
BIOETHICS OUTLOOK

John Plunkett Centre for Ethics in Health Care

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In this issue

◆ The first contribution to this issue of *Bioethics Outlook* is a commentary on Max Charlesworth's latest book *Bioethics in a Liberal Society*. In the book, Charlesworth argues that the principle of respect for personal autonomy is the primary moral value of any genuinely liberal society. In her commentary on the book, Bernadette Tobin criticizes that position arguing that it leads Charlesworth into oversimplifications of some ethical issues in the provision of health care and that it commits him to a reductive account of the value of a human being.

◆ The John Plunkett Centre is a joint research centre of Australian Catholic University and St Vincent's Hospital in Sydney. For some purposes it functions as an academic unit, for others it functions as a department of a teaching hospital. In the latter capacity, the Centre takes it turn twice a year in presenting some aspect of its current activities at Grand Rounds. The case study to be found in this issue, and associated commentaries (together with one made by Professor John Hickie), were presented on a recent occasion at Grand Rounds.

◆ Other items in this number include a review of a new book from the Linacre Centre in London, a report on a recent conference in Sydney on 'Health Outcomes' and advance notice of next year's Intensive Bioethics Course and a new Advanced Bioethics Course.

Respect for personal autonomy: is it the supreme value?

*A note on *Bioethics in a Liberal Society* by Max Charlesworth*

Bernadette Tobin

Max Charlesworth is a genuinely public philosopher, one of the two or three whose names (if not ideas) would be known to an educated though non-philosophical Australian audience. From the earliest days of medicine's new-found abilities - to prolong some lives almost indefinitely by technological means, to assist otherwise infertile couples (and individuals) to conceive children, to save lives by transplanting reusable organs from the recently-dead into the seriously-ill, etc. - Charlesworth has taken a leading part in Australian debates about the ethics of each new advance. The common thread in his contributions to these debates has been his commitment to the ideals of a liberal society, in particular to the value of respect for personal autonomy, and a corresponding insistence on the limits of legitimate state authority. In *Bioethics in a Liberal Society*, Charlesworth lays out for the first time the fundamental idea in his public philosophizing: the primacy of respect for personal autonomy. He then defends a series of claims about what is involved in a proper acknowledgment of this moral and political value in four ethically-problematic areas of health care.

I want to challenge Charlesworth's idea that respect for personal autonomy ought to be the moral centrepiece in sound thinking about the ethical aspects of the provision of health care. Though a liberal society ought to be on its guard against zealous ideologues who want to impose their sense of right and wrong on everyone else, and though there are ideas in this book which should strengthen the liberal counter-arguments, Charlesworth's commitment to respect for personal autonomy in the political realm seems to me to depend on an unsatisfactory account of its moral value.

1

Charlesworth thinks that the idea of autonomy is 'blindingly' obvious.

*"It simply means that if I am to act in an ethical or moral way, I must choose for myself what I am going to do. I may take advice from others and I may be subject to persuasion and pressure from external sources but, when the chips are down, I must decide and choose for myself. Only then is what I have done imputable to me so that it is my act, and only then am I responsible for it and praiseworthy or blameworthy for it."*¹

As for its political significance:

*"Put briefly, the ideal of a liberal society is based upon the principle of personal liberty, namely that, to the greatest degree possible, people should be free to make their own life-choices and decisions for themselves and that, as a corollary, the state, acting through the law, should as far as possible opt out of the province of personal morality only if a person's acts directly harm other people and prevent or inhibit the exercise of their personal liberty may the state through the law, intervene."*²

Charlesworth works out what he takes to be the consequences of a commitment to the primacy of personal autonomy with respect to four topics in the ethics of health care: end-of-life decisions, beginning-of-life decisions, reproductive technologies and resource allocation. In summary, he argues that we ought to be free to choose to die when we judge

that our continued survival is humanly pointless or that the quality of our future life is likely to be zero; that we ought to be free to decide for someone else (a disabled newborn child, someone who is comatose, someone in a persistently vegetative state) that his or her future quality of life is likely to be so minimal that medical treatment should be withheld or withdrawn; that women ought to be just as free to make decisions about the new and different modes of giving birth and forming families made possible by contemporary technological and contractual modes of reproduction as they currently are to use abortifacient and contraceptive technologies; and that there ought to be severe limits to the processes of (utilitarian, cost-benefit) bureaucratic planning in health care since such planning pays little regard to enhancing patient choice and professional autonomy.

