strong pro-euthanasia editorial policy) have seen no problem with this. One letter writer (Dorothy Kamaker, *SMH Letters*, 10 February 2009) thought he was competent to give orders for his own death. Another (Alan Mann, *SMH Letters*, 10 February 2009) thought Wylie would be eligible for euthanasia under euthanasia legislation with stringent verification procedures.

Wylie's daughters were denied a chance to farewell him. When Justins was sentenced, Wylie's daughter, Tania Shakespeare, told the media, "I'm heartbroken that I wasn't able to say goodbye to my father". The sentencing judge said Justins was selfish and cruel for denying the daughters an opportunity to say farewell. Kep Enderby who attended Justins' trial disputed the judge's assessment (*SMH Letters*, 11 February 2009).

The complex Wylie case highlights how fraught any euthanasia law would be, regardless of the stringent verification procedures involved. Regardless of our religious affiliations or comprehensive world views, we should exercise great prudence before approving any law which departs from the principle “do no harm”, regardless of the utility such change would offer the competent.

Most rights discourse is about setting the appropriate limits on an agreed right. For example, we might agree that there is a right to freedom of expression. We then need to discuss the limits to set upon the exercise of that right – so as to protect the other rights of others, such as your right to reputation and perhaps even my right to privacy. But discussion about the right to die is altogether different. What we need to discuss is not the limits on the right, but rather the limit on the class of persons who will be able “to enjoy” the right – those in the last stages of a terminal illness, those suffering unbearable pain etc. The problem is that unless we extend the right to all mentally competent adult persons, we need to discriminate between classes of persons who will legally be able to access the right. Some will think the line of demarcation arbitrary no matter where it is drawn. Inevitably the line will be moved and in only one direction - so that the right can be equally exercised by all without discrimination. The discussion will become one not of asking “Who is entitled to exercise the right to die?”, but rather, “What are the procedural steps to be followed by anyone who wants to exercise the right to die?” Some call this the slippery slope argument, and this one is a very slippery slope.

Let’s now consider the issue of conscience and patient autonomy. In his 1789 Letter to the Quakers, George Washington said,

“I assure you very explicitly, that in my opinion the conscientious scruples of all men should be treated with great delicacy and tenderness: and it is my wish and desire, that the laws may always be as extensively accommodated to them, as a due regard for the protection and essential interests of the nation may justify and permit.”^v

Martha Nussbaum holds a joint chair in law and ethics at the University of Chicago’s Department of Philosophy, Law School and Divinity School. Her latest book *Liberty of Conscience* provides a rich textured treatment of the place of religion in the public square. In her characteristic writing mode,

she shares personal anecdotes - this time her conversion from Christianity to Judaism on the occasion of marriage; she treats deftly the classics, and then delves into philosophical reflection on US jurisprudence not all of which travels well across the Pacific. In this book she reflects on the agonising dilemma of Sophocles’ Antigone when the State in the person of her uncle Creon has announced that she may not bury her brother, killed attacking the city. Her religion dictates that she must bury her brother. She speaks of Creon’s alarming rigidity: “He has defined public policy in a way that favours the interests of most people in the city. In the process, however, he has imposed a tragic burden on one person. The great Athenian statesman Pericles boasted that fifth century democratic Athens did things better, refusing on principle to put people in such dreadful predicaments. Athens, he said, pursues the good of the city, but not by requiring its citizens to violate the ‘unwritten laws’ of their religions.”^{vi}

Nussbaum nicely posits the Lockean position of state neutrality whereby “the state is free to regulate matters concerning property or health or safety even when they bear on religious organisations – so long as it does so impartially”^{vii} against the more subtle treatment of the seventeenth century American Roger Williams, founder of Rhode Island, who espoused religious accommodation with the declaration, “It is the will and command of God that (since the coming of his Sonne the Lord Jesus) a permission of the most paganish, Jewish, Turkish, or antichristian consciences and worships, bee granted to all men in all nations and countries”.^{viii}

Nussbaum sets down six normative principles, which I find useful in scrutinising laws and policies that impact on the free exercise of religion and on the broader freedom of conscience. I will take as a case study s.8(1)(b) of the recently enacted Abortion law Reform Act in Victoria. The issue is not the legality or desirability of abortion on demand. The issue is whether the law ought provide for compulsory referral by a conscientious objector. S. 8(1)(b) provides:

If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must refer the woman to another registered health practitioner in the same regulated health profession who the practitioner

knows does not have a conscientious objection to abortion.