2

Let me say what I admire in the book. The chapter on resource allocation is one of the best I have read on this difficult subject. In my experience there is no issue (or set of issues) on which clinicians are more keen for help from philosophers than that of justice in the allocation of resources. Though sometimes there is the hint of professional rivalry in these requests (the resources available for HIV medicine are a favourite target of such rivalry), there is none the less a widely-expressed hope that academic moral philosophy might be able to throw light on what constitutes individual and communal justice in the provision of health care at a time when even in well-off societies everyone cannot have all the health care he or she needs (let alone wants).

Here Charlesworth is at his best. He shows how complex the ethical issues are. He shows how the decisions to be made arise at different levels (from the level of policymakers and bureaucrats allocating funds to (say) defence and education as well as to health care, through the level of hospital administrators dividing up a budget between competing departments, to the level of directors of clinical units deciding which categories of patients to treat and which treatments to offer, and finally to the level of an individual practitioner deciding how to care for

a particular patient). He shows how the ethical issues often differ from one level to another (for instance, government bureaucrats have to decide whether infertility is a disability and, if it is, how serious a disability is it; the director of an neo-natal intensive care unit has to decide how future quality of life considerations enter into his understanding of what it is to respect the sanctity of human life). Claiming that the simplifications and shallowness of utilitarianism infect the work of health care economists, Charlesworth argues persuasively that large-scale bureaucratic decision-making about the efficient distribution of resources according to cost-benefit analyses - as in Oregon for example - simply neglects most of the ethical values at stake in health care.

3

Of course, the idea that respect for personal autonomy is critical to the provision of good health care is not new. When, in the Christian tradition the question was first asked: "What are the circumstances in which life-prolonging treatment may be legitimately refused?", it was asked against a background assumption that individuals have the responsibility to decide this wisely for themselves. This assumption is embedded in two more basic thoughts: first, that health is a human good, an aspect of one's flourishing, the pursuit of which is the responsibility of each individual; and second that since the extent to which a person can afford to cultivate or restore her health depends on her other commitments - and juggling these is a matter for her - health care decisions must ultimately lie with her.³

Nevertheless, even if the idea is not new, there are often good reasons for reasserting something which is already known but not sufficiently adverted to. Doctors and other professionals do sometimes pay insufficient attention to the fact that the person who trustfully seeks their advice and skill is (or ought to be) the real decision-maker about his or her own treatment and care. Charlesworth's book is a useful reminder of the moral fact that the patient himself or herself is the source of the right to treat.

4

However, I have two criticisms of Charlesworth's commitment to the primacy of respect for autonomy. First, I think it leads him into over-simplifying some issues. Secondly I think it commits him to a reductive account of the value of a human being, an account which treats as morally-central something which is no more than one expression of human value. Let me exemplify each criticism. First the over-simplifications.

In a discussion of the Rummelink Commission's report on euthanasia and assisted suicide in the Netherlands, Charlesworth concludes that it " ... is not at all evident that a policy of preserving human life at all costs, against the wishes of patients and over-riding their autonomy, testifies to community respect for the sanctity of human life". Given the medical profession's contemporary ability to keep people alive in circumstances in which most of us would not want to be kept alive and its sometimes-uncritical acceptance of an imperative to prolong life at any cost (together with the not-infrequent occurrence of doctors being threatened with legal action if "everything is not done for Mum"), Charlesworth's insistence on respect for autonomy has practical point. But the only social choice is not (as he implies) between legalizing euthanasia and assisted suicide on the one hand and preserving life at all costs on the other. We can also choose between legalizing euthanasia and assisted suicide on the one hand and (re)educating the community - patients, physicians, family members, significant others - about the goals internal to the practice of medicine (curing illness, stabilizing a reasonably satisfactory condition, relieving pain and other symptoms of illness) and thus of the appropriateness in certain circumstances of forgoing (for oneself or on behalf of another) life-prolonging treatments. If euthanasia and assisted suicide are to be legalized, it ought not to be on the grounds that that is the only way of avoiding a policy of 'preserving life at all costs in all circumstances'.

My second criticism of the view that respect for personal autonomy ought to be primary in our thinking about health care is that it distorts

what we really value about human life. Think of Anthony Bland, the young man whose lungs were crushed in the Hillsborough Football Stadium and who lay for four years in the Airedale General Hospital in a 'persistently vegetative state'. Think of a four month old foetus who is diagnosed with a nine in ten chance of contracting an earlier-onset genetic disease such as Thalassaemia Minor (or a one in ten chance contracting a late-onset genetic disease such as Huntington's Chorea). Think of Mrs Whitaker, the lady who had lived for forty years with an unsightly and injured eye whose doctor did not warn her of the remote risk that if she had surgery to improve her injured eye she might lose the sight in her good eye. Each presents us with difficult care and treatment choices. But I challenge the idea that the concept of respect for personal autonomy can throw much light on any of these cases. In brief, it cannot clarify how we stand in relation to other human beings, what our responsibilities to them as fellow human beings are, what our responses to them ought to be.

There is no doubt that wise decisions about the care and treatment of each of these individuals will involve acknowledgment of their being the kind of creature which has the capacity to be self-directed and whose well-being requires realization of that capacity. And so, it was right for Anthony Bland's doctors to be cautious about withdrawing life-supporting treatment from him in the absence of his deciding to forgo it himself, and right for the Courts to put so much store by what Anthony Bland's parents could say about what treatment *he would have wanted* had he been able to decide for himself. Similarly, decisions about treating foetuses with genetic abnormalities are uniquely difficult just because they have to be made in respect of human individuals who have not (yet) acquired the capacity for autonomous choice.

None the less the concept of respect for personal autonomy cannot structure (even in summary form) our moral responses to these individuals. Anthony Bland is no longer autonomous in any way at all, and yet he is still a fellow human being, one who we know can be treated in an undignified and disrespectful way whatever we think about whether his life should continue to be prolonged. The four

month old foetus who is diagnosed with a severe genetic disorder is not yet an autonomous being in any way at all, and yet can be recognized as our fellow, a member of the human community, an individual whose preciousness can be cherished whatever we think about whether his or her life must be prolonged by burdensome medical interventions. As for Mrs Whitaker. In not warning her of the remote risk that something disastrous might happen to her good eye if her bad eye were operated on, in not responding to her evident and deep anxiety about her good eye, her doctor failed to keep faith with the trust that she put in him as her doctor. What was wrong with his failure to disclose that risk to her can hardly be understood if it is thought of (primarily) as a failure to respect her autonomy. At heart, it was a failure to respond to her as an individual human being with her own priorities, hopes, anxieties, values, an individual who was not prepared to risk the sight in her one good eye. To think of the doctor's failure to disclose that risk primarily as a failure to respect her autonomy ignores everything else about her as a human being that gives point to respecting her autonomy.

Whatever view one has of the value of personal autonomy (whether it is a broadly Aristotelian one according to which it is one of the marks of moral maturity or a broadly Kantian one according to which it is the morally-crucial aspect of what is valuable in a rational being) it is not in the light of their being autonomous moral agents that we value human beings. It is not the concept of personal autonomy which illuminates the dignity of a human being. Rather what we value about human beings are all the other things which make it possible for them to be (more or less) autonomous moral agents. Put another way, it is only against a background of ways in which we are united in bonds of fellowship and justice to other human beings that we value them as autonomous beings. We do not cherish their autonomy in isolation from all the other things that it enables in them. We cherish its expression in affection and love, in courage and perseverance, in the pursuit of knowledge and the creation of literature and art, just as we deplore its expression in lack of sympathy or in

(Contd. page 8)

Case Study: Resource Allocation at the Institutional Level

Keith Joseph

Imagine that you are the Chief Executive Officer of a large provincial hospital. Your hospital has recently been introduced to Casemix as a funding and auditing mechanism. One benefit is that you now know the average costs of patients categorised both by medical diagnosis and by treating doctor. You are able to compare the outcomes of similar types of procedures against the average figures across the state and within the hospital. For the last three months you have noticed that one of your Visiting Medical Officers, Dr Jones, tends to keep his patients in for longer, at greater expense, than other Visiting Medical Officers who are treating patients with the same diagnosis.

You are under pressure from the Area Health Board. The Area's budget has been cut yet again, and the Area is running a deficit. If you cannot cut costs you and your Board may be dismissed (as happened three years ago to the Chief Executive Officer of the Royal Newcastle Hospital and the Board of the Hunter Area Health Service.)

Among other measures to save money, you examine the reports on Dr Jones. He is very highly regarded, both by his patients and by other clinicians. He gives freely of himself (and of the hospital resources). As Dr Jones sees it, his responsibility is to provide optimal care for each his patients. He will pursue any treatment or diagnostic option that will provide even a marginal benefit for a patient: a CAT scan, an extra night in hospital, his own time. As most of his patients are public patients, the hospital receives little or no additional funding for providing these services.