Justice Scalia has pursued the Lockean position on the US Supreme Court, as have groups such as Liberty Victoria in pursuing the enactment of the recent Victorian abortion law including this novel clause stipulating compulsory referral by a conscientious objector. The Williams approach finds expression in the judgments of Justice O'Connor on the US Supreme Court and in the criticisms offered by some of the faith based groups critical of clause 8(1)(b) of the Victorian abortion law. The supporters of clause 8 would be surprised to learn they are *ad idem* with Justice Scalia who has said, "we have never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the state is free to regulate."^x

Australia is a signatory to the International Covenant on Civil and Political Rights. The terms of that Covenant provide a convenient benchmark for most individuals and groups who espouse human rights. The freedom of conscience and religion is one of the few non-derogable rights in the Covenant. This means that a signatory may not interfere with the exercise of the right even during a national emergency -whereas other rights in the Covenant can be cut back during times of public emergency which threatens the life of the nation – but only to the extent strictly required by the exigencies of the situation and provided that that cut back applies in a non-discriminatory way to all persons. Furthermore the freedom of thought, conscience and religion is one of the few rights, which can be confined only if it be necessary "to protect public safety, order, health, or morals or the fundamental rights and freedoms of others".^x

Let's consider Nussbaum's principles:

1. The equality principle: all citizens have equal rights and deserve equal respect from the government under which they live
2. The respect conscience principle: - providing protected space within which citizens may act as their conscience dictates. All citizens enter the public square on equal conditions
3. The liberty principle: respect for people's conscientious commitments requires ample liberty – and not just a regime of equal constraint in which nobody has much religious freedom

4. The accommodation principle: sometimes some people (usually members of religious minorities) should be exempted from generally applicable laws for reasons of conscience.
5. The non-establishment principle: the state does not operate so as to set up and in-group and an out-group.
6. The separation principle

Nussbaum concedes that there may be a need for religion to bear some burdens "if the peace and safety of the state are really at stake, or if there is some other extremely strong state interest. But it seems deeply wrong for the state to put citizens in such a tragic position needlessly, or in matters of less weight. And often matters lying behind laws of general applicability are not so weighty; sometimes they come down to a mere desire for homogeneity and an unexamined reluctance to delve into the details of a little known or unpopular religion".^{xi}

It is useful to compare the UK and Australian responses to compulsory referral clauses placed in laws dealing with the delivery of medical services in morally contested fields. My argument is that the UK has more of a culture and architecture for discussion of rights and their limits than we do, and that is because they have had a Human Rights Act for 10 years and they have been subject to human rights jurisprudence from Strasbourg for decades.

When Lord Joffe's *Assisted Dying for the Terminally Ill Bill* was first drafted in the United Kingdom it contained a clause similar to section 8 of the Victorian *Abortion Law Reform Act 2008*. The original Joffe Bill imposed a duty on physicians who invoked their right to conscientiously object, to "take appropriate steps to ensure that the patient is referred without delay to a physician who does not have such a conscientious objection". The Westminster Parliament's Joint Committee on Human Rights remarked:

3.14 We consider that imposing such a duty on a physician who invokes the right to conscientiously object is an interference with that physician's right to freedom of conscience under the first sentence of Article 9(1), because it requires the physician to participate in a process to which he or she has a conscientious objection. That right is absolute: interferences with it are not capable of justification under Article 9(2).

3.15 We consider that this problem with the Bill could be remedied, for example by recasting it in terms of a right vested in the patient to have access to a physician who does not have a conscientious objection, or an obligation on the relevant public authority to make such a physician available. What must be avoided, in our view, is the imposition of any duty on an individual physician with a conscientious objection, requiring him or her to facilitate the actions contemplated by the Act to which they have such an objection.

3.16 In the absence of such a provision, however, we draw to the attention of each House the fact that clauses 7(2) and (3) give rise in our view to a significant risk of a violation of Article 9(1) ECHR.

The UK bill was accordingly amended to provide that “No person shall be under any duty to refer a patient to any other source for obtaining information or advice pertaining to assistance to die, or to refer a patient to any other person for assistance to die under the provisions of this Act” (cl. 7(3)). Under the revised UK provision, the doctor with a conscientious objection would have no additional legal duty other than “immediately, on receipt of a request to do so, transfer the patient’s medical records to the new physician”. (cl. 7(6))

When confronted with cl 8 of the *Abortion Law Reform Bill*, it was not surprising that the Victorian Scrutiny of Acts and Regulations Committee drew attention to the equivalent attempted provision in the UK, the response by the UK Committee, and the amendment proposed in the UK Parliament. The Victorian committee noted:

The Committee notes that clause 8 sets out the obligations of health practitioners who hold a conscientious objection to abortion, including (in clause 8(1)(a)) an obligation to refer women who request an abortion to another practitioner who has no conscientious objection. The Committee observes that some practitioners may hold a belief that abortion is murder and may regard a referral to a doctor who will perform an abortion as complicity in murder. The Committee therefore considers that clause 8(1)(a) may engage the Charter right of such practitioners to freedom of belief.

The Committee rightly observed that the compatibility of this clause with the Charter “depends on its satisfaction of the test in Charter s. 7(2), including whether or not there are less restrictive means available to achieve the purpose of the clause”.^{xii} The Committee then very properly referred two questions to Parliament for its consideration:

1. Whether or not clause 8(1)(a), by requiring practitioners to refer patients to doctors who hold no conscientious objection to abortion, limits those practitioners’ freedom to believe that abortion is murder?
2. If so, whether or not clause 8(1)(a) is a reasonable limit on freedom of belief according to the test set out in Charter s. 7(2) and, in particular, whether or not there are any less restrictive means available to ensure that women receive appropriate health care?

No credible answers were provided by Parliament. The questions could only have been answered, Yes to the first and No to the second.^{xiii}

Victoria is the first Australian state to have legislated a Charter of Human Rights and Responsibilities Act. It reproduces many of the rights in the ICCPR including the freedom of thought, conscience, religion and belief (s.14). Unlike the ICCPR, the Victorian Charter does not specify that any rights are non-derogable. And all rights can be restricted for reasons other than the need “to protect public safety, order, health, or morals or the fundamental rights and freedoms of others”.^{xiv} Section 7(2) specifies the justified limits on rights:

A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including—

- (a) the nature of the right; and
- (b) the importance of the purpose of the limitation; and
- (c) the nature and extent of the limitation; and
- (d) the relationship between the limitation and its purpose; and
- (e) any less restrictive means reasonably

available to achieve the purpose that the limitation seeks to achieve.

The Victorian Equal Opportunity and Human Rights Commission purported to answer the questions posed by the Scrutiny of Bills committee when their CEO wrote to *The Australian* on 1 October 2008 stating:

The purpose of the charter is to provide a framework to help us balance competing rights and responsibilities. Freedom of conscience is not the only issue at stake here, and to suggest so is to simplify an extremely complex issue. In this case, a doctor's right to freedom of conscience needs to be balanced with competing considerations such as a patient's right to make a free and informed choice. Sometimes limits on human rights are necessary in a democratic society that respects the human dignity of each individual.

Suffice to say that this simple solution is in stark contrast to the reasoning and conclusion reached by the UK Parliament in its consideration of a similar clause. The AMA Code of Ethics provides:^{xv}

When a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere.

Recognise that you may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one.

Recognise that you may decline to continue a therapeutic relationship. Under such circumstances, you can discontinue the relationship only if an alternative health care provider is available and the situation is not an emergency one. You must inform your patient so that they may seek care elsewhere.

The AMA thought cl.8(1)(b) unwarranted because it departed from the existing AMA Code of Ethics. AMA Victoria advised its members in these terms:

Last week, AMA Victoria met with Minister Andrews' adviser and Department of Human Services legal counsel to seek their

understanding of the clause, and we have also sought independent legal advice. The government and the advice confirmed that clause 8 changes the existing law. The existing common law and existing codes of practice require that a doctor with a conscientious objection to a particular service inform the patient of that conscientious objection and ensure that the service is available elsewhere. The existing law and practice also provide that doctors have a duty to assist in an emergency. AMA Victoria supports the existing law and ethical obligation to properly inform patients and ensure that services are elsewhere available.

The AMA asked the Premier to consider removing clause 8 and rely on the existing law, or amend the section to reflect the existing law. That remained the AMA's position right through the debate in both houses of parliament. It is still the AMA's position. In trying to avoid the draconian effect of the anti-conscience clause in the Victorian law, the AMA has now provided its members with a template letter for conscientious objectors stating:

Due to Dr [INSERT NAME]'s moral and ethical beliefs, s/he is not able to offer you abortion services. We do not wish patients who are seeking these services to suffer embarrassment or emotional upset, so we want to make this position clear. We ask that you respect Dr [INSERT NAME]'s beliefs by not requesting abortion services from him/her, as they are against his/her conscience.

To date there has been no challenge or test case on the issue. The abortion law provides no penalty for non-compliance with the compulsory referral provision, though presumably the Medical Practitioners' Board would have power to discipline or even strike off practitioners for non-compliance. Before such action was taken by the Board, it, being a public authority for the purposes of the Charter, would need to ensure that it did not act in a way that is incompatible with the human right of freedom of conscience. Given the Board's latitude for action, it would need to establish that in striking off a member for conscientious objection it could not reasonably have acted differently or made a different decision.^{xvi} This highlights the complete unworkability and incoherence of such a compulsory referral clause for a medical procedure that requires

no referral in a jurisdiction which boasts a Charter providing for freedom of conscience.

By requiring a compulsory referral (a requirement additional to the AMA Code of Ethics), s. 8 works interference on the right to freedom of thought, conscience and belief of a medical practitioner with a conscientious objection to abortion.

On 9 September 2008, *Liberty Victoria* issued its only press release on the bill stating, "The *Abortion Law Reform Bill* should be passed without amendment." Then writing in *The Age* on 24 September 2008, Anne O'Rourke, the vice president who had the public carriage of the issue for *Liberty Victoria* claimed that the conscientious objection clause was "consistent with the Australian Medical Association's code of ethics". She went on to say, "To claim the *Abortion Law Reform Bill* breaks new ground or imposes unprecedented obligations on hospitals or medical staff is wrong and misleading. The bill does not do so." Her assertion was contrary to the government's own legal advice to the AMA.