In total, these excess services are costing about \$160,000 per year (according to the figures in your Casemix reports) but are providing only

marginal benefits to these patients. If any other doctor were providing these services, the hospital would be saved about \$160,000. But Dr Jones resists any attempts by administrators to interfere in his relationship with his patients. As he sees it, his duty is clear: to provide the best possible treatment for his patients and not to act as a gatekeeper of the society's resources.

You are faced with a number of options. You could withdraw his rights as a Visiting Medical Officer and weather the political and community outcry when you are portrayed as interfering in the doctor/patient relationship. You could cut costs elsewhere (by the time-honoured methods of laying off casual nursing staff and closing some beds). You could reduce the number of elective admissions and extend waiting lists for elective surgery. Or you could try to convince Dr Jones that doctors are *de facto* gatekeepers of health care resources, that even a conscientious doctor who recognizes that his prime duty is to the good of his patient (rather than to (say) his own self interest) ought to have some sense of divided loyalties.

Issues for discussion:

- 1 Does a doctor have moral responsibilities other than to his own patients?
- 2 If so, how should considerations of the needs of other patients enter into the determination of proper care for a particular patient?
- 3 Who should make these 'institution-level' decisions about resource allocation?
- 4 How explicitly should one inform a patient that the level of treatment he or she receives is influenced in part by considerations of fairness to others?

Case study on Resource Allocation: First Commentary

Gerald Gleeson

The case involves two seemingly competing points of decision making. Decisions must be taken by Dr Jones and by the Chief Executive Officer (on behalf of the hospital). Both kinds of decisions involve ethical considerations. Dr Jones will be concerned primarily with his responsibilities in *fidelity* to his individual patients. The Chief Executive Officer will be concerned primarily with a *fair and just* allocation of resources. Are these ethical considerations necessarily in competition with each other?

At the level of general principle it is easy enough to reconcile fidelity to the particular patient with justice for all patients. While the Chief Executive Officer's overriding consideration is justice, he or she must allow for sufficient flexibility within the system of the hospital to provide scope for the particular decisions that doctors will take as they tailor their treatment to the particular needs of individuals.

On the other hand, individual doctors like Dr Jones, while primarily concerned with fidelity to their own patients, must recognise that they work within a system or complex of health care provision, a system which has provided for their education and professional registration, and which now provides the community resources which allow them to practice their profession. Accordingly the particular decisions a doctor takes cannot be isolated from consideration of fairness and just allocation.

But how can this twofold responsibility - to fairness and to fidelity - be exercised *in practice*? Must Dr Jones, when deciding whether to order another test for Mrs Smith ask himself: "In ordering this test for Mrs Smith, am I being unfair to Mr Brown and Miss Green?"

I do not think that these two kinds of consideration can or should be brought face to face at the bedside. To say that Dr Jones ought be sensitive to considerations of justice in the

allocation of resources is not to say that Dr Jones must be constantly adjudicating between treatment options among different patients.

Rather, the tension between fidelity and fairness must be adjudicated at a level "higher" than that of the bedside - at the level of the unit, the department, the institute and the facility itself. At these higher levels decisions should be taken after peer review and professional consensus - about the levels of *appropriate* care which the unit, department, institute or facility, can offer to patients, in the light of the numerous constraints (not simply money) under which they work. These levels or standards of appropriate care will be described in terms of criteria reflecting a patient's needs and the anticipated outcomes. For example, at St Vincent's in Sydney, criteria have been set down to determine appropriate levels of treatment for hip replacement, specifically with respect to the quality and life-span of the kind of prosthesis provided.

Given that a facility has agreed standards of appropriate care which respect both justice and fidelity, the Chief Executive Officer is entitled to try to bring someone like Dr Jones to acknowledge that he can and should fulfil his duty of care to his patients *within* a system which - for the sake of justice to all - recognises limits about what is both possible and appropriate. He ought not consider himself to be serving his patients in total isolation from other practitioners, and from the facility itself, in terms of an "abstract" ideal standard of care. As noted already, the facility must allow for flexibility and difference between practitioners. But most importantly, the practitioners themselves must come together and collaborate with administrators in the development of the standards of appropriate care which are just and reasonable in the circumstances. Both the facility and the individual practitioner will then be able to acknowledge openly the kinds and levels of treatment they are able to offer patients.