Liberty Victoria's public position was in stark contrast to the position taken by the AMA. In his letter to the Victorian Premier, Dr Doug Travers, the President of the AMA (Victoria Branch) pointed out that doctors are "not currently forced to provide a service they believe to be unethical or immoral". He acknowledged that "the existing common law and existing codes of conduct require that a doctor with a conscientious objection to a particular service inform the patient of that conscientious objection and ... ensure that the service is available elsewhere". But he pointed out that the proposed legislation went beyond this: it "infringes the rights of doctors with a conscientious objection by inserting an active compulsion for a doctor to refer to another doctor who they know does not have a conscientious objection. Respect for a conscientious objection is a fundamental principle in our democratic country, and doctors expect that their rights in this regard will be respected, as for any other citizen".

The highly respected Neil Young QC from the Melbourne Bar concluded that the drafting of cl 8(1)(b) "appears to go beyond" the AMA code of ethics. He pointed out that though under the AMA code of ethics, "the conscientious objector is required to provide information", "the objector is not required to ascertain or know the views of other practitioners or to refer the woman to a specific practitioner who does not have a conscientious objection to abortion".^{xvii} Young expressed the view

that "clause 8(1)(b) cannot be interpreted or applied consistently with the human right set forth in s.14 of the Charter" (the right to freedom of thought, conscience, religion and belief).^{xviii} Young concluded that cl 8(1)(b) cannot be justified by recourse to s 7(2) of the Charter.

Was a less restrictive means available? Yes. As Young says, "cl 8(1)(b) could have adopted the language used in the AMA Code of Ethics, which provides a satisfactory and reasonably available alternative. Other less coercive means can be postulated, such as the maintenance of a public register of practitioners who hold no conscientious objection to abortion".^{xix} None of this analysis was done by the Parliament, nor by the advocacy groups like *Liberty Victoria*, nor by the statutory bodies such as the Equal Opportunity Commission. The outcome was the opposite of that reached in the United Kingdom, and with much thinner, more ideological reasoning.

In my opinion, this was the first real test of the Victorian Charter of Human Rights and Responsibilities and it failed spectacularly to protect a core non-derogable ICCPR human right which fell hostage to a broader social and political agenda for abortion law reform and a prevailing fad in bioethics which asserts that doctors should leave their consciences at the door.

Groups such as *Liberty Victoria* provided no coherent answers. Academic experts on the Charter largely remained silent. However Professor George Williams, the principal draftsman of the Victorian Charter, has since circulated his opinion to human rights lawyers advising, "It was one thing to exclude abortion from the Charter's coverage, but another again to also exclude all related questions, such as that of conscientious objection. A federal law should be better drafted. There is an irony in the Victorian outcome given that the exclusion clause was not in the form that my committee proposed (it would not have had the same outcome)". The Equal Opportunity and Human Rights Commission simplistically dismissed freedom of conscience. The official spokesperson from *Liberty Victoria* said the Catholic Church had snookered itself by "lobbying to ensure the Charter cannot be used by women to seek a right to abortion, effectively hav(ing) curbed their own rights to conscientious objection"^{xx}. This is a serious task of rights protection for all; it should not be a partisan anti-religious game.

In the light of sustained, reasoned critique of the law and the law making process, the Victorian Human

Rights Commission has now expressed the view "that SARC's interpretation of the Charter is preferable and that the bill should have been accompanied by a statement of compatibility." It's just that no credible legal commentator is able to provide such a statement. The law is now a dead letter.

Since the Victorian debacle, the Australian Medical Council has been consulting on a national code of ethics for all Australian doctors. During their consultation, they reported that "there was a request for clear guidance in relation to conscientious objection". Last month they published their new code and provided such guidance, in contradistinction to the Victorian law. The Code states:

Good medical practice involves:

- Being aware of your right to not provide or **directly** participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.
- Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.

Some might prefer that the word "directly" be omitted. But it is quite arguable that legally enforced direct referral for a procedure that does not usually require a referral and which otherwise would not be performed except after appropriate counselling would constitute "direct participation". A conscientious objector would be entitled not to formally refer in these circumstances. The Victorian Medical Practitioners' Board has power to discipline or even strike off practitioners for non-compliance with Victorian law. Before such action was taken by the Board, it, being a public authority for the purposes of the Charter, would need to ensure that it did not act in a way that is incompatible with the human right of freedom of conscience. The new Code should be a sure guide for the Board.