Case study on Resource Allocation: Second Commentary

John Quilter

There are four points I would like to make on behalf of Dr Jones' perspective in the case before us.

The first is that the aim of health care delivery is the provision of care of a quality appropriate to the *particular patient* with all the idiosyncracies of his healthy condition as best we can ascertain it. Quality of care will certainly decline when we have to keep one eye over our shoulder to watch that we do not spend too much money. All patients are particulars, not just so-called outliers; Casemix funding works on averages which are blind to the peculiarities of patients. Quality of care under Casemix must decline where it matters most - in the individual case.

In his reply to this part of my comments, Professor John Hickie conceded that Casemix requires an average notion for kinds of case, but he argued that studies of Casemix do not show that this fact leads to any decline in quality of care. I have not seen the studies to which he appealed and will acknowledge that if that if they indeed do show this, my criticism of Casemix is weakened. On the other hand, empirical studies may themselves make assumptions about what quality *is* and how it is appropriate to "measure" it, assumptions that may unjustifiably make this conclusion too easy to get. The relevant notion (or notions?) of quality are shot through with ethical assumptions concerning what sort of care is in order, all things considered. We cannot settle such questions by empirical studies which assume what is in contention. But this general point only has force to the extent that the studies in question are vulnerable to this criticism. And as I say, I cannot say anything about that.

However, there is a *prima facie* dilemma in the very notion of pursuing patient-focussed quality care while at the same time conceiving of the patient in terms of the average notions involved in the use of Diagnosis Related Groups and Casemix. The nub of my worry can perhaps be put in the idea that given that the particularity of each patient is central to her

good medical care, every patient is an outlier in and of herself no matter how much she and her medical predicament have in common with other similar patients. It is a bit like what they say about statistics generally: they are like a swim suit - what they reveal is suggestive; but what they conceal is vital. What casemix conceals is that about the patient which makes her this particular case and which she does not share with other, admittedly otherwise-similar patients. One would expect that funding structures should have sensitivity to these non-overlapping medical characteristics of particular patients. Now the Casemix-booster will reply that that is what the notion of an outlier is supposed to do. But if this notion does that as well as we might need, we will all be outliers and Casemix will be a fifth wheel!

Secondly, quality care and the very fiduciary nature of the doctor's relationship with the patient requires confidentiality. Casemix funding requires that information concerning patients and doctors' care of them is under constant scrutiny, and invidious comparisons between professionals will be the natural outcome. This is no good for patients or for the profession. Health care certainly has to be considered a business. But that must be secondary to good care in a context of trust and respect, not self-defence.

Thirdly, people complain that doctors must be gatekeepers of society's health care resources: otherwise health care costs as a proportion of the society's wealth will escalate. They say that the extra money Dr Jones has spent on his patients achieves little marginal benefits for them and could be spent to more good for other patients. But that is a myth with little evidence. There is nothing to guarantee that dollars saved by Dr Jones' not spending the bit extra on his patients will go toward the care of someone else for whom it will do more good. Whether that is the case is more good luck when it happens than good management. Failing better knowledge of who is in need of what and when, all each individual doctor can do is his best by his

patient (subject to ordinary constraints of non-futility, etc). That is all Dr Jones is doing, so far as we know. (The case would be altered if we were to find out, for instance, that Dr Jones had become compulsively defensive in his medical care.)

Finally, good care with the best one can offer the patient makes good self-interested sense. With the patient's rights push (one I endorse, moreover), already high expectations of medicine and developments in the law, doctors are vulnerable if they do not do their best for the patients (again, subject to constraints imposed by reasonable ethical limits on care that are independent of considerations arising from the system of funding). The doctor's situation becomes impossible if he is pushed from another direction to cut the services he provides his patients for the sake of cost control. The doctor is damned if he does and damned if he does not. Something has to give. And I say that the argument is stronger that this funding system should go.

.....

Respect for Personal Autonomy

(Contd. from p. 4)

brutality, in ways of feeling and acting that are unfaithful or unjust, etc. Indeed, we continue to respect and cherish human beings when they can no longer express their autonomy in their lives or can do so only in a very diminished way - or at least we ought to.