Given that the referral clause was both unnecessary, unworkable, and more intrusive than state notification of available abortion providers, one can only conclude as did Justice Kennedy in the leading US gay rights decision *Romer v Evans*: the clause "seems inexplicable by anything but animus toward

the class it affects; it lacks a rational relationship to legitimate state interests."^{xxi}

I daresay many civil libertarians and Charter advocates are little worried by this first test of the Victorian Charter because they share the view of the Australian Oxford philosopher Julian Savulescu that doctors' consciences should be left at the door in the name of patient autonomy. Doctors are simply there to provide a service as if they are automatons. In his recent article "Conscientious objection in medicine", Savulescu commences with a literary reference – not to Sophocles' *Antigone* but to Shakespeare's *Richard III*. When Richard III roused from his dream before battle he made his declaration:

Let not our babbling dreams affright our souls: conscience is but a word that cowards use, devised at first to keep the strong in awe: Our strong arms be our conscience; swords our law.

Savulescu quotes only the sentence: "conscience is but a word that cowards use, devised at first to keep the strong in awe". Here is the context. During Richard's dream, he confronted the eleven ghosts of those he had callously murdered including the Ghost of Prince Edward, son to King Henry VI who proclaimed

"Let me sit heavy on thy soul to-morrow! Think, how thou stab'dst me in my prime of youth. At Tewksbury: despair, therefore, and die!" And the Ghost of King Henry VI who proclaimed "When I was mortal, my anointed body by thee was punched full of deadly holes. Think on the Tower and me: despair, and die! Harry the Sixth bids thee despair, and die!"

Richard III is hardly the model for the discerning medical practitioner; and his quote on conscience hardly the literary quote likely to evince sympathy for the primacy of conscience, a non-derogable human right. For those who want swords to be their law, there is every reason to view conscience as a word used only by cowards. It is those sorts of people who demand that conscience be left at the door.

Martha Nussbaum's concluding chapter in *Liberty of Conscience* is titled with a question: "Toward an Overlapping Consensus?" She makes the point that laws do matter as "good laws and institutions set limits on people's ability to act on their intolerant

and inegalitarian views". She describes Roger Williams' challenge to the new colonies: "that they find, and learn to inhabit, a shared moral space, without turning that space into a sectarian space that privileges some views over others".^{xxii} That challenge was not met when the Victorian Parliament, academy and civil society endorsed an unworkable, unprincipled, and useless compulsory referral clause trampling the conscientious beliefs of some medical practitioners with no workable benefit being accorded their patients.

Nussbaum finds hope in John Rawls' notion of overlapping consensus whereby those holding different religious and secular comprehensive doctrines can live together on terms of equal respect "agreeing to share a 'freestanding' ethical conception in the political realm, and agreeing, at the same time, to forgo the search for the dominance of any one comprehensive doctrine over the others".^{xxiii} Those who think that conscience is but a word cowards use are unlikely to forgo the search for dominance of their comprehensive doctrine over others. We still have much more work to do in Australia if we are to take seriously in law and policy Nussbaum's "respect conscience principle" and her "accommodation principle". Our protection of human rights for all will be much enhanced if we are better able to provide "protected space within which citizens may act as their conscience dictates"^{xxiv} and if we can acknowledge that "sometimes some people (usually members of religious minorities) should be exempted from generally applicable laws for reasons of conscience".^{xxv}

Utilitarianism and patient autonomy are not enough; the medical pledge to do no harm no matter what the cost effective benefits for the competent, and the conscience of the doctor are still key elements in any law which promotes good medicine. It is one thing for us to leave our religious and other comprehensive world views at the door of the Club or at the entrance of the public square; it does not follow that the doctor should leave her conscience at the door of the surgery which is so much more than a marketplace.

Church and other mission oriented groups should work hard to maintain and strengthen their commitment to health care which is universal and comprehensive – universal in that it is not confined only to those who can afford it, and comprehensive in that it is not confined to specialties thought to have distinctive appeal to mission oriented groups in society. Only by being a mainstream contributor to

health care across the board can churches make their optimal contribution to the quality of health care and to the ethics of same. Without a grounded, informed Church voice on ethical issues in the public square it will be even more difficult for parliaments and courts to make the right decisions about ethical health care in the future. Health facilities if run only by the State and the for-profit sector would lack a critical dimension in some of the more difficult ethical debates on health care.

Last month Chief Justice Martin gave a very sensible, uncontroversial decision in the Western Australian Supreme Court in the case *Bridgewater Care (Inc) and Rossiter*^{xxvi}. Mr Christian Rossiter is a profoundly disabled quadriplegic who is presently receiving nutrition and hydration through a PEG. He has had enough of life and wants his carers at Bridgewater Care to discontinue feeding him. The "right to life" and "right to die" advocates have been having a field day. You would think they had not read the judgment.

The Chief Justice said:

It is important I think to emphasise at the outset what this case is not about. It is not about euthanasia. Nor is it about physicians providing lethal treatments to patients who wish to die. Nor is it about the right to life or even the right to death. Nor is the court asked to determine which course of action is in the best interests of a medical patient. The only issue which arises for determination in this case concerns the legal obligations under Western Australian law of a medical service provider which has assumed responsibility for the care of a mentally-competent patient when that patient clearly and unequivocally stipulates that he does not wish to continue to receive medical services which, if discontinued, will inevitably lead to his death.

The judge said that if Mr Rossiter, having received competent medical advice, decided to request Bridgewater to cease administering nutrition and hydration, then in the absence of any revocation of that direction by Rossiter, Bridgewater should cease to provide nutrition and hydration. There would be no risk of criminal liability. The only risk would arise if the caregiver were to continue feeding without consent and direction because that could be an assault or a trespass on the person of Mr Rossiter.

This was nothing like the case of a person in a persistent vegetative state without the competence to decide and unable to communicate with the caregiver. As the judge made plain: "Mr Rossiter is not a child, nor is he terminally ill, nor dying. He is not in a vegetative state, nor does he lack the capacity to communicate his wishes. There is therefore no question of other persons making decisions on his behalf. Rather, this is a case in which a person with full mental capacity and the ability to communicate his wishes has indicated that he wishes to direct those who have assumed responsibility for his care to discontinue the provision of treatment which maintains his existence."

The reactions of the "Right to Life" and the "Right to Die" advocates were equally misleading and unhelpful. It is not only illegal, it is also immoral for a person to trespass on the body of a competent person, especially when consent has been sought and withheld. It is not only against the law. It is wrong. It is morally objectionable. Churches with a strong teaching tradition should assist their members to form and inform their consciences that they should not trespass on the bodies of the mentally competent without consent.

In future, the tasks of our parliaments and our courts will be more difficult if the reasoned voice of experience is not heard from churches who know what they are talking about when it comes to health care. Unless we are at the bedside in constant dialogue with the clinicians, we too risk becoming ideologues.

Bishop Anthony Fisher OP has now said, 'No one should force feed (Mr Rossiter) and if he is saying "No" to tube feeding, his nursing home is probably right to follow his instructions.'^{xxvii} As I understand, the bishop's concern was whether Rossiter was mentally competent to make such a request, in particular, whether he may have had undiagnosed and untreated depression. In this case, given the clarity that has been brought to the matter in the court proceedings, including the judge's finding that Rossiter was mentally competent and there being so suggestion of depression, I would go one step further and say that the nursing home would undoubtedly be wrong not to follow his instructions. After all, "treatment should not be administered to any competent patient...until the patient's free and adequately informed consent has been given"^{xxviii}. I would invoke the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* at #1.16.^{xxix}

Patients have the moral right to refuse any treatment which they judge to be futile, overly burdensome or morally unacceptable, and such refusals must be respected. In addition, healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not they agree with the patient's refusal.

I would see no application in a case like *Rossiter* for the rider: "There is, however, an obligation to prevent suicide when this is possible."^{xxx} Though some persons, including many Catholic health providers, might agree with Pope John Paul II 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"^{xxxi}, others (including Mr Rossiter) are entitled to take a contrary view. Even if the competent patient be wrong in his bioethical classifications, he is still entitled to insist that those with the viewpoint of Pope John Paul II desist from interfering with his bodily integrity by administering what he regards as an unwelcome medical act, a treatment that he regards as morally unacceptable, overly burdensome or futile. Even if there be a case for disputing Mr Rossiter's ethical analysis, there is no case for interfering with his bodily integrity against his wishes.

Furthermore, Christian charity may point to supporting him as he confronts death. Christian morality does not necessarily dictate that the health care provider of good conscience terminate any relationship with him.

Fr Kevin McGovern, Director of the Carolin  Chisholm Centre for Health Ethics, which is sponsored by the Catholic hospitals of Victoria, has now discussed the Rossiter case and said, "Except in exceptional circumstances a request to discontinue tube feeding could not be honoured in a Catholic hospital or aged care facility. It is against our values. A patient who persists in this request may have to transfer to another, non-Catholic facility." I ask, could not a Catholic facility in good conscience continue to provide care and spiritual support for such a competent patient while honouring his wishes? I am not saying that a Catholic facility would be obliged to, but neither do I think that a Catholic facility would be obliged to show him the door or force feed him as he approaches death. There is nothing new in this. My own mother was a young

doctor at the Brisbane Mater Public Hospital in 1951 when the patient in the bed at the end of the ward was a Jehovah's witness who received nothing but food, water and good pastoral care because he refused a necessary blood transfusion. He was not forcibly treated nor shown the door.