My rejection of the idea that respect for personal autonomy is the fundamental moral value or principle or truth amounts to this: It commits one to a reductive account of the distinctive dignity or preciousness of a human being. It reduces the concept of human individuality to a (shallow) capacity to pursue life in one's own way rather than a (deep) capacity to make oneself into a certain kind of person. It leads one to speak in ways that undermine the common humanity we share

with those whose lives are so diminished that they can (no longer) express themselves in autonomous action. (In a discussion of patients who do not wish to die in circumstances in which they will no longer be autonomous selves or persons in control of their own lives, Charlesworth says, "Biologically they will still be in existence, but as autonomous moral agents or persons they will no longer be there."⁴ But one can accept that there are sound reasons for thinking that we are not obliged to continue to provide life-prolonging treatment to (say) a person who is in a persistently vegetative state without thinking of him or her as a 'non-person'. That reductive thought will surely tempt us to abandon these fellow human beings who are so deeply troubling to us. It will degrade the deep moral questions about how best to care for our non-autonomous fellow human beings into a different set of questions closer to those about our how we ought to care for animals.)

Bioethics in a Liberal Society is a critique of modern practices in the provision of health care in the light of some ideas from contemporary moral and political philosophy. It raises ethical and political questions that deserve philosophical examination, and we owe Max Charlesworth a debt of gratitude for raising those issues in so sharp and challenging a way. In the end, however, I think that if we are to develop good policies in health care, we will need a deeper account of how we stand towards other human beings than one which reduces that relationship primarily to a respect for them as autonomous moral agents.

Notes

¹ Max Charlesworth, *Bioethics in a Liberal Society*, Cambridge University Press, 1993, p 10

² *Bioethics in a Liberal Society*, pp 15-17

³ In his introduction to *The Dependent Elderly: Autonomy, Justice and Quality of Care* (Cambridge University Press, 1992), Luke Gormally notes that the question has been discussed in the Christian tradition since the fifteenth century.

⁴ *Bioethics in a Liberal Society*, p 40

⁵ *Bioethics in a Liberal Society*, p 31

Health outcomes: the right thing for NSW?

Keith Joseph

The first New South Wales Health Outcomes Conference was held on 12-13 August 1994 in Sydney under the auspices of the NSW Department of Health. Nearly seven hundred people attended. The conference was designed to show how the concept of a 'Health Outcome' could be used in New South Wales to achieve a better health care system. It was a well organised conference: participants were given copious notes together with a handsome volume containing the programme and abstracts.

In the abstract of his talk "Health outcomes as guides for health policy", Professor Stephen Leeder explained the concept of 'health outcomes' in the following way:

"the measured or estimated consequences of health care interventions with special emphasis on changes in health status that follow from such interventions".

However, it became clear at the conference that the concept of health outcomes is used in a variety of ways. For health care administrators it is a tool to be used in allocating resources where they can achieve most effectiveness. For medical practitioners, it is a way of measuring the effectiveness of health interventions. For the representative of consumer groups, health outcomes can be used to compare the quality of different doctors and hospitals, and thus to enable better customer choice.

Given that most of the speakers were either administrators, medical practitioners or health economists, the focus of the conference was very specific. The main focus of the conference was on health outcomes as a way of effectively allocating health care resources to achieve the

most efficient use of resources - as it were, the greatest amount of health care for the taxpayers' dollars. Though so specific a focus is understandable, it does raise ethical concerns.

Ethical Considerations

There are three basic ethical considerations which are relevant to the distribution of health care: quality, efficiency, and justice. All patients should receive the best possible health care ('quality'). That health care should be provided in the manner which makes best use of available resources ('efficiency'). As for considerations of 'justice': these include 'equity of access', 'equity of outcome' and 'social justice'.

All members of the community should have equal access to health care ('equity of access'). All persons suffering from similar conditions, and otherwise similar, should have a similar outcome ('equity of outcome'). Finally, health care is but one social good. Social resources should be distributed in a just manner so as to ensure, for example, that all members of the community have equal opportunity to reach their full potential. And since there are many determinants of health which are unrelated to health care (such as education and socio-economic status), all these resources ought to be distributed in fair manner ('social justice').

The ideal, of course, is to have all three basic ethical considerations satisfied: that is, quality, efficiency and justice. Often, however, this is simply not possible. An obvious example is that of a small country hospital. It will never achieve the efficiency of a large city hospital: it simply cannot achieve economies of scale. It will probably not achieve the quality of care of a large hospital, in so far as it lacks access to specialist services. Nevertheless, for reasons to do with equity, it is very important to retain

such hospitals. They provide equity of access to health care for their own rural communities. They undoubtedly also serve other important social functions which are not, strictly speaking, part of the role of a health care facility (such as being a focus for community activities and providing health education).

Thus one would argue that we need to retain such small rural hospitals on grounds of justice even though they are relatively inefficient. However, if too much emphasis is laid on the efficiency with which certain health outcomes are achieved, the future of such country hospitals is at risk. What this shows is that efficiency in the provision of services should not be the only criterion for allocating resources.

Another aspect of concern in this debate is the concentration on the outcomes of health (and, in particular, hospital) care as a measure of the success of health interventions. Health care is only one contributor to the health of a nation. There are other crucial factors - the provision of clean water, good nutrition, and good standards of education - which have a significant impact on health. Such public health measures, which are so crucial to health outcomes, are often marginalised in discussion which focuses on the provision of hospital services.

Conclusion

There are several potential problems in the current emphasis on clarifying the outcomes of health care. The first is that the discussion may focus too narrowly on acute health care, as represented by hospitals and sophisticated interventions. Areas such as palliative care, community health, mental health, and public health, which often lack both political push and easily quantifiable outcomes, could end up being further marginalised. Given that the aim of the project to identify the outcomes of health care is to improve the health status of the community as a whole, then neglect of these sectors, especially public health, would be quite counterproductive.

Associated with this narrowness of focus on acute health care is a narrowness of focus on efficiency and cost-effectiveness in the allocation of health care resources. Certainly cost-effectiveness should be one of the considerations in the allocation of health care resources. However, other considerations which are not as easily quantifiable as efficiency, such as quality of health care and justice in the allocation of resources, also need to be taken into account in a significant way. It is not at all clear that the current interest in identifying the outcomes of health care can do this.

On legalizing euthanasia: a note on *Euthanasia, Clinical Practice and the Law*¹

Bernadette Tobin

A Select Committee of the English House of Lords was recently asked to consider the justifiability of conduct intended to end the lives of patients, and the consequences of legalizing such conduct. In January this year, the Select Committee, in a report to the House of Lords, rejected the idea that euthanasia should be legalized on the grounds that the prohibition on intentional killing of human beings is the cornerstone of law and social relationships.

In the course of its deliberations, the Select Committee called for submissions from the public. Over 150 submissions - from individuals

and institutions - were received. One such submission was from the Linacre Centre in London. That submission has now been published in a volume entitled *Euthanasia, Clinical Practice and the Law*.

Euthanasia, Clinical Practice and the Law is divided into two main parts (called 'books'). The first book consists in the re-publication of a report first published in 1982 by the Centre which has been out of print for several years now. That report was entitled 'Euthanasia and clinical practice: trends, principles and alternatives'. It focussed on the ethics of

euthanasia *in the clinical situation*, that is, on questions about what is the right thing to do as these questions arise for patients and for clinicians in the context of medical care.

The second book brings together several pieces which address some of the questions posed by proposals to *legalize* the practice of euthanasia. The first piece is the submission made by the Linacre Centre to the House of Lords Select Committee on Medical Ethics. The second is a paper by Professor John Finnis of the University of Oxford on Living Will Legislation. The third is an analysis by Mr Luke Gormally (Director of the Linacre Centre) of the case against the legalization of euthanasia which was made in the 1988 Working Party Report on Euthanasia prepared on behalf of the British Medical Association. The fourth contribution is made up of two papers by Mr John Keown of the University of Cambridge which critically analyse the Dutch experience of euthanasia.

Today there is much discussion of whether it would be desirable to accommodate the practice of euthanasia either by statute or by judicial decision. Those who believe that such accommodation would be desirable need to confront the contrary case: that euthanasia is incompatible with a true recognition of human dignity and that it is deeply corrosive of the authentic character of medical practice. I can think of no better account of that case than that which is cumulatively presented in this volume. I recommend the book to anyone interested in deepening his or her understanding of what is at stake in the debate about the legalization of euthanasia. But there is much more in the book than this.

There is, for instance, John Finnis' analysis of the common paradigm of advance directives

(either a 'living will' or an 'enduring power of attorney') by which individuals express their wishes as to their future health care and/or as to future decisions by others about that health care. Finnis argues (*inter alia*) that the Victorian Medical Treatment Acts of 1988/9 (along with legislation in most states in the United States) fail to distinguish the refusal of burdensome or futile treatment to avoid its burdensomeness or futility and the refusal of treatment in order to secure relief from distress and despair by hastening death. The legislation, he argues, is thus 'likely to have the "educative" effect of undermining public consciousness of the significance of intention in the context of suicide, homicide and, on the other hand, of upright and reasonable refusal of burdensome or futile treatment.'