Fr McGovern joins issue with me saying:^{xxxii}

Whether it is with a patient who asks to be killed or with another patient who asks for an abortion, both health care professionals and health care institutions must be free to exercise conscientious objection. In this country, Catholic hospitals follow the 'Code of Ethical Standards for Catholic Health and Aged Care Services in Australia', and they must be able to refuse to provide treatment which conflicts with this Code. It is never easy to remove oneself from a case, and health care professionals often feel very sad as they recognise that either they or their health care institution can no longer care for this patient. Even so, there are respectful ways of saying that you cannot support a patient's choices, and therefore that it would be better for everyone if they sought this treatment somewhere else. As health care professionals know, this respectful conversation is something quite different from "showing someone the door." The laws of the United Kingdom also create quandaries for health care professionals, and the Catholic Church there has provided guidance in a booklet titled 'The Mental Capacity Act and Living Wills: A Practical Guide for Catholics.' Question 5.6 considers what health care professionals should do if a patient has refused artificial nutrition and hydration. The Guide states that health care professionals "should not formally cooperate with the withdrawal of this aspect of care (if this withdrawal is clearly against the best interests of the patient.) They may have to withdraw from the care of the patient altogether." Catholic Health Australia and the Australian Catholic Bishops Conference have provided similar guidance in 'A guide for health care professionals implementing a future health care plan.' It also recognises that "in such cases, the health care professional or institution may have to decline to be involved further in the care of the patient or resident."

I cannot see that there is any great quandary in the case of Mr Rossiter in that we are dealing with an individual found by a respected judge on the available evidence to be competent. For me, it is the equivalent of a competent member of this audience announcing at the end of this lecture that she intends to starve herself to death. Unless I have a particular relationship with that attendee requiring me to act in what I regard as her best interests, I have no duty to do anything. I might try and talk her out of her intended course of action. If she is intractable and wishes to stay in my house while she starves herself to death, there would need to be a conversation between us and I would have the ultimate call on whether to invite her in (which I would be most unlikely to do). But if she had already been staying in my house for a considerable time, I might be loathe to show her the door at this, her hour of need. I do not see that any Church authority could order me to evict her. I might choose to ask her to leave – in part because her presence could cause 'scandal' in the theological sense of leading others into sin or because she might cause deep upset to me or other residents in my house. Then again, out of compassion, I might invite her to remain. Of course if the refusal of treatment were being used for some political purpose, a Catholic institution might feel it was being compromised by being asked to be a party to or host for some wrongful project; that same institution might, with ethical consistency, care for other patients such as the trenchant Jehovah's Witness, while declining to be part of a campaign for the so-called 'right to die'.^{xxxiii}

The *Rossiter* case is very different from the recent case of *Australian Capital Territory v JT*.^{xxxiv} JT is a 69 year old man who has been chronically psychotic for at least 17 years, suffering from paranoid schizophrenia characterised by religious obsessions. During his psychotic episodes he often says that he wishes to starve to death, though he is confident that God will save him. When more coherent, he expresses a desire to live. In recent times, he became increasingly violent during his psychotic episodes, protesting any attempt to feed him via naso-gastric intubation. Thus the question arose whether he should be given hydration and nutrition via a PEG (percutaneous endoscopic gastrostomy). Two psychiatrists decided that it would be for the best if JT were starved to death. Chief Justice Higgins in the ACT Supreme Court made the observation:^{xxxv}

There was also consultation with the Canberra Hospital Clinical Ethics Committee. Their response

was to the effect that, as JT was accepting of death, his mental state indicating capacity to consent should be ignored and his "wishes" respected. That is an outrageous approach to ethical standards which require a free and informed consent before a course involving such grave risk as premature death is adopted.

Higgins CJ pointed out "that JT lacks the capacity for informed consent and his 'wishes' are the product of delusional and irrational thought in turn the product of his severe mental illness. The approach to his care can be no less than would be the case if he lacked consciousness or was a helpless infant."

The Chief Justice distinguished Rossiter's Case:

That case, of course, is fundamentally distinguishable from the present. The patient here lacks both understanding of the proposed conduct and the capacity to give informed consent to it. Thus, those charged with JT's care remain under the common law duty to provide that care to the best of their skill and ability.

There are clearly instances in which the law should require that health care providers act in the best interests of the patient regardless of their expressed wishes at the time – especially when they are not mentally competent or free to make an informed decision.

The real quandary with assisted suicide through removal of nutrition and hydration is determining when the law will deem a decision to terminate life as irrevocable even though the patient will move in and out of consciousness. Not everyone who says, "I wish to die. Please terminate all nutrition" will remain clearly of that resolve. And yet, the only workable regime will be one that requires the patient to make an irrevocable choice in relation to life itself even though no one else would be adversely affected by the health provider having to comply with the revoked wish of the failing clutching patient. There will be a need to impose an obligation on health professionals to ensure that the choice to die remains firm until loss of consciousness. If this obligation were always to be faithfully discharged (which it won't be), it would be very onerous.

Neither the law nor directives from religious authorities will resolve all these future cases. The delivery of optimum health care will always require the application of the health professional's formed

and informed conscience. The health professional will always have to consider additional ethical questions when treating the incompetent patient. In a Catholic health care facility, the conscientious decisions of health care professionals will need to be augmented by Christian charity extended even to the autonomous patient whose ethical judgments we do not share. With sound formation and leadership by our religious authorities we might even be able to assist others who do not share our faith tradition but who occasionally display what Chief Justice Higgins described as "an outrageous approach to ethical standards".

Fr Frank Brennan SJ AO is a National Board Member, St Vincents Health Australia, and Chair of the National Human Rights Consultation Committee.

Fr Brennan gave this talk as the annual Sandra Day Oration at St Vincent's Private Hospital in Sydney. We are grateful to the hospital for permission to reprint it.

Endnotes

- ⁱ Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, "End of life decisions in Australian medical practice", 1997 *Medical Journal of Australia*, 161
- ⁱⁱ Hansard 12 May 2006, columns 1188-9
- ⁱⁱⁱ Lord Hope of Craighead, *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45
- ^{iv} *The Telegraph*, 19 October 2008
- ^v Quoted at p. 115
- ^{vi} *Ibid.*, 116
- ^{vii} *Liberty of Conscience*, Basic Books, 2008. p. 60
- ^{viii} *Ibid.*, quoted at p. 34
- ^{ix} *Employment Division v Smith*, 494 US 872 (1990) at 878-9
- ^x Article 18(3), ICCPR
- ^{xi} *Ibid.*, 117
- ^{xii} Scrutiny of Acts and Regulations Committee, Alert Digest No 11 of 2008, p. 6
- ^{xiii} Some civil libertarians and abortion advocates have made the point that there was no need for the government or the parliament to consider the impact of the proposed law on the freedom of conscience, religion or belief, as s.48 of the Victorian Charter exempts any law on abortion from Charter scrutiny. Legal opinion is divided on scope of that exemption. Neil Young QC and P G Willis advised, "In our opinion, s.48 was not intended to have the consequence that legislation subjecting health practitioners to newly defined rights, authorities or obligations in connection with their involvement, or potential involvement, in abortion advice or procedures concerning abortion is excluded from Part 3 of the Charter." (Joint Opinion in the Matter of the Abortion Law reform Bill 2008, para 79, 3 October 2008) They then added: "Further and in any event, even if we are wrong about our construction of s 48, it does not follow that it is inappropriate or irrelevant for Parliamentarians debating the bill to test the requirements of the Bill against the standards set out in the Charter...This is especially so given the high principles which the Parliament espoused in enacting the Charter and the fundamental importance of the human rights set out in the Charter." (para. 81)
- ^{xiv} Article 18(3), ICCPR
- ^{xv} AMA Code of Ethics, under the heading "The Doctor and the Patient: Patient Care", Para (p) – (r), p. 2. See the Appendix for recent developments with statements on ethics by various specialist medical bodies.

- ^{xvi} s. 38, Charter of Human Rights and Responsibilities Act 2006
- ^{xvii} N Young and P Willis, Joint Opinion, In the Matter of the Abortion Law Reform Bill 2008, 3 October 2008, para 57
- ^{xviii} *Ibid.*, para 59
- ^{xix} *Ibid.*, para 62
- ^{xx} Anne O'Rourke, Vice President, Liberty Victoria, *The Australian*, 27 February 2009
- ^{xxi} *Romer v Evans* 517 US 620 (1996) at 633
- ^{xxii} M. Nussbaum, op. cit., 360
- ^{xxiii} *Ibid.*, 361
- ^{xxiv} *Ibid.*, 22
- ^{xxv} *Ibid.*, 24
- ^{xxvi} [2009] WASC 229
- ^{xxvii} Catholic Weekly, 23 August 2009
- ^{xxviii} Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, Catholic Health Australia, 2001, p. 13, #1.5
- ^{xxix} *Ibid.*, p. 16
- ^{xxx} *Ibid.*
- ^{xxxi} John Paul II, Address to the International Congress on 'Life Sustaining Treatments and Vegetative State', 20 March 2004, p. 2
- ^{xxxii} See K. McGovern's posting on Eureka Street, 3 September 2009, <http://www.eurekastreet.com.au/article.aspx?aeid=15834>
- ^{xxxiii} If Mr Rossiter's request for termination of hydration and nutrition had been complied with once the court gave judgment, he would be dead by now. More than five weeks after the judgment the *Sunday Age* (20 September 2009) reported on Mr Rossiter's condition, speculating that he might die soon from a respiratory infection: "The sad irony here, according to Dr Nitschke, 'is that [after the court case] he'd picked up a bit in himself, because people have been paying him attention'. He'd been particularly cheered by the ministrations of an outreach carer from Perth Home Care services. *The Sunday Age* understands the woman, who has been refused permission to speak to the media, had encouraged Mr Rossiter to record his life story, notably about his childhood in South Africa, with the idea of publishing a memoir." Presumably he withdrew or never gave the instruction to withhold nutrition and hydration. What then was the court case about?
- ^{xxxiv} [2009] ACTSC 105 (28 August 2009)
- ^{xxxv} *Australian Capital Territory v JT*, [2009] ACTSC 105 (28 August 2009)

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