There is also John Keown's careful analysis of the Dutch experience of euthanasia (where doctors who practice euthanasia will not be prosecuted if it is carried according to certain criteria: that the request for euthanasia come from the patient and be free and voluntary, that the patient be experiencing intolerable suffering with no prospect of improvement, that euthanasia be a last resort, that it be performed by a physician, that the physician consult with an independent colleague who has had experience in this field). This study is important because Holland is often held up as a sensible and safe model for other countries to follow in the effort to give a sound ethical and legal basis for humane 'end-of-life' decisions. Keown argues that the criteria are so vague, the discretion of the doctor so wide and the reporting procedures so ineffective that the Dutch experience really illustrates the far reaching and serious dangers of a society's tolerating euthanasia.

¹ Luke Gormally (ed) *Euthanasia, Clinical Practise and the Law*, The Linacre Centre for Health Care Ethics, London, 1994

**International Theological Symposium
Beyond Mere Health: Theology & Health Care in a Secular Society
Queen's College, University of Melbourne
Friday 30 June - Wednesday 5 July, 1995**

This Symposium is organised by the Australian Theological Foundation. The Keynote speaker will be Professor Stanley Hauerwas, Duke University, Durham, USA.

For further information contact:
Mr Hilary Regan,
31a Robert Street
Croydon SA 5008
Phone/Fax 08 340 3060

NOTEBOOK

First students enrol in Master of Arts in Applied Ethics Health Care

The first students to undertake a Master of Arts in Applied Ethics (Health Care) in the New South Wales division of Australian Catholic University began their studies last month. The first two units being offered in 1994 are "Research Methods and Critical Thinking" and "Religion and Ethics in a Pluralist Society". "Ethical Decision-Making" will be offered in the first semester next year and "Ethical Aspects of Health Care Practices" will be offered in the second semester. Courses are taught at campuses of Australian Catholic University (either North Sydney or Strathfield) or on the Darlinghurst campus of St Vincent's Hospital.

Anyone interested in this fee-paying course should contact Dr Robert Gascoigne, Head of the School of Theology and Philosophy at Australian Catholic University on (02) 739 2193.

Intensive Bioethics Course

The second annual Intensive Bioethics Course is provisionally planned to take place on the weekend of 21-23 April at St Patrick's College, Manly. The weekend will provide a general introduction to ethical, theological, legal and economic aspects of health care. Further details will be provided in the next issue of *Bioethics Outlook*.

Advanced Bioethics Course

The first Advanced Bioethics Course to be run by the John Plunkett Centre is provisionally planned to take place on the weekend of 15-17 September at St Patrick's College, Manly. The topic for study during this weekend will be: *The contribution of Christian moral theology to contemporary bioethics*.

Centre News

We welcome Dr Martin Kelly, MSC, who has joined us at the Centre. Dr Kelly will be here for half a day each week until the end of the year and for a day a week next year. Dr Kelly, a surgeon by training, is currently studying philosophy at Macquarie University and theology at St Paul's Seminary where he is a novice with the Missionaries of the Sacred Heart.

Dr Gerald Gleeson is on study leave from September 1994 until January 1995. Mr John Quilter will be on study leave in the first semester of 1995.

Dr Bernadette Tobin has been appointed to the Australian Health Ethics Committee, a principal committee of the National Health and Medical Research Council. The appointment is for three years.

Seminars

The Centre for Health Law, Ethics and Policy at the University of Newcastle is hosting a visit by Dr Eric Juengst, formerly chief of the Ethical, Legal and Social Implications Branch of the US National Centre for Human Genome Research. Dr Juengst will give a public lecture on the evening of Thursday October 13 and lead a workshop on the morning of Friday October 14.

The Australian Association for Professional and Applied Ethics (AAPAE) is holding an afternoon seminar on "Codes of Ethics: Do they work?" at the St James Ethics Centre on Saturday 15 October. Speakers include Professor Seamus Miller, Charles Sturt University, and Dr Simon Longstaff, St James Ethics Centre.

For further details of these seminars contact Keith Joseph on (02) 361 2869 or (049) 21 5186.

Bioethics Outlook is a quarterly publication of the John Plunkett Centre for Ethics in Health Care, a Research Centre of Australian Catholic University and St Vincent's Hospital, Sydney.

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